

BACKGROUND PAPER

VIOLENCE AGAINST ADOLESCENT GIRLS: FALLING THROUGH THE CRACKS?

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Background

The recent passage by the United Nations of the 2030 Agenda for Sustainable Development recognises that eliminating violence against women and girls (VAWG) and violence against children (VAC) are both essential to achieving sustainable development (See Box 1). Despite the inherent overlap between the two goals, there has historically not been much dialogue between the two fields.

Guedes and Mikton (2014) suggest at least four compelling reasons why coordinating efforts could be beneficial in achieving greater impact in both research and programming (Guedes and Mikton, 2013). These are: the co-occurrence of VAC and VAW in the same households; the consequences of VAC and VAW for victims are similar; both types of violence share many risk factors; and finally, strategies to prevent either type of violence are likely to have spillover effects on the other. An additional reason is that a significant proportion of both VAC and VAW is directed towards the same population – adolescent girls, who may be classified either as “children” or “women,” according to the focus of the research (Figure 1). Adolescent girls experience much of the same violence directed towards younger children such as corporal punishment and sexual abuse by parents, caregivers or family members or school violence. At the same time, they are vulnerable to other forms of violence most often directed towards women, such as early and forced marriage, female genital mutilation/cutting (FGM/C), intimate partner violence and intimate partner homicide. Although boys also experience new forms of violence during adolescence, such as gang violence and bullying, the characteristics and consequences of this violence are different.

Much of the research on violence against children fails to take into account the differences that adolescent girls and boys experience compared to younger children, as well as differences among adolescents by virtue of gender. At the same time, research and policies on VAW often do not recognise the specific risks that adolescent girls face that may pave the way to future violence and discrimination as women. As a result of the lack of a gender and life course perspective, the specific needs and vulnerabilities of adolescent girls often remain invisible or fall through the cracks in the development of policies and programs to end VAC and VAW (Patton et al., 2012).

In this paper we discuss how and why current conceptual frameworks and evidence fail to address the specific conditions of adolescent girls and their vulnerability to violence, as well as examine opportunities for strengthening policies and programs for responding to and preventing violence against adolescent girls. We argue that a gender perspective is crucial for understanding how structural factors such as differential access to education, resources, and rigid gender norms define the different challenges and opportunities that boys and girls face. At the same time, research and programming on VAC and VAW must incorporate a life course approach, viewing development as occurring over time with health outcomes resulting as a function of an interplay of a variety of interpersonal, familial, generational, social and environmental contexts, with adolescence playing a critical role in the life course development.

Adolescent girls are at the nexus of VAC and VAW, and understanding the complexity of their lives is crucial for improving interventions to respond to and prevent both forms of violence. The Sustainable Development Goals create both an imperative and an opportunity to address these issues in a coherent, coordinated way.

Box 1

The Sustainable Development Goals 2015-2030

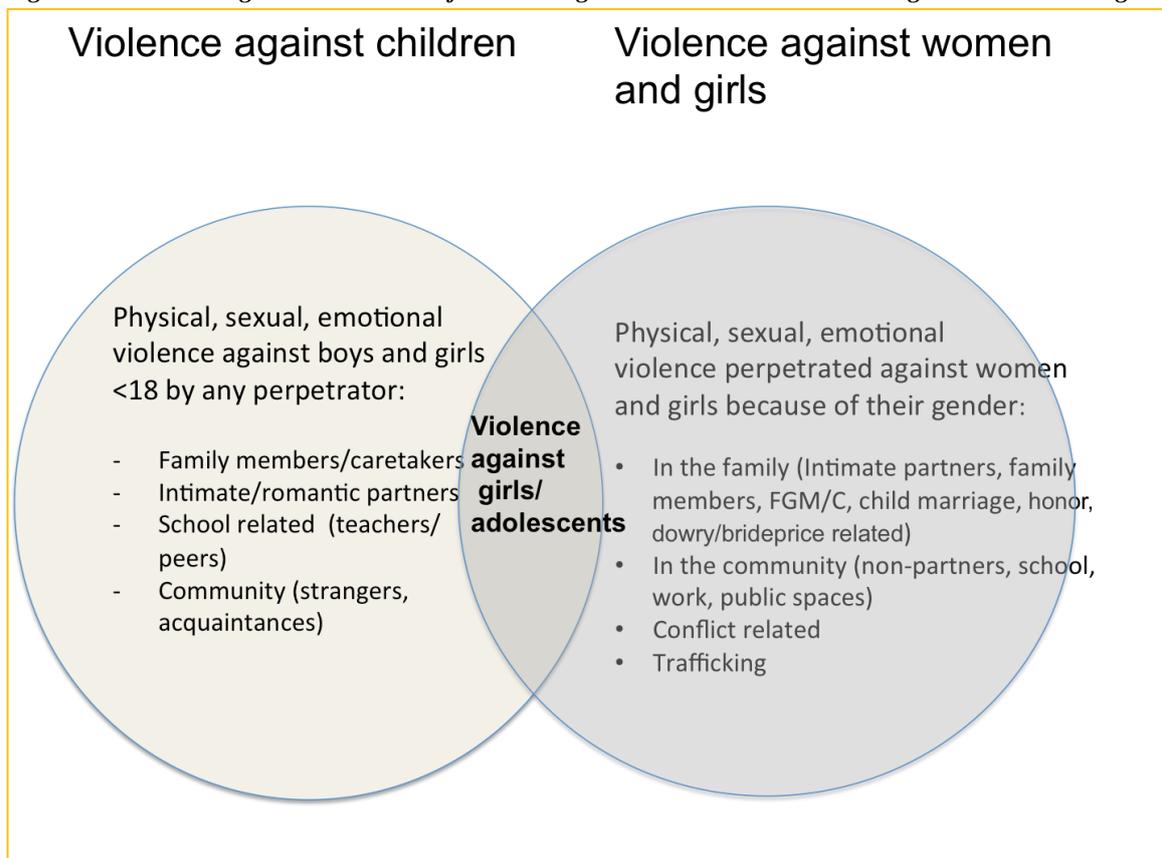
Building on the success of the Millennium Development Goals (MDG), in 2015 the United Nations (UN) passed the 2030 Agenda for Sustainable Development to guide the international community's priorities for the next 15 years. While the MDG's Goal #3 (Promote gender equality and empower women) focused on reducing gender disparities in education, the workforce and representation in government, the new Sustainable Development Goals (SDGs) have taken this one step further by including a specific target and indicator on the elimination of violence against women and girls (VAWG) under SDG #5 (Gender Equality and empowerment of women and girls). The international community has set targets to:

- Eliminate all forms of VAWG in public and private spheres, including trafficking and sexual and other types of exploitation (#5.2); and
- Eliminate all harmful practices, such as child, early and forced marriage and female genital mutilation (#5.3).

Moreover, SDG # 16, which refers to the promotion of peaceful and inclusive societies, includes a target to "End abuse, exploitation and trafficking and all forms of violence against and torture of children" (#16.2, UN, 2015).

Tied to these targets, governments will be required to report against specific indicators. This ambitious agenda will require rigorous evidence to guide policy and programs by identifying effective programs, as well as to monitor States' progress in achieving the targets. In addition, the new indicators will require governments to develop the capacity to collect and analyse data in order to report on trends of VAWG and VAC, including harmful practices.

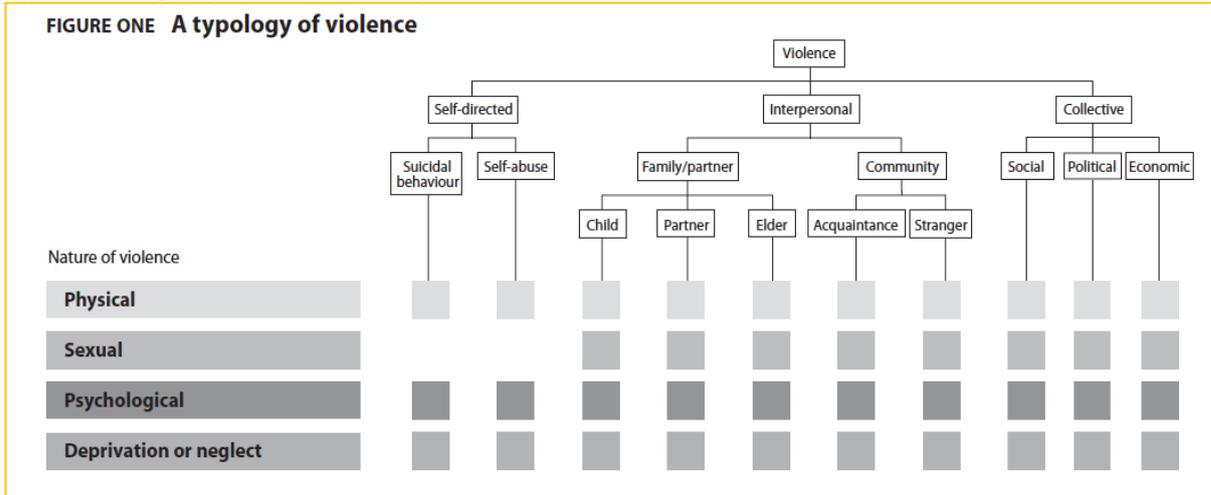
Figure 1. Adolescent girls at the nexus of violence against children and violence against women and girls.



Definitions and Conceptual Issues

One of the key difficulties in identifying the myriad forms and consequences of violence against adolescents, and girls in particular, lies in historical and conceptual differences in the way that research and programming on VAC and VAW have developed. The World Report on Violence and Health was a landmark attempt to bring different forms of violence into a broad conceptual framework (Krug, 2002). The Report presents a typology of violence, using three subtypes: self-directed violence, interpersonal, and collective violence (Figure 2). Violence against children fits largely into two groups of violence: Self-directed (including self-harm and risky behaviours) and interpersonal violence, both within the family violence (child maltreatment by caregivers) and the community (child sexual abuse outside of the family, youth violence, school related violence). Intimate partner violence is conceptualised as a form of interpersonal violence. Although gender is acknowledged as an influencing factor for violence in general, it does not form part of the typology of violence, where the key constructs for interpersonal violence are age (child, adult, elder), relationship between victim and perpetrator (partner, acquaintance, stranger), and location of violence (home, community).

