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Intimate partner violence against women

Foundation for prevention and for an educational
programme for new couples in an Iranian city.

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ABSTRACT

Understanding how community members conceive the occurrence and prevention of intimate partner violence against women (IPVAW) can help set the stage for context-relevant and sustainable preventive interventions, including educational programmes. The studies forming this thesis are part of such an assessment and concern community members in the city of Kermashah (Iran). They aim to gather the opinions of various stakeholders to better understand the social conceptions about causes and means of prevention of IPVAW.

A survey was conducted among a convenience sample of married women (face-to-face interviewed; n=435) and men (self-administration; n=447) using a questionnaire mainly composed of closed questions. Questions were asked about the risk factors, consequences and means of prevention of IPVAW. Thereafter, other community members were individually interviewed, including key informants (n=23), gatekeepers (instructors of premarital education centres and their supervisors ; n= 8) and husbands-and wives-to-be (n=22). Focus was then placed on preventive issues and a qualitative approach was used.

Married women were in agreement with most of the potential causes and triggers of IPVAW already documented in the scientific literature and raised in public health settings. Married men had split opinions that clustered into four main patterns. Men who expressed opinions very similar to those of women constituted the biggest group (about 33%) and three other groups either disagreed or had mixed opinions. As a potential trigger of IPVAW, behaviour by wives with the potential to humiliate a husband in front of other people was ranked highly among both men and women. This, combined with a tendency for other stakeholders to put the blame on the victim (see below), constitutes a source of concern and requires further intervention.

There was considerable agreement among married men and women that life skills training and raising awareness could help to prevent IPVAW. Even among key informants, community education about relationship issues was often mentioned, although counter-measures at various levels were also put forward (individual, relational, community and societal). A tendency towards “victim blaming” was observed among some key informants.

Almost all husbands-to-be, wives-to-be and gatekeepers believed that premarital education could help to prevent IPVAW but none of the education centre supervisors did. Suggestions for the course curriculum dealt with skills training rather than raising awareness.

In conclusion, strong agreement on the effectiveness of educational programmes in general and premarital educational programmes in particular is a good sign of the potential acceptance of such programmes in the target community. Educational programmes in the field of IPVAW should focus on mutual responsibilities with more emphasis on the perpetrator developing non-violent problem-solving skills and an overall campaign against victim-blaming attitudes.

Key words: primary prevention, premarital educational programmes, victim blaming

LIST OF PUBLICATIONS

This thesis is based on the following papers, which are referred to, in roman numerals as follows:

- I. Hamzeh B, Garousi Farshi M, Laflamme L. Opinions of married women about potential causes and triggers of intimate partner violence against women. A cross-sectional investigation in an Iranian city. *BMC Public Health*; 2008 8: 209. (available on the internet at <http://www.biomedcentral.com/qc/1471-2458/8/209>)
- II. Hamzeh B, Garousi Farshi M, Laflamme L. Opinions about potential causes and triggers of intimate partner violence against women. A population-based study among married men from Kermanshah City, Iran. *Int J Inj Contr Saf Promot*; 2008: 15(4): 253-263.
- III. Hamzeh B, Garousi Farshi M, Vaez M, Laflamme L. A social assessment of representations concerning the prevention of intimate partner violence against women: opinions of married people and of key informants in an Iranian city.
- IV. Hamzeh B, Garousi Farshi M, Laflamme L. The potential of premarital education as a means of prevention of intimate partner violence against women: opinions of husbands- and wives-to-be and gatekeepers in an Iranian city.

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LIST OF ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
DHCK	District Health Center of Kermanshah
HAC	Hierarchical Ascendant Classification
IPVAW	Intimate Partner Violence Against Women
SPAD	Statistical Package for Augmented Design
SPSS	Statistical Package for the Social Science
TA	Thesis Author
WHO	World Health Organization

1 INTRODUCTION

Intimate partner violence against women (IPVAW) is highly prevalent around the world. The violence mostly occurs behind doors, hidden from public view. Most of the time, victims don't say anything to others. Love, dependency, fear of reprisal, the future of their children and similar causes keeps them silent. Society remains uninformed of the magnitude of the problem because of this silence. When, on the contrary, women decide to talk about the problem, they may feel that other people do not react appropriately: people do not seem to regard this as a big problem or consider it should be solved as a private matter. It is not unlikely that the violence will continue and escape is not possible for the victims whose pain and sadness are not measurable.

The individual, relational and community consequences of IPVAW are profound and prevention in many forms is imperative.

In Iran, the public health sector lacks any intervention programmes for the prevention of IPVAW. Working in the public health system for many years made me aware of the various potential avenues of intervention in this field. To prevent IPVAW, participation may be necessary from many community sectors. In that respect, trying to have a prevention programme in the public health system could be a step forward because the public health sector may have a determinant role to play as an initiator and promoter of various programmes.

This thesis, composed of various social assessments in Kermanshah City in Iran, represents an attempt to gather the opinions of various stakeholders to better understand the social conceptions about causes, consequences and means of prevention of IPVAW. This, in turn will serve as a basis for the intervention that would be developed later on. The ultimate goal of the work conducted is to lay the groundwork for a preventive educational programme targeting couples-to-be before marriage so as to prevent the occurrence of IPVAW in the home.

2 BACKGROUND

Violence has been investigated by many academic disciplines e.g., sociology, psychology, and criminology. Criminal policies are often the most visible part of public policies to reduce the rate of violence ⁽¹⁾. In recent years, it has come to be regarded as a public health issue because it affects population health, and dealing with it provides benefit for a large number of people by preventing health problems and an extension of safety to the entire population. Since the public health approach is science-based and uses knowledge acquired by any involved sector and also emphasizes collective actions, it has the opportunity to be innovative and responsive to health problems including violence. Epidemiologic and preventive actions by the public health sector offer a broader response than focusing only on punishment by the justice system ^(1,2)

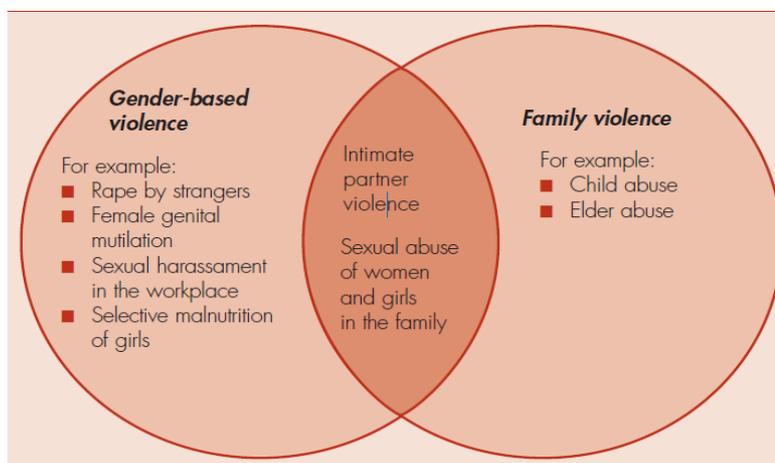
IPVAW is the most common but most disregarded form of VAW ⁽³⁾. People of every ethnicity, culture, socioeconomic class, education, income, and age are exposed to IPVAW. No society can claim to be free of this kind of violence; the only variation is in the patterns of violence in different regions ⁽²⁾. Over the last three decades more attention has been drawn to IPVAW. Its high prevalence and consequences have been shown by many studies and IPVAW has been recognized as an important public health issue around the world ⁽⁴⁾. Despite the great magnitude of the problem and the wide-ranging consequences, intervention programmes remain scarce in low and middle income countries and in many areas it is still considered as a private matter ⁽⁵⁾.

A majority of the actions being taken in all parts of the globe aim at minimizing the consequences of the violence perpetrated by protecting the affected people or penalizing and offering treatment to the offenders ^(4,6-13). For their part, primary prevention measures that address the onset of IPVAW by decreasing its acceptance or reducing its use are relatively uncommon ⁽¹⁴⁻¹⁷⁾.

2.1 DEFINITIONS

As cultures, religions and norms vary around the world, so do the conceptions and definitions about what is to be regarded as violence: there is no globally accepted definition ⁽¹⁸⁾. The World Health Organization (WHO) has defined violence as: “The intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment or deprivation” ^(2; p.5). Intentionality is an important element of violent actions in this definition and violence is divided into three main categories including: self-directed, interpersonal, and collective violence. A subdivision of interpersonal violence is family violence which in turn includes child, partner, and elder abuse ^(2,19). Partner violence includes IPVAW which is also a part of gender-based violence because it mainly occurs due to female subordination in society ⁽¹⁹⁾. The conceptual overlap between family violence and gender-based violence (violence against women) is illustrated in Figure 1 ⁽¹⁹⁾.

Figure 1. The overlap between family violence and gender-based violence from “Researching Violence Against Women: A Practical Guide for Researchers and Activists.” (19)



Violence against women in turn has been defined by the United Nations Declaration on the Elimination of Violence against Women as: "any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life" (20). Harm is the core of the definition, although being gender-based this may somehow represent intentionality. According to the U.S. Centers for Disease Control intimate partner violence is physical, sexual, or psychological harm by a current or former partner or spouse and can occur among heterosexual or same-sex couples and does not require sexual intimacy. It can vary in frequency and severity and occurs on a continuum, ranging from one blow that may or may not impact the victim to chronic, severe battering (21). Regarding the definitions mentioned above, IPVAW could be defined as a part of the violence against women perpetrated intentionally by an intimate male partner. In many studies, it has been mentioned that IPVAW has been defined by the WHO as: "the range of sexually, psychologically and physically coercive acts used against adult and adolescent women by current or former male intimate partners" (22,23,24,25,26,27,28,29,30).

2.2 MAGNITUDE OF THE PROBLEM

Although population-based studies of the prevalence of IPVAW with representative samples were new in low and middle income countries in the 1990s (3), WHO in their World Report on Violence and Health (2002) reported that a review of surveys from all parts of the globe shows that from 10% to 69% of all women have been assaulted physically by an intimate male partner at least once in their lives (6). During recent years, there has been an increasing concern in low and middle income countries to study IPVAW. These studies are often the results of interviews and surveys. Data is collected about life-time prevalence as well as the past 12 months. For instance some studies with various settings in different countries are shown in Table 1.

Table 1. Prevalence of physical IPVAW reported in some studies conducted in some low and middle income countries during the past decade.

Country	Sample size		Proportion of women abused by a partner	
	Women	Men	During the previous 12 months %	Ever %
Albania ⁽³¹⁾	1039		37.0	
Ethiopia ⁽³²⁾	384		30.2	52.6
Vietnam ⁽³³⁾	883		8.3	30.9
India ⁽³⁴⁾	2000 ^a			47.6 ^b
Pakistan ⁽³⁵⁾	300			44
Iran ^(36, 37)	2400		15.0	
	386			31.9
Nigeria ⁽³⁸⁾		600		64.4
Nigeria ⁽³⁹⁾	217		23.5	
		214	42.5	
China ⁽⁴⁰⁾	1665			37
		1658		31

^a pregnant women

^b at sometimes during pregnancy

It must be reemphasized that these studies have different definitions of violence, different methods and sampling frames which make it difficult to compare the results of different studies. The WHO Multi-country Study on Women's Health and Domestic Violence against Women, conducted on 24 000 women from 15 sites in 10 countries, is an attempt to address this problem. According to The WHO Multi-country Study on Physical Abuse of Women by their Partners in Bangladesh, Brazil, Ethiopia, Japan, Namibia, Peru, Samoa, Serbia and Montenegro, Thailand, and the United Republic of Tanzania, this varies from 13% in Japan to 61% in Peru ⁽⁴¹⁾.

