Measuring Gender-Based Violence:Towards Improved Services forVictims in Sāmoa

Ramona Boodoosingh, PhD candidate, National University of Sāmoa

Abstract

Combating gender-based violence (GBV) and providing services for victims requires a multi-sectoral approach to data collections as well as service provision. This paper reviews definitions and approaches to GBV and the sources of data in Sāmoa. It argues that data collection by different agencies should be improved and suggest that the Sāmoa Bureau of Statistics should be given the resources and responsibility for gathering relevant data from the Ministry of Justice and Courts, and the Ministry of Health on an annual basis and providing a summary report for the use of the various stakeholders in government and non-government sectors to ensure continuity of policy development and provision of programmes.

Keywords: Sāmoa, gender-based violence, data, policy development.

Introduction

This paper will seek to highlight the important role data plays in understandingGBV in Sāmoa and its importance when deciding upon the services needed for survivors. GBV is a catch-all term that refers to violence that is directed at an individual based on his or her biological sex, gender identity, or perceived adherence to socially defined norms of masculinity and femininity. It includes physical, sexual, and psychological abuse; threats; coercion; arbitrary deprivation of liberty; and economic deprivation, whether occurring in public or private life (USAID 2014:1). The 2013 *Commission on the Status of Women Agreed Conclusions on the Elimination and Prevention of All Forms of Violence Against Women and Girls* stated in item 11: "violence against women" means any act of GBV that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women and girls, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in pubic or in private life (UN Women 2013a:33).

GBV is a global issue. According to the World Health Organisation (WHO) (2013: 2) 35 percent of women worldwide experienced either physical and or/sexual partner violence or non-partner sexual violence. This figure has risen to 70 percent of women having experienced physical and/or sexual violence in their lifetime by an intimate partner in some national studies. In the Pacific the levels of violence are high.An estimated 68 percent of ever-partnered women in Kiribati reported experiencing at least one act of physical or sexual violence or both by an intimate partner and in the Solomon Islands 64percent of ever-partnered women aged 15 to 49 reported physical and/or sexual violence by an intimate partner (UN Women 2012: 8).

According to the WHO (2014:3)women who have experienced intimate partner violence are twice as likely to experience depression, almost twice as likely to have alcohol use disorders, 16percent more likely to have a low birth weight baby, and 1.5 times more likely to acquire HIV and 1.5 times more likely to contract syphilis infection, chlamydia or gonorrhea, and 38 percent of all murders of women globally were reported as committed by their intimate partners. Children who have witnessed violence in the home are also more likely to become victims and perpetrators of violence as adults (UN Women 2012: 8).

Another dimension of the problem is the economic cost. The direct and indirect cost of GBV includes lost economic productivity, health care costs and a negative impact on the quality of life. In Fiji the estimated cost was US $135.8 million or 7 percent of the Gross Domestic Product (GDP) in 2002 (UN Women 2012: 8). Duvvury et al. (2013:22) cited data gathered by the Centres for Disease Control in the US in 2003 which estimated that in the US in 2003 the cost was $5.8 billion dollars in health care costs, missed work days and foregone earnings. This was estimated at 0.065percent of the GDP. To indicate the comparative magnitude of the cost, in that year 1.56 percent of the GDP was spent on primary education (Duvvury et al.2013:22). Duvvury et. al. (2013:23) also cited data gathered by Walby in 2004 which estimated that in the UK there were 626,000 incidents of violence which was 2.8 percent occurrence of violence and the cost of £23 billion per year was attributed to the cost of service provision, economic output and human and emotional costs. This was estimated to be 1.91 percent of GDP compared to which the cost of primary education was 1.15 percent of GDP (Duvvury et al. 2013:23).

How has the World Responded?

There have been many strategies employed by countries as they continue to recognise the importance of addressing GBV. Two thirds of the countries around the world have laws which are specific to domestic violence; however, many countries do not clearly state that marital rape is illegal (UN Women 2012:9). Many countries have ratified UN Treaties on women's equity and the rights of the child. To date 187 out of 194 countries have ratified the *Convention to End all Forms of Discrimination against Women* (CEDAW); and 194 countries are parties to the *Convention on the Rights of the Child*. Under Section C of the *2013 Commission on the Status of Women Agreed Conclusions on the Elimination and Prevention of All Forms of Violence Against Women and Girls* it was recommended that adequate resources services be established to serve the needs of the survivors of violence against women and girls including the police and justice sector, legal aid, health care services (sexual and reproductive health, medical, psychological and other counseling services), state and independent shelters, counselling centres, and public housing services among other services (UN Women 2013a: 12).