Figure 2. A typology of violence (Krug et al., 2002)



In contrast, a gender and power analysis is the basis for the conceptualisation of violence against women (VAW) as a distinct form of violence. The UN Declaration on the Elimination of Violence against Women (1993) defines violence against women as “any act of gender-based violence that results in or is likely to result in physical, sexual or emotional harm, or suffering to women...” (Box 2). This definition includes acts of violence occurring in the family, the community and perpetrated or tolerated by the State. Examples of VAW include: physical, sexual, and psychological abuse by an intimate partner; non-partner sexual assault; sexual harassment in schools, the workplace and public spaces; prenatal sex selection; femicide; honour and dowry-related violence; trafficking, and conflict-related sexual violence. Both the UN Declaration and the Beijing Platform for Action (UN, 1995) explicitly recognise that VAW is rooted in historically unequal gender relations. Definitions of VAW also use a life course approach, identifying distinct types of violence experienced by women and girls at different stages, from birth through old age. More recently, the term has been expanded to “violence against women and girls,” acknowledging the life course approach to understanding VAW. The convergence of VAWG and VAC lies in the inclusion of both young and adolescent girls (Figure 1). However, differences in how gender and age are conceptualised and measured in both fields of research tend to obscure common elements instead of enhancing them.

Box 2**The United Nations Definition of Violence against Women**

The term “violence against women” means any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or private life. Accordingly, violence against women encompasses but is not limited to the following:

- a) Physical, sexual and psychological violence occurring in the family, including battering, sexual abuse of female children in the household, dowry-related violence, marital rape, female genital mutilation, and other traditional practices harmful to women, non-spousal violence and violence related to exploitation;
- b) Physical, sexual and psychological violence occurring within the general community, including rape, sexual abuse, sexual harassment and intimidation at work, in educational institutions and elsewhere, trafficking in women and forced prostitution
- c) Physical, sexual and psychological violence perpetrated or condoned by the State, wherever it occurs.

Acts of violence against women also include forced sterilisation and forced abortion, coercive/forced use of contraceptives, female infanticide and prenatal sex selection.

United Nations, 1993.

How is Violence Against Adolescent Girls Measured?

In the last 20 years, population-based research has greatly increased the amount of evidence collected on the prevalence and characteristics of both VAC and VAW, particularly in low and middle-income countries. The Multi-cluster International Children’s Surveys (MICS), carried out by UNICEF, include information on child maltreatment by caregivers against boys and girls. The Violence against Children Surveys (VACS), carried out by the Together for Girls Coalition, collect information on physical, sexual and emotional violence against boys and girls under the age of 18 by different perpetrators. These surveys are the most complete information on VAC in low and middle-income countries. In the United States, information on the prevalence of child sexual abuse is regularly collected in the Youth Risk Behaviors Survey. The most frequently used surveys on violence against women are: the WHO Multi-Country Studies on Women’s Health and Domestic Violence against Women, the International Violence against Women Surveys (IVWS), and the Violence against Women Surveys carried out from the European Union Agency for Fundamental Rights (FRA). The Demographic and Health Surveys (DHS) and the Reproductive Health Surveys (RHS) both include a special module on domestic violence that has been conducted in over 40 countries to date.

Although most of the VAC and VAW surveys measure experiences of physical and sexual violence against adolescent girls, including intimate partner violence, it is difficult to compare the findings

across the surveys, due to differences in the way they are measured and presented. For example, the WHO study and the DHS interview women between the ages of 15-49 (although more recently, some countries are using 15-64 in order to explore the experiences of older women). Both lifetime and 12-month prevalence of IPV (physical, sexual, emotional) among ever-partnered women is presented for the whole sample and by age groups, with the youngest age cohort being 15-19 year olds in both the DHS and WHO studies. In addition, the WHO survey asks respondents about experiences of physical and sexual violence since the age of 15 by someone other than an intimate partner, and sexual violence before the age of 15 by anyone. The age cutoff of 15 for child sexual abuse was to facilitate recall and to avoid the problem of truncated data, since all of the respondents would have already reached the age of 15. Because the definition used in most countries for an intimate partner was marriage or co-habitation, dating violence is not specifically presented. However, one of the main perpetrators of sexual violence both before and after 15 was a “boyfriend.” It is not known whether this refers to the same person who eventually became an intimate partner, or whether it was a romantic partner who is not mentioned in the IPV questions. Some versions of the DHS also ask about lifetime experiences of sexual assault by a non-partner. A revised version of the WHO questionnaire proposes to ask specifically about sexual violence before 18, as well as the age of the victim and perpetrator at the time of the first instance of sexual abuse, in order to increase comparability with the VAC surveys.