Again, taken as a whole, the data indicate that violence against women by their partners is significant and occurs worldwide ⁽⁴²⁾.

2.3 THEORIES OF CAUSATION

There are many theories for the occurrence of IPVAW but no one theory is universally accepted. The theories based on two individual and Socio-cultural domains have been widely used in the literature ⁽⁴³⁾.

2.3.1 Individual theories

There are three individual theories widely referred to in the literature on IPVAW:

- *The social learning theory* focuses on childhood period learning from parents' and peers' relationship and witnessing or experiencing physical abuse as potential causes of violence in future family in adulthood ^(43, 44);
- *The Background/situational model*. In this model, expanded on social learning theory, individual, societal, and historical elements as background factors

interact with situational factors which precipitate the occurrence of violence (e.g., alcohol consumption may lead to IPVAV ^(43,45);

- *Personality/typology theories*. These theories try to relate the occurrence of IPVAV to psychopathology and the personality characteristics of individuals. ^(43,46)

2.3.2 Sociocultural theories

The following sociocultural theories have been widely used in the literature on IPVAV:

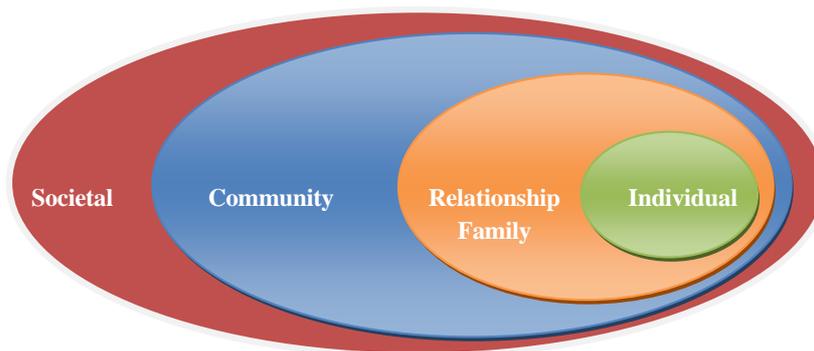
- *Feminist theory*. This theory focuses on gender inequality and women's subordination in society as the root cause of IPVAV ^(43,47);
- *Power theory*. According to this theory interaction among gender inequality, social acceptance of violence and family conflict result in intimate partner violence. This theory suggests that power imbalances in the family may result in greater conflict and subsequently violence ^(43,48).

2.3.3 The ecological model

IPVAV does not result from a single risk factor and it is a multifaceted problem ^(3,6).

Usually, the tendency of researchers to use single factor theories, a small study area, and also small samples make it difficult to understand that the phenomenon of IPVAV is the result of interactions among several factors and little is known about the relevant interactions between social and individual factors ^(1,49). The ecological model (Figure 2) tries to show the interplay among potential risk factors of IPVAV in multiple domains ^(2,4,50,51).

Figure 2. The ecological model – showing interactions between individual, relationship, community, and societal factors which may lead to IPVAV.



The ecological model is widely used in public health and shows different domains with a potential risk factor for IPVAV from the innermost to the outermost circle respectively individual, relationship, community and societal factors facilitating the conditions for the occurrence of IPVAV. The approach stresses the importance of taking into account the global context of the occurrence of IPVAV in order to better

understand why it occurs and – perhaps more importantly – how preventive efforts can be tailored to different groups.

2.3.4 Potential causes and triggers

Following the classification of the ecological model, documented potential risk factors of IPVAV could be listed as follows:

- *Individual factors:* young age ^(6, 52 - 54), heavy drinking ^(6, 40 - 58), substance abuse ⁽⁵⁸⁾, depression ^(6, 59), personality disorders ^(6, 60), low academic achievement ^(6, 33, 58, 61 - 65.), low income ^(6, 33, 34, 65 - 67), witnessing or experiencing violence as a child ^(6, 57, 68, 69), and boy child preference ⁽⁴⁹⁾;
- *Relationship factors:* marital conflict ^(6, 49, 56), marital instability ⁽⁶⁾, male dominance in the family ^(6, 70), dowry harassment ^(57, 58, 61, 69), economic stress ^(6, 69), poor family functioning and lack of spousal communication ^(6, 61, 69), age differences between the partners ⁽⁷¹⁾, and unsatisfying sexual relationship ⁽⁷²⁾;
- *Community factors:* weak community sanctions against domestic violence ⁽⁶⁾, poverty ^(6, 61), and low social capital ⁽⁶⁾;
- *Societal factors:* traditional gender norms ⁽⁶⁾, and social norms supportive of violence ⁽⁶⁾.

There are also the events that act as triggers. Underlying factors, mentioned above, are primary determinants of abuse whereas precipitating factors are the triggers which lead to immediate violent outbursts ⁽⁷³⁾. Some potential triggers are as follows:

Not obeying the man ⁽⁶⁾, arguing back ⁽⁶⁾, not having food ready on time ⁽⁶⁾, not caring adequately for the children or home ^(6, 69), questioning the man about money or girlfriends ^(6, 69), going somewhere without the man's permission ⁽⁶⁾, refusing the man sex ⁽⁶⁾, and the man suspecting the woman of infidelity ^(6, 58).

2.4 CONSEQUENCES

IPVAW affects not only the life of the victims in its entirety but also that of their fetuses and children. It is associated with a range of immediate and long-term negative health consequences ^(6, 42, 74 - 83), e.g., physical, psychological, sexual and reproductive. Frequently mentioned consequences are listed below.

- *Physical health* – injury, bruises and welts, gastrointestinal illness, chronic pain syndromes, partial or permanent disability, ocular damage, fractures, lacerations, and reduced physical functioning.
- *Sexual and reproductive health* – gynaecological problems, pelvic inflammatory disease, sexual dysfunction, unwanted pregnancy, sexually transmitted infections, AIDS, and pregnancy problems (e.g., low weight gain, anaemia, first and second trimester bleeding and preterm labour).
- *Psychological health* – stress-related problems, multiple personality disorders, obsessive compulsive disorder, emotional distress, eating disorders, reduction

of women's self-esteem and their ability to care for themselves and their families, alcohol drug abuse, suicidal thoughts, and suicidal attempts. Also, witnessing IPVAV during childhood may result in many psychological and social problems during life.

2.5 PREVENTION

2.5.1 Types of prevention

The public health approach to prevention considers three different types, including primary, secondary and tertiary preventions^(17, 42). In the case of IPVAV, *primary prevention* addresses causal factors and exposure level and the counter-measures often stated relate to changes in norms and acceptance level of the occurrence/perpetration of IPVAV, by the victim/perpetrator in particular and the society in general. Therefore, population based educational programmes are put forward in order to affect social norms and individual behaviours^(15 - 17) and so are programmes addressing partners, influencing close personal relationships and working to create healthy family environments^(3, 42). *Secondary prevention* comes into play when violence has occurred and offers various forms of immediate responses, including but not limited to urgent medical care of the victim. It focuses on people who are at a higher risk of violence^(3, 17, 42). *Tertiary prevention* for its part aims to prevent disabilities due to violence and offers long-term care to the people affected^(17, 42).

A majority of actions taken in response to IPVAV in all parts of the world are of a secondary and tertiary prevention nature, that is *post facto*^(14 - 17, 42, 69). For the victims, shelters are set up that provide them with counselling, job training, and legal and treatment assistance. Police stations with all-women staff have also been established to provide more support for victims. There are also screening programmes in health services that provide (suspected) victims with appropriate support such as treatment or referrals. Criminalization on the other hand is a common manner of dealing with the perpetrators in many countries. Complementary – or alternative – approaches include life skills training programmes of various context and duration^(4, 6 - 12).

It is understandable that providing medical care for the victims, building shelters and reaction to the perpetration of violence have priority but dealing with the secondary and tertiary prevention is only the tip of the iceberg⁽⁴²⁾ and addressing the remote determinants of IPVAV is essential in order to counteract its offset. Nonetheless, primary prevention measures that deter the development of IPVAV by lowering its acceptance or reducing its use (in various forms) are relatively uncommon^(14 - 17, 42, 69).

2.5.2 The special cases of public education and premarital education

Among primary prevention counter-measures, there are some that include population-based educational programmes aiming at influencing both social norms and individual behaviours which may play an important role, if not alone as part of multifaceted intervention programmes^(6, 15 - 17, 42). This helps to increase public understanding of the undesirability of IPVAV and to lower the social acceptance – or silence. For example, using the mass media and school programmes has shown positive effects on enhanced

public awareness and modified attitudes regarding partner violence⁽⁸⁴⁻⁸⁶⁾. Education in non-violent forms of conflict resolution may also be useful⁽¹⁷⁾. Yet, working on the creation of family environments and relationships between partners free from violence as well as on the promotion of a culture of non-violence in general are crucial components of long-lasting efforts to prevent IPVAW⁽⁴²⁾.

As is the case for many other behaviour patterns, changing a violent one is far more difficult than learning not to use it before behaviour is established^(42, 87). Therefore, educating at an early stage those who are about to share their life under the same roof regarding how one avoids or deals with the onset of violent behaviour is a potentially important element of a successful primary prevention programme at community level. It is known that premarital educational programmes can help in building relationship skills^(88,89). National intervention programmes in the field of premarital education are few; the only one identified thus far being from 1990s where the Australian Federal Government started its National Families Strategy. The main part of this strategy is marriage and relationship education to promote healthy family relationships through early intervention programmes⁽⁹⁰⁾. Something important to remember is that such programmes, when dealing with the prevention of marital conflicts, usually show short-term effects and there is limited evidence for long-term behaviour changes⁽⁸⁹⁾.

2.5.3 Prerequisites for prevention in a public health perspective

The Green model, a comprehensive planning framework [developed in 1991], suggests that the modification of health behaviour according to various community-specific assessments ought to be made prior to an intervention^(91,92). The model has been widely used in health promotion and proposes that health education planning be conceived as a diagnostic approach, starting with the ultimate quality of life goal and ending with a health promotion program. The components of the model help practitioners to plan programmes that exemplify an ecological perspective and incorporate a continuous series of steps in the planning, implementation, and evaluation of those programmes^(91,92). The assessments steps of the model include: social, epidemiological, behavioural and environmental, educational and ecological, and administrative and policy assessments. Thereafter, implementation, process evaluation, impact evaluation, and outcome evaluation will take place^(91,92). Investigating beliefs and motivations regarding IPVAW has also been proposed elsewhere as being useful for the prevention of IPVAW⁽¹⁾. The need for this kind of assessment is what has initiated the studies forming this thesis. In fact, gathering the views of stakeholders about different aspects of IPVAW including causes, consequences and means of prevention helps to acquire a better understanding of the social conceptions about IPVAW and serves as a basis for any population-based intervention that may be developed later on.

2.6 IRAN

2.6.1 Characteristics

The Islamic Republic of Iran is located in the Middle East in Asia (see Figure 3). Its area is over 1.6 million sq km (the seventeenth largest country in the world)⁽⁹³⁾ and it had a population of 73,312,000 in 2008⁽⁹⁴⁾. More than 99% of the population are Muslims⁽⁹³⁾. The population is young and the median age was 24 years in 2005⁽⁹⁴⁾. Iran is a middle income country and the GDP per capita was 10,031 US\$ in 2006⁽⁹⁵⁾. The unemployment rate in urban and rural areas was respectively 13.4 % and 7.1%⁽⁹³⁾. Life expectancy at birth was 70.5 years and adult literacy rate was 84% in 2006^(93, 95).

