Gender-Based Violence, Health and the role of the Health Sector

at a glance

What is Gender Based Violence?

Gender-Based Violence (GBV) occurs as a cause and consequence of gender inequities. It includes a range of violent acts mainly committed by males against females, within the context of women and girls subordinate status in society, and often serves to retain this unequal balance (Human Rights Watch, 1996). GBV includes, but is not limited to: (1) *Domestic Violence (DV)* by an intra family member and *Intimate Partner Violence (IPV)* including physical, sexual or psychological harm by a current or former partner or spouse; (2) *Sexual Violence (SV)* including rape, sexual abuse, forced pregnancies and prostitution; (3) *Traditional harmful practices* including female genital mutilation (FGM), honor killing and dowry-related violence; and (4) *Human trafficking.*

This brief focuses on DV, IPV and SV against females in their reproductive years. It provides insight into the magnitude of the problem, the risk factors and the health effects, as well as the costs to society and impact on economic growth. Finally the brief outlines some feasible health sector interventions, which would minimize the prevalence and impact of GBV on the individual and the society.

Determinants of Gender Based Violence

GBV is a complex and multidimensional problem embedded within the broader socio-economic, political and cultural context with traditional norms influencing the likelihood of GBV. The key risk factors for GBV are best described in an ecological model in recognition of the multiple causes of violence and the interaction of risk factors operating at the individual, relationship, community and social level (Table 1).

GBV is more prevalent in situations of political, social and economic inequity and conflict[1]; as well as in patriarchal societies with rigid notions of manhood, weak institutions, poor access to information and poor reinforcement of human rights; societies where violence is socially accepted as a means to settle inter-personal disputes. Female empowerment might increase GBV temporarily when traditional gender roles are challenged, but living in a community where women are empowered and have higher socio-economic status is protective against GBV (Jewkes, 2003; Koenig et al, 2003).

Poverty and lack of economic opportunities make men more likely to engage in violence and substance abuse, increasing the risk of GBV (World Bank, 2000). The odds of domestic violence are about six times higher when the husband gets drunk frequently, compared to not at all (Kishor and Johanson, 2004).

The risk of GBV is particularly high among prostitutes, where the perpetrators commonly include law enforcement officers, e.g. 49 percent of female sex workers in Bangladesh had been raped and 59 percent beaten by the police within the previous year (Jenkins, 1998). A less obvious high-risk group is females with disabilities (Young et al, 1997).

The magnitude of Gender Based Violence

GBV is arguably the most widespread of all human rights violations, a pervasive and systemic public

> "Violence against women and girls continues unabated in every continent, country and culture. It takes a devastating toll on women's lives, on their families, and on society as a whole. Most societies prohibit such violence—yet the reality is that too often, it is covered up or tacitly condoned."
>
> *Ban Ki-Moon,*
> *UN Secretary-General*
> *8 March 2007*

[1] More than 200,000 female refugees were raped during the Rwandan war (Carballo and Solby, 2001); about 75 percent of the females demobilized in Liberia had been sexually assaulted (McDonald L and P Rockhold, 2008); HIV/AIDS infected soldiers made systemic use of rape as a weapon of war in Liberia, Mozambique, Rwanda, and Sierra Leone (Elbe, 2002).

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Table 1: Risk Factors for Violence based on the Ecological model

Societal	Community	Relationship	Individual
Broad factors that reduce inhibitions against violence	Neighborhood, schools and workplaces	With family, Intimate partners and friends	Personal factors that influence individual behavior
■ Poverty ■ Economic, social and gender inequalities ■ Poor Social Security ■ Masculinity linked to aggression & dominance ■ Weak legal and criminal justice system ■ Perpetrators not prosecuted ■ No legal rights for victims ■ Social and cultural norms support violence ■ Small fire arms ■ Conflict or post-conflict ■ Internal displacement & ■ Refugee camps	■ High Unemployment ■ High population density ■ Social isolation of females & family ■ Lack of information ■ Inadequate victim care ■ Schools & workplaces not addressing GBV ■ Weak community sanctions against GBV ■ Poor safety in public spaces ■ Challenging traditional gender roles ■ Blaming the victim ■ Violating of victim confidentiality	■ Family dysfunction ■ Inter generational Violence Poor parenting practices ■ Parental conflict involving violence ■ Association with friends who engage in violent or delinquent behavior ■ Low socio-economic status Socio-economic stress ■ Friction over women's empowerment ■ Family honor more important than female health and safety	■ Gender, age & education ■ A family history of violence ■ Witnessing GBV. ■ Victim of child abuse or neglect ■ Lack of sufficient livelihood & personal income ■ Unemployment ■ Mental health and behavioral problems ■ Alcohol & Substance abuse ■ Prostitution ■ Refugee Internally displaced ■ Disabilities ■ Small fire arms ownership