It was also noted by the UN Special Rapporteur (Manjoo 2013:19) that the state could fulfill this individual due diligence obligation of protection by providing women with services such as telephone hotlines, health care counselling centres, legal assistance, shelters, restraining orders, and financial aid. Many developed countries have the financial capacity to support welfare programs which provide support throughout the process of transition to a new life. However for developing countries this cost is prohibitive. According to UN Women (2014:13), the availability of services is limited for survivors, especially in remote areas. What has become clear is that the issue of GBV cannot be solved by the application of any single solution; it is a complex multifaceted issue with many contributing factors including culture and societal norms, social class and economic status as well as other factors such as drug and alcohol use (World Health Organisation 2012:3–5,8).

Sāmoa's Commitment to Tackling Gender Based Violence

Sāmoa is a small island developing state in the Pacific with a population of approximately 187,000 spread across the two major islands of Upolu and Savai'i. According to United Nations

development criteria,Samoa graduated from Least Developing Country Status in January 2014 (Government of Samoa 2014: 2). As a relatively young state having gained independence in 1962, Sāmoa has made many strides towards placing GBV on the national agenda. This includes changes initiated by the government, the private sector, the nongovernmental sector and different donors.

There are a number of state initiatives. A Domestic Violence Police Unit was established in 2007 to handle domestic violence matters and to handle submissions for protection orders. There are two main police stations: one on Upolu and one on Savai'i with six outposts on Upolu and three on Savai'i. There is a female officer at each outpost to take reports from women who come in. All cases of sexual assault or an offence which carries a sentence of five years or greater are transferred to the Criminal Investigation Division and are seen by the Supreme Court. Matters which remain with the Domestic Violence Unit are seen by the Family Court; previously these types of matters were seen by the District Court on specifically allocated days. The Family Court officially commenced operations in June 2014 with the passage of the *Family Court Act*; however, it unofficially commenced operations towards the end of 2013. There are only two other Family Courts in the Pacific Region: New Zealand and Australia. The Government of Sāmoa has included in its *Strategic Plan 2012–2016* an increased reporting of crime and a reduction in crime levels, community policing programs enforced and a promotion of customary based justice and the formal justice system as some of its key indicators (Ministry of Finance 2012: 13).

Domestic legislation has been passed which coversGBV such as the criminalisation marital rape under the *Crimes Act* of 2013. However, there are certain aspects of the Act which are contradictory and/or do not consider the power relationships in GBV. According to the Act any individual of the age of sixteen or older engaged in incest can be charged. However, this does not factor in the power differential in these types of relationships and Sāmoa put out a draft of the *Child Rights Bill* in 2014 for public comment and within the Bill, a child is considered up to the age of 18.Anotherimportant piece of domestic legislation which was passed in 2013 was the *Family Safety Act* 2013 which includes a No Drop Policy provision (Duty to Prosecute) where complaints filed with the Domestic Violence Unit cannot be withdrawn by the individual and must be processed by the Unit. Should the officer fail to pursue the matter, they will face disciplinary action.

The National Human Rights Institute was established in December of 2013 under the Office of the Ombudsman and among its responsibilities, it will conduct reviews of existing and proposed legislation to determine if they adhere to human rights principles and make recommendations based on those reviews.In the event that there is a systemic or widespread situation where human rights are violated, an inquiry will be conducted and recommendations made (Ombudsman 2013).

Sāmoa has also shown commitment to international conventions with the ratification of CEDAW in 1992 and the *Convention on the Rights of the Child* in 1994. Sāmoa is current with CEDAW reporting and submission of CEDAW Shadow reports (prepared by Non-Governmental Organisations). TheSāmoa Law Reform Commission is presently conducting an assessment of CEDAW compliance. The draft Child Rights Bill was put out for public comment mid-2014 and comments are currently being compiled by staff within the Division of Women within the

Ministry of Women, Community and Social Development (MWCSD). Under the MWCSD there are also National Policies for Women, Children and Youth.

There have been a number of other public initiatives including media campaigns, project grants and community awareness action. The Transformational Leadership Development Programme has been an initiative of the United Nations Development Programme that began in 2013 with three week-long workshops. These trained a group of participants from various walks of life on ways to initiate changes to reduce violence against women and increase the empowerment of women. One of the major outcomes has been an increase in the visibility of GBV as an issue that is covered and addressed in editorials in local newspapers, particularly the main daily, *Samoa Observer*.