Figure 3. Location of Iran in world and region map⁽⁹⁶⁾



2.6.2 Public health care system

There are three levels of public health care in Iran: health houses in rural areas, health centres in rural and urban areas, and polyclinics and hospitals in the cities. Health workers, who train for two years, are called Behvarzes and provide the rural population with free health care most of which is to mothers and children under five, e.g. vaccines, contraceptives, and other basic preventive and curative services in health houses^(97, 98). The health houses are supported by the rural health centres. Approximately the same free health care as for the rural population is provided to the urban population by urban health centres⁽⁹⁹⁾. Rural and urban health centres are staffed with physicians and midwives and other health workers. Some particular urban health centres provide premarital health education mainly about sexual issues, family planning and genetic diseases to engaged couples. In Iran, premarital health education is compulsory.

2.6.3 IPVAW in Iran

Like other low and middle income countries, the body of the literature about IPVAW has been growing in Iran in recent years. All studies are city-based. They have mainly investigated prevalence and potential risk factors of IPVAW by self-report of representative or convenience samples of women. Data has been collected about life-

time prevalence as well as the past 12 months. As shown in Table 1 presented earlier, the prevalence is neither the lowest nor the highest in a global perspective ^(36, 37,100-102).

Regarding prevention of IPVAW, as in other parts of the globe, the main focus is on secondary and tertiary prevention. IPVAW is illegal in Iran and the justice system punishes the perpetrators. There are also state-funded victim support services. Although the mass media include many programmes regarding communication skills between husbands and wives, all in all IPVAW remains a criminal justice rather than a public health issue and primary prevention is scarce. There is no prevention programme in the public health system regarding IPVAW.

2.7 SUMMARY OF KNOWLEDGE AND RELEVANCE OF THE RESEARCH

IPVAW is the most common, but most hidden, form of violence against women. It is a global problem, and it is present in all countries and societies. People of every ethnicity and culture, socioeconomic class and education, and income and age are exposed to IPVAW. No society can claim to be free of this violence; the only variation is in the patterns of violence in different regions. Population-based surveys from different parts of the globe show that from 10% to over 69% of women have experienced physical violence by a male partner at least once in their lives. However, it is believed that the majority of the available data are conservative and unreliable.

IPVAW is a multifaceted problem. Individual factors (e.g. low academic achievement and low income), relational factors (e.g. marital conflict and marital instability), and societal factors (e.g. traditional gender norms) can be determinants of IPVAW. The phenomenon has many physical, sexual, and psychological health consequences and all aspects of women's lives may be affected by it.

Prevention and intervention in relation to IPVAW require a community-wide response to individual risk factors, personal relationship, and larger cultural, societal and economic factors at all primary, secondary and tertiary prevention levels. Primary counter-measures include influencing individual and collective norms and behaviours by community education which may play an important role, if not alone as part of multifaceted intervention programmes. Intervention models usually come from high income countries. These models might not be effective, sustainable and feasible in other settings. So, there is a need to gather data about causes and protective factors in different societies.

To our knowledge, little is known about the nature of IPVAW in Iran. A social assessment including investigations concerning what people consider as potential causes of IPVAW in the community and also what they regard as potential means for prevention will contribute to specific contextual analysis to design of appropriate educational programmes.

3 AIM

The overall aim of this thesis is to present a community social diagnosis which lays the foundation for the development of educational programmes and is based on the conceptions and opinions of community members concerning both factors susceptible to lead to the perpetration of IPVAW and potential means of prevention.

Research questions

The following research questions are addressed:

Causes and triggers

- How do married women consider documented potential causes and triggers of IPVAW in their own context (study I)?
- How do married men consider documented potential causes and triggers of IPVAW in their own context (Study I)?

Means of prevention

- What are the views and suggestions of key informants, and of married men and women concerning potential means of prevention of IPVAW (Study I and Study II)?
- To what extent and in what way do gate-keepers, husbands-to-be and wives-to-be consider that premarital education can be a means of prevention of IPVAW (study III)?

4 MATERIALS AND METHODS

The social diagnosis achieved by this thesis rests on the opinions of target groups representing a variety of perspectives relevant to the understanding and prevention of IPVAW. Table 2 summarizes the main characteristics of the studies included in the thesis.

Table 2. Focus domains, objectives and summary of materials and methods of the studies and the articles

Focus domain	Study	Objectives	Data collection instrument	Data collection strategy	Participants	Articles
Causes and triggers of IPVAW	I	To define how married women assess potential causes and triggers of IPVAW	Structured questionnaire	Face-to-face interviews	435 married women	I
		To define how married men position themselves regarding potential causes and triggers of IPVAW	Structured questionnaire	Self-administration	447 married men	II
Means of prevention of IPVAW	II	To highlight views of key informants, and married men and women about potential means of prevention of IPVAW	Semi-structured questionnaire	Face-to-face interviews	23 key informants	III
			Structured questionnaire	Face-to-face interviews	435 married women*	
			Structured questionnaire	Self administration	447 married men**	
	III	To explore perceptions of gatekeepers, husbands- and wives-to-be about the manner in which premarital education is regarded as a possible means of prevention of IPVAW	Semi-structured questionnaire	Face-to-face interviews	8 gate-keepers, 9 husbands-to-be and 13 wives-to-be	IV

*The 435 married women in articles I and III are the same.

** The 447 married men in articles II and III are the same.

Study I is concerned with what married men and women can already contribute to the understanding of how the community perceive various potential causes, triggers and consequences of IPVAW. Study II turns to key informants and, on the basis of their own experiences, investigates what they think can help to prevent IPVAW. Their

opinions are compared with those expressed in Study I by married men and women. Study III turns to gatekeepers involved in pre-marital education and includes even husbands- and wives-to-be enrolled in routine education programs and investigates in more detail what they think premarital education can contribute.

4.1 SETTING

4.1.1 General information

The studies forming the basis for the thesis were conducted in Kermanshah City, capital of the Kermanshah Province located in the Middle West part of Iran, bordering Iraq (see Figure 4). It is one of the 30 provinces of Iran with a population of 1 879 000 of which 67% reside in the urban area. The total land area is 24 434 square km, about 1.5% of the country's total. Of the total population 14% is under the age of 15, 26.5% aged from 15 to 24, 30% from 25 to 44, 14% from 45 to 64 and 5.3% aged 65 years and older⁽⁹³⁾.

Kermanshah City (study area) has a population of 794 000 (42% of the province's population) (reference year 2006)⁽³¹⁾. 87.5% of the population of 6 years and older are literate (91% of men and 84% of women). The total population is Muslim. Three main ethnic groups, the Kurds (in the majority), the Fars and the Laks (minority) who cohabit in the city. Kurds also live in Iraq and Turkey, the Laks live only in the western part of Iran – where Kermanshah is situated – and the Fars are in the majority in most of the rest of the country. Although there are some big industrial factories, Kermanshah is not a heavily industrial city, and its economy is based on service industries, light industry, and agriculture and animal husbandry.

Kermanshah City is covered by 48 urban public health centres who provide public health care for all population. These centres are supported by the District Health Center of Kermanshah (DHCK) and all provide free health care to mothers and children under five, e.g. vaccines, contraceptives, and visits to the doctor and midwife. Nine premarital educational centres, located in nine urban public health centres, provide education on sexual issues, family planning, and genetic diseases to couples-to-be before marriage by trained health workers as a part of public health mandate (five centres for urban couples and four centres for rural couples). In Kermanshah, there is a family court with several judges where all domestic cases coming to court are dealt with, and also forensic medicine organization in which physicians visit victims of IPVAW who want to prosecute their assailant. In police stations, there are staff trained in psychiatry who offer consultation to victims and perpetrators of IPVAW in the police stations.

4.1.2 Marital information

Prior to a traditional marriage, the man, as a suitor, can become more familiar with the woman under the supervision of her family, and usually there is very little contact before this. The engagement period is usually short. All marriages are religious in

Figure 4. Map of Iran and location of Kermanshah province ⁽¹⁰³⁾.



Kermanshah and Iran. The family is the most important social unit in Kermanshah, and being divorced bears a social stigma. The average age of marriage for men is 25.8 and for women 20.3. The rate of divorce is 3.4% (104). A certificate confirming attendance at premarital education sessions about sexual issues, family planning, and genetic diseases is required for couples to be registered as married.

4.2 INDIVIDUAL STUDY DESIGN, MATERIALS AND METHODS

4.2.1 Study I – Potential causes and triggers of IPVAW

In Study I, married women and men received the same questionnaire but it was administered in two different ways. Even sampling, recruitment strategies and data treatment differed between the groups.

Questionnaire

A questionnaire in five parts consisting mainly of closed questions was developed and pre-tested. It started with a series of questions on the participants' and their spouses' socio-demographics (Part I), followed by questions on prior victimization (for women) – or perpetration (for men) of IPVAW (Part II). The questions were restricted to a set of non-physically abusive acts including moderate forms of violence, like shouting and physical threats on the grounds that physical IPVAW is illegal in Iran and participants may feel more comfortable if not directly questioned on such matters.

Thereafter respondents were presented with a list of well-documented potential causes and triggers of IPVAW, both individual and relational, often referred to in the international literature and some others raised either during the pre-test with men and women or during the following discussion within the research group (Part III). Part IV asked questions related to what one regarded as the potential individual and familial consequences of IPVAW. The interview ended with some questions relative to the potential means of prevention of IPVAW (Part V). In Part III and Part IV, Likert scales were used to determine the extent to which the respondents agreed with the statement proposed. The answer alternatives were: completely disagree, disagree, don't know, agree and completely agree.

Sampling and data collection procedures

Females (article I): Women were interviewed face to face during August 2005. The inclusion criteria retained were:

- living in Kermanshah city;
- being currently married;
- having at least five years of experience of marriage;
- being 25 to 45 years old.

Using the Cochran formula the sample size was estimated at 460 women, allowing about 15% non-response rate or attrition.

Due to the high coverage rate of the public health centres for women in Kermanshah city (80% of married women of reproductive age), women were approached when they sought free health care for themselves or their children from any one of the city's 48 public health centres. Not usually being accompanied by their husband during their visits to a public health centre was also a safety factor for the choice of the centres to recruit women. Women were recruited consecutively, on site, by trained interviewers in all 48 public health centres in proportion to each centre's population coverage.

Three trained female interviewers, all of whom were experienced and university graduates collected the data consecutively and in a convenient manner. Interviews were conducted privately at each health centre on every day of the week. 435 of 460 eligible women participated in the study (non-response rate: below 6%).

Males (article II): Data were gathered during August and September 2005 in Kermanshah City. The same selection criteria as for women were retained (see above). The sample size was estimated at 480 men using the Cochran formula allowing for 20% non-response rate or attrition.

Participants were contacted at work during working hours. It was felt that this would secure a relatively good response rate without male participants experiencing that their particular relationship with their wife was being scrutinized (as could have been the case in e.g., a household-based survey). Prior to data collection, five occupational groups were identified that were appropriate to give an accurate representation of the social fabric of the city. Workplaces likely to participate were identified in consultation with experts in the DHCK who are in continuous contact with other organizations, offices and factories in Kermanshah City. Thereafter an introductory letter signed by the head of the DHCK was handed over in person by the thesis author (TA) to the decision maker at each identified workplace. The managers of all the workplaces approached consented to participation in the study. Following a positive response, the TA prepared and organized the data collection procedure locally, taking work conditions into consideration. The whole data collection was based on voluntary participation and in every workplace selected it was made clear to all participants that their participation was not mandatory. Participants received the explanations individually or in groups according to the work conditions. There was no compensation for participation. In total, 447 of the 480 men approached filled in questionnaires anonymously (non-response rate: below 7%). Women and men were selected as shown in Table 3.

Table 3. Number of participants (women and men), their job situation and place of their recruitment.

