The development and implementation of questions on violence in national health surveys in Denmark and Finland.

A comparative study under the DAPHNE program 2000-2003.

Karin Helweg-Larsen
Vanita Sundaram
Markku Heiskanen
Minna Piispa

National Institute of Public Health
Statistics Finland

Copenhagen April 2003

Prevalence and Health Sequels of Violence
Final Report

The project Prevalence and Health Sequels of Violence was coordinated by the National Institute of Public Health, Denmark with financial support of the European Commission, under the Daphne programme to combat violence against children, young people and women (Contracts 00/106/WC-1 and 00/106/WC-2).

The contents of this publication do not necessarily reflect the opinion or position of the European Commission, Directorate-General for Justice and Home Affairs.

Preface

This report presents the results of the project Prevalence and Health Sequels of Violence (JAI/00/106/WC). The European Commission supported the project under the Daphne programme, by contractual agreement with the National Institute of Public Health, Denmark. The main objective of the project was to develop a limited number of standardised questions on experienced violence and sexual abuse and to test the feasibility of implementing these questions in national health surveys in two EU Member States, namely Denmark and Finland. Hereby, the project aimed to achieve data on the magnitude of violence in the MS and the health impact of violence for women and men, as well as to obtain information on the practical issues related to implementing sensitive questions in national health surveys.
The following Member States were thus signed as contractual partners:
- Denmark, represented by Karin Helweg-Larsen, National Institute of Public Health.
- Finland, represented by Markku Heiskanen, Statistics Finland.

Scotland was signed as a sleeping partner (non-paid) to the project, represented by David Stone, University of Glasgow. Scotland was kept informed of the project’s progress and results on an ongoing basis. The project was implemented with reference to the policy of European Women Lobby and the Danish National Women Council. The European and the Danish Observatory on Violence against Women were sleeping partners to the project.

The partners were asked to describe the data achieved on the magnitude of violence and its associations to health measures included in the national health surveys. Additionally, partners were asked to supply information about the response rates achieved overall for the health surveys, as well as specifically for the violence questions, this information being used as an indicator of the feasibility of the study.

In Denmark, the implementation and coordination of the project was carried out by Karin Helweg-Larsen and Vanita Sundaram, who were also responsible for data analysis, layout and writing of the final report. Bjarne Laursen and Michael Davidsen carried out the statistical analyses on both Danish and Finnish data.

In Finland, data collection was carried out by Markku Heiskanen and Minna Piispa.

The project team wishes to thank its partners and all contributors to the project and writing of the final report.

Karin Helweg-Larsen  Mette Madsen
Project leader  Deputy director
1. Executive summary

Introduction

The project Prevalence and Health Sequels of Violence was conducted with financial support from the Daphne programme – a 4-year EU programme to combat violence against children, young people and women. The project complied with the priority areas stated in the mission for the Daphne programme, which emphasised the need for concerted worldwide action to defend human rights and eliminate violence, through the exchange of information, coordination and cooperation between non-governmental organisations and public authorities and through raising public awareness and exchanging best practices learned from research projects.

The Daphne programme, as well as such initiatives as European Women’s Lobby (EWL) launched under Daphne, have emphasised the need for improved, reliable and comparable data on violence in order to gain a comprehensive picture of the magnitude of violence in the different Member States (MS) and to analyse the impact of violence on people’s lives, including health status and health-related quality of life. The World Health Organisation’s recent report on Violence and Health has emphasised that violence is a global public health problem, responsible for 1.6 million lives lost every year and countless more damaged in both visible and “invisible” ways. A great deal of research points to the different types of violence that men and women experience and the gender-specific consequences violence therefore has for health. It is pertinent that we continue to obtain and improve our knowledge of the impact of violence on health, including the gender differences in experiences of violence and its consequences. As World Health Organisation has pointed out, knowledge of the mechanisms underlying violence and its consequences are imperative in order to develop targeted prevention strategies.

The present project focused on obtaining knowledge about the magnitude of interpersonal violence and its consequences, while recognising that the range of abuses people commit against one another encompasses many more forms of violence. The WHO World Report on Violence and Health emphasised that different forms of violence feed off each other, such that victims of child abuse or intimate partner violence are more likely to harm themselves in the future. Male victims of child abuse, both sexual and physical, are more likely to exercise violence as adults, including against their intimate partners. Numerous studies and international authorities have pointed to the severe and long-term effects that interpersonal violence has on health. The present project thus aimed to obtain reliable and comparable data on the magnitude of interpersonal violence and its health-related consequences for both genders through national health surveys in a limited number of MS.

Aim

The overarching aim of the present project was to improve knowledge of the prevalence and nature of interpersonal violence and its effects on health. The project sought to develop a limited number of standardised questions on experienced violence and sexual abuse and to test the feasibility of integrating these questions into national health surveys in two MS. A derivative aim of the project was to collate data on the magnitude of violence and sexual abuse in the respective MS and to link these data with health data from the health interview surveys (HIS) in order to analyse the impact of violence on health status. The inclusion of violence questions in regularly conducted national health surveys also opened for the monitoring and follow-up of violence data. Six standardised questions were thus developed and implemented into national health surveys in Denmark and Finland. Scotland was a non-paid (sleeping) partner in the project. It was agreed with Dr. David Stone, Glasgow University, that he would be kept informed of the progress and results of the project, with a view to future implementation of the same questions in a local or national health survey.

Method and material

Denmark has been the principal coordinator of work related to the project. The Danish questions were included in a self-administered questionnaire that was supplementary to the Danish National Health
and Morbidity Survey. Respondents answered the questionnaire after the interview was completed and returned it by post. Finland introduced the questions into two national health surveys: the Consumer Survey (a telephone interview) and a self-administered mail questionnaire, supplementary to the National Health Survey. The Finnish partners were asked to provide data on experienced violence and sexual abuse and self-rated health for both genders. The latter variable was included in the Finnish Consumer Survey in order to obtain information about correlations between violence and self-reported health. In Denmark, it was also possible to analyse correlations between physical violence and specific indicators of morbidity.

Information about the response rates for each of the surveys in the respective countries was vital for the present project, as an integral aim was to test whether there would be a decrease in response rate when sensitive questions were introduced into national health surveys. The data from Denmark and Finland were analysed and experiences in implementing the questions and obtaining the data were compared.

Results

With financial support from the Daphne programme, it was possible to develop six standardised questions on experienced violence within the past year and lifetime experience and sexual abuse, experienced in childhood and in adulthood. The Nordic Research Network on Health and Violence participated in the development of these standardised questions. The questions were translated into Danish and Finnish at a joint partner meeting and were thereafter integrated into existing national health surveys. Information was thus obtained about the prevalence of physical and sexualised violence in each partner country, as well as the correlations between violence and self-reported health – and in Denmark, specific symptoms of morbidity. This information was obtained for both men and women, thereby enabling us to analyse gender differences in exposure to violence and in the impact of violence on men and women’s lives.

A further result of the present project was that the response rates did not decrease due to the inclusion of sensitive questions in national health surveys – and thereby affect representativity, as had been feared. In Denmark, the questions on violence and sexual abuse were included in a supplementary self-administered questionnaire and this therefore did not affect the response rate of the national health interview survey. In Finland, the questions included in the self-administered questionnaire supplementary to the national health survey and did not affect the response rate – it remained relatively high. The response rate for the telephone interview was also relatively high. Therefore, it could be concluded that it was feasible to implement questions on violence in national health surveys, an important result for the project as it aimed to promote the inclusion of standardised questions on violence in national health surveys as a future European standard.

The Daphne programme and EWL have as mentioned, emphasised the lack of existing reliable and comparable violence data. The information gained from the present project in this respect is valuable in two ways:
The data gathered increases and improves our knowledge about violence and its impact for health in two MS and is pioneering in both partner countries, in that never before have violence questions been included in national, and regularly conducted health surveys. The standardisation of the violence questions allows for comparability between the partner countries.

Secondly, the feasibility of implementing the questions in national health surveys without causing a decrease in response rate, establishes a future model or standard on which other MS can base their collection of valid, reliable and comparable data on violence and health consequences.

Response rate

The response rate on all the questions on physical violence was relatively high for both partner countries. In Denmark, the response rate on physical violence questions in the self-administered question-
naire was on average 96% for both men and women. The response rate did decrease with age, but still remained high for those aged over 67 years at 91% for men and 88% for women.

In Finland, the response rate for the physical violence questions was lower than in Denmark for the self-administered mail questionnaire (national health survey). Overall, 83% of men and 88% of women answered the violence questions. There was a marked decrease by age amongst the men, such that 69% of men and 89% women aged over 67 years answered the violence questions. On the other hand, the response rate for the violence question in the telephone interview was very high at 99.5% for both men and women.