In contrast, the VAC Survey interviews boys and girls between the ages of 13-24. Respondents are asked about any experiences of sexual abuse by anyone before the age of 18. To avoid the problem of truncated data, these questions are only asked of the 18-24 age group. Respondents aged 13-17 are asked about sexual abuse during the last 12 months. Data are collected on the age of the respondent at the time of abuse, the age of the perpetrator, and the relationship between the respondent and the perpetrator. The VAC Surveys include more detailed questions on sexual violence than the WHO study, including transactional sex, commercial sexual exploitation, video and cyber-stalking. Additionally, ever-partnered respondents are asked about physical (but not sexual) intimate partner violence. However, the results on physical IPV have not been presented in the national reports to date. The results on sexual violence are disaggregated by sex, but not by age-groups. Therefore, it is difficult to discern the different types of violence that children may be subjected to at different stages in the life-cycle (maltreatment by caregivers, intimate partners, etc). Although intimate/romantic partners are the largest group of perpetrators of sexual violence against girls, it is not possible to identify the prevalence of sexual IPV among ever-partnered girls, nor the prevalence of non-partner sexual violence. It is not possible in either the VAC or VAW surveys to identify the lifetime or 12-month prevalence of different forms of violence among adolescent girls aged 10-18, nor among older adolescents (15-18).

Why is Adolescence Important?

Adolescence marks the developmental transition from childhood to adulthood, a time when many important social, economic, biological, and demographic events set the stage for adult life. Further,

given the youthful demographics of the world today, ensuring that adolescents can successfully navigate adolescence has significant social and economic consequences. However, poor health and violence may substantially undermine the ability of adolescents to lead full and productive lives.

A key challenge in addressing issues related to adolescents is the lack of a universal definition for this population. Childhood is defined by the Convention on the Rights of the Child as 18 years and under, and adolescence is defined by WHO and UNICEF as those aged 10-19. However, this definition has not been adopted consistently by countries and researchers, leading to differential and/or incomplete data specific to adolescents.

Traditionally, the period known as adolescence did not exist in most countries because young women moved from childhood straight into adulthood. Urbanisation, delays in the age of marriage, increases in secondary education, declines in age of menarche, and transitions from agricultural to more technological societies led to a new phase of development in developing countries in the last several decades. Despite these advances, early and forced marriage remains a significant concern in many low and middle-income countries.

Adolescence is one of the most rapid phases of human development. Although the order of many of the changes appears to be universal, their timing and the speed of change vary among and even within individuals. Both the characteristics of an individual (e.g. sex) and external factors (e.g. inadequate nutrition, an abusive environment) influence these changes. Important neuronal developments are also taking place during the adolescent years. These developments are linked to hormonal changes but are not always dependent on them. Developments are taking place in regions of the brain, such as the limbic system, that are responsible for pleasure seeking and reward processing, emotional responses and sleep regulation. At the same time, changes are taking place in the pre-frontal cortex, the area responsible for what are called executive functions: decision-making, organisation, impulse control and planning for the future. The changes in the pre-frontal cortex occur later in adolescence than the limbic system changes.

Linked to the hormonal and neurodevelopmental changes that are taking place are psychosocial and emotional changes and increasing cognitive and intellectual capacities. Over the course of the second decade, adolescents develop stronger reasoning skills, logical and moral thinking, and become more capable of abstract thinking and making rational judgments. These developmental changes vary according to sex, with physical growth and reproductive maturation typically taking place between the ages of 10 and 14 for girls and 12-16 for boys (Dixon-Mueller, 2008). By the age of 14-16 for girls and 15-17 for boys, brain structures and cognitive development mature sufficiently for complex abstract thinking. Changes taking place in the adolescents' environment both affect and are affected by the internal changes of adolescence. These external influences, which differ among cultures and societies, include social values and norms and the changing roles, responsibilities, relationships and expectations of this period of life.

In many ways, adolescent development drives the changes in the disease burden between childhood to adulthood — for example, the increase with age in sexual and reproductive health problems, mental illness and injuries (intentional and unintentional).

Gender disparities with respect to access to education, health, economic, and social opportunities exist across the lifespan; however, these disparities surge during adolescence. Girls and boys in cultures throughout the world are treated differently from birth onward (and even antenatally where selective abortion of female fetuses is practiced), but at puberty this gender divide increases significantly. During adolescence, opportunities expand for boys and contract for girls. As boys begin to take advantage of new privileges reserved for men, girls endure new restrictions reserved for women. Boys gain autonomy, mobility, opportunity, and power (including power over girls' sexual and reproductive lives), while girls are systematically deprived of these assets. During adolescence, gender socialisation is reinforced and pressures to conform to hegemonic notions of masculinity and femininity are heightened (Barker, 2000; Ricardo, 2006). Adolescent boys are encouraged to be aggressive and dominant, including sexually. In contrast, girls are expected to be chaste and submissive in the face of male domination. During this period, as adolescents are beginning to engage in romantic and sexual relationships, the internalisation of these norms has important implications both for perpetration and victimisation of violence.

