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An Interview with Avni Amin (WHO)

Violence is preventable! But addressing it requires joint efforts

Von Carine Weiss

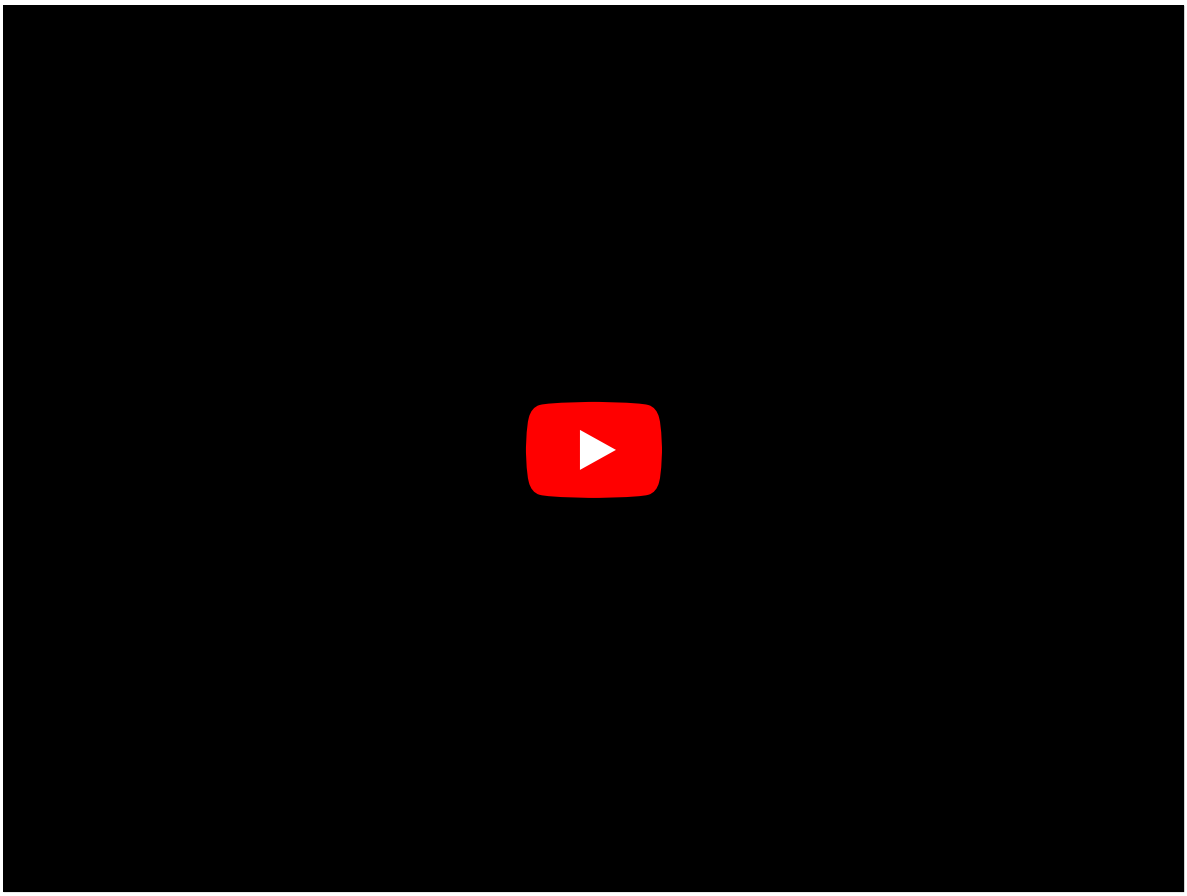
Every day, millions of women and girls around the world experience violence. This abuse takes many forms, including intimate physical and sexual partner violence, female genital mutilation, child and forced marriage, sex trafficking and rape. Listen to the interesting talk with Avni Amin, technical officer at the department of reproductive health and research at WHO.

Avni Amin at the MMS/aidsfocus.ch conference 2018. Photos: Daniel Rihs /

Carine Weiss: Avni, at the conference you talked about intimate partner violence. What is the current evidence concerning this? Who is affected by it? And what exactly is intimate partner violence?

Avni Amin*:* The definition of intimate partner violence is the experience of physical, sexual and/or psychological violence from someone to whom the victim is married or is cohabitating with (e.g. a husband or boyfriend), or a dating partner or former partner. In some cultural contexts, it refers only to husbands; in others, it includes a wide range of partnerships. The definition needs to be quite broad to capture all types of partnerships and it must recognise that, starting from a fairly young age, women might be in dating relationships or partnerships and, in many settings, girls get married at quite an early age.

You can watch the full interview here:



Physical violence includes a range of acts such as slapping, hitting, strangling, pushing somebody or using weapons against them. Sexual violence refers to any acts of coerced sex i.e. forcing a person to do sexual acts that they do not want to do, which includes rape.

Psychological violence includes a wide range of acts such as insulting somebody, humiliating or threatening them or their loved ones or making a person feel really bad about him or herself in front of other people.