Participants	Occupation	Place of recruitment	Number of participants
Married women	Housewife	48 public health centres	373
	Employed or student		62
	Total		435
Married men	Factory workers	Seven factories	142
	Teachers	Three places of routine educational sessions for teachers	54
	Office workers	20 offices and organizations	190
	Shopkeepers	Centres for issuing health card	42
	Drivers	Centres for issuing health card	13
	Others		6
	Total		447

Data treatment

Females (article I): Univariate frequencies for each response alternative were compiled and arranged in descending order of agreement, all respondents aggregated (using SPSS version 14). Also, item by item, comparisons were made between groups of respondents considering selected socio-demographics (marriage duration, number of children and spouses' ethnic group), education level and employment, and also prior exposure to violence. Two by two comparisons were made and the significance of the difference was estimated with 95% confidence intervals, using a test for two independent proportions (VassarStats: Web Site for Statistical Computation).

Males (Article II): As a whole, the respondents tended to use all answer alternatives on most questions. For the analyses, the original five response alternatives were grouped into three (agree, no idea, disagree) for each potential cause and trigger of IPVAW. The re-coded values were analyzed simultaneously, employing a cluster technique called the Hierarchical Ascendant Classification (HAC)^(105, 106) most suitable for the treatment of categorical data. In the statistical software used (SPAD version 6.5), it is suggested that the HAC is applied following a Factorial Analysis of Correspondence performed on the original categorical data. These are data-reduction techniques that focus on the attributes (categories) of variables rather than on any set of variables taken as a whole. The HAC is a classification technique that divides events under investigation into a number of (unempty) classes in such a way that each individual belongs to one and just one class. Earlier applications of HAC in injury studies can be found from occupational⁽¹⁰⁷⁾, road traffic^(108, 109) and home⁽¹¹⁰⁾ settings.

Once the patterns (classes) were identified, the association between classes and consequences, socio-demographic attributes, and perpetration of violence were tested by means of chi-square test.

4.2.2 Study II (Article III) – Perceptions of key informants on alternatives for prevention

Two target groups

Key informants and married men and women were approached and questioned in different manners. Key informants (n = 23) were individually interviewed at a place of their convenience (usually their workplace) during the autumn of 2006. The question grid used with them covered potential causes, triggers and means of prevention of IPVAW and included a wider range of open questions relative to the prevention of IPVAW. The opinions of married women (n = 435) and men (n = 447) were gathered regarding means of prevention of IPVAW during study I (Part V of the questionnaire used in Study I).

Sampling and data collection instrument and strategy

Key informants

Purposive sampling was used and a number of people were identified who, through their profession (e.g., medical, juridical, religious), were likely to be in contact with victims or perpetrators of IPVAW for a variety of purposes. For instance, in Kermanshah, there is a family court with several judges where all domestic cases coming to court are dealt with and the forensic medicine organization in which physicians visit victims of IPVAW who want to prosecute their assailant. Also there is a shelter for battered women in which trained staff take care of them. In police stations, in addition to police officers, there are psychiatric counselors who offer consultation to victims and perpetrators of IPVAW in the stations. Public health centres and hospitals may be involved in the treatment of victims of IPVAW. Clergymen as religious leaders offer guidance to people.

After getting approval from the head of the organization in each workplace, a key informant to be interviewed was identified by the TA consulting with the chairperson and considering how much everyone was involved in matters related to IPVAW. Key informants were interviewed at a date and time at their convenience. They were then asked by the TA whether they would be willing to participate in the study. The interviews were recorded with the permission of the participants. Codes rather than names were placed on the questionnaires and tapes to ensure confidentiality. Table 4 shows the number of key informants and some of their characteristics.

Table 4. Number of key informants and some of their socio-demographic characteristics

Occupation	Number of interviewees	Gender		Marital status	
		Female	Male	Married	single
Judges in the family court	3	1	2	3	-
Physicians in forensic medicine	3	2	1	3	-
Policemen	3	-	3	2	1
Psychiatric counselors in police stations	3	1	2	2	1
Shelter staff	3	3	-	1	2
Hospital workers	3	3	-	2	1
Public health workers	2	2	-	1	1
Clergymen	3	-	3	3	-
Total	23	12	11	17	6

Each key informant was interviewed face-to-face by the TA utilizing a semi-structured interview questionnaire including eight open-ended questions, among which basic demographic information and personal opinions about potential causes, consequences, and means of prevention of IPVAW. Participants were asked to share their opinions regarding possible means of prevention of IPVAW. Finally, the last two questions aimed at finding useful educational programmes in key informants' views and also their suggestions as to how to organize an educational programme for new couples.

Several discussion meetings were held with experts to prepare the questionnaire (average interview time: 30 minutes).

It can be commented that a snowball recruitment strategy was also planned whereby at the time that key informants were identified and contacted, they were also asked to recommend other persons/groups to be contacted in the study area (for snowball sampling). As it happened, no other organization or individual was mentioned.

Men and women survey

As described for Study I.

Data treatment

Key informants

The interviews were performed in Farsi. They were transcribed verbatim. The text was analyzed by means of Directed Content Analysis⁽¹¹⁾. The transcribed texts were read several times. To obtain contextual information the whole texts were read (reading horizontally) and to identify common points, the respondents' answers to each question were read (reading vertically). Meaning units were marked in the data reduction by the TA. Meaning units were translated to English by the TA and then translated back by a professional translator. Condensed meaning units and codes were abstracted and grouped independently by the TA and one of the co-authors to generate categories. Themes were also searched for by interpretations of the codes and categories to represent their underlying interrelationships. Categories and themes were finalized in the research group after several re-readings and through discussions.

Men and women

Sex-specific frequencies were compiled for each response alternative from the questionnaire filled in by men (self-administered) and women (interviewed) (using SPSS version 15). In addition, correlations between each variable as well as with sex and age of the respondents were compiled and even correlations between variables.

4.2.3 Study III (Article IV) – Premarital education as a means of prevention of IPVAW

Perceptions of gate-keepers involved in premarital education of couples-to-be and also a sample of eventual target group for premarital education about IPVAW including husbands-to-be and wives-to-be about the manner in which premarital education is regarded as a possible means of prevention of IPVAW explored in Study III during the winter of 2007.

Setting

In Kermanshah City, there are five urban educational centres in which trained health workers (instructors) provide education on sexual issues, family planning, and genetic diseases to urban couples-to-be before marriage. These centres are affiliated to the eDHCK and are located in five urban public health centres. The main task of instructors in premarital educational centres is to educate married couples-to-be. A certificate confirming attendance at such a session is required for couples to be registered as

married. On average, 700 couples per month attend premarital educational sessions. A trained health worker and the head of the district family health unit in DHCK are responsible for the supervision of all premarital educational centres in Kermanshah district. At the provincial level, responsibility for supervision is with the head of the provincial family health group and a trained health worker.

Participants

Two sets of respondents participated in the study:

Gate-keepers. The first group included four instructors (health workers) who educated couples in four urban premarital educational centres and also all supervisors at the district level ($n = 2$) and province level ($n = 2$). All gate-keepers were female.

Husbands-to-be and wives-to-be. A convenience sample consisting of nine men and 13 women preparing for marriage composed the second group of respondents. They were approached at premarital educational centres. To achieve socio-economic diversity, men and women were recruited from all five centres. Saturation recruitment strategy was used to ensure a sufficient number of interviews.

Data collection

The supervisors, the directors of all centres and the instructors approached consented to participation in the study. Following a positive response, the TA prepared and organized the data collection procedure locally.

The TA took the responsibility to face-to-face interview all gatekeepers and the husbands-to-be and interviews of the wives-to-be were taken care of by two trained and experienced female interviewers who were university graduates. Interviews were conducted in a confidential setting. The provincial and district supervisors were interviewed at their workplace and husbands- and wives-to-be and instructors at the premarital educational centres. Gate-keepers were interviewed at a date and time at their convenience and husbands- and wives-to-be, after the program-based education session. They were then asked by the interviewer whether they would be willing to participate in the study after being informed briefly about the study and the possibility of withdrawing from the interview at any time. For reasons of safety, only one representative of each couple was interviewed. The interviews were recorded with the permission of the participants. Codes rather than names were placed on the questionnaires and tapes to ensure confidentiality.

Instrument

A semi-structured questionnaire was used for the interviews (average interview time: 25 minutes), including socio-demographic data. A total of 14 open-ended questions were asked among which some dealt with the possible role of premarital educational programmes in the prevention of IPVAV and others aimed to find out what the participants' suggestions were for the curriculum of a premarital educational programme about IPVAV (in general and also gender-specific). Gatekeepers received an extra question about characteristics of current routine premarital educational programmes. Prior to this, some questions were also asked regarding their perceptions of acts of violence, and the potential causes, consequences, and means of prevention of

IPVAW by women. The interview ended with a question regarding participants' suggestion for better premarital educational program. The semi-structured questionnaire was prepared during several discussion meetings in the research group.

Data analysis

The interviews were performed in Farsi. They were transcribed verbatim. The material was analyzed by means of Directed Content Analysis⁽¹¹¹⁾. The transcribed texts were read several times. To obtain contextual information the whole texts were read (reading horizontally) and to identify common points, the respondents' answers to each question were read (reading vertically). Meaning units were marked in the data reduction by the TA. They also were marked randomly by an independent co-examiner to check the validity. Meaning units were translated to English by TA and then translated back by a professional translator. Condensed meaning units and codes were abstracted and grouped independently by the TA and one of the co-authors to generate categories. Themes were also searched for by interpretations of the codes and categories to represent their underlying interrelationships. Categories and themes were finalized in the research group after several re-readings and through discussions.

5 RESULTS

5.1 MARRIED MEN AND WOMEN

5.1.1 Potential causes and triggers

Figures 5 and 6 show the frequencies of answer alternatives about causes and triggers used by the respondents. While men tended to use all answer alternatives on most questions, women mainly agreed with items presented.

Figure 5. Frequencies of answer alternatives about potential causes of IPVAV used by the respondents