Sources: Buvinic, Morrison and Shifter 1999; Heise and Garcia Moreno 2002; Jewkes, Sen and Garcia Moreno 2002; Krug et al 2002; *http://www.dcp2.org/pubs/DCP/40/Table/40.3*

health issue affecting all socio-economic and cultural groups throughout the world at a high cost to the individual and society. Worldwide, an estimated *one in three women* will be *physically or sexually abused*; and *one in five* will experience *rape or attempted rape in their lifetime* (WHO, 1997). The large majority of GBV takes place in the home, where the victim often experiences repeated attacks (Willman, 2008). Sixty to 80 percent of sexual perpetrators are males known to the victim (Heise, Ellsberg and Gottemoeller, 1999). While men might be exposed to GBV the health impacts on women are often more severe. From 1993 to 2001 about 33 percent of all US female homicide victims, but only four percent of males, were killed by an intimate partner (US Department of Justice, 2003). Studies from developing countries report somewhat similar findings (Heise and Moreno, 2002).

> "I think that it is not going too far to say the world will never successfully confront the global AIDS pandemic if it does not simultaneously confront the epidemic of sexual violence in the world today, because sexual violence is behind women and girls' vulnerability to the disease."
>
> *Holly Burkhalter*
> *IJM VP of Government Relations*
> *2009*

The prevalence and incidence rate[2] of GBV varies depending on the type of violence and the "population" included in the study. Most studies focus on DV, IPV, or SV. GBV is often seriously underestimated due to measurement problems, the sensitivity of the issue, stigma and ethical concerns. Most studies use non-standardized methodologies and comparability is rarely possible. Demographic Household Surveys (DHS) use standardized sentinel questions and modules. The prevalence is substantially higher and closer to the true value with the use of modules (personal communication with Andrew Morrison, World Bank

[2] The prevalence of gender based violence refers to the proportion or percentage of females in a population who have experienced GBV during the previous 12 months (point prevalence) or at any time in their life time (life time prevalence). The incidence is the number of assaults per population at risk over a given time period.

2009). *WHO's Multi-country Study on Women's Health & Domestic Violence against Women* (WHO, 2005), which used a standardized methodology to collect data on IPV from over 24,000 women from 15 sites in 10 countries found:

- The lifetime prevalence of females being exposed to IPV ranges from 20 percent in Japan to 70 percent in Ethiopia, with more than 50 percent in Bangladesh, Ethiopia, Peru and Tanzania. About 15 percent had experienced IPV within the last year.
- Four to 32 percent of all women were exposed to IPV during pregnancy; ranging from 14 to 32 percent in low-income countries, compared to 4 to 11 percent in high-income countries.
- About 19 percent of female adolescents in Mozambique and 48 percent in the Caribbean had experienced forced sexual initiation[3].

Gender Based Violence as a Major Public Health Problem

A large body of evidence documents the often severe and long lasting impact of GBV on human health including, but not limited to: (i) fatal outcomes; (ii) acute and chronic physical injuries and disabilities, (iii) serious mental health problems and behavioral deviations increasing the risk of subsequent victimization and (iii) gynecological disorders, unwanted pregnancies, obstetric complications and HIV/AIDS (Table 2).