For many years non-governmental organisations (NGOs), as social support providers, have been expected to take the lead in addressing GBV. As in other developing countries with limited state resources and social welfare provisions, NGOs are funded by public donations and development assistance partners, and have taken the lead in providing advocacy and services. In Sāmoa several organisations address GBV and currently the most prominent of these is the Sāmoa Victim Support Group which provides a helpline service for persons to call in for assistance, temporary shelter for survivors of abuse in their villages, shelter for women made pregnant through rape or incest, shelter for their babies and for children who have been sexually abused or placed in the care of SVSG while their abused mother seeks alternative housing. In Sāmoa there is no shelter for abused women. Other NGOs such as the GOSHEN trust provides care for low risk patients in need of mental care (referred by the State National Health Service) and others provide counselling for depressed and suicidal patients, such as *Fa'ataua Le Ola*. However, there is little accessible documentation about these organisations and the services which they provide. Some NGOs are utilizing the radio stations and television as avenues to raise issues of family violence (which includes GBV and violent punishment of children). For example the Adventist Development and Relief Agency (ADRA) has an 'Open the Door' programme (a media campaign to foster improved communication within families on sensitive issues) and the *Ekalesia Fa'apotopotoga Kerisiano Samoa* (EFKS) church-owned TV station provided free televised coverage for the Ending Violence in Sāmoa Roundtable (a discussion forum hosted by UN Women regarding this issue). There are also grants now available specifically targeted to the UN goal of 'Ending Violence against Women' such as the Pacific Grant Funding Facility run by UN Women that are open to applicants whose projects are focused on this area (UN Women 2013c). Sāmoa Victim Support Group, previously mentioned, was a recipient of this funding facility.

The Problem of Data in Sāmoa

The Government of Sāmoa has noted the importance of statistical data on violence against women and children within the *Sāmoa Strategy for the Development of Statistics* 2011–2021 which highlighted Statistics against Women and Children as priority statistics for 2014/2015 (Government of Sāmoa 2012:34). The lack of segregated data to enable comprehensive gender analysis was noted as a challenge in the *Millennium Development Goals Second Progress report 2010 of Sāmoa*in addressing violence against women (Government of Sāmoa 2010: 30). Recommendations from the report include the institutional strengthening of the Sāmoa Bureau of Statistics, to enable better data for analysis.

Because GBV is an extremely sensitive issue, it is likely to factor into the reticence about reporting and disclosure by survivors. According to the *Sāmoa Family Health and Safety Study* (SPC2006: 49), 91.4 percent of never abused respondents and 92.3 percent of abused respondents thought family problems should be kept private. Women who have been abused may also not report because they are worried about the consequences of shaming their family; although abused respondents also cite personal embarrassment as a factor. 41 per cent said they did not report because it would be bad for their family's reputation (SPC2006: 43). Most respondents accepted that violence was normal (72.5 percent) and this was the reason given for not seeking help by abused respondents (SPC 2006: 43).

Statistical information may not be gathered systematically due to the financial cost and human resource availability. Relevant data is spread across different ministries and agencies and there is no system to collect it in a centralised repository, or analyse it. Examples of relevant institutions that can generate categories of data needed to better understand and prevent GBV include the following:

- The National Health Service: the number of women who go for emergency care at the National Hospital with domestic violence identified as the underlying cause; the number of these women who reported the abuse to the Domestic Violence Unit; the proportion of cases referred by doctors to the Domestic Violence Unit; the proportion of cases that are admitted to hospital and are seen by the social workers at the Social Services Unit.
- The Domestic Violence Unit within the Police: the number of cases referred to the Criminal Investigation Division (CID) due to the type of offence or severity of offence.
- The Division of Correction, Enforcement and Maintenance in the Ministry of Justice and Court Administration: information from perpetrators of domestic violence about underlying triggers for violence; information from survivors about the impact of the violence, and the services which they need; and information on the outcomes of family conferences that have taken place on place upon the instruction of the Family Court judge.