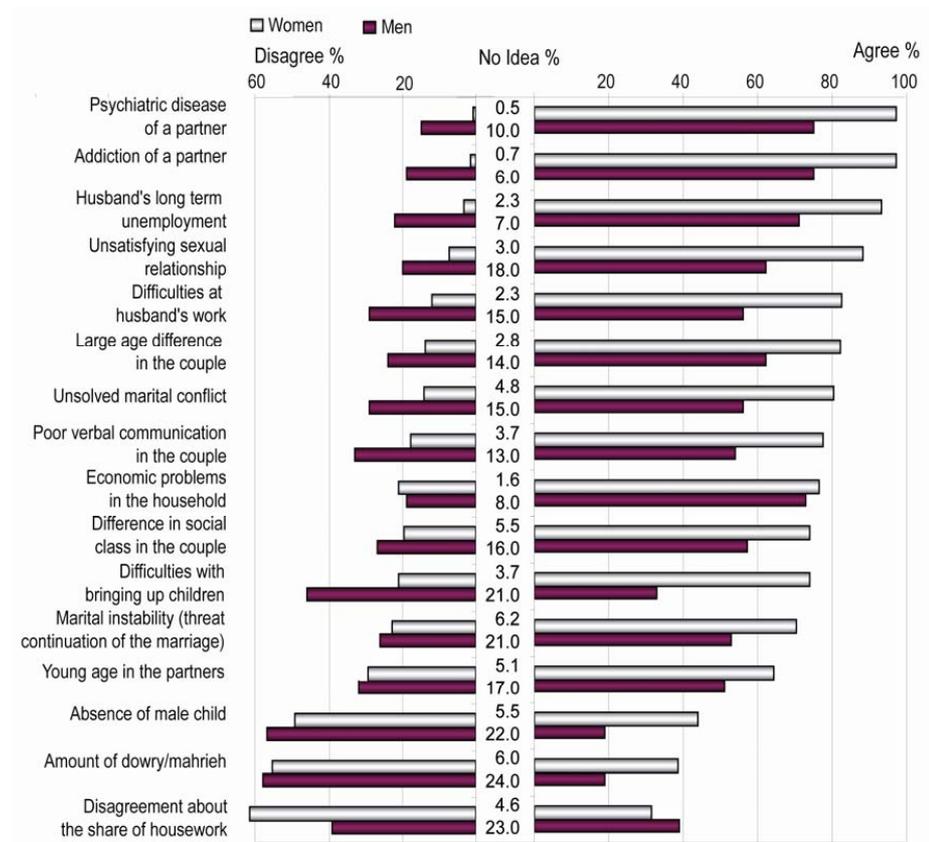
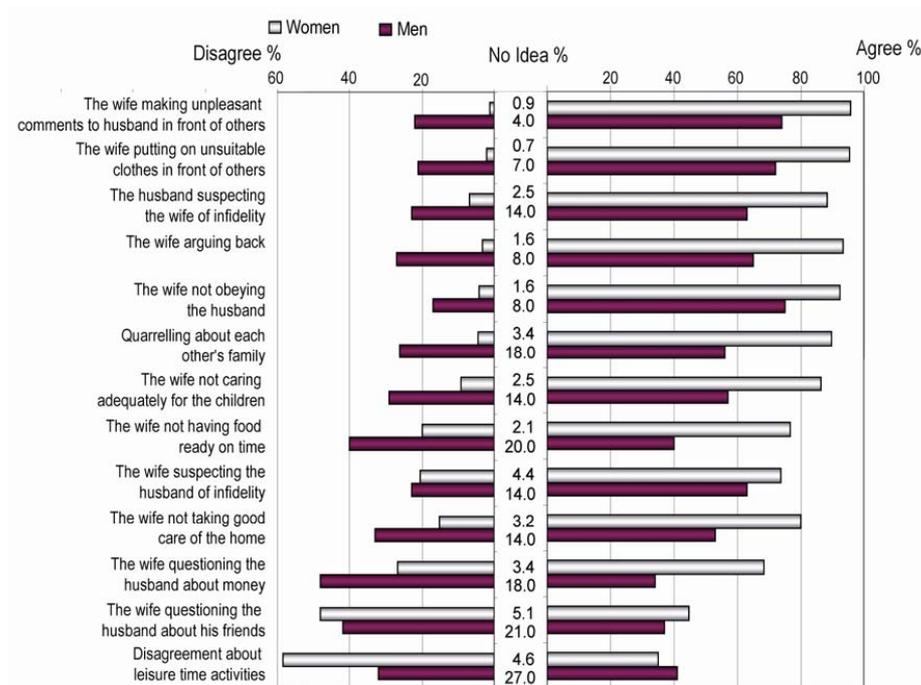


Figure 6. Frequencies of answer alternatives about potential triggers of IPVAW used by the respondents



About 90% of women agreed on four potential causes. Of those, the first two deal with the partner's mental health and attained a very high consensus: "addiction of a partner" and "mental disorder of a partner". They are followed by the husband's unemployment and their sexual relationship. It can be underlined that, "addiction of a partner" and "husband's unemployment" ranked first when women were asked to rank the top two causes or triggers of IPVAW. Absence of male child, dowry, and sharing housework attained the lowest rates of agreement and the highest rates of disagreement.

Over 95% of the women completely agreed with the triggering effect of the first two items, both of which can imply a husband losing face in front of others: unpleasant verbal communication and unsuitable clothes. Items related to home chores and household matters (care of child and home, and meals) scored about 80%. Lowest on the list were potential triggers related to leisure time activities and, otherwise, women asking questions about husband's friends.

Among men percentages of agreement of around 70-75% were found for triggers such as one's wife "not obeying", "expressing unpleasant comments in front of others" and "wearing unsuitable clothes in front of others" and causes like "addiction", "psychiatric disease", "economic problems", and "unemployment". Absence of a male child and amount of dowry/mahrieh reached the highest rates of disagreement. "No idea" was chosen at a frequency of between 4.0% (unpleasant comments in front of others) and 27.0% (disagreement about leisure time).

The men used all answer alternatives proposed for most questions. Four response patterns (classes or clusters) were identified among men by means of HAC (see Table 5). They are described below, focusing on the modality of answer (positive, neutral, and negative) and questions most representative of the class. Each class is assigned a name that reflects the “direction” of their answer and the causes or triggers that most significantly contributed to its formation.

Class 1. Class 1 groups 33% of the respondents who had in common that they tended to agree in significantly higher proportions than all men aggregated with nearly all causes and triggers. The three most significant items were triggers related to home chores (care of the home, care of the children and making sure that food is ready on time by the wife). This is followed by disputes (i.e. the wife arguing back or the partners quarrelling about their respective family) and relational problems (i.e., the wife’s eventual infidelity, the clothes that she wears, her questioning about the husband having girlfriends). Only two variables (absence of male child” and “amount of dowry”) had less than 50% men agreeing.

Class 2. Men not regarding most items proposed as potential causes or triggers (18.9%). In Class 2, 21 of 29 items were marked by a significant over-representation of disagreement compared with all men aggregated. The most significant sources of disagreement were the wife making unpleasant comments and wearing unsuitable clothes. This is followed by the addiction and a psychiatric disease of a partner and by various relational and family factors like care of the home and the children, infidelity by the wife, unemployment of the husband and economic problems.

Class 3. Men ambivalent – most significantly concerning the wife questioning the husband regarding sensitive matters and children issues (20.3%). Men from Class 3 answered “no idea” to most questions (23 out of 29) in higher proportions than all men aggregated. They were also somewhat more in agreement in higher proportions for two questions: addiction of a partner and marital conflict. The most significant items of ambivalence for the men from this group were money problems, care or bringing up of children as well as the wife questioning the husband’s friends or questioning him about girlfriends. *Class 4.* Men with mixed opinions but more negative than all men aggregated in some aspects (27.4%). Men from class 4 disagreed to a much greater extent with item that otherwise also received relatively high disagreement among all men aggregated. Among the 16 questions that differentiated them significantly from all men aggregated, the most significant ones – in the “negative” direction were money matters (money and dowry), followed by bringing up of children, leisure time and husband’s friends. The three items to which these men agreed in higher proportions than was observed among all men aggregated were related to women’s unpleasant comments, unsuitable clothes and addiction of a partner.

Table 5. Description of the men's response patterns (classes)

Men's response pattern	Number of participants forming the class (%)	Most significant variables		Proportion in the class %	Proportion (%) of all participants N= 423
		Name	Significant answer alternative		
Men regarding most items proposed as potential causes or triggers of IPVAW (class 1)	141 (33.0)	The wife not taking good care of the home	Agree	89	53
		The wife not caring adequately for the children		92	57
		The wife not having food ready on time		75	40
		The wife arguing back		94	65
		Quarrels about each other's family		87	56
		The husband suspecting the wife of infidelity		92	63
		The wife questioning the husband about having girlfriends		80	49
		The wife putting on unsuitable clothes in front of others		97	72
Men not regarding most items proposed as potential causes or triggers (class 2)	80 (18.9)	The wife making unpleasant comments to husband in front of others	Disagree	87	22
		The wife putting on unsuitable clothes in front of others		85	21
		Addiction of a partner		75	19
		Psychiatric disease of a partner		66	15
		The wife not taking good care of the home		79	33
		The wife not caring adequately for the children		83	29
		The husband suspecting the wife of infidelity		72	23
		Husband's long term unemployment		70	22
Men ambivalent – most significantly concerning the wife questioning the husband regarding sensitive matters and children issues (class 3)	86 (20.3)	The wife questioning the husband about money	No idea	56	18
		Difficulties with bringing up children		55	21
		The wife questioning the husband about his friends		55	21
		The wife questionings the husband about girlfriends		47	16
Men with mixed opinions but more negative than all men aggregated	116 (27.4)	The wife questioning the husband about money	Disagree	85	48
		Amount of dowry/mahrieh		90	58
		Difficulties with bringing up children		78	46
		Disagreement about leisure time activities		62	32
		The wife questioning the husband about his friends	72	42	
		The wife questioning the husband about his friends	89	74	
		The wife putting on unsuitable clothes in front of others	87	72	
		Addiction of a partner	89	75	

5.1.2 Comparisons between opinions expressed

As shown in Table 6 the order of agreement for potential causes and triggers of IPVAV is quite similar among the socio-demographic sub-groups and even groups of victimized women.

Table 6. Percentages of the complete agreement on items reaching >50% complete agreement by group of respondents

Potential triggers and causes	All	Experience of non-physical violence ^a		Occupation		Husband's education			Husband's ethnicity		
		Yes	No	House wife	Work or study	Up to grade 8	High-school	Graduate	Kurd	Fars	Lak
Number of respondents	435	319	115	373	62	181	159	94	294	73	56
Triggers											
Unpleasant verbal communication	88.5	89.3	87.0	89.0	85.5	89.0	89.3	86.2	87.4	87.7	94.6
Unsuitable clothes	86.9	88.1	84.3	88.7*	75.8*	90.1*	86.8	80.9*	85.7	89.0	91.1
Suspicion of infidelity	75.9	77.4	72.2	76.9	69.4	78.5	74.8	72.3	75.2*	69.9°	87.5*
Arguing back	72.9	76.5°	63.5°	75.1*	59.7*	80.7*	73.6°	57.4**	71.8	78.1	73.2
Not obeying	69.2	72.7°	59.1°	71.8*	53.2*	77.9*	68.6°	54.3**	68.4	75.3	69.6
Quarrel about in-laws	65.7	69.6°	55.7°	67.8*	53.2*	67.4*	70.4°	55.3**	65.0	71.2	66.1
Causes											
Addiction	92.2	92.8	91.3	92.8	88.7	93.4	91.8	90.4	93.2	90.4	91.1
Mental disease	88.7	91.2°	82.6°	90.1*	80.6*	89.5	87.4	89.4	89.8	86.3	85.7
Unemployment	83	83.4	82.6	83.4	80.6	82.9	84.9	79.8	82.0	90.4	78.6
Unsatisfying sexual relationship	75.9	74.6	80.0	76.7	71.0	77.9	76.1	72.3	73.1	80.8	82.1
Husband's work problems	62.1	63.9	57.4	64.9*	45.2*	66.3*	67.9°	44.7**	61.6	65.8	57.1
Age difference	53.3	54.5	50.4	54.7	45.2	56.9	52.2	48.9	51.4	61.6	51.8
Marital conflict	53.3	54.2	51.3	51.7	62.9	53.0	52.2	55.3	52.7	60.3	53.6

a) Which may not be considered as violence in the study area.

* * figures with each of these symbols have significant differences with each other in their sub-group (they are in bold fonts).

Of the socio-demographic characteristics measured, being a housewife and being married to a low-educated husband, though not affecting the ranking of potential causes/triggers that much, does significantly push the level of agreement upwards. Even one's prior experience of moderate forms of violence has little effect on the ranking. For their part, marriage duration, number and sex of children and age have little – if any – effect on women's opinions.

Among men, there are strong relationships between patterns of opinions and men's education, as well as with their own and their wife's occupation. Most remarkably, less educated men and manual workers are over-represented in Class 2 (men in high disagreement); men with a higher level of education and those employed as office

workers are over-represented in Class 3 (men answering “no idea”). There is no significant association between pattern of answers and ethnic group as well as perpetration of IPVAW. Table 7 shows an association between men’s patterns of opinions and perpetration of IPVAW, and selected socio-demographic characteristics

Table 7. Association between men’s patterns of opinions and perpetration of IPVAW, and selected socio-demographic characteristics.

