WMA STATEMENT ON VIOLENCE AND HEALTH

Adopted by the 54th WMA General Assembly, Helsinki, Finland, September 2003
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INTRODUCTION

In the year 2000 there were over 1.6 million people who lost their lives to violence - meaning that every day more than 4,000 people around the world die a violent death. Roughly half of these deaths are due to suicide, almost a third due to homicide, and the remainder arise from conflict-related violence. These fatalities are only the tip of the iceberg - available data tends to come from higher income countries with established reporting systems and it is known that many forms of violence are more prevalent in lower income settings that may not provide data to the World Health Organization. In addition to potential data collection problems, a variety of different forms of violence, child abuse and neglect, intimate partner violence and elder abuse, to name a few, are systematically underreported, owing to fear, shame, or cultural norms.

For every young person killed by homicide, at least 20-40 other youth receive hospital treatment for violence-related injuries. One in five females and 5-10% of males report being sexually abused during childhood. International population-based studies indicate that between 10 and 69 percent of women report having been physically assaulted by an intimate partner. In addition to the direct effects of injury arising from violence there are a wide range of health effects, including mental and reproductive health problems, sexually transmitted diseases, and other health problems. Health effects arising from violence can last for years, and may include permanent mental or physical disability. From a societal perspective, the economic costs associated with violence are substantial, with direct costs for health services alone amounting to 5.0% of GDP in some countries.

No single factor drives violence, either at the level of the community or the individual. Violence arises out of a complex interplay of individual, relationship, community, societal and political factors.

In 1996 the World Health Assembly adopted resolution WHA49.25, which declared violence a global public health priority. One year later, resolution WHA50.19 was adopted, which endorsed the World Health Organization's integrated plan of action for a science-based public health approach to the prevention of violence and called for further work in this field.

INVOLVEMENT OF THE INTERNATIONAL MEDICAL COMMUNITY

Irrespective of the diversity of factors that give rise to violence, there is one feature common to all forms of violence: the health effects suffered are a direct concern for the medical community.

Doctors can be victims of violence in the workplace or in other settings. In some cases doctors can be involved in committing acts of violence or neglect. Doctors of every description also deal with the victims of violence on a daily basis. They make decisions regarding referral and coordinated care across specialties and health sectors, they plan for long-term follow-up and care of disabilities, and in some settings they have contributed as a profession to the prevention of violence. Whether as a pediatrician assessing if a child is a victim of abuse, an emergency physician or surgeon tending to a shooting victim, a psychiatrist dealing with the psychosocial impacts of intimate partner violence or any number of other possible encounters, the reality is that more than any other profession the medical community is absolutely central in terms of responding to the health effects of violence.

The manner in which the medical community can respond is varied and will depend as much as anything else upon contextual features and realities. In some settings more structured forms of data collection are of paramount concern and doctors may be the only group within such settings with the ability to lobby for health systems to adequately integrate systematic data collection related to violent injury. In other settings that are more advanced, clinicians and public health practitioners can play a major role in facilitating or conducting focused studies that examine an aspect of violence or violence prevention. The provision of such data to policy-makers in a timely and appropriate fashion can contribute to further development of evidence-based policies to reduce violence.

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RECOMMENDATIONS

National Medical Associations are encouraged to contribute to more systematic approaches to dealing with violence, including:

Advocacy - violence is a global health problem and its victims are frequently among the poorest, most powerless or otherwise most vulnerable within society. The medical profession should advocate at local, national and international levels for effective strategies to prevent violence and limit its impact on health. Moreover, the medical profession should denounce all depictions or uses of violent behaviour as solutions for personal, societal or political problems.

Data collection - the medical profession should play a central role in ensuring that routine data collection occurs and is of a sufficient standard and comprehensive enough to be a valuable tool to guide public health policy. Research has shown that a large proportion of victims of violence are not reported in police statistics because they are not the victims of a crime (e.g. forms of family violence, bullying, etc.) or have avoided being reported to the police.

Medical training - in recognition of the substantial burden of global morbidity and mortality that is related to violence and the fact that violence and injury as a threat to health is largely absent from medical training, the medical profession should take steps to ensure the integration of injury and violence prevention into medical school curricula.

Prevention - the medical profession should use the unique opportunity during clinical encounters, where appropriate, to counsel patients and families with respect to creating safer, less violent household environments. They can also use their clinical judgment to detect victims of violence or those at potential risk for violence and make arrangements for appropriate care.

Coordination of victim assistance - whether through detecting victims that may suffer from violence but do not know how to bring themselves to medical attention, or through appropriate referral to deal with the related health conditions or the physical, psychosocial or long-term disability associated with injury, doctors can play a vital role in enhancing the quality and comprehensiveness of victim assistance.

Research - violence is an under-documented global public health problem. Better understanding of causes and consequences of violence is necessary, along with an enhanced understanding of the effectiveness of various strategies to prevent violence.

Social example - the medical profession should contribute to the creation and reinforcement of social norms by not participating in or tolerating various forms of violence, such as torture or mistreatment or neglect of certain populations such as prisoners, and actively opposing such violence.

Policy-making - many countries still lack comprehensive national or local violence prevention policies and plans of action. The medical profession should encourage the development of such policies and in some cases take a leading role in developing them

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