The response rate for the questions on sexual abuse was also relatively high for both partner countries. In Denmark, the response rate was 96% for both men and women. In Finland, the response rate for the health survey was lower at 89% for men and 81% for women. For the telephone interview however, the response rate was almost 100% for both genders.

Physical violence

The present study showed that recall bias and other factors strongly influence the reported incidence of lifetime experience of violence. In the Danish health survey, the cumulative incidence of physical violence decreased sharply by age, such that men aged 45-66 years reported an incidence three times lower than that of young men aged 16-24 years. The present study therefore focused on the incidence of violence experienced in the past year.

The incidence of physical violence experienced during the last 12 months was higher amongst men than amongst women in both countries across most age groups. The exception was for the age group 45-66 years, where Finnish women experienced slightly more violence than Finnish men in the corresponding age group and the reported incidence for Danish men and women was equal. Generally, both Finnish men and Finnish women reported experiencing more violence during the past year compared to Danish men and women. The most marked difference was however, between Danish and Finnish women. Finnish women reported experiencing physical violence approximately twice as much as Danish women across all age groups, on average 12.3% versus 5.8%.

Sexual abuse

The incidence of sexual abuse experienced in childhood, adolescence and in adulthood was much higher amongst women than amongst men in both countries. In Denmark, the rate of childhood sexual abuse for girls was highest at 4.4%, compared to 2.5% in the Finnish self-administered questionnaire and 3.1% in the telephone interview. For coerced sexual activity experienced in adolescence, the incidence was higher in Finland, overall 6.9% compared to the Danish incidence of 4%. Forced sexual activity experienced as an adult was also highest in Finland at 10% compared with 4.6% in Denmark.

There were age differences in the reported incidence of sexual abuse experienced in adulthood, such that the highest incidence was reported amongst women aged 25-44 years in both partner countries. In the Danish health survey, 5.9% of women aged 25-44 years had experienced coerced sexual activity once or more. In the Finnish health survey, the corresponding figure was 13.6% and in the Finnish telephone interview, the figure was highest amongst 16-24 year-olds at 21.4% and 4.3% amongst 25-44 year-olds.

Correlations between violence and self-reported health

Primarily Danish data was used for these analyses, as the Danish sample comprised a significantly higher number of respondents than the two Finnish samples. Poor self-reported health was reported significantly more by female victims of violence than non-victims. As expected, poor self-rated health is reported most amongst the older age groups. There is no significant difference in poor self-reported health between male victims of violence and non-victims.
Correlations between violence and specific morbidity symptoms

The analyses were conducted on correlations between experienced violence and morbidity symptoms experienced within the past 14 days. It was found that female victims of violence were significantly more likely to experience all of these symptoms than female non-victims, when data had been adjusted for age and socio-economic status. There was no significant difference in reporting of morbidity symptoms between male victims and male non-victims.

Conclusions and recommendations

The present project was able to develop and integrate six standardised questions on violence and sexual abuse into national health surveys in two Member States: Denmark and Finland. The questions on violence and sexual abuse achieved a relatively high response rate, despite the sensitive nature of the questions and therefore, the data obtained in the project are valid and reliable. The standardisation of the questions meant that the data collected on violence were comparable between countries.

Based on the results of the present project, it can be concluded that the implementation of a limited number of standardised questions into national health surveys, which are conducted amongst a broad sample of the population, constitutes a valuable tool by which reliable and comparable violence data can be collected. A major strength of the study is that national health surveys are conducted regularly, providing opportunity for follow-up and monitoring of violence trends, knowledge which in turn can be implemented in developing targeted prevention strategies. The project therefore promotes the implementation of standardised questions on violence in national health surveys as a future standard for European MS.

In terms of ethical aspects, the project followed the ethical principles for medical research, adopted by the World Medical Association in the Helsinki Declaration. The project also followed the WHO recommendations for domestic violence research, which emphasise the safety of the respondent and the researcher, that the study design should aim to cause the woman the least amount of distress and should take into consideration how to minimise the underreporting of violence, and that researchers should ensure that their results are interpreted properly and are used to advance policy and intervention development.

The present study did confirm that questions regarding lifetime experience of violence do not minimise the underreporting of violence. On the contrary, reported incidence of lifetime experience of violence decreases sharply with age, due to recall bias amongst other factors, amongst both genders. In relation to questions about sexual abuse experienced in childhood, we inevitably have to be aware that recall bias may affect the reporting rate and the reported incidence. Therefore, the study also included questions on violence experienced within the past year. Generally, it is recommended that as data on lifetime prevalence of physical violence and sexual abuse in adulthood are so unreliable, future questions on experienced physical and sexualised violence in national health surveys should refer to the last 12 months as a minimum.

The use of Strauss-defined questions on physical violence is also recommended for future national health surveys. The differentiation between six different forms of violence enables us to analyse the different forms of violence, according to degree of severity.

In conclusion, the acknowledgement of violence as a growing public health problem naturally opens for questions on experienced violence and sexual abuse to be integrated into national health surveys. By implementing standardised questions on violence in health surveys conducted amongst a broad segment of the population, valid and comparable data on the correlations between violence and health can be obtained. The authors of the present study wonder why this has not been done earlier, given the well-documented connection between the violence and health and the evident opportunity by which to obtain reliable and comparable data. The main recommendation of the study is that the
developed questions on violence and sexual abuse continue to be implemented in national health surveys in the different European MS, with a view to collecting comparable violence data, analysing the health impact of violence on people’s lives and implementing a tool by which violence trends and subsequent prevention strategies can be monitored.

2. Introduction

Violence pervades the lives of many people around the world, and affects all of us in some way. To many people, staying out of harm’s way is a matter of locking doors and windows and avoiding dangerous places. To others, escape is not possible. The threat of violence is behind those doors – well hidden from public view. This statement opens the preface of the World Health Organization’s World report on violence and health (WHO 2002). The victims of the hidden violence are children, young people and women. They are victimized by domestic violence, violence in schools, verbal violence and sexual violence including trafficking and prostitution. Minority groups, handicapped and ethnic minorities, are especially vulnerable to the hidden violence.

The European Commission’s Daphne Programme was set up in 1997 to support action to combat violence against all forms of violence against children, young people and women. In the following years, in all EU Member States a great number of initiatives have been developed. Many countries have inaugurated national plans of action to prevent violence against women, and through the Daphne Programme a large number of national and local projects have been conducted.

Policy implications of the lessons learned from the Daphne projects are being utilized in the Commission’s own initiative projects on data collection concerning violence against women, young people and children.

By December 2002, under the Danish EU Presidency, indicators concerning domestic violence were adopted with a view to future follow-up to the Beijing Platform for Action concerning domestic violence against women. The indicators include profile of female victims of violence. However, at present very few member states have access to data sources that currently may illuminate this indicator. Some of the proposed characteristics of the victims may be well described in population-based surveys on violence, but only a limited number of member states have conducted such surveys. Furthermore, most surveys do not contain current data, and only few surveys will be repeated within a reasonable period to monitor the trends in the problem.

At present, very few countries have integrated information about experienced physical violence and sexual abuse in the national health surveys – few countries conduct regularly victim-surveys or have access to gender disaggregated data in their criminal statistics - and questions about the proportion of women, who seek help from health services can only be answered by a few countries. Therefore, there exists a serious lack of data needed for monitoring trends in violence against women, and thus for monitoring the outcomes of national plans of action against violence.

Both WHO, OECD and the EU require the European countries to produce reliable and comparable health statistics. Health data derived from health interview surveys are an important source for this statistics. An overview of national health interview surveys in Europe found that such surveys are performed in most Member States of the European Union, and that most include fourteen health topics, some only seven. All surveys include questions on health status, e.g. self-assessed health, whereas lifestyle topics are less often included, and no survey included questions about physical or sexualised violence (Hupkens et al. 1999).

European Policy Action

In 1997, the European Women Lobby (EWL) created its internal Policy Action Centre on Violence against Women where the mission it is to guide the EWL in its policy development on all issues of violence against women. Over the years the Observatory has conducted projects under the Daphne Programme, among these a review of official data on domestic violence in the 15 member states of the European Union: Unveiling the hidden Data of Domestic Violence in the EU.

The report pointed to the lack of adequate data and statistics on the incidence of violence against women and urged for development of good practices for data collection based upon research results. During the last two years, through the Daphne Programme national observatories on violence against women have been established in some member states, among those in Denmark. The national observatories work in close cooperation with EWL’s Action Centre, and one of the outcomes of the collaboration is the present project.
The project responded to the EWL’s pledge for better data on violence against women and has from the onset been based on a close collaboration between the Danish National Observatory on Violence against Women under the Danish National Women Council and the European Action Centre under EWL.

The immediate objective of the project was to test the ethical and practical issues of integrating sensitive questions on physical and sexual violence into national health interview surveys, and thereby test the feasibility of regular data collection on violence through health surveys in the Member States.