Variable	Alternatives	Class 1 n = 141	Class 2 n = 80	Class 3 n = 86	Class 4 n = 116
Perpetration	No	30	22	21	27
	Yes	37	15	20	28
	Total	33	19	21	27
Chi-squared = 3.9; d.f. = 3; p = 0.27 (n.s.)					
Education	Up to 8 grades	26	45	10	19
	High-school	29	22	14	35
	Graduates	40	6	30	24
	Total	33	19	21	27
Chi-squared = 69.48; d.f. = 6; p = 0.000					
Job	Worker	31	30	9	30
	Office worker	36	10	29	25
	Total	33	19	21	27
Chi-squared = 42.63; d.f. = 3; p = 0.000					
Wife’s job	Housewife	34	22	15	29
	Work/study	30	10	38	22
	Total	33	19	21	27
Chi-squared = 25.43; d.f. = 3; p = 0.000					
Ethnicity	Kurd	35	19	17	29
	Fars	30	18	30	22
	Lak	28	16	28	28
	Others	16	17	50	17
	Total	33	19	21	27
Chi-squared = 6.82; d.f. = 6; p = 0.338 (n.s.)					

5.1.3 Consequences

Figure 7 shows the frequencies of answer alternatives about consequences used by the men and women. Among women, not only do children's and the wife's mental problems attain the highest rates of complete agreement but they also come first when women are asked to freely order the most important consequences. All items attained over 80% of agreement apart from "economic problems".

As shown in Figure 7 and Table 8, men from all classes but Class 2 (negative stand) are in high agreement for psychological problems of husband and wife and also marital instability and in low agreement for the inability of the wife to do her family duties, economic problems and children mental problems. Men from Class 2 on the contrary are split in their opinions about most consequences. Opinions expressed among men

from Class 4 for the item concerning children’s learning problems are very similar to those of men from Class 2 but not those from Classes 1 and 3 who are in high proportion in disagreement.

Figure 7. Frequencies of answer alternatives about consequences of IPVAW used by the respondents

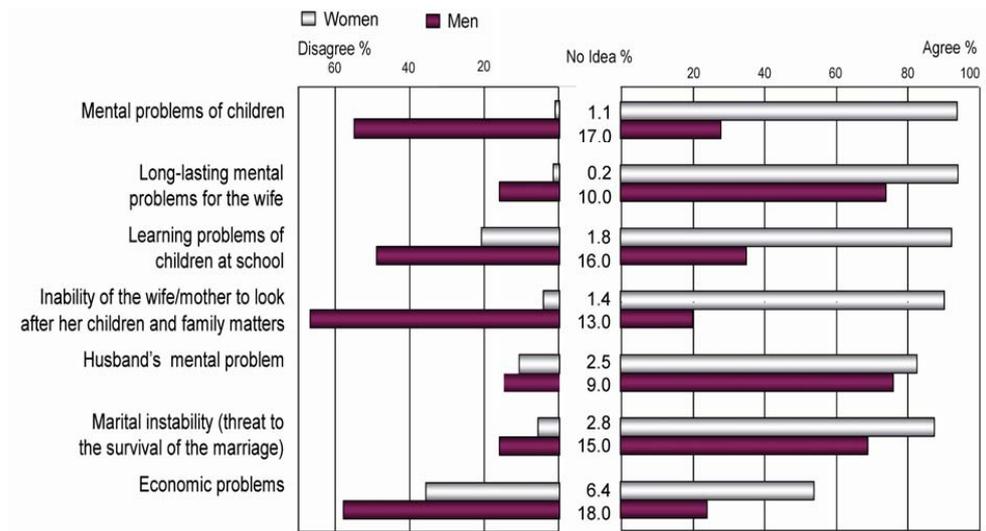


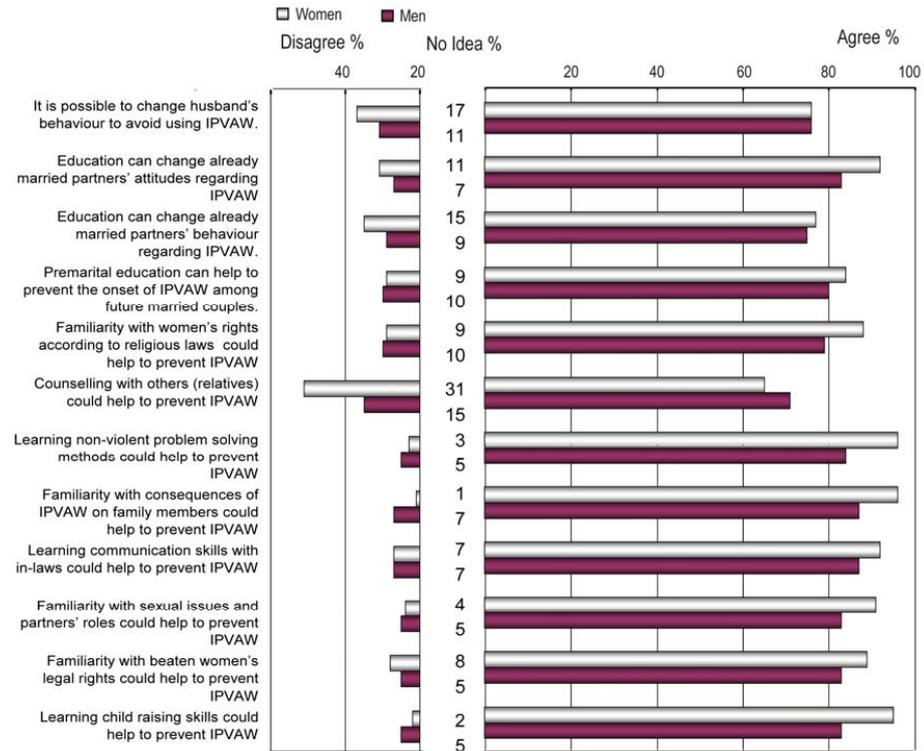
Table 8. Association between patterns of opinions and consequences of IPVAW

Variable	Alternatives	Class 1 n = 141	Class 2 n = 80	Class 3 n = 86	Class 4 n = 116	Total n= 423
Husband psychological problem	Agree	88	39	85	80	76
	No idea	9	13	8	8	9
	Disagree	4	49	7	12	15
Chi-squared = 96.6; d.f. = 6; p = 0.000						
Long lasting psychological problems for the wife	Agree	91	39	76	77	74
	No idea	8	14	12	10	10
	Disagree	1	48	13	13	16
Chi-squared = 92.16 d.f. = 6; p = 0.000						
Marital instability	Agree	84	26	73	76	69
	No idea	12	19	19	15	15
	Disagree	4	55	8	9	16
Chi-squared = 123.16; d.f. = 6; p = 0.000						
Inability of the wife	Agree	7	51	9	21	20
	No idea	9	16	21	9	13
	Disagree	84	33	70	70	67
Chi-squared = 84.45; d.f. = 6; p = 0.000						
Economic problems	Agree	12	44	17	29	24
	No idea	19	21	20	14	18
	Disagree	69	35	63	57	58
Chi-squared = 36.75; d.f. = 6; p = 0.000						
Psychological problems of children	Agree	14	45	23	36	28
	No idea	11	24	23	14	17
	Disagree	74	31	53	50	55
Chi-squared = 47.36; d.f. = 6; p = 0.000						
Learning problems of children at school	Agree	23	45	27	49	35
	No idea	11	23	23	14	16
	Disagree	67	33	50	37	49

5.1.4 Means of prevention

Figure 8 shows the compilation of the opinions of the married women and men about means of prevention of IPVAW. Respondents are mainly in agreement, women more often “completely”. Also, men being in higher proportions answered “no idea”. Hence, over 75% of the women and men both agreed and completely agreed with the possibility of changing husbands’ behaviour to avoid resorting to IPVAW. Items related to the effects of education on changing already married partners’ attitude and ubehavior and that of premarital education on prevention the onset of IPVAW score 75% to 84% when both “agree completely” and “agree” are considered.

Figure 8. Frequencies of answer alternatives about means of prevention of IPVAV used by men and women



Regarding the eight proposed potential means of prevention of IPVAV, all items except one (“counselling with others”) are agreed or completely agreed upon by four of five respondents. “Counselling with others” attains 65% and 71% both agreement and complete agreement in women and men respectively which is the weakest agreement. The difference between men and women in “complete agreement” is more than 30% in all items except again in “Counselling with others”. The highest “complete disagreement” and “disagreement” are also seen in this item in both women and men.

When asked to rank order the proposed potential means of prevention “Familiarity with women’s rights according to religious laws” ranked first. Finally, the respondents didn’t propose additional counter-measures either when asked about that in an open ended question.

Overall high correlations are seen between opinions and more of them are significantly correlated with sex rather than with age. The first four items concerning the possibility of changing husbands’ behaviour, the potential effect of education on already married partners’ attitudes and behaviours regarding IPVAV and that of premarital education on preventing the onset of IPVAV are not correlated with sex but the last eight items (proposed potential means of prevention) are significantly correlated with sex.

5.2 KEY INFORMANTS

Three themes represent underlying meanings of potential means of prevention: ⁽¹⁾ improve individual knowledge and skills for men, women or both, ⁽²⁾ putting responsibility on the wife, ⁽³⁾ coordinated community interventions.

Improve individual knowledge and skills for men, women or both

The theme of “improve individual knowledge and skills for men and/or women” includes proposed potential means targeted on education and training. It represented the most common theme. This theme consisted of three categories including “personal and cultural knowledge”, “religious knowledge” and “interpersonal relationship skills”. The former included various subjects/areas of interest like moral education, increasing knowledge among young people to enable them to choose a well-matched spouse, and sexual education in high schools. The other category in this theme is “religious knowledge” including some codes suggesting importance of religious educational issues for prevention of IPVAV.

The category labelled “interpersonal relationship skills” for its part consisted of the most common potential means including both men and women, in premarital education, and “communication training”.

Putting responsibility on the wife

Some of the participants came up with opinions that focused on the wife’s behaviour as a means of preventing IPVAV including the categories “commitment and intimacy by the wife” and “more responsibility for the wife than husband”. According to them, if the wife loves her husband and tries to have good communication with him, IPVAV will be reduced. Avoidance of infidelity is another comment. “Patience of the wife”, “finding the roots of conflicts and trying to remove them by the wife” and “reduction of stimulants by the wife” are the comments which show their opinion about how the wife should accept more responsibility to prevent IPVAV.

Coordinated community interventions

“Breaking cultural taboos” is the most common category in the “coordinated community interventions” theme in which proposed potential means of prevention needed multi-sectoral interventions to be achieved. Some respondents directly mentioned that there is a need for a cultural change, presenting suggestions like: “breaking the taboo of mental consultation and increasing the rate of it”, “caring about moral values”, and “increasing the age of marriage” are some comments in this field .

Other categories in this theme include “societal support to the wife” and “economic improvement”.

5.3 GATE KEEPERS, HUSBANDS-TO-BE, AND WIVES-TO-BE

5.3.1 Preventing IPVAV by premarital education

Most of the interviewees, with the exception of the supervisors, including husbands-and wives-to-be and instructors consider that an educational programme about IPVAV in the premarital educational centres could influence the couples and help to prevent IPVAV.

5.3.2 Suggested course curriculum

Two main themes could be identified: ⁽¹⁾ improving mental and behavioural relationship skills, ⁽²⁾ improving knowledge.

Improving mental and behavioural relationship skills

Most items proposed can be considered as suggestions in line with improving skills (theme). This theme includes six categories consisting of subjects related to personality, empathy and self awareness, stress management, effective communication, private interpersonal relationships, and putting more responsibility on the wife than the husband.

Personality

Participants stated that education of couples about some personal characteristics including calmness, patience, being logical, not making hasty decisions, being good-natured, accepting criticism, having a relaxed approach, and truthfulness could help future married couples to avoid IPVAW.