Violence Against Adolescent Girls: Gender and Age Matters

Both boys and girls of all ages are subject to multiple forms of physical, sexual and emotional violence, with potentially devastating effects on their health and future wellbeing. However, a gender and life course perspective reveals distinct patterns, consequences and risk factors of violence according to sex and developmental stage. In general, boys report a higher prevalence of physical punishment, by caretakers, teachers, and among peers, and they face more violence through peer groups and strangers outside their home (Thompson, Kingree, and Desai, 2004). Girls are more likely to experience sexual violence with about 20 percent of women and 5-10 percent of men reporting sexual abuse as children (WHO, 2006). They are more likely to experience violence from people they know; family members and intimate or dating partners.

Until recently, much of the evidence regarding sexual violence of children came from high-income countries. However, emerging data from low and middle-income countries indicate that the prevalence and characteristics of sexual violence against boys and girls vary widely across settings. A comparative review of the Violence against Children Surveys (VACS) in 7 countries found that among 18-24 year olds, the prevalence of any form of sexual violence before the age of 18 ranged from 4.4 percent among females in Cambodia to 37.6 percent in Swaziland, with prevalence in most countries greater than 25 percent. Among boys the range was from 5.6 in Cambodia to 21.2 in Haiti. Sexual abuse was higher among girls in all countries except Cambodia (Sumner et al., 2015). However, completed unwanted sex (pressured or forced penetrative sex acts) was several times higher among girls in all countries except Haiti. For example, in Zimbabwe, 13.5 percent of girls

reported coerced sex compared to 1.8 percent of boys (Sommarin, Kilbane, Mercy, Moloney-Kitts, and Ligiero, 2014).

The perpetrators of sexual violence are also different for adolescent boys and girls. In the VACS, the main perpetrators for sexual abuse against boys were neighbours, schoolmates and friends, whereas between 45-77 percent of sexual violence against girls was perpetrated by a romantic or intimate partner (Sommarin et al., 2014). Although these data are not disaggregated by age group, it is likely, given global patterns of sexual debut and marriage, that most of the cases of IPV occur among adolescents, rather than younger children. Although IPV is also reported by boys, albeit in lower proportions, the patterns and potential health impact of IPV for girls and boys are distinct. It is noteworthy that the majority of boys in the VACS report that sexual violence was perpetrated by females: this contrasts with findings from other international studies on child sexual abuse. For example, a retrospective study in Nicaragua of adults on experiences of sexual abuse in childhood found that 25 percent of women and 20 percent of men reported sexual violence before the age of 19. Attempted or completed rape was reported by 15 percent of women and 7 percent of men. Among the women, 96 percent of the abusers were men and 66 percent were family members. Among the men, about half were abused by other men, and the most frequently mentioned abuser was a woman who was not a member of the family (Olsson et al., 2000). The Nicaraguan study was conducted among adults in an anonymous survey, whereas the VACS are conducted among youth aged 13-24 in face-to-face interviews. Given the extreme sensitivity and stigma surrounding male-on-male sexual violence, it is possible that the difference in reported victimisation of boys by male perpetrators is due to methodological issues, rather than true differences.

The high rates of IPV reported by adolescent girls in the VACS are consistent with global estimates based on research on VAWG. The WHO estimates the lifetime prevalence of physical or sexual violence from an intimate partner among ever-partnered girls aged 15-19 at about 30 percent. This is similar to the overall lifetime prevalence of IPV among women of reproductive age (Devries, Mak, and Garcia-Moreno 2013). This is remarkable, considering that girls have been exposed to the risk of IPV for a much shorter period. A review of data from the WHO Multi-country Study on Women's Domestic Violence in nine countries found that the 12-month prevalence of IPV among adolescent and younger women aged 15-24 ranged from eight to 57 percent. This was significantly higher than IPV rates in older women in all but one country, indicating that IPV starts early in the relationship (Stockl, March, Pallitto, Garcia-Moreno, and WHO Multi-country Study Team, 2014).

For adolescent girls in low and middle-income countries, IPV is closely linked to child marriage. It is estimated that one in three girls in the world are married before the age of 18. Currently, nearly 70 million girls between the ages of 18-24 were married before the age of 18 (UNFPA, 2013). In the VACS report from Malawi, 27 percent of women 18-24 were married or co-habiting with a partner before the age of 18, compared to 3 percent of men (VACS Malawi, 2013). The negative consequences of child marriage are well documented and extend throughout a girl's lifetime. A girl who is married before the age of 18 is not only more likely to suffer intimate partner violence; she is

less likely to continue her education, her earning potential is greatly diminished, and she is likely to be isolated from family and social networks. In addition to child marriage there are other forms of violence and harmful practices that only girls are also subjected to, such as FGM/C, femicide, violence related to dowry/brideprice and honour-related violence (Garcia-Moreno et al., 2015). 100-140 million women and girls have been subjected to FGM/C and an estimated 3 million girls are at risk of FGM/C every year (Ellsberg et al., 2015).