3. Background for the project

The European Union launched the Daphne programme to prevent violence against children, young people and women, to provide support to the victims of violence and prevent their future exposure to violence. The need for concerted worldwide action to defend human rights and to eliminate violence has long been recognized at different levels and in different ways. Several measures have been taken along these lines, such as the 1979 Convention on the Elimination of All Forms of Discrimination against Women, the 1989 Convention on the Rights of the Child, the platform for action of the 1995 Beijing Conference, and the 1996 Stockholm Declaration and Agenda for Action at the first World Congress against the Commercial Sexual Exploitation of Children. At the second World Congress against the Commercial Sexual Exploitation of Children, in Yokohama in December 2001, the Daphne programme implemented by the European Commission was acknowledged as a very useful tool.

Violence in itself is demeaning, cruel and unjust and it undermines health. Acknowledging this, in 1996 the World Health Assembly adopted a resolution declaring violence a major and growing public health problem across the world. The public health aspects of violence were recently described in WHO’s World report on Violence and Health. The report brings all forms of intentional violence together and makes clear how much the different forms of violence feed on each other. People who are subjected to child abuse or violence by an intimate partner are much more likely to harm themselves or to be repeatedly victimized by interpersonal violence (Heath, BMJ 2002). Almost every form of violence predisposes another and it presents a strong risk factor for health problems and deteriorated well-being.

Violence against women and health

Violence in its physical, mental and psychological forms is increasingly being recognised as a public health problem that has long-term human and economic costs (WHO 2002; Watts & Zimmerman). An increasing amount of research is beginning to offer a global picture of the extent of violence, particularly against women. This official and global recognition of the dangerous impact of violence against women, particularly intimate partner violence, has led to an increased public awareness around an issue, which was previously silenced and underplayed as a “normal” aspect of social and gender relations. Additionally, the increasing focus violence has contributed to dispelling myths of violence against women as a phenomenon that occurs only in developing and non-industrialised societies. Violence against women has been documented as a globally occurring form of gender oppression, present across social, ethnic and religious strata. Violence against women has otherwise been termed “gender-based violence” and has been defined by the World Health Organisation as acts that “result in physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivations of liberty, whether occurring in public or private life” (United Nations Commission on the Status of Women 1992).

Gender-based violence is estimated to be responsible for one out of every five healthy days of life lost to women of reproductive age (Heise, Pitanguy, and Germain 1994). Intentional injuries, violence - constitute a large part of all injuries and present a serious health threat particularly to children, young people and women. Globally, it is estimated that intentional injury ranks fifth amongst the leading causes of burden of disease amongst younger adults (Euro-Barometer 2002). It has been documented that violence has both physical and mental health consequences for both genders (Breslau 2002; Coxell et al. 1999; Forjuoh et al. 1997). However, it appears that poor physical and mental
health disproportionately affects women who have experienced violence, across age groups, ethnic groups and socio-economic classes (Lown and Vega 2001; Mouton et al. 1999).
The differential health impact of violence on men and women is likely due to the differing, gender-specific types of violence that men and women experience. The majority of violence experienced by men is perpetrated by other men and primarily occurs in public spaces. They are usually isolated incidents of violence, rather than repeated, ongoing abuse and men’s violence towards each other is accepted and normalised as a “natural” aspect of male/masculine behaviour. Thus, it is rare that one is construed as a victim and the other as an abuser — rather, it is a mutual display of power and “masculinity”.

Violence against women is conversely primarily perpetrated by a male intimate partner or family member and occurs within the confines of the home, the private sphere of the family. The violence is often repeated, continuous and a means by which to control the woman’s actions and behaviour. The physical abuse coupled with social and economic factors often render the woman powerless and the male abuser powerful. Societal and legal norms often render it difficult for the woman to seek and obtain help and support to leave her abuser.

Violence against women encompasses physical, sexual, emotional, psychological and financial abuse amongst a wide scope of abusive behaviours and is associated with a range of health problems, such as injuries; sexually transmitted diseases and HIV; pregnancy complications and mental health problems and a high prevalence of headaches, chronic pain and sleep problems (Frank and Rodowski 1999; Roberts et al. 1998a; Dienemann et al. 2000). The majority of quantitative research has been conducted on the magnitude and health impact of physical and sexual violence for women. The following reviews the existing literature on health sequels of violence. Despite the clear link between violence and health, patterns of violence and its sequels cannot be statistically mapped based on current data, due to the widely differing ranging study designs, study populations and response rates.

**Physical violence and health**

Women reporting physical violence by an intimate partner report more depression, anxiety, sleep disorder, smoking and suicidal ideation amongst other symptoms, than women who have not experienced violence (Hathaway et al. 2000; Jaffe et al. 1986). Plichta & Falik (2001) also point out that women who experience physical violence have poorer mental and physical health, and also experience increased problems with access to medical care. In their study of women in America who had experienced physical violence, they found that only one-third had discussed any consequent health problems with a physician, thereby perpetuating their deteriorated health status (Plichta and Falik 2001).

The negative effects on health from physical violence appear to be salient even when the violence is categorised as low-severity i.e. pushing and grabbing or threats, as compared with hitting, slapping or choking.

McCauley et al. (1998) conducted a study to determine whether the number of physical symptoms, psychological distress, or substance abuse differed amongst women who experienced low-severity violence, in comparison with women who had never been abused, and those who experience high-severity violence. The study found that the number of physical symptoms and psychological distress increased with increasing severity of violence, and that women with current violence were more likely to report a history of substance abuse than women who had never experienced physical abuse (McCauley et al. 1998).

**Social reactions to violence**

Post-assault social reactions have also been documented as correlative with victims’ health perceptions. Tangible aid and information support following assault was related to poorer health perceptions, whereas emotional support was related to better health perceptions amongst victims. Additionally, more severe physical violence was associated with poorer current perceptions of one’s health and this association was mediated by negative social reactions to victims (Ullman and Siegel 1995). Battered women’s perceptions of loss and perceptions of health are found to be significantly related (Wang and McKinney 1997). Negative perceptions health and loss were found to decline even after five days away from the abusive situation.

**Sexual abuse and health**

Sexual abuse is also associated with a range of somatised symptoms and a general deterioration in health-related quality of life. Dickinson et al. (1999) found that history of sexual abuse in their patients
was linked not only to physical symptoms of poor health, but also psychiatric symptoms and diagnoses. Further, there was a linear relationship between the severity of the abuse and detriment to health-related quality of life, as has been documented to be the case with physical abuse (Dickinson et al. 1999).

Sexual assault has also been associated with poor subjective health and this has been documented to be regardless of gender, ethnicity or sample (Golding, Cooper, and George 1997). The authors found that even after controlling for depression, the correlation between sexual assault and poorly rated health was not mediated. Poor self-rated health appeared to be most strongly associated with multiple sexual assaults by stranger or spouse.

The manifestation of actual physical symptoms as a consequence of sexual and physical abuse history has also been documented. Women with particularly severe abuse history are much more likely to report somatic symptoms related to panic, depression, musculoskeletal disorders and genitourinary disorders (Leserman et al. 1998). Additionally, women experiencing sexual abuse are found to be more likely to have a history of multiple sexually transmitted diseases, worry about having an HIV infection and suffer from pelvic inflammatory disease (Schei B 1991). Salmon et al. (1996) also find a correlation between childhood physical and sexual abuse and increased hospital admissions and surgical procedures in adult life (Salmon and Calderbank 1996).

The few studies conducted on physical violence among men have primarily shown that a greater share of men experience violence compared with women in corresponding age groups. However, few if any studies have analysed the physical and psychological health consequences of physical violence for men. A recent study exceptionally analysed the effects of physical intimate partner violence for both men and women and found that men were more likely than women to experience verbal abuse alone, whereas women were significantly more likely to experience all other measures of intimate partner violence – physical, psychological and sexual. Both men and women experienced negative health outcomes as a result of the violence, although physical violence was more strongly correlated with chronic disease, depressive symptoms and substance use than verbal abuse (Coker et al. 2002).

A few studies have been conducted on the effects of childhood sexual abuse for both men and women. These studies show that childhood sexual abuse among males is associated with a greater prevalence of psychological problems, alcohol abuse and self-harm in adulthood. Substance abuse, suicide attempts and various reproductive health problems in adulthood have been correlated with childhood sexual abuse among women. The research shows that experienced sexual abuse (both childhood and adulthood) is more prevalent among women than men; however, the issue of underreporting must also be considered as a potential bias in the known prevalence amongst men.

Very few, if any surveys have implemented questions on experienced violence addressed to both men and women, thus giving the possibility for analysing the magnitude and character of health problems amongst male and female violence victims, as well as analysing gender differences in the violence-health correlations. This knowledge is essential for developing and targeting violence prevention and treatment strategies.

