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EDITORIAL

Violence: News on a public health problem

KARIN HELWEG-LARSEN

In 1996, the UN World Health Assembly adopted a resolution that declared violence to be a major and growing public health problem across the world. The resolution drew attention to the serious consequences of violence, both in the short and the long term, for individuals, families, communities and countries, and stressed the damaging effects of violence. The World Health Organization (WHO) was requested to set up public health activities to deal with the problem. In 2002, the WHO published the first world report on violence and health [1]. It addressed violence as a global health problem, and covered youth violence, child sexual abuse and neglect, intimate partner violence, abuse of the elderly, sexual violence, self-inflicted violence, and collective violence (violence during armed conflicts).

The WHO defines violence as the intentional use of physical force or power, threatened or actual, against oneself, another person or a group or community that either results in or has the likelihood of resulting in injury, death, personal harm, maldevelopment, or deprivation. It covers a broad range of outcomes, including injuries, chronic diseases, psychological harm and adverse development, that pose a substantial burden on individuals, families, and communities. The world report on violence and health primarily described the physical, psychological and social problems of intimate partner violence and sexual violence against women, and, to a lesser degree, the possible long-term, health-related consequences of violence against men.

Collective violence was subdivided into social, political and economic violence, committed by larger groups of individuals or by states. It included war and related violent conflicts. Apart from the direct health effects on combatants during war and armed conflicts, violence against women and girls has risen sharply since the start, in 2003, of the war in Iraq [2], and as a result of other regional conflicts [3].

In 2002, the Council of Europe adapted recommendations to combat violence against women in the Member States. Consequently, the Council was to receive annual follow-up information at a national level regarding the provisions of this recommendation. In this respect, in 2005, the Council implemented a set of indicators to monitor the Member States' initiatives to combat violence against women. Among these indicators were current and nationwide sex-differentiated register data on police-reported cases of violence, and data on emergency department contacts due to violence. Furthermore, to monitor the trends in violence against women, it was recommended to include questions on violence in the Member States' regular, national health interview surveys.

The Danish National Institute of Public Health considers violence to be a serious risk factor for physical and mental health problems. Hence, since 2000, the national health interview surveys have included standardized questions on exposure to threats of violence, physical violence, and unwanted sex. The regulations on register-based research in Denmark permit the merging of survey data and

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register data on the basis of the personal identification number, which is used both in the health interview surveys and in national registers. By this means, data on violence exposure among men and women have been linked to data in the Danish criminal statistics and national patient register. These comprehensive data on self-reported and publicly known cases of violence have enabled various analyses of the amount, characteristics and possible health consequences of violence in both sexes, and also a description of the trends in intimate partner violence from 2000 to 2005. Recently, a decrease in the prevalence of intimate partner violence among women was noted. Similar trends are now being reported in some regions of the USA (personal communication). The results of the Danish database on violence against women and men are available on the Internet (www.lige.dk).

In 2006, an editorial in this journal designated violence against women as a global public health crisis [4]. It summarized the scope of violence against women (gender-based violence), including intimate violence, sexual assault and child sexual abuse, female genital mutilation, trafficking of women and girls, and sexual violence in armed conflict situations. Although a number of studies had reported long-term physical and mental health problems among women related to prior exposure to violence, the editorial pointed to the lack of comparable data on the prevalence, characteristics and epidemiology of the various types of violence against women. It was stressed that existing data are difficult to compare, due to various definitions, time frames and study populations. It was recommended to embed questions on violence in epidemiological studies on health issues.

The editorial further referred to the ongoing WHO multi-country study on women's health and domestic violence as an example of standardized questionnaire and data-collection procedures. This study was conducted between 2002 and 2003 in non-European, primarily developing, countries, and the results were recently published [5]. Similarly to previous studies, significant associations were found between lifetime experiences of partner violence and self-reported poor health in all 10 countries that were included in the multi-country study.

Previously, various European countries have conducted population-based surveys on violence against women; among these were an early Finnish survey in 1997 [6] and a Swedish study in 2000 [7]. These surveys did not focus on the possible health consequences of violence, whereas the first Norwegian national study of violence against women, which was recently published in this journal, examined exposure

to partner violence and self-reported poor health. Significant associations were found [8].

Violence seems to have devastating consequences for the women who experience it. However, a causal relationship between experienced violence and poor health cannot be shown by cross-sectional data; victims of violence may, at baseline, present different health problems from persons who have not experienced violence. In spite of the possible bias in survey data, intimate partner violence is reported to account for between 5% and 20% of health years of life lost in women aged 15–44 years [9]. No similar calculations exist for male victims of violence.

The relatively few studies on gender differences in health outcomes of violence have focused on female and male sexual violence and abuse in childhood and adolescence [10]. An exception is a study published in 2005, which, based on data in the Danish national health interview survey 2000, analysed gender differences in physical violence, self-rated health, and morbidity [11], and a recent US study [12] on chronic disease and health risk behaviours associated with intimate partner violence.

In 2007, the Danish study was followed up by analyses on violence and health problems among both women and men. For both sexes, significant associations were found for exposure to physical violence during the last year and psychological distress and suicide attempts. Among women, about 40% of all violence was committed by a partner, and among men, 10% [13]. These studies point to the importance of partner violence as a public health issue for both women and men, and to the fact that it has a range of long-term health consequences.

Accurate and comparable data have been needed and are still needed to strengthen advocacy efforts, help policy-makers understand the problem, and guide the prevention interventions for intimate partner violence and other types of interpersonal violence. Relatively recently, an increasing understanding of the links between witnessing domestic violence as a child and a later risk of exposure to partner violence and to health problems has been obtained. The risk of dating violence among adolescents has been reported to be associated with having lived in abusive households.

Work-related violence is increasingly reported as a serious risk factor for poor health and social problems. In Denmark, the prevalence of such violence has increased during the last 5 years. Høgh and co-workers report a high risk of physical violence and threats of violence, and of work-related violence towards healthcare workers during training and the first year at work after graduation. Independently of gender, age, sense of coherence and health at

baseline, violence in previous jobs had a significant impact on the health of victims at follow-up. A tendency towards an impact on their health of exposure to violence during training was also found at follow-up [14]. The study indicates a need for violence prevention in training programmes and workplaces.

Interventions to prevent violence against women, men, adolescents and children must target very

different aspects of interpersonal violence. Primary interventions, including early schooling programmes that target gender equality and human rights, may in the long term prevent both domestic violence and other forms of violation. One major challenge is to reconsider domestic violence as a public, not a private, offence, and to strengthen the responses from the healthcare and social service sectors.

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