Surveys Conducted in Sāmoa

The first research report on domestic violence was conducted by the NGO *Mapusaga O Aiga*. This NGO was founded to raise awareness about sexual abuse and domestic violence and to educate the population on these matters. It received support from the Sāmoan Government under the three-year Assistance Programme for Sāmoan Women (established in 1994). The report was published in 1996 based on data collected in 1995 from interviews with 257 women aged 15 and older in major regions of Sāmoa. This survey found that a little more than 50 percent of women were aware of violence against women in their villages and about 25 percent were victims of violence (SPC 2006: 7).

The largest study done in Sāmoa was the Sāmoa*Family Health and Safety Study* which was part of a joint research initiative of the MWCSD and the United Nations Population Fund. This study was among the first parts of a multi-site study and used the method and questionnaires developed for the WHO multi-country study of women's health and domestic violence. The goals of the study were to collect detailed information on the prevalence of

violence, frequency of violence, risk and protective factors, health and legal consequences, strategies and interventions used by victims, families and communities, and to assess the impact of attitude on the prevention and intervention of violence. The study included a qualitative study to identify key issues related to domestic abuse upon which the WHO questionnaires were modified for the Sāmoan context. The resulting questionnaire was administered to 1646 women and a separate questionnaire developed for men was administered to 664 men (SPC 2006:1). Only one woman per household was interviewed in this study. In the men's study, only one male per selected household within the age range of 15–49 was interviewed. The data was collected in 2000 and the report was not published until 2006. To date, this study remains the base for many reports generated which discuss the impact of domestic violence in Sāmoa. In this study the estimated prevalence was 46.4 percent among women between the ages of 15–49. There have been many changes since the study was conducted, including services presently available through NGOs, legal and judicial changes by the state, and changing attitudes to violence.

In 2009, the Sāmoa Ministry of Health in collaboration with the Sāmoa Bureau of Statistics and technical assistance from ICF Macro undertook the *Sāmoa Demographic Health Survey*. Funded by World Bank/International Development Association, the Australian Agency for International Development and the New Zealand Agency for International Development, the survey was nationally representative and a total of 2247 households were interviewed and in all of the households selected for interview, all eligible women between 15–49 were administered the women's survey and in every other selected house (half of the houses) all males between 15–54 were administered the men's survey (Ministry of Health 2009:20).Designed to improve health care in Sāmoa, the survey gathered detailed information on fertility, marriage, sexual activity, fertility preferences, awareness and use of family planning methods, breastfeeding practices, nutritional status of women and young children, childhood mortality, maternal and child health, awareness and behaviour regarding HIV/AIDS and other sexually transmitted infections (STIs) (Ministry of Health et al.2010: 19).

The Survey included a section on Women's Empowerment and Demographic and Health. In this section there were questions related to attitudes towards wife beating, decision making, refusing to have sex, contraceptive usage, and family planning. This survey is repeated every five years and has recently been administered using the same survey instrument, with the addition of questions on disability and nutrition. While it does not provide data on prevalence of violence, it provides invaluable information on changing attitudes towards violence and levels of women's empowerment.

Another small but relevant study is the *Mother and Daughter Study* which was conducted inSavai'iin April 2014 by the Division of Women under the MWCSD (Division of Women 2014:1–10). The project included a pre-test and post-test component to assess the knowledge levels of different components of the training programme. The *Mother and Daughter Study* targeted the mother and daughters from four villages in Savai'i and included participants who were adolescents and older. The training covered communication and decision making skills on sexual and reproductive health, awareness of CEDAW and positive parenting, and livelihood skills to raise the levels of self-esteem of mothers and daughters. While the sample size was small (the maximum sample size was 35), there were some very interesting results obtained. There was little awareness that family planning was intended to help space out

births of children and is reflected in the results of the pre-test survey; 6/29 of Tufutafoe participants understood what family planning means for women, 11/35 for Falelima, only 7/25 from Satupaitea and 10/25 for Neiafu. There was poor recognition of symptoms of sexually transmitted infections in several villages; Falelima and Tufutafoe showed little understanding of STI symptoms (14/35 and 9/29 participants) and while there was great awareness of the impact of violence (that 95 percent of the violence within families impacts women and girls) there were respondents who were not aware of the different forms of violence. In Satupaitea, 5 out of the 15 women respondents (33.3 percent), and in Neiafu, 8 out of the 21 (38.1 percent) were not aware of the different forms of violence. In the discussion with the women, there were mixed opinions on whether a woman could refuse sex to her partner. This study highlights the need for increased awareness programmes on violence, legislative changes and sexual and reproductive health (Division of Women 2014: 9).