**Lack of data**

The WHO World report on violence points out that the painstaking collation of available data on violence allows useful conclusions to be drawn about those factors that seem to make violence more likely. However, there exists a serious lack of data to evaluate the health impact of violence and to monitor the effect of prevention strategies and health care services. Hence, accurate estimation of the global health burden of violence against women is hampered by lack of data. Due to significant under-reporting of intentional interpersonal violence, criminal statistics are inadequate in estimating the prevalence and nature of violence and consequent victimisation (Heise, Pitanguy, and Germain 1994), and other data sources should therefore be developed.

We briefly describe the existing initiatives and recommendations for violence data collection in the European Union.

**The Daphne programme**

The European Union launched Daphne, a four-year programme implemented by the European Commission to prevent violence against children, young people and women, provide support to the victims of violence and prevent their future exposure to violence. The Daphne programme runs from 1 Janu-
ary 2000 to 31 December 2003. Daphne encourages NGOs to set up or reinforce existing European violence-prevention networks and helps them implement innovative pilot projects, the results of which can be disseminated to other Member States and regions (http://europa.eu.int/comm/justice_home). Daphne emphasises the need to raise societal awareness of the detrimental personal and social effects of violence on victims, their families, communities and society at large. The focus is on exchange of information, coordination and cooperation between the NGOs and voluntary organisations in the different Member States and public authorities, including law-enforcement officers and social workers; raising public awareness and exchanging best practices by means of data collection in pilot projects and research programmes.

_European Policy Action Centre on VAW_  
As described above, in 1997, the first ever European Policy Action Centre on Violence Against Women was established under the auspices of European Women’s Lobby, to provide a forum for women’s NGOs to enable them to take a leadership role in engaging policy and decision-makers to take responsibility for violence against women. The European Policy Action Centre on Violence Against Women additionally focuses on the development of indicators and criteria of good practice in the field of violence and published a “Guide of Good Practice” (2001). The guide also includes a table of indicators to monitor progress in combating violence against women. The Action Centre on Violence continues to report a serious lack of reliable violence data. The absence of reliable and comparable data and statistics on the incidence of violence against women, the lack of and/or inadequate information, documentation and research on all aspects of violence against women impede efforts to establish a coherent picture of the magnitude and impact of violence and to design specific intervention strategies. The Action Centre on Violence Against Women conducted a study on official data on domestic violence in the 15 Member States of the European Union, entitled Unveiling the Hidden Data of Domestic Violence in the EU (http://www.womenlobby.org). The recommendations put forward in this report were a major inspiration to the present project. The European Women’s Lobby has emphasised that data collection on violence is vital for assessing the needs and gaps in prevention and survivor services, as under-reporting and normalisation of interpersonal violence distorts the true picture. The EWL has pointed out that the issue of data collection is a sensitive one. They emphasise that data and statistics must never cause a backlash to women, by undermining individual women and/or further causing harm. The detrimental effects of recording data can be found in some parts of the USA where a practice of systematic recording of incidences of domestic violence by hospitals and/or by the police has led to the intervention of child protection/welfare agencies resulting in an investigation of children’s welfare with the possible outcome of the woman losing child custody. Furthermore, a computerised file on the individual woman is stored and brought up every time she consults the agencies (a hospital for example) regardless of the reason for contact, and this practice in the USA may influence upon her access to appropriate health care (http://www.womenlobby.org).

In this type of example, the shortcomings of an individualised recording system result in maintaining women in a dependant relationship: the individual controlled relationship by a male partner is replaced by a controlled relationship by the State. Therefore, EWL have recommended that data recording and statistics must be used to measure progress and not as stated undermine the empowerment of women, either individually and/or collectively (http://www.womenlobby.org).

In many countries, women do not report acts of male violence to statutory agencies, particularly, when the perpetrator is known to them. This under-reporting does lead to a “normalisation” of male violence with the result that surveys and research are also weakened when trying to estimate the full extent of the problem. In 1999, the EWL carried out a study on domestic violence in the European Union and reached the conclusion that this form of violence concerns 1 in 4 women throughout the 15 Member States. Clearly this type of data necessitates preventive strategies that need to be implemented throughout the early stages of the life cycle of the girl child and young boys who, in adulthood remain the main perpetrators of violence against women.

_The European Union Indicators on domestic violence_  
By December 2002, the Danish EU Presidency proposed seven indicators with a view to a future follow-up to the Beijing Platform for Action with regard to domestic violence against women and invited future Presidencies to follow-up the indicators.  
The seven indicators are:

1. **Profile of female victims of violence**
a. The number of victims according to criminal statistics
b. The number of victims according to surveys
c. The number of fatalities as a result of domestic violence
d. The proportion of domestic violence as a percentage of all violent crimes
e. Any other relevant statistical data concerning female victims and the existence of dependent children
f. Characteristics of the victim:
   i. Relation of victim to the perpetrator
   ii. Age
   iii. Marital status
   iv. Citizenship
   v. Any other relevant background information, e.g. educational background, labour status

2. Profile of male perpetrators
   a. The number of perpetrators according to the criminal statistics
   b. The number of perpetrators seeking assistance through official or voluntary programmes
   c. The number of perpetrators according to surveys
   d. Any other relevant statistical data; e.g. the number of perpetrators seeking assistance in the health system
   e. Characteristics of the perpetrator
      i. Relation of victim to the perpetrator
      ii. Age
      iii. Marital status
      iv. Citizenship
      v. Any other relevant background information, e.g. educational background, labour status

3. Victim support
   a. Counselling-centres
   b. Emergency services
   c. 24-hours hotline
   d. Women Crisis Centres
      i. number of shelters per population
      ii. number of requests for shelter
      iii. number of refusals
      iv. funding of centres
   e. Guide on the available support
   f. Special police-units/task forces
   g. Legal advice for victims
   h. Official information on the Internet
   i. Support for victims to help re-enter the labour market
   j. Health protocols concerning medical care and treatment
   k. Co-ordination of the public support system
   l. Special support services for vulnerable groups
   m. Any other support measures

4. Measures addressing the male perpetrator to end the circle of violence
   a. Counselling
   b. Psychological/psychiatric treatment
   c. Re-socialisation programmes during imprisonment
   d. Male crisis centres
   e. Any other measures

5. Training of professionals
   a. Type of training
   b. Target groups
6. State measures to eliminate domestic violence against women  
   a. Legislation and justice
      i. Current status
      ii. Legislative changes within the last 5 years
      iii. Number of judgements
      iv. Number of convictions
      v. Number of cases dismissed
      vi. Number of successful recourses to civil remedy
      vii. Any other measures
   b. Surveys and projects
      i. Projects initiated by the State within the last 5 years
      ii. Other projects initiated within the last 5 years
   c. Policy
      i. Strategy/Action Plan on VAW
      ii. Elements of an Action Plan
   d. Awareness raising
      i. Information campaigns aimed at the perpetrator
      ii. Information campaigns aimed at the victim
      iii. Information campaigns aimed at the professionals working with victims and/or perpetrators
      iv. General information campaigns
      v. Other awareness activities
   e. Budget

7. Evaluation
   a. Progress made
      i. Statistical changes in indicators
      ii. Progress-reports on measures taken
      iii. Any other measures to monitor progress
   b. Lessons learned

The indicators aim to present an instrument for monitoring progress in strategies for the prevention of intimate partner violence in the individual member states and to promote further initiatives concerning the problem. To fulfill this purpose, statistics and specific data concerning the different indicators are urgently needed. Very few member states have access to data that can describe the profile of victims and perpetrators, describe the health care services utilised by the victims or evaluate progress. There therefore exists a strong demand for the introduction of new methods to obtain current, valid and comparable data on violence against women, young people and children in the member states.
4. The present project

The project generally addresses the lack of data on violence and on the health consequences of violence, and tests the feasibility of achieving valid and comparable data on violence and health through national health interview surveys. The immediate aim of the present project is to develop and implement a limited number of standardised questions on experiences of violence in European health interview surveys, with a view to collecting representative, reliable and comparable data on interpersonal violence. Thereby, a tool will be developed for documenting violence and sexual assaults in the population and for monitoring prevention strategies.

The overarching goal of the project is the prevention of intentional injuries and violence, including also prevention of the consequences of violence. The evidence-based acknowledgement of violence as a public health threat will facilitate the establishment of preventative measures. Evidence-based preventative strategies will decrease the incidence of violence, as well as the magnitude of health problems stemming from experienced violence. Hence, it is important to gain knowledge of the extent and nature of violence in the population. The inclusion of information on violence and consequences of violence in the national health surveys will contribute considerably to fulfilling these aims.

The questions will address both physical and sexualised violence and will be addressed to both men and women.

The project includes an evaluation of the possible decrease in response rate and thereby the impact upon the representativity of survey data effected by the inclusion of sensitive questions about violence and sexual abuse.