In high-income countries, dating violence is the most common form of IPV reported. Dating violence refers to physical or sexual violence that occurs in a relationship that is neither marriage nor a long-term dating relationship. International research, mostly collected in Europe and North America suggests that adolescents start dating between 13-15 years (Leen, 2013). In the U.S., 72 percent of adolescents (13-16) have had dating experience, whereas in the UK 88 percent of adolescents >15 report dating experience (Leen, 2013). A review of adolescent violence found a prevalence of physical adolescent dating violence between 10 and 20 percent of general population samples. The prevalence estimates were similar for both boys and girls, with a trend towards slightly higher male victimisation. In a study of Swedish adolescents, male victimisation was substantially higher (20-59 percent in boys, 10-43 percent in girls), particularly for the most serious abuse (Danielsson, Blom, Nilsson, Heimer, and Hogberg, 2009). For sexual dating violence the tendencies are reversed. Although great variability is found, sexual dating victimisation is higher for girls than for boys. This is consistent with IPV data from low and middle-income countries.

A recent UNICEF report showed that children aged 15 to 19 constitute over half of the homicides among children, followed by children under the age of five (UNICEF, 2014). The risk of homicide is particularly high for boys, who account for 70 percent of all child homicides, with a dramatic increase in late adolescence. The majority of adolescent homicide victims live in low- and middle-income countries, with the highest child homicide rates found in Latin America and the Caribbean, followed by West and Central Africa (UNICEF, 2014). Again, gender plays an important role, with boys aged 15 to 19 in Latin America and the Caribbean having a homicide rate that is seven times higher than that for girls in that region (UNICEF, 2014). The UNICEF report further found that homicide is the leading cause of death among adolescent boys in seven countries in Latin America and the Caribbean, and it is estimated that three in ten homicides in this region are gang related (UNICEF, 2014).

Gang violence is an important source of violence against adolescents, starting in early adolescence and peaking at age 15-17. Gang membership and violence predominantly affects adolescent boys, despite recent increases in female gang memberships. Girls however seem to navigate gang membership differently, using their gender to accomplish their criminal activity and to temper their involvement in criminal activities. Also, boys are more often the intended target of gang attacks, not girls (J. Miller and Decker, 2001). Reasons to join gangs are based on a number of risk factors, including community factors such as poverty, lack of economic and educational opportunities and alternatives, marginalisation and isolation, firearm and drug availability and unstable

neighbourhoods. Gangs often offer a sense of belonging, a replacement for the family and a life opportunity (UNICEF, 2014).

Young adolescents are also often forced to become gang members and once they are recruited find it impossible to get out again.

Health Consequences of Violence Against Adolescent Girls

In addition to marked differences by gender in the prevalence and patterns of different forms of violence, there are also variations in the consequences of childhood abuse, both during adolescence and in adulthood. A meta-analysis of sexual abuse of boys found that adolescent boys who had been sexually abused were more likely than non-abused boys to report unprotected sex, multiple sexual partners and involvement in a pregnancy (Homma et al., 2012). A U.S. study of long-term health consequences of physical abuse of children found that men were more likely than women to have sustained a serious injury in adulthood, use alcohol daily in the past year, and use illegal drugs in the past month. Women were more likely than men to have acquired a physical health condition in adulthood, acquired a mental health condition in adulthood, used tranquilisers in the past month and used anti-depressants in the past month. The study concludes that physical childhood violence is more prevalent among males, and although it is related to adverse health outcomes for both genders, the effect was generally greater for females (Thompson et al., 2004).

The consequences of IPV for women's health and well-being have been well documented. IPV has been associated with a series of mental health conditions including depression, anxiety, suicidality, and Post Traumatic Stress Disorder as well as injuries, chronic pain, alcohol and substance abuse, high risk sexual behaviours and poor sexual and reproductive health

(Devries et al., 2014; Ellsberg, Jansen, Heise, Watts, and Garcia-Moreno, 2008). Women and girls who have experienced IPV or child sexual abuse are more likely to have thought of or attempted suicide. This is of particular concern in light of the recent finding that suicide has surpassed maternal mortality as the main cause of mortality among adolescent girls (UNFPA, 2015).

Violence in pregnancy, which affects 4-24 percent of women globally, is associated with a host of adverse pregnancy outcomes, including miscarriages, insufficient weight gain, fetal growth retardation, low birth weight, and infant and child mortality (Campbell, Garcia-Moreno, and Sharps, 2004; Devries et al., 2010; Valladares, Ellsberg, Peña, Högberg, and Persson, 2002).

Intimate partner violence also increases the risk of HIV infection among women and girls. Meta-analyses of studies from a variety of settings indicate that intimate partner violence increases women's risk of HIV by 52 percent (Devries, Mak, and Garcia-Moreno, 2013). A longitudinal study in South Africa among young women (15-24 years) suggested that about 12 percent of new HIV infections, could be attributed to IPV (R. K. Jewkes, Dunkle, Nduna, and Shai, 2010).

Both child marriage and child physical and sexual abuse also greatly increase a girl's likelihood of having either an unwanted or early pregnancy. A matched case-control study of pregnant adolescent girls between 10-16 years of age in rural Nicaragua found risk and protective factors at the individual, family and community level (PATH, 2012). The pregnant girls were more likely to have an early marriage and sexual debut (<15 years), more likely to have experienced physical violence by family members and intimate partners, as well as sexual abuse before the age of 12, compared to their non-pregnant peers. Importantly, their mothers were more often adolescents when they were born, indicating the extent to which the effects of adolescent pregnancy extend to the next generation. The non-pregnant girls expressed more equitable social norms, higher self-esteem, more family support, and higher educational attainment (>6th grade) (PATH, 2012).