Importance of Data

There are many reasons why statistical information is necessary in decision making, especially in regard to addressing the issue of GBV or domestic violence. Data can provide information on the number of women affected, the women who are coming forward to report violence, the types of services which they need and are being utilized and the list continues.Two examples illustrate the need for information that is current and comparable.

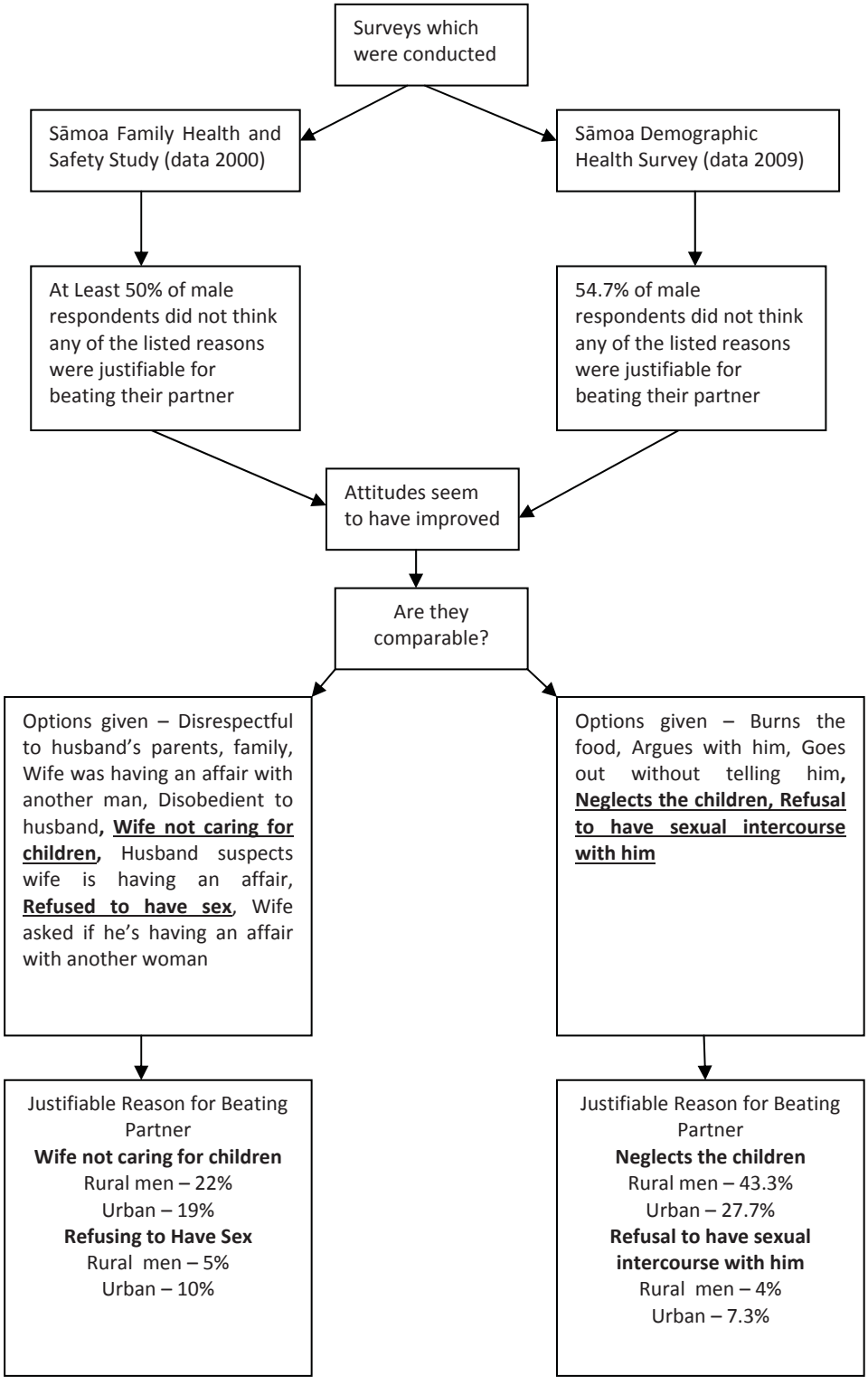
First, high levels of underreporting of cases of GBV is a significant issue, as survivors will not be able to access services if the referral system is attached to the reporting mechanism and does not provide essential information to the government on the gravity of the issue to be addressed. In Table 1 below, estimated numbers of women between the ages of 15–49 experiencing abuse in 2006 and 2011 have been calculated using the prevalence figures from the *Sāmoa Family Health and Safety Study* and the population census for 2006 and 2011 (Sāmoa Bureau of Statistics 2011: 30) Data on the cases reported by the Domestic Violence Unit for 2007 and 2011 (UN Women 2013b: 2–4) have been inserted and the number of Family Court Matters seen and or scheduled for 2010–2011 (Ministry of Justice and Court Administration2011: 21) and 2009–2010 (Ministry of Justice and Court Administration 2010: 17).