Implementing violence questions in national health surveys addressed to both men and women opens for comprehensive analyses of the magnitude and health impact of violence. Information on gender differences in the magnitude and health sequels of violence that can be implemented in the development of targeted violence prevention and treatment strategies. Hence, the present project aims to promote the inclusion of standardised questions on violence in future health surveys as a future European standard.

The main beneficiaries of this project are children, young people and women as this population group is predominantly affected by violence and/or sexual assault and its negative consequences.

The goal of the project is prevention of intentional injuries and violence that also comprises the prevention of consequences of violence. Evidence-based preventative strategies will decrease the incidence of violence as well as the magnitude of health problems stemming from experienced violence. The acknowledgement of violence as a public health threat will facilitate the establishment of preventative measures.

The expected results of the project will be to have evaluated the inclusion of six questions on violence in two national health surveys, and further, to have informed the relevant health authorities of the results with a view to achieving consensus about the standardised questions, which are to be included in future European HIS.

Implementation of the project

Two European Union member states participated in the project; Denmark and Finland. There exists a strong tradition in both countries for epidemiological research based on national representative data. Data sources comprises national hospital registers that includes administrative and medical data on all hospital contacts due to illness and injuries; criminal statistics concerning all police reported cases of violence; and regular population surveys, including health interview surveys and focused surveys on violence.

However, neither Denmark nor Finland included previously questions on violence and sexual abuse in the health surveys or questions on self-reported health and morbidity in the surveys on violence. Hence, the existing data did not allow to analyses of correlations between experienced violence, sexual abuse, well-being and health.

In the preparation of the project, experiences from former population based surveys on violence against women were canalised through the Nordic Research Network on Health and Violence (NordVold 1998). Based on the questionnaires used in the Canadian, Icelandic and Finnish surveys we
developed a limited number of questions that could illuminate the extent and the form of physical and sexualised violence by being integrated in the regular health surveys that are conducted in most European countries.

In December 2000, a meeting was held for all the partners in the project, at which the English formulation of the selected questions on experienced violence and/or sexual assault for inclusion in the HIS was conducted. Thereafter, they were translated into Danish and Finnish, for implementation in the respective national health surveys.

The EWL’s Action Centre on Violence against Women and the Danish National Women Council were consulted and kept informed during the initiation and implementation of the project.

**Denmark**

The National Institute of Public Health, Denmark has since 1987 regularly conducted studies on the health and morbidity status of the adult population (aged 16 years and above). In 1987, 1994 and 2001 respectively, general studies on the health and morbidity of the population were conducted.

The overarching aim of the health and morbidity survey is to describe the prevalence and distribution of health and morbidity in the population. The health survey additionally describes the prevalence and distribution of factors that are significant for state of health e.g. health behaviour, lifestyle, health risks at work, health-related resources and contacts to health services. Comparisons with previous health surveys enable the construction of a health and morbidity timeline, by which development in health status can be monitored.

The core elements included in the health and morbidity studies are presented in the following overview of the most recent Danish national health interview survey:

- **Health behaviour**
  - Attitude towards health promotion
  - Exercise habits/dietary habits
  - Alcohol and smoking
  - Health promotive medical check-ups

- **External health risks and resources**
  - Housing
  - Social network
  - Work environment

- **Social and demographic background information**
  - Age
  - Sex
  - Occupation and employment
  - Residence
  - Cohabitation
  - Education

- **Health**
  - Perceived health
  - Perceived quality of life
  - Functional capacity

- **Morbidity**
  - Long-standing disease
  - Specific disease
  - Symptoms
  - Accidents

- **Illness behaviour**
  - Reactions to symptoms
  - Use of health services
  - Use of alternative treatment

- **Consequences of disease**
  - Activity limitations
  - Functional limitations

Data collection is by face-to-face interview in the respondent’s home and the most recent health survey was also supplemented with a self-administered questionnaire to be completed by the respondent after the interviewer had left. We integrated the questions on experienced violence and sexual abuse in this self-administered questionnaire.

**Finland**

The National Institute of Public Health, Finland regularly conducts national representative surveys amongst the adult Finnish population (aged 16 years and above) in order to gather and report health-
monitoring data on a national and local scale. The themes addressed in the health surveys address physical measures of illness and health such as symptoms and diseases. However, psychosocial measures of health and life-quality are also included e.g. self-reported health, ability to cope with daily activities, health related quality of life and health behaviour e.g. smoking, food choices, alcohol consumption, and physical activity. The national health surveys also use monitoring data as a basis for scientific research involving developmental trends of health habits and health differences (e.g., by education and other indicators of SES) and to develop and evaluate community wide health promotion programmes. Data collection is conducted by mail questionnaire.

Statistics Finland conducts regularly telephone interviews that provide information about factors that influence upon the population’s social welfare. The interview lasts approximately 5-10 minutes. The survey does regularly not include data about health and health behavior. In 2002 a consumer survey was conducted. The random sample consisted of 4,400 adults, aged 15-64. Statistics Finland agreed to include the standardised questions on violence and also a limited number of information about health and morbidity.

Violence questions

The questions about physical violence, which were implemented in the present project asked about six different forms of violence, previously tested in the Canadian Violence Against Women survey - experienced ever and during the last 12 months. The questions are based upon the scale of different forms of physical violence developed by Strauss and implemented in former surveys on violence against women, e.g. the Canadian survey in the early 1990s, the Icelandic survey in 1994 and the Finnish survey in 1998 (Heiskanen and Piispa 1998). The Nordic Research Network on Health and Violence participated initially in the development of the standardized questions. Questions about experienced threat of violence and perceptions of and reactions to danger presented by violence were included.

The questions are presented in Table 4.1.

Table 4.1 Information about physical violence and threats of violence.

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes, within past 12 months</th>
<th>Yes, previously</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Have you as an adult ever been subjected to one or more of the following forms of violence?</td>
<td>a. Pushed, shaken or struck lightly</td>
<td>Yes, within past 12 months</td>
<td>Yes, previously</td>
</tr>
<tr>
<td></td>
<td>b. Kicked, struck with a fist or object</td>
<td>Yes, previously</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>c. Thrown against furniture, into walls, down stairs or similar</td>
<td>Yes, previously</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>d. Strangulation attempt, assault with a knife or firearm</td>
<td>Yes, previously</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>e. Other form of violence</td>
<td>Yes, previously</td>
<td>No</td>
</tr>
<tr>
<td>If other form of violence, please specify:</td>
<td>Have you as an adult been subjected to threats of violence that were so serious that you became afraid?</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Yes, within the past 12 months</td>
<td>Yes, previously</td>
<td>No</td>
</tr>
</tbody>
</table>

Table 4.2 Information about contact to health care service.

<table>
<thead>
<tr>
<th>If you have been subjected to violence within the past 12 months:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mark one in each line</td>
</tr>
<tr>
<td>Did you receive injuries or become ill as a consequence of the violence? Did you seek medical attention from your general practitioner or the on-duty doctor, as a consequence of the violence?</td>
</tr>
<tr>
<td>Did you seek medical assistance at the emergency department as a consequence of the violence?</td>
</tr>
<tr>
<td>Were you admitted to hospital as a consequence of the violence?</td>
</tr>
<tr>
<td>Did you receive other assistance or take other action as a consequence of the violence?</td>
</tr>
<tr>
<td>If you received other assistance, please specify:</td>
</tr>
</tbody>
</table>
Child sexual abuse and non-consensual sexual experiences were illuminated by questions about coerced sexual activity during early childhood, adolescence and adulthood (Table 4.3).

**Table 4.3 Information about sexual abuse experienced in childhood and coerced sexual activity in adulthood.**

<table>
<thead>
<tr>
<th>Have you ever been subjected to any form of coerced or attempted coerced sexual activity?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes, as a child (under the age of 13)</td>
</tr>
<tr>
<td>Yes, as an adolescent (aged between 13 and 17 years)</td>
</tr>
<tr>
<td>Yes, aged 18 or older</td>
</tr>
<tr>
<td>No</td>
</tr>
</tbody>
</table>

*If you have been subjected to coerced or attempted coerced sexual activity as an 18-year old or older*

<table>
<thead>
<tr>
<th>Did it occur within the last year?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
</tr>
<tr>
<td>No</td>
</tr>
</tbody>
</table>

*Mark only one*
Questions about the perpetrator of the physical violence and sexual abuse were also included and made it possible to distinguish between intra-familial and extra-familial child sexual abuse and sexual abuse by current partner (marital rape).

Table 4.4 Information about the perpetrator.