GBV has devastating consequences, not only for the person who experiences it, but also those who witness it, in particular children. Victims of GBV often have severe feelings of guilt and are stigmatized and blamed by family, friends, and society. This often compounds the damaging consequences of GBV (WHO, 2002). GBV undermines the dignity, autonomy and security of the victims; and the overall social and economic development of the entire society, hereby often re-enforcing gender in-equalities.

The Economic Impact of Gender Based Violence

In 1993 the World Bank estimated that *nine million Disability-Adjusted Life Years (DALYs) are lost annually*, alone, due to IPV. While this might be an over estimate, domestic violence and rape ranks higher than cancer, motor vehicle accidents, war and malaria in the global estimates of selected risk factors for increased morbidity, disability and mortality, accounting for an estimated 5 to 16 percent of healthy years of life lost by females aged 15 to 44 years of age (WHO, 2002).

Table 2. Health Consequences of Domestic, Intimate Partner and Sexual Violence

Physical Health	Mental Health & Behavioral Problems	Sexual & reproductive health
Immediate Injuries to: the head, face, ear, nose, eyes and teeth, neck, upper torso, and abdomen with abrasions, lacerations, burns, fractures & homicide	■ Depression ■ Anxiety ■ Post Traumatic Stress Disorder ■ Phobias & panic disorders ■ Sleeping disorders ■ Low self-esteem ■ Psychosomatic disorders ■ Obesity or Anorexia ■ Alcohol & substance abuse ■ Aggression &Violence ■ Inter generational violence ■ Sexual risk taking ■ Self harm incl. Suicide	**Sexual & Gynecological disorders** ■ Pelvic Inflammatory disease ■ STI/ HIV/AIDS ■ Cervical Cancer ■ Sexual dysfunction
Chronic Conditions: ■ Headache ■ Fatigue ■ Chronic lower abdominal pain ■ Functional limitation and disability ■ Chronic pain syndromes ■ Fibromyalgia ■ Gastrointestinal disorders ■ Premature Mortality		**Obstetric complications** ■ Unwanted pregnancy ■ Abortions (safe and unsafe) ■ Miscarriages ■ Premature labor ■ Low birth weight ■ Fetal injuries ■ Increased maternal, neonatal & infant mortality

Adapted from WHO (Heise and Garcia Moreno), 2002 (pg 101); and Heise et al 1999 (pg 18). Stark et al, 1981; Shanks et al 2000; Women's Wellness Center, 2006; Cambel 2002; Golding 1999; Cardozo et al 2005; UNAIDS, 2004; *http://siteresources.worldbank.org/INTGENDER/Resources/Health.pdf* .

The costs of GBV and the impact on economic growth and poverty reduction are substantial, but the estimates of costs vary substantially based on the data and methodology used, the inclusion or exclusion of different categories, and the monetary value allocated to human life and suffering. Most, of the few studies available, are from High Income Countries and largely based on crime reports, hospital records and surveys, underestimating the true prevalence and not including the impact of witnessing or being the victim of GBV as a child. The most commonly used approach is the accounting methodology incl.; (1) direct costs due to expenditures on prevention, health care etc, and (2) indirect costs due to lost productivity, impaired quality of life and cost of time.

In 1993 the CDC estimated the annual cost of IPV in the US to more than 5.8 billion USD incl. medical & mental health services, & lost productivity of about 5.3 million victims.

The estimated annual direct medical cost of treating victims of IPV at Kingston Public Hospital in Jamaica was close to half a million USD in 1991.Morrison and Orlando (1999) estimated the total annual cost of lost productivity due to DV to 1.73 billion in Chile and 32.7 million in Nicaragua. Including the estimated direct medical cost Buvinic and Morrisson (1999) found the annual cost of DV alone to contribute two percent of GDP in Chile and 1.6 percent of GDP in Nicaragua. In 2003 Colombia spent close to 0.6 percent of GNP, or 73.3 million USD, to prevent, detect and provide services to survivors of GBV. The UK cost of sexual & domestic violence is around 5.7 billion GBP a year incl. cost of health care, criminal justice, housing and the overall loss to the national economy (Walby, 2004, *http://www.equalities.gov.uk/pdf/Summ%20cost%20of%20domestic%20violence%20Sep%2004.pdf*).