Based on the expected number of cases of abuse (416/ 19, 770) approximately 2 percent reported those cases to the Domestic Violence Unit in 2011 and approximately 1.1 percent in 2006. This is an extremely high level of under reporting and more research is needed to identify the characteristics of those who are reporting and the reasons why there is such a high level of reporting. It should also be noted that cases of sexual assault or matters which carry a sentence of five years or more are transferred to the Criminal Investigation Division and are not factored in the number reported by the Domestic Violence Unit. Also, the estimated numbers of women affected by violence are for the age ranges of 15–49; the cases reported to Domestic Violence Unit include cases involving victims over the age of 49. This implies that the estimated number of cases annually is even higher as these estimated figures do not include women over the age of 49.

Table 1: Estimated Number of Women Experiencing Abuse in 2006 and 2011 Based on Prevalence Measures from the *Sāmoa Family Health and Safety Study*	Census Year	
	2011	2006
Population	187820	180741
Women	90830	86895
Number of Women between 15-49	42609	40768
Prevalence of All forms of Abuse from Sāmoa Family Health and Safety Study	46.40%	46.40%
Number of Women between 15-49 who may have suffered abuse (46.4%)	19770.58	18916.35
Prevalence of Physical Abuse from Sāmoa Family Health and Safety Study	37.60%	37.60%
Number of Women who could have suffered physical abuse (37.6%)	16021	15329
Prevalence of Emotional Abuse from Sāmoa Family Health and Safety Study	18.60%	18.60%
Number of Women between 15-49 who may have suffered emotional abuse (18.6%)	7925	7583
Prevalence of Sexual Abuse from Sāmoa Family Health and Safety Study	19.60%	19.60%
Number of Women between the age of 15-49 who could have suffered sexual abuse (19.6%)	8351	7991
Number of Cases Reported to DVU *used 2007 data	416	*148
Number of Reported Cases to Family Court using 2010-2011 and *2009-2010 data	151	*501

The second example is that while the *Sāmoa Demographic Health and Safety Study* and the *Sāmoa Demographic Health Survey* include questions related to attitudes on acceptable reasons for physical abuse, the reader must exercise caution in looking at the figures. The options presented within these questions may differ, affecting the ability to consider the overall figures as representative of changing attitudes. One example is the question posed to men in both the *Sāmoa Family Health and Safety Study* and the *Demographic Health Survey* regarding acceptable reasons for wife beating or physical abuse. Based on the overall attitude towards acceptable reasons for hitting of a spouse or wife beating, there appeared to be some improvement between 2000 and 2009 from 50 percent to 54.7 percent of male respondents not thinking that the reasons given were acceptable (Figure 1).

Figure 1: Interpreting Survey Data on Male Responses



However, the options presented within these questions differed, barring two which were neglect of children and refusal to have sex. While there was decreased acceptance that refusal to have sex was a reason for violence, there was a large increase in the acceptance that neglect of children was a justifiable reason for violence. This highlights the need to scrutinise gross figures and to look at underlying comparability. Data is needed to make informed

decisions on service provision for survivors of violence to maximise the available resources.A lack of or insufficiency of data means that it is very difficult to assess the sufficiency of services available to GBV survivors, or measures to reduce the prevalence. Duvvury et al.(2013: 43) note that a major weakness in the data available in low and middle income countries is that there is no annual survey of crime victimisation as in the United States of America or other Organisation for Economic Cooperation and Development (OECD) countries. This is why the UN CEDAW Committee adopted General Recommendation 19 in 1992, which required national reports be made to the Committee to include statistical data on the incidence of violence against women, information on the services provided for victims, and information regarding legislative and other measures taken to protect women from violence in their everyday lives (UN Women 2002–2009). For this means that the Bureau of Statistics should be given the resources and responsibility of gathering relevant data from the agencies of the Ministry of Justice and Courts, and the Ministry of Health on an annual basis and providing a summary report for the use of the various stakeholders in government and non-government sectors to ensure continuity of policy development and provision of programmes.