<table>
<thead>
<tr>
<th>Who subjected you to the coercion?</th>
<th>Mark all that apply</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Current spouse/partner</td>
<td></td>
</tr>
<tr>
<td>b. Previous spouse/partner</td>
<td></td>
</tr>
<tr>
<td>c. Current or previous boyfriend/girlfriend</td>
<td></td>
</tr>
<tr>
<td>d. Parents/foster parents</td>
<td></td>
</tr>
<tr>
<td>e. Other family member</td>
<td></td>
</tr>
<tr>
<td>f. Friend or acquaintance</td>
<td></td>
</tr>
<tr>
<td>g. Playmate of same age (if below 18 years of age)</td>
<td></td>
</tr>
<tr>
<td>h. Colleague/person at your workplace</td>
<td></td>
</tr>
<tr>
<td>i. Stranger</td>
<td></td>
</tr>
<tr>
<td>j. Other person</td>
<td></td>
</tr>
</tbody>
</table>

The questions were implemented in two of three rounds in the Danish national health survey, comprising a sample of 16,684 adult persons randomly selected from the Central Population Register in Denmark. Of these, 12,028 (72%) participants were interviewed and given the self-administered questionnaire. Statistical analyses showed that the sample was nationally representative in the younger age groups and among elder men. Among women the non-response rate increased by age. The respondents in the face-to-face interview were representative for the adult Danish population regarding civil status (married, widows, single) and regionally representative as well. Only Danish citizens were included in the sample. The questions on experienced violence and sexual abuse were, as described above, included in the self-administered questionnaire. The response rate of this part of the survey is described in results, Chapter 5.1.

Finland

In Finland, the six questions on experienced violence and /or sexual abuse, identical to those used in the Danish HIS, were implemented in a supplementary round of the Finnish national health survey in Spring 2002. The Finnish national health survey has a corresponding structure to the Danish survey, and data on violence and sexual abuse can be correlated to information about health, socio-economic factors and health behaviour. The survey in 2002 was based upon a self-administered questionnaire. The present additional Finnish National Health survey consisted of a random sample of 4,000 persons aged 15-74 years.

In Finland, violence and a limited number of health data were also included in the national Consumer Survey that was carried during spring 2002. The telephone interview survey comprised a random sample of 4400 adults.

The response rates of the Finnish surveys are described in chapter 5.1.
5. Results

We present the overall response rates in the three surveys, the Danish national health interview survey, the Finnish national health survey and the Finnish consumer survey, as well as the response rates to the questions on experienced physical violence and sexual abuse.

The incidence of reported physical violence during the last 12 months and lifetime experiences of violence is described by age groups, and the Danish and Finnish figures are compared.

The correlations between experienced violence during the last 12 months and self-reported health have been analysed and compared between the Danish and the Finnish health surveys. Furthermore, we have analysed the correlations between specific symptoms of illness, experienced physical violence during the last 12 months and sexual abuse as presented in the Danish National Health Survey. A number of these results will shortly be published in international journals (Sundaram et al. 2003; Boegh et al. 2003).

Gender differences between health and violence are described in respect to results in the Danish national health survey.

Scotland was a non-paid partner in the Daphne project. Professor David Stone (Glasgow University) is being kept informed about the results of the project in order to consider the possibility of including the 6 questions in either a local Scottish survey or a UK survey in the future.

The EWL’s Policy Action Centre on Violence against Women has continuously been kept informed about the results of the project. The project leader is the Danish representative of the center. At the inauguration of the Danish national observatory on violence against women in October 2002 the Danish Women Council and the project leader jointly presented the results of the project.

Impact of violence questions on response rate

The primary result of Phase One of the present project was that the inclusion of questions about experienced violence and/or sexual assault in national health interview surveys was feasible. Neither in Denmark nor in Finland had questions on experienced violence previously been part of the national health surveys. The present Daphne project opened for the possibility, however some difficulties were encountered related to concerns that the inclusion of such questions might invalidate the surveys’ representativity by decreasing the response rate. In Denmark, the inclusion of questions about experienced violence in the self-administered questionnaire had no influence upon the response rate in the health interview survey, which was conducted as a face-to-face interview.

Response rate; questions on physical violence

Denmark: In the random sample of 16,684 persons a total of 12,028 persons were interviewed, presenting a response rate of 74%. The drop-out rate was mainly due to refusal to participate or lack of contact obtained to the sample person.

The self-administered questionnaire was presented to the interview person at the end of the interview. A total of 10,458 persons (87%) returned the completed self-administered questionnaire, corresponding to 64% of the original random sample. It was 4,975 men and 5,483 women. The return rate (response rate) was highest among women, about 90%. Any or all questions on violence were answered by 99% (10,434 persons) of those who returned the self-administered questionnaire. There were no gender differences in response rate on the specific questions about physical violence.

The response rate is comparable to those obtained in population based studies on violence against women. For example the 1998 Finnish study, Faith, hope and battering, obtained a response rate of 70,3% (Heiskanen and Piispa 1998), and the Swedish survey in 2000 a response rate of 68,7% (Lundgren et al. 2001).

All questions on violence were answered by 97% to 99% of the 16-66 year-olds, who returned the self-administered questionnaire. This response rate is comparable or even higher than the rate of other questions in the self-administered questionnaire, e.g. questions about living conditions. The age and gender related response rates are presented below (Table 5.1). The lowest response rate was found among the elderly women.
Finland: The random sample in the Finnish health survey was 4,000 persons aged 15-74, a total of 2,572 persons returned the questionnaire, representing a response rate of 64% after two follow-ups. The response rate was highest among women, 72%. The response rate of the specific questions on violence achieved a response rate of 86% and varied between 83% for men and 89% for women. Among men the response rate decreased by age. In the youngest age group, 15-24 year-olds, the response rate among men was 94% and among women 97%. It is the age group that reported the highest incidence of experience physical violence (Table 5.2).

Table 5.2. Response rate on all questions on physical violence in the Finnish self-administered questionnaire, by sex and age group.

<table>
<thead>
<tr>
<th></th>
<th>16-24</th>
<th>25-44</th>
<th>45-66</th>
<th>67+</th>
</tr>
</thead>
<tbody>
<tr>
<td>Men</td>
<td>97.0</td>
<td>98.9</td>
<td>97.7</td>
<td>91.1</td>
</tr>
<tr>
<td>Women</td>
<td>97.8</td>
<td>99.2</td>
<td>97.5</td>
<td>88.0</td>
</tr>
</tbody>
</table>

The Finnish telephone consumer survey was based upon a random sample of 4.400 aged 16-64, and 3,097 participated in the interview (70%). The response rate to the questions on violence was high, 99.5%, both for men and women.

Response rate, questions on sexual abuse
In the Danish survey, the response rate to the questions on sexual abuse was about the same as for the questions on physical violence, but lower in the Finnish health survey, 89% among men and 81% among women. In the telephone interview survey the response rate remained very high also for questions about sexual abuse, nearly 100% answered the questions. Thus, it appears that respondents were more liable to answer the sensitive questions in a telephone interview, than in a “private” setting such as for the mail questionnaire.

Comparison of response rates in Denmark and Finland
Figure 1 presents the response rates of the questions on physical violence by the self-administered questionnaire of the Danish and Finnish surveys and by the Finnish telephone interview. The Danish data presents the crude response rate among the persons who participated in the face-to-face interview and thereby received the self-administered questionnaire. The non-responders, about 25% of the random sampled, are not included.

Figure 5.1. Response rates; questions about physical violence in the Danish and Finnish surveys, by sex.
Ethical issues

WHO has developed recommendations regarding the ethical conduct of domestic violence research. The recommendations emerged from discussions concerning the WHO Multi-country Study on Women’s Health and Domestic Violence against Women and focused particularly on the ethical and safety considerations associated with population based surveys. The recommendations address in particular, population based surveys based on face-to-face interviews, which contain more apparent ethical and safety problems than surveys conducted through self-administered questionnaires or telephone interviews. However, a number of pertinent issues are common for all research on domestic violence against women. The present study was based upon the ethical principles for medical research, adopted by the World Medical Association in the Helsinki Declaration. In reporting the data, we are guided by the recommendations of WHO, cited below.

**Ethical and safety recommendations for domestic violence research**

1. The safety of respondents and the research team is paramount, and should guide all project decisions.
2. Prevalence studies need to be methodologically sound and to build upon current research experience about how to minimize the under-reporting of violence.
3. Protecting confidentiality is essential to ensure both women’s safety and data quality.
4. All research team members should be carefully selected and receive specialized training and on-going support.
5. The study design must include actions aimed at reducing any possible distress caused to the participants by the research.
6. Fieldworkers should be trained to refer women requesting assistance to available local services and sources of support. Where few resources exist, it may be necessary for the study to create short-term support mechanisms.
7. Researchers and donors have an ethical obligation to help ensure that their findings are properly interpreted and used to advance policy and intervention development.
8. Violence questions should only be incorporated into surveys designed for other purposes when ethical and methodological requirements can be met.
The Nordic tradition for data collection is regulated by specific directives for each survey and for the linkage of data. These directives were adhered to the present study. The Danish Health Interview Survey included as described both a face-to-face interview and a self-administered questionnaire that included the questions on violence. Trained interviewers conducted the face-to-face interview based upon informed consent. For persons below the age of majority, 18 years in Denmark, the parents gave the informed consent.

