In a preface to the World Report on Violence and Health, issued by WHO in 2002, Gro Harlem Brundtland, then WHO Director-General wrote: “Violence pervades the lives of many people around the world, and touches 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”. On Nov 24, WHO exposed this hidden violence to public view, in their report on the WHO Multi-country Study on Women’s Health and Domestic Violence Against Women. The report analyses data collected in household surveys by trained female interviewers from over 24 000 women in 15 sites in 10 geographically, culturally, and economically diverse countries. The study confirms that violence against women is pervasive and that violence by intimate partner, rather than by other perpetrators, is the dominant form in women’s lives. The study was coordinated by WHO with a core team of experts from the London School of Hygiene and Tropical Medicine, the Program for Appropriate Technology in Health (PATH), and WHO itself. WHO started developing the study in 1997, and worked to overcome the many methodological and ethical challenges. In particular, measures were needed to ensure privacy, confidentiality, and safety, both for the women and the interviewers.

For ever-partnered women, the lifetime prevalence of physical or sexual violence, or both, by an intimate partner ranged from 15% to 71% in the different sites. Across all countries, between 20% and 75% of women had experienced one or more acts of emotional abuse. The use of standardised definitions and methodologies allows meaningful comparisons to be made. Risk factors and protective factors can be analysed to explain differences in prevalence within countries and between countries, and to provide an evidence base for preventive measures. This analysis is not included in the present report. It is important to continue to mine this rich database.

Violence against women has only recently started to be viewed as a public-health issue. A World Bank report estimated that rape and domestic violence account for about 5% of the total disease burden in women aged 15–44 years in developing countries. Although a cross-sectional survey cannot establish whether violence causes particular health problems (with the obvious exception of injuries), the WHO study lends strong support to research which has found clear associations between partner violence and physical and mental symptoms of ill-health. Violence should not be seen as just a health problem in itself. Particularly when it is chronic and recurrent, violence is also a risk factor that increases women’s risk of various diseases and conditions. By damaging a woman’s physical, mental, and emotional capacity to care for her family, violence also affects the health of other family members, particularly young children.

The study reveals some disturbing findings about women’s attitudes and responses. In several of the study sites, most women thought wife beating was justifiable under some circumstances, including refusal to have sex. These attitudes are symbolic of a general pattern of acceptance of victimisation as part of being female. A culture of silence also prevails. In all countries, the interviewer was the first person many of the abused women had ever talked to about their partner’s physical violence. Even in countries where resources for abused women are available, barriers such as fear, stigma, and the threat of losing their children stopped many women from seeking help.

Actions to address this problem have to be multisectorial. For the health sector there are challenges and opportunities. The health sector has to address the barriers and stigma that prevent abused women from seeking help. Reproductive health services can and should be used for identifying women in abusive relationships and for delivering support or referral services. Routine antenatal care can be an appropriate portal. Mental health services should also recognise and address violence
against women as an important underlying factor in women’s mental health problems.

The release of the report was timed to coincide with the International Campaign Against Violence Against Women, which began on Nov 25, the International Day for the Elimination of Violence Against Women, and ends on Dec 10, the International Human Rights Day. This 16-day campaign links violence against women and human rights, emphasising that all forms of violence, whether perpetrated in the public or private sphere, are a violation of human rights.

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I declare that I have no conflict of interest.

Alcohol and ischaemic heart disease: probably no free lunch

A quarter of a century ago, The Lancet published an ecological observation by St Leger and colleagues of “a strong and specific negative association between ischaemic heart disease (IHD) deaths and alcohol consumption”. The authors attributed the association to wine consumption and concluded that: “If wine is ever found to contain a constituent protective against IHD then we consider it almost sacrilege that this constituent be isolated. The medicine is already in a highly palatable form.”

This study was among a number published during the 1970s and 1980s supporting a rare good-news public-health story. In 1990, Ellison’s provocative editorial entitled “Cheers”, encapsulated what remains the dominant belief today that “small to moderate amounts of alcohol are good for your health”. The benefit is attributed mainly to a protective effect of light to moderate drinking on IHD risk that is believed to outweigh adverse health effects in this window of modest consumption. A meta-analysis confirmed these earlier observations: self-reported consumption of between one and three standard alcoholic drinks (a standard drink included about 10 g of alcohol) a day is associated with a 20–25% reduction in the risk of IHD.

We believe it timely to challenge this belief in a “window of protection” given the increasing evidence of uncontrolled confounding in non-randomised studies of IHD.

The counter argument to the apparent coronary protection has attributed the observed protective association to misclassification and confounding. Shaper and colleagues proposed that ex-drinkers who stopped drinking because of cardiovascular-related illness (sick quitters) were often misclassified with never drinkers, thus artifactually raising the coronary risk in non-drinkers. This hypothesis has now been discarded as new studies report a protective association after excluding ex-drinkers.

The more likely explanation for an artifactual association—uncontrolled confounding—has been too readily dismissed by many researchers, including ourselves. But this year, Timothy Naimi and colleagues have revived the confounding hypothesis using data on cardiovascular risk factors from a telephone survey of over 200 000 adults in the USA. Of 30 cardiovascular-associated risk factors or groups of factors assessed, 27 (90%) were significantly more prevalent in non-drinkers than in light to moderate drinkers. The authors suggest residual confounding or unmeasured effect modification could account for some or all of the reported coronary protective associations.

The recent debacle over postmenopausal hormone