For more details on economic dimensions of GBV please refer to :

1. WHO, 2004, (*http://www.who.int/violence_injury_prevention/publications/violence/economic_dimensions/en/*).
2. Bott et al, 2005 (*http://www-wds.worldbank.org/external/default/WDSContentServer/IW3P/IB/2005/06/28/000112742_20050628084339/Rendered/PDF/wps3618.pdf*).
3. *http://www.dcp2.org/pubs/DCP/40/*
4. Willman, 2008. Valuing the impacts of Domestic Violence: A review by sector. The World Bank: Washington, DC.

> "Experience has shown that public health approaches to violence can make a difference. The health sector has unique potential to deal with violence against women, particularly through reproductive health services, which most women will access at some point in their lives"
>
> *Joy Phumaphi*
> *Vice President, Human Development Network*
> *World Bank*
> *formerly, Assistant Director General*
> *General, Family, and Community Health, WHO*

The Role of the Health Sector

GBV is very common, but most health care providers fail to diagnose and register GBV, not only due to socio-cultural and traditional barriers, lack of time, resources and inadequate physical facilities; but even more so due to lack of awareness, knowledge and poor clinical practices with limited direct communication and failure to do a full physical examination, not to mention register and monitor the effectiveness and quality of care. Further the fear of violence and stigma reduces many victims' willingness to use health services (WHO, 1998). The large majority turns to informal networks of friends and community members for help (Heise et al, 1999; ICRW, 2002).

The health sector can minimize the prevalence and impact of GBV though improved:

1. Primary prevention; e.g., promote community awareness and prevent GBV.
2. Secondary prevention; e.g., early identification, confidentiality, monitoring and respectful treatment of survivors addressing physical, mental and reproductive health care needs.
3. Tertiary prevention; e.g. more long-term counseling, mental health care & rehabilitation.
4. Referral to social, economic and legal support.

Improving the patient-provider interaction is the most feasible, affordable and efficient intervention within any health care system aiming to address the survivors of GBV effectively.

Many countries are building capacity to prevent and manage GBV, and while the effectiveness of the various approaches still needs to be evaluated, there is no doubt that violence is preventable (*www.dcp2.org*, Chapter 40). The most promising interventions include some key elements outlined below:

Addressing GBV calls for a Systemic Health Sector Approach

1. National, regional and municipal health policies, strategies, plans, budgets and legislation

a. Build *Political will* and ensure allocation of *adequate resources* to address GBV.
b. *Embark on a gender-sensitive coordinated System*

Wide Approach linking local, regional & international mechanisms to prevent, monitor and manage GBV.

c. *Integrate selective or comprehensive services for victims of GBV* into primary, secondary and tertiary care, as part of overall or selective health care services, especially sexual and reproductive health, including adolescent health, ANC, Postnatal care, Family planning & HIV/AIDS/STI; Child health care, emergency medicine; mental & psycho-social health; ear, nose & throat care; dental care;
d. *Health Infrastructure w/ adequate security & private examination & counseling rooms.*
e. *Clarify providers role* and include *education and training in GBV* into the pre and post service training of health personnel.
f. *Gender sensitive services.*
g. Include males in sexual and reproductive health and childcare, not only as providers, but as true partners.
h. *Primary Prevention.*
i. *Rehabilitation and management* of chronic conditions.
j. *Forensic Exams.*

2. Improve Quality of Care for Survivors of GBV (and others)

a. *Sensitize, educate, train, supervise, support and monitor health personnel*: To improve provider knowledge, attitudes and practices around GBV;
b. *Develop, introduce and monitor GBV management protocols and guidelines* to ensure;
c. *Screening to ensure early diagnosis and intervention* as an integrated part of reproductive and sexual health services, as well as in other parts of the health sector and when physical injuries, health conditions *and client behavior raise the suspicion;*
d. *Emotional support & counseling* – listen with respect to the survivor acknowledge her autonomy, the abuse and injustice;
e. Personal examination and routine enquiry in *privacy*; ensuring *confidentiality* and adequate *registration.*
f. *Treatment and management* of victims of GBV, incl. testing, post exposure treatment and counseling on HIV/AIDS/STIs and pregnancy incl. emergency contraception.
g. *Referral* to legal social and community services in recognition of the need for safety, legal justice and social services.
h. *Community-based care* with early identification and support to victims of GBV and their families.