These are the criteria by which violence is measured. The most common form of violence is intimate partner violence. The data shows that, globally, 30 percent of women between the ages of 15 and 49 experience this form of violence. There is some variation across regions, but there is no country in the world where such violence does not occur. Even in Switzerland, the data shows that at least 20 percent of women are affected. In other settings like the Middle East, regions in South-East Asia, Latin America and even North America, the rates are not that different from Switzerland. In Latin America, the rate is around 30 percent; in the region defined by WHO as South-East Asia, it is 37 percent. A positive outcome is that the data shows us that such violence is not natural: it is not endemic and it is preventable.

There are some factors which make it more likely that women will experience violence; in other settings, there are factors which make it less likely. It is important to understand that violence is both universal and preventable.

Carine Weiss: What are the causes and health effects of IPV?

Avni Amin: Research shows there are two sets of factors which increase the likelihood that a person will experience violence and that a man will perpetrate violence on his intimate partner. These are: a history of violence in childhood and gender inequality.

A history of violence in childhood is related to the fact that violence is a learnt behaviour. At a very young age, boys and girls see violence happening in their homes, communities, societies and even in their schools and this has an impact. Secondly when children themselves are subjected to violence by their parents, school teachers or other community members, the trauma and effect will make it more likely that they will experience or perpetuate violence when they grow up. So childhood violence is a big cause and this is an important thing to remember because this is a key area for prevention.

The second set of factors has to do with gender inequality. One such factor is settings where girls and women have less access to educational and employment opportunities.

Then there are gender norms. These are norms that condone violence and instil what we can identify as a culture of men's privileges and power over women. In such cultural contexts, societies, communities, the family and sometimes even the legal framework condones this kind of violence or fails to punish it. People tend to accept it as a normal part of life. When this becomes the case, many women also think it is normal. They won't report it and members of society will not come forward to prevent it. So we have to address the lack of power experienced by women. We also must address the lack of opportunities for women at an educational and employment level. And we need to tackle what we call "gender norms".

Within this we also have relationship factors, such as relationships with very high rates of marital or relationship conflicts where people lack the skills and ability to solve such conflicts without violence. We are very careful to say that alcohol or drug abuse are not the causes of violence because there are settings where there is no alcohol or substance abuse and there are still high levels of violence. But alcohol and drugs can be a trigger of violence where there is already stress, conflicts, etcetera.

There are also what we term "micro-community factors" which can play a role: poverty and communities facing high levels of violence (e.g. gang violence). In these communities, violence is often tolerated, law enforcement might be weak, and weapons may be more widely available, etcetera.

Carine Weiss: What can we do to prevent IPV?

Avni Amin: The body of work to prevent such violence is growing based on the evidence we have available. A number of large initiatives begun around five years ago are systematically and rigorously acquiring evidence about what works to prevent violence. We now have a good level of knowledge but we need even more knowledge about the best way to prevent violence in different contexts. Based on the fact that there are two sets of factors, gender inequality and experience of childhood violence, researchers and programmers have started to implement interventions to tackle these two groups, while also taking into account issues around poverty.

We have interventions focused on preventing violence in childhood: working with parents to prevent child abuse, with schools to prevent violence there, with adolescents and groups of children to undertake group reflections on non-violence and conflict resolution.

For example, in Uganda there has been an implementation and trial in 250 schools (Karen M Devries, et al (2015): The Good School Toolkit for reducing physical violence from school staff to primary school students: a cluster-randomised controlled trial in Uganda) of what we call the "Good School Toolkit". This is an entire school approach where teachers, students, the school administration and everyone else work together to create a violence-free environment. Teachers are forbidden from carrying out corporal punishment, bullying between children is prevented, parents are brought into the discussion to prevent corporal punishment in the home, school administrators take responsibility for ensuring that, if incidences of violence do occur, they are handled in the correct way. When this intervention was trialled with a rigorous study design, it proved that we can reduce physical violence against children, with the hope that this will lead to a reduction in these children perpetuating violence themselves as they get older.

On the gender equality side, a range of interventions are being trialled. There are interventions that seek to empower women and girls, and others that provide economic livelihood training to women and girls and grant micro-finance and loans to women so they can set up their own businesses and become economically independent. These interventions have been trialled in South Africa, Tanzania, Peru and other settings. In South Africa, there was a 55 percent reduction in the prevalence of intimate partner violence in the community where this

intervention was implemented (Kim, J. C., et al (2007). Understanding the Impact of a Microfinance-Based Intervention on Women's Empowerment and the Reduction of Intimate Partner Violence in South Africa).

There are interventions trialling changes in gender norms which work with the whole community. Norms are upheld by everyone, not just by an individual, family or household. So participatory interactive approaches have been implemented to make everyone in the community understand how power and the misuse of power affects families, and to lead them through a process of change whose ultimate goal is to enable people to recognise non-violent, non-abusive ways of behaving to each other. This was trialled in Uganda as "SASA"(Starmann E. et al (2018). Examining diffusion to understand the how of SASA!, a violence against women and HIV prevention intervention in Uganda) (SASA! is a groundbreaking community mobilization approach developed by Raising Voices for preventing violence against women and HIV), where it evidenced a 52 percent reduction in the prevalence of intimate partner violence. It is now being replicated in other settings.