Empathy and self awareness

Expression of items including self-knowledge, understanding one another, understanding the opposite-sex and understanding the real conditions of life like family finances and having reasonable expectations from the spouse could be categorized as empathy and self awareness related items.

Stress management

The stress management category includes the items proposed to avoid of being incompatible in the family. non-violent problem solving, discussing things with the husband after he has calmed down, to bite her lip and not get drawn into conflict, not to continue conflicts, avoiding verbal abuse and trying to find the roots of conflict are items proposed by participants to be educated.

Effective communication

Items related to proper behaviour with the spouse and at home were subjects frequently proposed in all groups. It also represents the most common category. Learning communication skills was the most commonly proposed item. Adoption of religious rules in the relationship, learning how to treat the husband, sharing housework, and respecting each other's interests are examples of other items proposed in this category.

Private interpersonal relationship

Education regarding not discussing internal family matters with others was stressed by some participants in all groups to prevent IPVAW. The category includes not letting other people interfere in family matters, keeping such matters confidential, not criticizing the wife in public and solving family problems internally.

More responsibility for the wife than the husband

To avoid IPVAW some participants proposed items to adapt to all the husband's demands. Biting one's lip, trying to do what husband wants, explaining to the husband about what makes him angry, and obeying the husband were proposed items in this theme and category.

Improving knowledge

This theme covers two categories including basic education and coping strategies.

Basic education

Some participants in all groups think that increasing knowledge about issues including religious rights, human and women's rights, causes and consequences of IPVAW, and sexual information could help to prevent IPVAW.

Coping strategies

This is the least common category including the items related to education about what should be done to counter IPVAW. Training in a whole range of coping strategies and as a final resort going to court were among the items proposed.

Gender-specific suggestions

There are differences in the kind of suggestions formulated by men and women (gatekeepers and wives-to-be). Only wives-to-be proposed training for the husbands-to-be to be able to accept criticism. Having a discussion with the husband after he has calmed down is proposed only by the husbands-to-be. Not discussing family matters with others is stressed only by the husbands-to-be. Sharing housework, obeying each other, and respecting each other's interests are expressed only by wives-to-be. All items in the category of "more responsibility for the wife than husband" (except one) are proposed only by the wives-to-be. Gatekeepers and wives-to-be proposed more subjects than husbands in the basic education category.

6 DISCUSSION

The prevention of IPVAW requires a community-wide response to individual risk factors, personal relationships, and cultural, societal and economic factors^(3, 42).

Although similar interventions may rest on evidence-based strategies, the manner in which they are conducted, their content, and their mode of implementation need to be contextualized^(91, 92). The overarching aim of this thesis was to provide a community-based social assessment encompassing both factors regarded as likely to lead to the occurrence of IPVAW and potential means of prevention. It was expected that bringing together the perspectives of various community members in a specific city – and country – where there is limited knowledge on the determinants of and preventive means against IPVAW, would help lay the groundwork for context-relevant interventions by clarifying conceptions and misconceptions relative to IPVAW. In particular, the combination of the opinions and views expressed by women and men, married or about to be married, key informants and gatekeepers was expected to help in the clarification of norms and attitudes that can be targeted by an educational programme for “couples-to-be”, the potential barriers to be dealt with, and also to understand the broader context into which they take place^(91, 92).

6.1 CAUSES AND TRIGGERS

6.1.1 Findings

Views of married men and women

One primary finding is the high similarity in the views expressed by married women concerning potential triggers and causes of IPVAW. They mainly agreed or completely agreed with nearly all factors they were asked to consider as potential causes/triggers of IPVAW. The consensus varied most often between two-thirds and nearly all women. Consensus was very high for some items related to individual disorders (e.g. addiction or mental disorder) and female spouse behaviour (e.g., “unpleasant verbal communication”, and “unsuitable clothes”). Women were split only on culture-related factors (e.g. not having a male child, the size of the dowry), and some relational ones e.g., questioning the husband about his friends.

A second finding is how split – but still typified – the views of men were. As opposed to married women, married men made use of all response alternatives for each question, including not agreeing and not taking a stand. Yet, four patterns of response emerged where various homogeneous standpoints across questions came out quite clearly. The biggest group in size (Class 1, 33%) included one in three men who regarded most items proposed as potential causes or triggers of IPVAW. By contrast, another group of men, those from Class 2, did not consider most items as plausible triggers or causes (18.9%). This group also strongly disagreed about “addiction” and “psychiatric diseases” being possible triggers/causes. Among the men who stood out as ambivalent, a group almost similar in size to the latter one (Class 3, 20.3%), the ambivalence was more pronounced for potential causes and triggers related to relational

matters. Finally, the men with mixed opinions (Class 4, 27.4%) strongly agreed with humiliating items such as “unpleasant comments”, “unsuitable clothes” and also with “addiction”.

Additional exploratory findings

Although the data on socio-demographic differences are only descriptive, some observations can be highlighted. Among women for instance, the order of agreement for potential causes and triggers of IPVAW is quite similar across the socio-demographic sub-groups and even considering whether women disclosed victimization themselves or not. Of the socio-demographic characteristics measured, being a housewife and being married to a low-educated husband, though not affecting the ranking of potential causes/triggers that much, did significantly push the level of agreement upwards. It is noteworthy that among men, education and occupation were associated with their patterns of answers. Less well-educated and blue-collar men were more likely to be found among those from Class 2 (men who did not regard most items proposed as potential causes or triggers) and better-educated and white collar men were more likely to be found among those from Class 3 (no idea).

It also has to be underlined that women’s prior experience of moderate forms of violence had little effect on their ranking and neither did men’s disclosure of perpetration of ‘mild’ forms of intimate partner violence against their spouse. Likewise, ethnicity, marriage duration, number and sex of children, and age had little effect on women’s and men’s opinions. As suggested by others, the diversity of opinions about IPVAW can to a limited extent be accounted for by the diversity in people’s background or experiences ⁽¹¹²⁾.

6.1.2 Comparison between men and women

Similarities and differences of views

Although men were more split than women, the pattern of answers in the biggest group of men (Class 1) is very similar to that of women as a whole. Both groups believe that most potential causes and triggers proposed may, at some point in a relationship, engender IPVAW.

There are also similarities in the views expressed by men and women in general regarding the items that acquired the highest and lowest agreement. ‘Absence of a male child’ and ‘the size of the dowry’ are among those producing the lowest agreement and ‘unpleasant verbal communication in front of others’, ‘unsuitable clothes in front of others’, ‘addiction’, and ‘psychiatric diseases’ are among those producing the highest agreement among women and all men aggregated.

The two potential triggers, “unpleasant verbal communication in front of others” and “unsuitable clothes in front of others” which are the top two among women and two of the top three among all men aggregated, are behaviours that are likely to humiliate the male partner in front of others ⁽¹¹³⁾. This may reflect the “victim blaming” attitude in the study area where there is little thought given to the mutual responsibility of the couple to avoid IPVAW.

An additional finding is that women were highly in agreement with the multifaceted, potential consequences of IPVAW; except for economic problems in the family unit, the men disagreed with some of them. Also, men's answers to the potential consequences of IPVAW are not fully in line with their opinions otherwise expressed on potential causes and triggers. The men who do not regard most items proposed as potential causes or triggers (Class 2) are split in their opinions as regards consequences. The men from the other three classes strongly acknowledged mental problems for the wife and the husband and also marital instability as a potential consequence and disregarded any other consequences. This can be interpreted as a form of desirability bias, whereby those men as a group tend to legitimize the act but deny its potential consequences particularly for children.

Comparison with other studies

It remains difficult to assess how much the results are specific to the participants in the study or whether they are similar to those from other settings, in or outside the country, as opinion surveys about potential causes of IPVAW are uncommon. One conducted in the USA reports findings consistent with the current one in that social and cultural factors were not as much mentioned as potential factors and substance abuse and men's mental problems ranked high which is in line with our findings⁽¹¹²⁾.

6.1.3 Strengths and limitations

Samples. Although considerable efforts were deployed to cover large spectrums of various social groups among married women and men, the samples remained convenience ones, for both ethical^(114, 115) and logistical reasons and the results cannot easily be inferred to the rest of the target population. The convenience sampling strategies used yielded a high response rate (94.5% for women and 93% for men), which could be attributed to the precautions taken to secure individual confidentiality^(114, 115) and a limiting of the questions related to victimization/perpetration.

Data collection. We trust that the case recruitment and data collection procedures followed have not led to serious coverage biases although under-reporting of the victimization/perpetration of IPVAW is likely among the respondents. It is doubtful that the non-respondents declined participation for reasons of victimization/perpetration alone. It may also be underlined that a significant association was not found between victimization/perpetration of IPVAW and opinions/patterns of opinions. The questionnaire was developed for and adapted to the study area and it was also pre-tested. Considerable care was taken to ensure a reliable recruitment process; the interviews were conducted on an individual basis and by three trained interviewers for women. During the data collection, the TA had weekly meetings with the interviewers. The TA also conducted the data collection procedure for men by himself. As can be expected however, we suspect that, in spite of this, individual victimization/perpetration is under-reported⁽³⁾.

Although confidentiality was guaranteed and the questionnaires were anonymous, a social desirability bias may have come into play. The low acknowledgement of the absence of a male child and of the (small) size of the dowry as being causes potentially

linked to the occurrence of IPVAW among men and women might be interpreted as a form of social desirability bias. This could be the case where most men tended to deny the potential consequences of IPVAW for children.

6.2 MEANS OF PREVENTION

6.2.1 Findings

Views of married men and women

The married men and women who took part in this study expressed rather consensual views about educational programmes as a means of primary prevention of IPVAW, although men were relatively more reserved than women. This puts the participants in a different light as their view regarding various potential determinants of IPVAW showed that men and women answered quite differently, with women showing positive views (as herein) and men being more split.

The eight potential means of prevention proposed attained high consensus. The respondents largely agreed that raising awareness about the consequences of IPVAW and women's rights and also communication skills training could help to prevent IPVAW. Answers are not only strongly correlated across items but also with sex of the respondents. Women tend to be more in "complete agreement" and men in "agreement" which mirrors well what we have observed in an earlier study on their opinions about the potential causes of IPVAW. However, adding those two alternatives makes the sex-specific proportions of positive responses very similar. It is noteworthy that the only item that differs in this regard, counselling with others, requires that one divulges IPVAW outside the couple and this attains the lowest consensus.

Views of key-informants

Perhaps because of the diversity of their knowledge and field of expertise, the means proposed by the key informants cover a wide range of sources of determinants and encompass individual, relationship, community and societal factors as included in the ecological model put forward in the public health approach ^(2, 4, 50, 51). The key informants, in spite of their wide ranging field of competence and the multifaceted alternatives for prevention identified by them collectively showed positive views regarding the potential of educational programmes as a primary means of prevention of IPVAW. Proposed counter-measures encompass education relative to individual and relational factors that are modifiable. Although not as much as individual and relational factors, the respondents targeted community and societal factors when talking about economic improvement and also more societal support to the wife as means of prevention of IPVAW.

It is noteworthy that some informants tended to put the responsibility for the prevention of IPVAW mainly on the wife. Patience from the wife, efforts on her behalf to find and alter the roots of conflicts, and reduction of stimulants by the wife are examples of comments that point in that direction. Although some of the comments in the theme of "more responsibility for the wife than husband" could be interpreted as improving

interpersonal relationship skills, putting the responsibility for the prevention of IPVAW only on the wife is a matter of concern.

Views of gatekeepers, and husbands-to-be and wives-to-be

A first finding is that the gatekeepers, and husbands-to-be and wives-to-be are split regarding the potential effects of premarital education to prevent IPVAW. More positively, almost all husbands- and wives-to-be and those gatekeepers in direct contact with them during their education consider that premarital education could help to prevent IPVAW. By contrast, those supervising the premarital educational centres believed that it would not work. It is difficult to tell exactly what leads to this divergence of opinions.