References

Division of Women, 2014.*Mothers and Daughters Report: Tufutafoe, Falelima, Neiafu, Satupaitea*. Apia: MWCSD.

Duvvury, N., Callan, A. and Carney, P. 2013. "Intimate Partner Violence; Economic Costs and Implications for Growth and Development" *Women's Voice Agency and Participation Research Series 3.*

Government of Sāmoa2010.*Millennium Development Goals: Second Progress Report 2010*. Apia: Government of Samoa.

Government of Sāmoa. 2012. *Sāmoa Strategy for the Development of Statistics 2011–2021*. Apia: Government of Samoa.

Government of Sāmoa. 2014. *Samoa's Smooth Transition Strategy Report*. http://www.un.org/en/development/desa/policy/cdp/ldc_documents/2015-cdp-samoa-transition.pdf (accessed 23 October 2015).

Manjoo, R. 2013. *Report of the Special Rapporteur on Violence against Women, its causes and consequences*.Geneva:United Nations.

Ministry of Finance. 2012. *Strategy for the Development of Sāmoa 2012–2016.*Apia: Ministry of Finance.

Ministry of Health, Bureau of Statistics, and ICF Macro. 2010. *Samoa Demographic and Health Survey 2009.* Apia: Ministry of Health.

Ministry of Justice and Court Administration.2010. *Ministry of Justice and Court Administration of Sāmoa Annual Report* 2009–2010. Apia: Ministry of Justice and Court Administration.

Ministry of Justice and Court Administration.2011. *Ministry of Justice and Court Administration of Sāmoa Annual Report* 2010–2011.Apia: Ministry of Justice and Court Administration.

Ombudsman. 2013. *Ombudsman, Human Rights Institution*. http://www.ombudsman.gov.ws/(Accessed 10 August 2014).

Sāmoa Bureau of Statistics. 2011.*Population and Housing Census 2011 Analytical Report.* Apia: Samoa Bureau of Statistics.

SPC. 2006. *The Sāmoa Family Health and Safety Study.* Noumea, New Caledonia: Secretariat of the Pacific Community.

UN Women.2002–2009.*Convention on the Elimination of All Forms of Discrimination Against*

Women: General Recommendations made by the Committee on the Elimination of Discrimination Against Women.
http://www.un.org/womenwatch/daw/cedaw/recommendations/recomm.htm (accessed April 28th 2015).

UN Women. 2012.*Post MDG Development Framework: Why Gender Equality Matters What Future Do You Want*. Suva, Fiji: UN Women

UN Women 2013a.*Elimination and Prevention of All Forms of Violence against Women and Girls—2013 Commission on the Status of Women Agreed Conclusions*. New York: UN Women.

UN Women.2013b.*Sāmoa Country Review.* Apia: UN Women.

UN Women 2013c.*Pacific Regional Ending Violence Against Women Facility Fund—FAQ.* Suva, Fiji: UN Women.

UN Women. 2014. *Pacific Brief*: *UN Women's Position on the Post 2015 Stand Alone Goal on Achieving Gender Equality*. Suva, Fiji: UN Women.

Walby, S. 2004. *The Costs of Domestic Violence, Women and Equality Unit.*Leeds: University ofLeeds.

World Health Organisation. 2012. *Understanding and Addressing Violence Against Women.* http://apps.who.int/iris/bitstream/10665/77432/1/WHO_RHR_12.36_eng.pdf?ua=1. (accessed 28 April 2015).

World Health Organisation. 2013.*World Health Organisation, Global and Regional Estimates of Violence against Women.*
http://apps.who.int/iris/bitstream/10665/85239/1/9789241564625_eng.pdf, (accessed 28 October 2014).

World Health Organisation. 2014. *Factsheet Violence Against Women: Intimate Partners and Sexual Violence Against Women*.
http://apps.who.int/iris/bitstream/10665/112325/1/WHO_RHR_14.11-eng.pdf (accessed 5 November 2011).

USAID. 2012. *Strategy to Prevent and Respond to Gender Based Violence Globally.*
http://www.usaid.gov/sites/default/files/documents/2155/GBV_Factsheet.pdf. (accessed 20 October 2014)