3. Information, Education and Communication (IEC)

a. *Gender sensitive IEC – including boys and men.*
b. *Target children and young people.*
c. Address the societal and cultural norms underlying gender-based violence to create *increased public awareness of gender inequities, GBV and the human rights of women and children .*
d. *Inform and educate*; civil servants, teachers, police, lawyers, social workers, public media and others on GBV.
e. *Mass Media* education entertainment programs.

4. Better data collection, research and knowledge sharing on GBV

a. Strengthen *medical & health information record keeping, documentation and confidentiality.*
b. *Include GBV in Demographic and Household Surveys* (Bangladesh DHS 2004).
c. Build local, national and international research capacity for knowledge collection, management to inform and advocate for policy reforms in the area of GBV and monitor the effectiveness and efficiency of interventions.

5. Strengthen Inter-sectoral collaboration, networking and partnership with other ministries, civil society, NGOs (incl. Disabled Peoples Organizations) and the private sector to enhance awareness, prevent, monitor and manage GBV. Effective community and society interventions are based on coordination between the legal, social, health and education system and the work place (Bott et al, 2005). This is often furthered through decentralization:

a. *Social services*: shelters, child protection, income generating activities, community support and women's groups.
b. *Education*: Involve the education system in the prevention and management of GBV amongst others though; promoting greater respect for girls and women and human rights, as well as non-violence; enhance school safety (safe latrines for girls); school health education and school health. Include education in GBV in the Higher education of health care providers, lawyers, social workers, teachers, police etc.
c. *Legal*: build alliance with legal system to enhance enforcement of laws related to gender based violence.

Promising Interventions with focus on the Health Sector

1. National, regional and municipal health policies, strategies, plans, budgets and legislation

World Bank, IDB and PAHO worked with respectively 10 and 6 countries in Central and Latin America to develop national plans against domestic violence and promote an integrated health sector approach to GBV through strengthening of policies and legislation related to violence, increasing

access to services, and multi-sectoral networks at a community level for violence prevention (Velzeboer et al, 2003, *http://www.paho.org/English/AD/GE/VAW-HealthSectorResponds.pdf;* Castillo-Ruiz et al, 2002, *http://idbdocs.iadb.org/wsdocs/getdocument.aspx?docnum=361928;* Morrison and Biehl, 1999, *http://www.iadb.org/publications/book.cfm?id=926677&lang=es*).

2. Improving Quality of care for survivors (and others)
Improving provider knowledge, attitudes and practices around GBV;

a. ***Vezimfilho***, a training program enabling health staff to address GBV, implemented and evaluated in two districts in the Eastern and Western Cape provinces in South Africa (Jewkes and Jacobs, 2002, *http://www.ijgo.org/article/S0020-7292(02)00044-9/abstract).*
b. The department for Health in Western Cape, South Africa developed standard ***"Guidelines for management of survivors of rape***"(Guedes, 2004).

A comprehensive literature review looking at promising models for integration of GBV into the health services from 1995 to 2005 identified nine models in eleven countries, ref. I to III below (ICRW, 1999a, *http://www.who.int/bulletin/volumes/86/8/07-045906/en/index.html#R40).*

I. Integration of selected services into vertical programs.
Counseling for victims of GBV integrated into;

a. The medical school health center in Brazil (d'Oliveira, 2005; Schraiber and d'Oliveira, 2002, *http://www.igwg.org/eventstrain/tecupdate2.htm*).
b. The regional mental health clinics in Honduras (PAHO, 2003).