It is encouraging that instructors are positive about the idea because of their crucial role in determining the chances of success of various interventions, but the less positive view shown by their supervisors is a source of concern. It is possible that their consideration of the limited amount of time available in current premarital educational programmes makes them more negative. An alternative explanation is that they may consider that other health issues deserve greater priority and are more easily dealt with than IPVAW by premarital educational programmes. Supervisors are the link between policy-makers and implemented programmes.

An additional finding is that most items proposed by the interviewees for the course curriculum relate to “skills training” (e.g., learning communication skills and acquiring good personality traits). One positive aspect of this is that it reflects an understanding that the behaviour in question is better dealt with through skills development than awareness-raising. Unfortunately, the likelihood of this happening in the current, short education sessions is very limited. Among those aspects more easily covered in programmes of short duration, the participants proposed improving knowledge (e.g., human and women’s rights, and causes and consequences of IPVAW).

A third finding is that a number of answers reflected a tendency to blame the victim. In the category of “more responsibility for the wife than husband” they tended to put the responsibility for the prevention of IPVAW mainly on the wife.

A last finding is that the inclusion, in the training, of strategies that would help women to cope with IPVAW when it occurs is much less covered by the suggestions put forward by the participants. It could be interpreted that at the beginning of a marriage couples are hopeful and optimistic and think that the probability of IPVAW in their relationship is very low, so they don’t suggest strategies for dealing with it.

6.2.2 Comparison between groups of respondents across studies

The majority of participants regarded educational programmes as a means of prevention of IPVAW in a positive light. Married men and women largely agreed with the effects of educational programmes on the prevention of IPVAW and also with the effects of specific counter-measures mainly in the field of raising awareness and interpersonal relationship skills training which could provide the content of an educational programme to prevent primarily IPVAW. When asked whether they

thought couple/partners' education could induce changes at all in violent behaviour by husbands in particular or in the prevention of various forms of IPVAW, the married men and women had similar views and expressed optimism. Although we know that studies show that male partners can learn how to control outbursts of IPVAW ⁽¹⁾ the views expressed by the participants contrast with those reported in another study from New York State (USA) in which more than half of the participants agreed that abusive behaviour is not alterable ⁽¹¹²⁾.

Key informants also collectively showed positive views regarding the potential of educational programmes as a primary means of prevention of IPVAW. While married men and women didn't mention any counter-measure in the community and social level when they were asked an open question, key informants proposed counter-measures at the individual, relationship, community, and societal level. Among these measures, education about relationship issues was top on the list.

Husbands- and wives-to-be and also their instructors who are in direct contact with them supported premarital educational programmes dealing with IPVAW as a potential means of its prevention. The participants who collectively didn't support the effectiveness of premarital educational programmes for prevention of IPVAW were the supervisors of premarital educational centres.

The results are difficult to compare with those of prior assessment studies of this kind. Indeed, we could not find opinion studies of this kind in the published literature.

6.2.3 Strengths and limitations

The difficulties of addressing the subject of IPVAW in various forms of field studies may affect the accuracy of the responses obtained. In the Methods section, explanation is provided about the procedures followed to avoid biases as much as possible. Some additional considerations follow.

Married men and women

As already mentioned above, for the surveys among married women and men, it can be commented that the case recruitment and data collection procedures followed have not led to serious coverage biases for each respective group, and because of that, high response rates could be reached, which is an additional strength.

It is possible however that the high consensus among men and women regarding the effectiveness of "education" as a means of prevention of IPVAW may result from a social desirability bias, regardless of the manner of data collection. Indeed, it is hard to tell whether the respondents' relative optimism is a sign of trust in the approach or a reflection of a desirability bias as the ultimate goal of the study was disclosed to them prior to their completion of the questionnaire. Further, we cannot tell whether the participants believe more in education than they would in punishment – or the fear of it – as questions of this kind were not asked. Neither did the respondents propose additional counter-measures when asked about that in an open-ended question.

Key informants

In the published scientific literature, this seems to be one of the first studies which addresses the opinions of key informants about IPVAV, generally and in Iran in particular. The key informants interviewed were selected based on the diversity of the perspectives they could bring to preventive issues relative to IPVAV. A total of 23 people were interviewed (of which 12 females and 11 males) as follows: family court judges (n=3); forensic physicians (n=3); policemen and psychiatrists in three police stations which were selected from three different socio-economic areas (poor, moderate, rich) of the city (three interviews by occupational group); staff in a women's shelter (n=3); hospital workers (n=3); and two health workers (though not so much involved; two interviews were conducted); clergymen (religious leaders; n=3). There are good reasons to believe that the local coverage is accurate, in part because all key informants identified accepted to take part in the study and also because the snowball recruitment strategy used with them didn't identify any further organization or individual to contact.

All interviews were conducted by one single person (the TA). Among participants, some of them could have been asked to check the primary results. Meaning units were also marked by an independent co-examiner in some interviews to ensure that the TA had analyzed the data correctly.

Gatekeepers, husbands-to-be and wives-to-be

In the study area the contextual knowledge regarding IPVAV is scarce. Because of that, for the development of a training course and its introduction in pre-marital education sessions, considering the opinions of both the gatekeepers (who will carry the course out) and the target group (people about to be married) is a crucial and necessary step. All instructors and supervisors at the premarital educational centres were interviewed and so were husbands- and wives-to-be until saturation was reached. It ought to be underlined that the gatekeepers, all of whom were women, were interviewed by a man (the TA). Although this might have introduced some desirability bias, it can be underlined that the TA was a person already known by the gatekeepers, but in another function, which may have introduced an element of trust important for discussions around the difficult topic covered.

Interviewers who conducted the interviews of wives-to-be had a meeting with the TA before each interview day to get feedback about previous interviews. Interviews with husbands-to-be were conducted by the TA. Among participants, some of them could have been asked to check the primary results. An independent co-examiner also marked the meaning units in some interviews to check the validity.

7 CONCLUSION

This thesis provides a community social assessment based on the opinions of various community members concerning both the potential risk factors of IPVAW and potential means of its prevention. Hopefully this material will help lay the groundwork for locally adapted interventions by clarifying norms and attitudes that can be targeted by an educational programme, in particular one for couples-to-be.

Women's opinions indicate that what they regard as potential causes and triggers of IPVAW are mostly those already documented in the scientific literature and raised in public health settings. Married men have split opinions that tend to cluster and can be summarized in four main patterns. The biggest one (one-third of men) included men who expressed opinions much similar to those of women. The three others either disagree or have mixed opinions.

There are also similarities in the views expressed by men and women in general regarding the items less agreed upon. In particular the least collectively agreed-upon potential causes, and this is the case for all men and women, were the absence of a male child and the amount of dowry which are culturally important in this area. This finding is surprising in the context of Iran where both these elements are much valued and it is difficult to judge whether this is a true denial or not. Further investigation might be required for a better understanding.

Another aspect that deserves consideration – and could be something essential to address in the development of a prevention programme – is that those forms of behaviour by the wife that have the greatest potential to humiliate a husband in front of other people acquired the highest agreement in both groups of women and men. These opinions are a source of concern as they can be regarded as supportive of a kind of “victim-blaming” attitude.

The majority of the participants regarded the use of educational programmes as a means of prevention of IPVAW in a positive light. Married men and women largely agreed on the benefits of educational programmes for the prevention of IPVAW and also on the effects of specific counter-measures mainly in the field of raising awareness and interpersonal relationship skills training. Key informants also widely proposed community education about relationship issues to prevent IPVAW.

Husbands-to-be, wives-to-be and also their instructors supported premarital educational programmes dealing with IPVAW as a potential means for its prevention. However, lack of support from the supervisors of premarital educational centres regarding the effectiveness of such programmes reveals that there are some barriers that should be identified and removed before any programme implementation. Deciding on an appropriate course curriculum, bearing in mind the time limitations of the current premarital educational programme, is another issue. Relationship skills training was suggested much more than raising awareness for the course curriculum for the premarital educational programme by the husbands-to-be, wives-to-be and gatekeepers. But an education programme in the field of raising awareness is more practical

considering the current time limitations of the programme. It is important to bear in mind that this is a brief course and could not in or by itself bring about a long-lasting sustainable change, but the fact that all couples-to-be are exposed to such training is a very important opportunity for the presentation of societal values. To include among these a number of values relative to the non desirability of IPVAW could be a first step towards individual, relational, community and societal change.

It is important to note – and to further address – the persisting idea- albeit present only among a limited number of participants – that the main responsibility for prevention lies with the women. This misconception is once again in line with a victim-blaming attitude.

Considerations for policy and practice

Since this project started, many studies have been conducted, in low- and middle-income countries in particular, related to IPVAW. Most of them have focused on exposure to and potential risk factors of IPVAW. Surprisingly few deal with primary prevention or with public opinions, attitudes and norms about IPVAW in particular. It seems that most public health actions regarding education and prevention of IPVAW have been undertaken in the absence of contextual diagnoses, including data on local understanding⁽¹¹²⁾.

The ultimate goal of this thesis was to lay the ground for the development of a premarital educational programme to prevent IPVAW resting on a social assessment of opinions of various community members, as a source of understanding of local attitudes and norms. Currently, in their educational sessions, premarital educational centres inform about three main topics: sexual issues, family planning, and genetic diseases. This forms part of their public health mandate and the information is provided by trained female health workers. Participation in such a training session is compulsory for a marriage to be registered. It is envisaged that part of this session could include a number of key messages relative to IPVAW.

But the training is neither long nor repeated (or followed up), which are important limitations for long-lasting effects. The current sessions take less than one hour and the part on IPVAW could probably not last more than around 10 minutes. But having a message about IPVAW for all couples-to-be in the country could be a good start for primary prevention of IPVAW.

A pilot project could be conducted that could select a number of those key messages and thereafter assess how they affect the knowledge and attitude of couples and how long-lasting this effect seems to be. The general agreement on educational programmes as a means of prevention of IPVAW among all groups of participants encountered during the thesis work can be regarded as a sign of community acceptance of such a programme. The material gathered throughout this thesis could be used to raise the following considerations:

1. The one-sided, victim blaming attitude observed among a number of key informants and other participants is a misconception that warrants particular consideration. Efforts should be undertaken to change the attitude that wives

deserve the violence perpetrated against them if they behave in certain ways to an attitude that recognizes that violence is never an appropriate response to a wife's behaviour, no matter how frustrating. Educational programmes, including premarital ones, should focus on two-sided responsibility with more focus on the perpetrator to develop non-violent problem-solving skills and avoid the victim-blaming attitude. Premarital educational programmes could emphasize the mutual responsibility of the couple for stress management in the family.

2. High consensus among women regarding the documented potential causes and triggers of IPVAW and similar views between men and women regarding the potential causes and triggers that acquired the highest and lowest agreement could be something essential to address.
3. Participants focused on both relationship skills training and raising awareness in premarital educational centres to prevent IPVAW but the former was more emphasized. However, an education programme in the field of raising awareness is more practical considering the time limitations of the current premarital educational programme. Starting with raising awareness makes it more feasible to develop relationship skills training later.
4. Supervisors of premarital educational centres didn't regard the idea of premarital educational programmes as a promising one. Their thoughts about this need to be better understood for better results.

Of course addressing individual and relationship factors which are among those more easily dealt with in the family would be one of many necessary interventions and steps in order to decrease acceptance and legitimacy of the perpetration of IPVAW. In a public health perspective addressing risk factors on all individual, relationship, community and societal levels is necessary from many community sectors to prevent IPVAW.

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