In low and middle-income countries, where the bulk of adolescent births occur, 90 percent are within a marriage or a union (Langer et al., 2015). According to a recent UNPFA report, about 11 percent of births worldwide are among girls of 15-19 years of age. Of the 7.3 million births to girls under 18, 2 million births are to girls under 15 (UNPFA, 2013). Adolescent pregnancy carries significant risks for both mother and child. Obstetric complications were the second most common cause of death for girls aged 15-19 worldwide in 2010 (Langer et al., 2015). Compared with women aged 20-24, pregnant girls before 19 or younger have a greater risk of adverse maternal health outcomes, including eclampsia, systemic infections and pre-term birth (Langer et al., 2015). They are more likely to develop obstetric fistula from prolonged or obstructed labor, and more likely to undergo unsafe abortions. There is some evidence that maternal mortality is greater among adolescents, particularly those under 15 (Nove et al., 2014). The results of a Latin American study showed that girls under 15 who gave birth were four times more likely to die during childbirth than women aged 20–24 years (Conde-Agudelo et al., 2005). According to a recent multi-country study, the children of young mothers have a greater risk of low birth weight, stunting at 2 years, failure to complete secondary schooling and lower adult height compared with mothers aged 20-24 years (Fall et al., 2015).

Social Determinants of Violence Against Adolescent Girls

The risk factors for perpetration and victimisation of violence against adolescents are similar throughout the literature; however, they operate differently for boys and girls. For example, experiences of violence in childhood and witnessing violence against the mother increases boys' risks of perpetrating violence against his partner as an adult (Fulu, Jewkes, Roselli, and Garcia-Moreno, 2013). In contrast, girls who witness violence against their mothers, or experience sexual abuse in childhood, are more likely to be victimised by their partners as adults (Abramsky et al., 2011).

The main risk factors for IPV against young women across most sites were – witnessing violence against the mother; partner's heavy drinking, concurrent relationships and engaging in fights; having experienced unwanted first sex; frequent quarreling with partner, and partner's controlling behavior (Stockl et al., 2014).

There is evidence that rigid gender norms play a role in predicting both perpetration and victimisation of violence against adolescents (Guedes and Mikton, 2013). A multi-country study on men's use of physical and sexual violence against women found that men who used violence were more likely to endorse inequitable gender norms, and favorable attitudes towards the use of violence against women (Barker et al., 2011). Of particular concern is that among men who have sexually assaulted a woman, the majority of them committed their first act of rape before the age of 20 (Fulu et al., 2013).

The influence of gender norms on increased risk of IPV goes beyond individual level attitudes. A recent meta-analysis of over 50 data-sets on IPV found that social norms, including the view that IPV against women is justified in certain circumstances, and male control of women's bodies, together with women's limited access to divorce and property emerged as the most significant risk factors shaping the prevalence of IPV globally (Heise and Kotsadam, 2015)

Implications for Policy and Programmes

As we have shown, adolescent girls are at the nexus between VAW and VAC. Addressing violence against adolescents, and particularly adolescent girls, is critical for achieving results across all of the SDGs, not just those addressing gender equality and children. To address violence against adolescents effectively requires multi-sectoral coordination and integrated approaches, including appropriate laws, services and prevention strategies.

Laws and Policies

There has been great progress in improving legislation on violence against women and harmful practices worldwide in the last 20 years. Out of 100 countries included in a recent World Bank report, 75 have enacted or reformed domestic violence laws (World Bank, 2015). Legislations against gender-based violence more broadly have also been put in place by several countries, including Rwanda, Nicaragua and Guatemala. Laws criminalising FGM/C and child marriage, and regulating dowry and brideprice have also been passed in many countries where these practices are common. However, enforcement of the laws is still very weak in most countries. Most of the new laws do not include allocations in national budgets, and impunity is rampant. Moreover, there are still inconsistencies and gaps in the legal framework in many countries. For example, some countries absolve a rapist if he marries the victim. In South Sudan, girls who have been raped are considered "spoilt" and may be required by her family and customary courts to marry the rapist against her will to avoid the shame and stigma (Murphy et al., 2015). In many countries, marital rape is still not considered a crime. In others, there is lack of access to safe abortion, even in the case of rape or endangerment of the mother's life. In some countries, such as the Philippines, the age of consent, and thus of statutory rape, is as low as 12. In other countries, for example in Nicaragua, very young adolescent mothers are unable to register their babies in the national registry because they themselves are underage and cannot be registered without a guardian.

Adolescent-Friendly Services

The lack of services for children and adolescents is reflected in the VACS data, which revealed that most victims do not seek help. In Zimbabwe, only 3 percent of females and about 2 percent of males who experienced sexual violence before the age of 18 received professional help.