II. Integration of a comprehensive range of services into one facility.

a. *The One-Stop Crisis Centre (OSC Center) for battered women* offering a comprehensive package of medical, legal, psychological and social services, linking up to the police, social workers, a legal aid office and women's groups. Commonly used in secondary & tertiary care in *High Income Countries* (Family Violence Prevention Fund, 2004, *http://www.endabuse.org/programs/healthcare/files/Consensus.pdf*).
b. Established at Kuala Lumpur Hospital in *Malaysia* in 1993, and scaled up to cover 34 hospitals throughout the country. In the process Malaysia addressed the need for; (i) forensic medical officers, (ii) shelters for the victims and (iii) training of the health staff in how to handle victims of GBV with sensitivity (WHO, 2002; Rastam, 2002; Hii, 2001).
c. Replicated in *Thailand* (Grisurapong, 2002), *Namibia* (Mayhew, 2004); (Ministry of Women and Children Affairs, Dhaka, *http://www.mspvaw.org/*).

III. Integration of a comprehensive range of services into one facility with external referrals to other facilities for specialized services:

a. *PPF's projects in Latin America* integrated violence screening, counseling, legal advice and support groups into existing *family planning clinics* and strengthened the off-site referrals to local NGOs providing psychological support and shelter in. The projects strengthened patient privacy and confidentiality; increased detection of GBV and improved provider attitudes and practices, as well as the overall quality of women's health care.
b. Inppares in Peru (Guezmes and Vargas, 2003)
c. Plafam in Venezuela (Guedes et al, 2002).
d. Profamilia in the Dominican Republic (Rogow, 2006; Guezmes and Vargas, 2003)
e. *The Woman Friendly Hospital Initiative in Bangladesh*, providing a comprehensive package of care, aimed to develop a good relationship between all stakeholders to ensure a friendly atmosphere making strategies more effective; changing the knowledge, attitude and practices of providers and nurturing leadership (Haque and Clarke, 2002, *http://linkinghub.elsevier.com/retrieve/pii/S0020729202000437*).
f. The Gender Based Violence Recovery Center in the Nairobi Women's Hospital in Kenya provides medical and psychological care and refers to NGOs for legal and economic support, shelter and police investigations. (Fleishman, 2005, *http://www.csis.org/media/csis/pubs/0505_strengthening.pdf*).
g. *GBV integrated into a polyclinic's reproductive health services in Armenia* with external links to counseling, legal aid social support, hotline services and shelter (IntraHealth, 2004, *http://www.prime2.org/prime2/voice/home/454875.html?article=398*).

3. Information, Education and Communication

a. ***Stepping Stones*** community "training packages" used in seven sub-Saharan countries and the Philippines. The program aims at encouraging communities to question and rectify the gender inequalities that lead to GBV, HIV/AIDS and other health problems with workshops, community-wide meetings, drama, and peer group discussions that include changing male roles and conceptions of masculinity. (*http://www.voanews.com/english/archive/2006-11/2006-11-20-voa35.cfm?CFID=12*

8158502&CFTOKEN=16211123&jsessionid=0030593d9bc8ec54d272796d153b23752e13).

b. ***Men as Partners***, established in 1996 by EngenderHealth. The program enhance men's knowledge and attitudes in the area of HIV/AIDS, GBV and gender roles, targeting and engaging men as positive partners, through skill building workshops; training the health care system to make male friendly care; public education campaign; and international networking. Programs in 15 countries in Africa, Asia, Europe, Latin America and the US. (*http://www.engenderhealth.org/our-work/gender/men-as-partners.php*).

c. ***Sexto Sentido*** (The Sixth Sense) is a weekly radio and TV series produced in Nicaragua by the Puntos de Encuentro. It increases young peoples access to information as young people grapple with sexuality, family violence, rape, and HIV/AIDS in the show. (*http://www.ciir.org/progressio/internal/90521/sixth_sense_the_nicaraguan_soap/*).

d. ***Soul City***, entertaining and educational television and radio program on social norms, GBV, HIV/AIDS, Sexual and reproductive health, have had positive impact on knowledge and attitudes. Conducted by South Africa's Institute for Health and Development Community. (*http://www.soulcity.org.za/programmes*).