Under the DFID-funded initiative, "What works to prevent violence against women" (What Works to Prevent Violence), there are many more such projects being implemented to build a robust body of evidence in different settings so we can discover whether these different approaches work in all cultural and economic settings, or whether they are more likely to work only in certain settings.

This is what is happening at present which means that, in a few year's time, we will have a lot more evidence.

What we are learning from some of these projects is that prevention works best when you don't insist on a "one-size-fits all" or single type of approach. Prevention requires a multiple number of approaches to work together. In SASA, and in some of the studies in South Africa and Tanzania, a number of different approaches have been implemented in the community. It is not enough just to empower women economically: you must simultaneously work with men and community members so they also realise the importance of the issue. Otherwise, there tends to be a backlash. If you just empower women, men might feel threatened and more violence may occur as a result. The idea is to prevent this by working simultaneously with men and key members of the community like religious leaders or community leaders to change norms when you are working to empower women.

Carine Weiss: In short, the message is that you need to take multiple approaches at multiple levels, and you have to implement them over an adequate period of time for change to occur?

Avni Amin: Change does not occur immediately, but it can occur over a reasonable period of time. You have to allow for at least six to eight months or even a year for this kind of change to become embedded. Because people are grappling with norms, attitudes and behaviours that have become entrenched in their psyches for a very, very long time. That is why you need time to overcome the problem.

Carine Weiss: What is WHO in particular doing to prevent and minimise IPV?

Avni Amin: WHO's work focuses on four different areas, and for each area we have multiple activities, projects and products.

Our first priority is to collect evidence and build data. If we have the data and evidence, we can make a difference by convincing policy makers, communities and programme implementers that this kind of violence is an important issue. So we have been working on the WHO multi-country study (Garcia-Moreno C, et. al., (2005): WHO multi-country study on women's health and domestic violence against women: initial results on prevalence, health outcomes and women's responses). This was an instrument developed 10 or 15 years ago to conduct comparable prevalence studies across different countries. We are focusing on updating the survey instrument to include more measures of sexual violence, including sexual harassment, and also to improve how we measure the incidence of emotional and psychological violence.

We are also working to develop estimates of prevalence rates. In 2013, we published the first set of estimates of the prevalence of intimate partner violence and partner sexual violence (WHO et. al. (2013): Global and regional estimates of prevalence of violence against women: prevalence and health burden of intimate partner violence and non-partner sexual violence). We are now working to update these estimates because it was already five years ago since they were measured and many more countries have undertaken surveys and studies in the meantime. We want to publish a new set of estimates to see whether things are improving. This is contributing to the global monitoring of the SDGs (sustainable development goals), in particular target 5.2 (eliminating all forms of violence against women) which has two indicators: a) prevalence of intimate partner violence; b) prevalence of non-intimate partner sexual violence. In this way we are contributing to the global monitoring of the SDGs.

Our second priority is to keep in line with our mandates on health systems and the health sector. We have many tools and guidelines connected with strengthening health systems in response to violence against women. Preventing and responding to violence requires a multi-sector approach. Health has an important role to play both in mitigation and prevention because, in the health sector, health workers are often community leaders, role models in the community, advocates and champions. They can work with policy makers from health and other sectors to present the data and explain how a public health approach for prevention can work. They can also respond to survivors in a compassionate, empathetic and appropriate way and link these survivors to other services if they need legal help, shelters or social services.

Our third priority is to build evidence and advocate for prevention. In this field, we have published several tools that can be used to collect evidence of what works in preventing violence against women. We are also developing with other UN partners a tool for policy makers on prevention and we are building a lot of capacity in health ministries around prevention.

Our fourth priority is to provide advocacy and technical support to countries in order to strengthen capacities in health ministries, both in prevention and response. This is how the global action plan came about: it is a result of requests from member states and we have worked with these states to negotiate its creation. Now we are working on implementing the global action plan in countries to advocate governments, partners, donors and the general public to address violence against women as a public health issue. A lot of work is going on in countries themselves to help them develop national protocols and guidelines and to strengthen the capacity of their health workers via trainings.

Carine Weiss: Thank you very much for this very interesting talk. Would you like to have a final word?

Avni Amin: Violence is preventable! But it requires a lot of sectors and institutions to work together to amplify this message and we really need joint efforts to address GBV.

In every type of programming we do, whether it is in health, agriculture or economic development, it is important to think about how we can prevent and respond to violence. Because inevitably, in all these sectors and settings, women who are there either as beneficiaries or implementers are facing violence. It is important to think about the potential harms of any projects with regards to violence, and to tackle violence, harassment and different types of abuse, as an integral part of a project, whether it be connected to health, economic development, education, etcetera.

We always say that anywhere you have large or even small groups of women they are going to face violence: they are facing violence in their personal lives and many of them might also face violence in their workplace. This is simply the nature of the patriarchy and the privilege of power. So we all have to be thinking about how to tackle and prevent violence in every context.

Thank you for this interesting interview!

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- The health-systems' response to violence against women
- From work with men and boys to changes of social norms and reduction of inequities in gender relations: a conceptual shift in prevention of violence against women and girls
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