The self-administered questionnaire used in the Danish and Finnish Health Survey was completed in privacy.

The project leader and the researchers in Finland and Denmark have long experience in conducting population surveys and have previously initiated and conducted surveys on violence against women and child sexual abuse (Heiskanen and Piispa 1998; Helweg-Larsen and Larsen 2002).

In the Nordic countries, victims of violence have access to free counselling and medical care. We did not encounter any criticism from the participants in the survey and did not learn about any undesirable reaction among the respondents.

The results of the project have been disseminated to the public through the media, integrated in the Danish National Action Plan on Violence against Women, and served in the preparation of the Danish EU Presidency’s recommendations of seven indicators for partner violence.

**Physical violence**

The survey included questions about experienced physical violence during the last 12 months and lifetime experience of violence. The results of the present study demonstrate clearly that recall bias and other factors strongly influence on reporting of lifetime experience of violence.

A previous study of time dependent memory decay compared injury rates from three independent studies found that recall periods of greater than two months are likely to significantly underestimate injury rates (Jenkins et al. 2002).

In the Danish survey the lifetime experience (cumulative incidence) of physical violence decreased by age (Table 5.3). Men aged 45-66 reported three times lower incidence than men aged 16-24.

![Table 5.3. Reported life-experience of physical violence, by sex and age group.](image)

<table>
<thead>
<tr>
<th></th>
<th>16-24</th>
<th>24-44</th>
<th>45-66</th>
<th>67+</th>
</tr>
</thead>
<tbody>
<tr>
<td>Men</td>
<td>54.7</td>
<td>42.3</td>
<td>18.9</td>
<td>5.0</td>
</tr>
<tr>
<td>Women</td>
<td>30.8</td>
<td>25.6</td>
<td>18.1</td>
<td>5.8</td>
</tr>
</tbody>
</table>

We therefore chose to focus upon the incidence of physical violence during the last 12 months, which was highest among the youngest men both in Denmark and in Finland. We compared the results of the Danish and the Finnish health surveys and found that strong differences existed in the reported incidence in the two countries, especially among women (Fig. 5.4).
last 12 months, two times higher than among the Danish young women. The reported incidence of physical violence is related to socioeconomic factors and marital status. Analyses of the Danish survey data showed that low educational status was correlated to a high incidence of violence. Among men, single marital status was a strong risk factor for violence. This was a little less so for women (Table 5.4).

Table 5.4. Odds Ratios for relative risk of physical violence during the last 12 months, by civil status. Adjusted for age and sex. Danish Health Survey

<table>
<thead>
<tr>
<th>Civil Status</th>
<th>OR</th>
<th>Conf.Interval</th>
</tr>
</thead>
<tbody>
<tr>
<td>Married</td>
<td>1.00</td>
<td>0.26-0.90</td>
</tr>
<tr>
<td>Cohabitant</td>
<td>1.95</td>
<td>1.71-2.21</td>
</tr>
<tr>
<td>Single (divorced)</td>
<td>2.84</td>
<td>2.36-3.42</td>
</tr>
<tr>
<td>Single (widow)</td>
<td>0.98</td>
<td>0.72-1.33</td>
</tr>
<tr>
<td>Single (Unmarried)</td>
<td>2.00</td>
<td>1.73-2.31</td>
</tr>
</tbody>
</table>
We compared the incidence of the different forms of physical violence reported by the young women in the three different surveys. Being pushed, shaken or struck lightly were the most common reported forms of violence (Fig. 5.5). The most serious forms of violence, attempts of strangulation or being threaded or hurt by arms (knife or firearms) were experienced by about 1% of the young women who participated in the health surveys, and was reported by nearly 2% of young women by the telephone interview.

Figure 5.5. Reported incidence of different forms of physical violence during the last 12 months among women aged 16-24 years, Danish and Finnish health surveys.

Threats of violence and fear

Women reported experiences of severe threats of violence more often than men, however the incidence during the last 12 months was relatively low, 3.3% among all women in the Finnish Health Survey, and 4.6% among 16-24 year-olds. One out of every eight young women in Denmark had experienced physical violence and/or severe threats of violence during the last 12 months. The fear of violence impacts on women’s lives. In Denmark, nearly half of all women reported that fear of violence influenced on their daily lives. They did not circulate freely by night, did not take public transportation and therefore avoided activities outside the home after dusk. Less than one of every ten men reported feeling such a fear.
Sexual abuse

In the surveys, sexual abuse is defined as having been subjected to forced sexual activity either as a young child before the age of 13, in adolescence 13-17 years old, or as an adult, 18 years +. The incidence among women (girls) was much higher than among men (boys). The highest rate of child sexual abuse among girls was reported in Denmark, 4.4%, compared to 2.5% in the Finnish Health Survey and 3.1% in the Finnish telephone survey. However, the rate of sexual abusive experiences in adolescence was higher in Finland than in Denmark, 7.6% of Finnish women reported having being abused as 13-17 year-olds (Finnish health survey). The results concerning all women are shown in Table 5.5.

Table 5.5. Incidence of ever having experienced coerced sexual activity among women, in childhood, in adolescence and in adulthood. Danish and Finnish surveys.

<table>
<thead>
<tr>
<th>Data source</th>
<th>N</th>
<th>&lt; 13</th>
<th>13-17</th>
<th>18 +</th>
</tr>
</thead>
<tbody>
<tr>
<td>Danish Health Survey</td>
<td>5,479</td>
<td>4,4</td>
<td>4</td>
<td>4,6</td>
</tr>
<tr>
<td>Finnish Health Survey</td>
<td>1,443</td>
<td>2,5</td>
<td>7,4</td>
<td>10,1</td>
</tr>
<tr>
<td>Finnish Consumer Survey</td>
<td>1,632</td>
<td>3,1</td>
<td>6,4</td>
<td>10,1</td>
</tr>
</tbody>
</table>

The highest incidence in this age group had once or more experienced coerced sexual activity once or more. The Finnish health survey reported also the highest incidence among 25-44 year-olds, 13.6%. The Finnish telephone survey reported the highest incidence among 16-24 year-olds, 21.4%, and 4.3% among 25-44 year-olds.

The survey data included information about the perpetrator of coerced sexual activity. A stranger, a family member or an acquaintance was most frequently reported as the perpetrator in cases of sexual abuse in adulthood. However, about 10% of women victimised by sexual abuse reported a current boyfriend, and the same percentage a former partner or husband. About 5% reported that a current husband or partner was the perpetrator.

6. Violence and health

In reporting analyses of correlations between violence and health we primarily use the Danish data. As described above, the Danish sample comprised a much higher number of respondents than the two Finnish samples. Case-control analyses (cases defined as victims of violence during the last 12 months, and controls persons not victimized by violence) are statistically most reliable when based upon the large Danish sample.

There were tendencies in the Finnish health survey showing correlations between poor or very poor self-reported health and having experienced physical violence during the last 12 months in the young age group, but reverse correlations in health and physical violence among the middle aged.

Physical violence

The prevalence of poor-self reported health amongst the female victims of violence and female non-victims is shown in Figure 6.1.

![Figure 6.1. Prevalence of poor self-reported health amongst female victims of violence and non-victims, by age group. Danish Health Survey.](image-url)
The figure indicates that significantly more female victims of physical violence reported poor self-rated health than non-victims. As expected, poor self-rated health is reported most amongst the older age groups.

The following figures present the correlations between disease specific symptoms and experienced violence during the last 12 months. The figures present comparisons between female victims and non-victims. The symptoms are those experienced during the last 14 days. Data about chronic diseases are not presented.

In all age groups, victims of violence reported having had periods of depression during the last 14 days more frequently than non-victims. The differences were greatest among the young women (Fig. 6.2).

Figure 6.2. Prevalence of depression during the last 14 days among female victims of violence and non-victims, by age group. Danish Health Survey.

Stomach pain is reported relatively often by women and may be a symptom of distress. The analyses showed that young female victims of violence reported such symptoms twice as often as non-victims (Fig. 6.3).
Figure 6.3. Prevalence of stomach pain amongst female victims of violence and non-victims, by age group. Danish Health Survey.

General anxiety was also reported more frequently by female victims of violence than by non-victims. Figure 6.4 shows that anxiety was most prevalent among the elderly women, aged 45+, and that twice as many victims of violence in that age group reported anxiety.

Figure 6.4. Prevalence of anxiety amongst female victims of violence and female non-victims, by age group. Danish Health Survey.
Sexual abuse

It was documented that women experience significantly more frequently sexual abuse in childhood and adulthood than men. There exist evidence-based knowledge about a range of social and health consequences to child sexual abuse, and a number of studies have demonstrated a high prevalence of health problems among victims of adult sexual abuse.

Our data show similar correlations between poor health and sexual abuse in adulthood. Among women aged 16-44 years, significantly more victims than non-victimized women reported poor health, OR 1.76 (1.26-2.67).