4. Better data collection, research and knowledge sharing on GBV

a. World Bank supported Demographic and Health Surveys including questions on GBV. (*http://www.un.org/womenwatch/daw/egm/vaw-stat-2005/docs/expert-papers/Kishor.pdf*).

b. WHO's Multi-country Study on Women's Health and Domestic Violence Against Women. (*http://www.who.int/gender/violence/multicountry/en/*).

c. The Sexual Violence Research Initiative (SVRI) is a global initiative promoting research on sexual violence to enhance the recognition of sexual violence as a priority public health problem. (*http://www.svri.org/*).

5. Inter-sectoral collaboration, networking and partnership strategies are outlined in dcp2. (*http://www.dcp2.org/pubs/DCP/40/Table/40.4*).

Resource Libraries and Useful Websites

1. **An overview of some documented interventions,**
   http://siteresources.worldbank.org/INTGENDER/Resources/bottprofiles.doc
2. **Violence Against Women**
   http://www.un.org/womenwatch/daw/vaw/index.htm
3. **Committee on the Elimination of Discrimination against Women**
   http://www2.ohchr.org/english/bodies/cedaw/index.htm
4. **Understanding the Issue: An Annotated Bibliography on GBV**
   http://www.policyproject.com/gbv/Documents/AnnotatedBibliography.pdf
5. **Violence and Injury Prevention and Disability** (WHO)
   http://www.who.int/violence_injury_prevention/violence/en/
6. **Gender-Based Violence** *http://www.who.int/gender/violence/en/*
   a. WHO Multi-country Study on Women's Health and Domestic Violence against Women
      http://www.who.int/gender/violence/who_multicountry_study/en/index.html
   b. *http://www.who.int/gender/violence/who_multicountry_study/fact_sheets/en/index.html*
7. **Joint Consortium on Gender Based Violence** *http://www.gbv.ie/category/resource-library*
8. Eldis **Gender Based Violence** *http://www.eldis.org/index.cfm?objectid=233132A3-9116-DA80-AC333E02F4EBEB3B&qt=Gender+Based+Violence&search_type=&go.x=13&go.y=5*
9. **Sexual Violence Research Initiative** *http://www.svri.org/*

Toolkits and Manuals

1. **Violence against women: the health sector responds.** (PAHO, 2003)
   http://www.paho.org/English/AD/GE/VAW-HealthSectorResponds.pdf
2. **Integrating Poverty and Gender into Health Programmes: A Sourcebook for Health Professionals: Module on Gender-based Violence.** (WHO 2005)
   www.wpro.who.int/NR/rdonlyres/E517AAA7-E8OB-4236-92A1-6EF28A6122B3/0/gender_based_violence.pdf
3. **Addressing Gender-based Violence through USAID's Health Programs: A Guide for Health Sector Program Officers.** (USAID 2006)
   http://pdf.usaid.gov/pdf_docs/PNADH194.pdf
4. **Improving the Health Sector Response to gender Based Violence.** A resource Manual for Health Care professionals in developing countries, 2004
   http://www.ippfwhr.org/files/GBV_Guide_EN.pdf
5. **Violence against women. A health system response.** An information booklet for Medical Officers in the Public Health System, (CHETNA)
6. **Guidance on how to establish legal justice for survivors of GBV**
   http://www.arcrelief.org/gbvbooks/cdrom/content/Book_1_Toolkit/BOOK1.pdf
7. **How to Conduct a Situation Analysis of Health Services for Survivors of Sexual Assault**
   www.svri.org/analysis.htm
8. **Manual for estimating the economic cost of injuries due to Inter-personal and Self-directed violence**
   http://whqlibdoc.who.int/publications/2008/9789241596367_eng.pdf
9. **Clinical management of rape survivors: developing protocols for use with refugees and internally displaced persons** (WHO, 2004)
   http://who.int/reproductive-health/publications/clinical_mngt_rapesurvivors/clinical_mngt_rapesurvivors.pdf
10. **Guidelines of Impact or Outcome evaluation for projects funded by UNIFEM Trust Fund to eliminate violence against women** (World Bank, 2006)
    http://siteresources.worldbank.org/INTGENDER/Resources/UNIFEMEvaluationGuidelinesFinal.pdf

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