No significant correlations were found between sexual abuse in adolescence and poor health, 13-17 year-olds, OR 1.36 (0.87-2.13).

**Single marital status and unemployment were significant risk factors for having experienced sexual abuse in adolescence or adulthood. These factors are also strongly related to anxiety and depression. Nonetheless, even after controlling for single marital status and unemployment, sexual abuse was significantly related to both anxiety and depression.**

Gender differences in violence and health

In general women report poorer health than men. The gender difference is more pronounced between male and female victims of violence and especially amongst young women and men aged 16-25 years, with 21% of women rating their health as poor compared with 9% of men (Fig. 6.6).

**Figure 6.6 Prevalence of poor self-reported health amongst victims of violence, by gender and age group.**
**Danish Health Survey.**

Presented earlier was data about women’s fear of violence, which differed from that of men. Female victims of violence also reported anxiety significantly more frequently than male victims (Fig.6.7).
It is well known that significant correlations exist between health, socio-economic factors and marital status. These factors also influence the risk for being victimised by physical and sexualised violence. Therefore in the analyses of gender differences in correlations between violence and health, we controlled for these potential confounders. The results of the logistic regression analyses are shown in Figures 6.8 and 6.9.

For men, only stomach pain was significantly correlated to having been a victim of physical violence during the last 12 months. For all other health complaints adjusting for confounders minimised the correlations, and the significance disappeared.

When data for female cases and controls were controlled for potential confounders, significantly more female victims of violence reported poor health and morbidity on all symptoms than female controls. The only exception was for headache, for which the difference in reporting between victims and controls was not significant (Fig. 6.9).
Female victims seem to suffer more from poor self-reported health and morbidity symptoms compared with men in corresponding age groups. It is not possible to establish causality from the present results, as they are obtained from a cross-sectional population study. However, as Figures 5.6 and 5.7 indicate, there is a significant difference in e.g. anxiety and depression between the female baseline population and female victims of violence. Significantly more female victims of violence report both morbidity symptoms across all age groups, the difference in prevalence is two-fold amongst 25-44 year-olds.

It is well documented that women have higher rates of anxiety and depression than men. It is also well known that women have higher exposure to childhood sexual abuse and sexual assault (Sariola
et al. 1992; Helweg-Larsen and Larsen 2002). A longitudinal study in New Zealand has analysed these gender differences. Controlling for the gender related difference in exposure to sexual violence reduce the associations between gender and anxiety and depression. However, after such control, gender was still significantly associated with both anxiety and depression (Fergusson et al., 2002).

**Causality**

The fact that a significant correlation was found between violence and different health problems does not justify drawing definitive conclusions about a causal correlation between violence and ill health. Victims of violence may, at baseline, present other health problems than women not victimised by violence, which might present a serious bias.

in a clinical study, one third of adult female patients with neurological disorders reported previous domestic violence, and a higher frequency of violence was endured among patients with diagnoses of migraine, depression or vertigo (Diaz-Olavarrieta et al. 1999). Furthermore, health problems among victims of violence may be associated with risky health behaviour. A Swedish study of employed women’s health and living conditions included information about sense of coherence (SOC) and found the lowest score of SOC among women exposed to domestic violence (Hensing et al. 1998). Low SOC may influence both women’s risk of exposure to partner violence and their general health behaviour (Helweg-Larsen and Kruse 2003). Female victims of violence could constitute a very different population in terms of health behaviour, risk-taking behaviour and lifestyle compared with the female reference population. However, our finding confirms that of previous studies - that a large part of women victimised by violence present serious health problems.

Easy access to professional counselling and health care providing gender sensitive acute treatment and follow-up may diminish the social and health consequences of violence, and must therefore be part of any action plan against violence.

**7. Impact of the project**

During the preparatory stages of the present project, the different elements of the study design and project implementation were discussed with sparring partners in the EWL’s European Action Policy Centre on Violence Against Women. During the course of the project, the project leader informed the EWL of the project's intermediary results on an ongoing basis, such that the outcomes of the project itself have influenced the development of EWL policy on collection of reliable and comparable data on violence.

During the Danish EU presidency, the project leader participated in meetings and planning groups regarding the development of the seven EU Indicators on Partner Violence. The experiences from the present project were utilised in forming realistic and comprehensive indicators by which to obtain data on intimate partner violence in the EU Member States. It was a priority that as many MS as possible should have access to as much of the data contained in the indicators as possible. The experiences of the project leader in developing standardised, widely applicable questions on violence were therefore very pertinent to these discussions.

The results of the present project have been disseminated in the national media, with a view to raise public awareness and direct attention to violence, particularly intimate partner violence, as a continuing problem in Denmark and Finland, one that has a heavy public health toll, particularly for women. Already at present, national campaigns have been launched in Denmark to draw attention to the impact on children who witness violence in the home and national women’s and crisis centre organisations have also been able to utilise the results of the present project - including the message that violence against women continues to damage many women’s lives - to strengthen their work. In
Finland, the results of the project have been implemented in the national Action Plan for Violence Against Women.

The project results are furthermore being published in international journals, and the data are currently being analysed as part of an ongoing PhD project in Denmark. The project aims to analyse the gender differences in exposure to violence and its health-related impact. Therefore, the data collected in the present project are very valuable. Some of the results from the PhD project have already been presented at international conferences in 2002 and 2003.

**8. Conclusions and recommendations**

The present project was able to develop and integrate six standardised questions on violence and sexual abuse into national health surveys in two Member States: Denmark and Finland. The questions on violence and sexual abuse achieved a relatively high response rate and their inclusion did not affect the overall response rate of the national health surveys, despite the sensitive nature of the questions. Therefore, the data obtained in the project are valid and reliable. The standardisation of the questions meant that the data collected on violence were comparable between countries.

Based on the results of the present project, it can be concluded that the implementation of a limited number of standardised questions into national health surveys, which are conducted amongst a broad sample of the population, constitutes a valuable tool by which reliable and comparable violence data can be collected. A major strength of the study is that national health surveys are conducted regularly, providing opportunity for follow-up and monitoring of violence trends, knowledge which in turn can be implemented in developing targeted prevention strategies. The project therefore promotes the implementation of standardised questions on violence in national health surveys as a future standard for European MS.

In terms of ethical aspects, the project followed the ethical principles for medical research, adopted by the World Medical Association in the Helsinki Declaration. The project also followed the WHO recommendations for domestic violence research, which emphasise the safety of the respondent and the researcher, that the study design should aim to cause the woman the least amount of distress and should take into consideration how to minimise the underreporting of violence, and that researchers should ensure that their results are interpreted properly and are used to advance policy and intervention development.

The present study did confirm that questions regarding lifetime experience of violence do not minimise the underreporting of violence. On the contrary, reported incidence of lifetime experience of violence decreases sharply with age, due to recall bias amongst other factors, amongst both genders. In relation to questions about sexual abuse experienced in childhood, we inevitably have to be aware that recall bias may affect the reporting rate and the reported incidence. Therefore, the study also included questions on violence experienced within the past year. Generally, it is recommended that as data on lifetime prevalence of physical violence and sexual abuse in adulthood are so unreliable, future questions on experienced physical and sexualised violence in national health surveys should refer to the last 12 months as a minimum.

The use of Strauss-defined questions on physical violence is also recommended for future national health surveys. The differentiation between six different forms of violence enables us to analyse the different forms of violence, according to degree of severity.

In conclusion, the acknowledgement of violence as a growing public health problem naturally opens for questions on experienced violence and sexual abuse to be integrated into national health surveys. By implementing standardised questions on violence in health surveys conducted amongst a broad segment of the population, valid and comparable data on the correlations between violence and health can be obtained.
The authors of the present study wonder why this has not been done earlier, given the well-documented connection between the violence and health and the evident opportunity by which to obtain reliable and comparable data.

The main recommendation of the study is that the developed questions on violence and sexual abuse continue to be implemented in national health surveys in the different European MS, with a view to collecting comparable violence data, analysing the health impact of violence on people’s lives and implementing a tool by which violence trends and subsequent prevention strategies can be monitored.

9. References

Golding JM, Cooper ML, George LK. Sexual assault history and health perceptions: seven general population studies. Health Psychol 1997;16:417-5.


**NIPH - National Institute of Public Health - Denmark**

Svanemollevej 25
2100 COPENHAGEN KOBENHAVN
Danmark
Phone: +45 3920 7777
Fax: +45 3920 8010
E-mail: niph(AT)niph.dk
Website: [http://www.si-folkesundhed.dk](http://www.si-folkesundhed.dk)

- Karin HELWEG-LARSEN
  E-mail: khl(AT)niph.dk
Statens Institut for Folkesundhed - Sweden
National Institute of Public Health
Health consequences of intentional injuries in EU countries.
Daphne project: 2000-106