There has been a huge increase in the number and quality of services to address VAC and VAW. However, few services provide holistic services available to adolescents. Boys are unlikely to attend services meant primarily for women, and girls are unlikely to attend services directed at older or married women. In fact, in some countries, adolescents do not even have access to basic sexual and reproductive health services, such as family planning and STI services, where support for violence might also be made available. One solution that has emerged in recent years is the “One Stop Centers” often located in hospitals, that provide services to survivors of sexual and intimate partner violence. Examples of these are the Thuthuzela centers in South Africa, GBV One Stop Centers in Rwanda, and Family Support Centers in Papua New Guinea. Most centers have specialised services for children and women including psychological counseling, medical care and police personnel to take declarations if a survivor decides to make an official report. In poorly resourced settings, the OSC may consist of a private room in a hospital staffed by a nurse, on top of her regular duties. In Sub-Saharan Africa, “post-rape care” is often provided in the context of HIV testing and counseling programs. The Ciudad Mujer center in El Salvador, in addition to GBV services, also offers technical training, micro-finance programs and other economic and social programs for women. Specialised police stations for women and children represent another model that has been established throughout Latin America, South Asia and Africa. These typically are staffed by trained female police officers, and occasionally provide counseling or referrals to specialised care as well. Although the establishment of these centers is an important first step in drawing attention to VAC and VAW as a public health problem, the majority of them are poorly resourced and lack adequately trained staff and standard procedures. Moreover, there is very little evidence about the effectiveness of OSCs in responding to and preventing violence (Ellsberg et al., 2015).

An Emphasis On Prevention

Although evidence is still scarce about what works to prevent violence against adolescence, some promising approaches have been identified. In high income countries, school-based interventions to prevent dating violence, such as Safe Dates in the United States, and Fourth R in Canada have been effective in reducing both perpetration and victimisation among both boys and girls (Foshee et al., 2012; Wolfe et al., 2009). In India, a program called the Gender Equity Movement in Schools (GEMS) was effective in changing gender norms among young adolescents, including the value of girls’ education, and sharing household chores (Verma et al., 2007). Stepping Stones, an HIV prevention program, was found to reduce perpetration of IPV among young men (although it did not reduce victimisation reported by girls) (R. Jewkes et al., 2006). Other programs are gender specific, such as Project H, developed in Brazil by Promundo, which has been adapted and tested in many

countries, including India, Ethiopia, and the Balkans. The program in India, Yaari Dosti, significantly reduced perpetration of IPV by young men in the program (Verma et al., 2008). Another approach for engaging men and boys in violence prevention involves sports programs. The Coaching Boys into Men program was originally developed by Futures without Violence and adapted for India (Miller et al., 2015). The program engages male coaches as positive role models and trains them to deliver messages to their male athletes about the importance of respecting women and understanding that violence does not equal strength. Parivartan engaged cricket coaches, mentors in schools and the community to teach boys lessons about controlling aggression, preventing violence, and promoting respect. At the end of the program, participants reported improved gender-attitudes compared to non-participants (Miller et al., 2015).

Opportunities for Working with Older Adolescents and Younger Adolescents

Programs such as Entre Amigas in Managua targeting adolescent youth of 10-14 years of age promote the understanding of sexual and reproductive issues among young girls in addition to strengthening their negotiation skills in sexual relations. This program targeted adolescent girls at the individual, family, community, and societal levels to increase the likelihood of behaviour change. Impact studies show that peer methodology is a useful tool in improving knowledge and attitudes among preadolescent youth (Pena et al., 2008).

Evidence in both high income and low to middle-income countries show that the most effective approaches share common features (Ellsberg et al., 2015; Bourey et al., 2015):

- Address multiple forms of violence (youth/gang, IPV, caretaker, school-based)
- Address negative or discriminatory gender social norms
- Engage both boys and girls, although some activities might be carried out separately
- Combine multiple approaches as part of a single intervention (group training, livelihoods, social communication)
- Engage multiple levels of the social-ecological framework
- Have a longer duration (at least 6 months)
- Include structural interventions to address social determinants of violence against adolescents

Looking Forward

Despite the advances in research in the last 20 years on VAC and VAW, the evidence base on violence against adolescents, and adolescent girls in particular, is still weak, particularly in LMIC. We need to expand our knowledge on different forms of violence against adolescents, using both a gender and developmental approach. In particular, the following challenges must be addressed:

- How to address both victimisation and perpetration among girls and boys? Need to look at different patterns and risk by age group and sex. How can we improve the disclosure of sexual violence, particularly by boys?
- How can we reconcile child protection and gender equality agendas for these age groups?
- How to improve comparability of data on violence against women and girls (VAWG) and violence against children (VAC)? We need to standardise indicators and methods for measurement, so that violence against adolescents is visible and comparable across settings and surveys. This also means that surveys need to address issues that are specifically relevant to adolescent girls, such as FGM/C, child marriage and adolescent pregnancy (or gang violence among boys).
- How to scale up and adapt to different settings specific research gaps: humanitarian settings, inequities (race, ethnicity, gender identity and/or sexual).
- More evidence on effectiveness of interventions to reduce violence against adolescents, with outcome measures that measure both attitudes and behaviours.
- How to segment programs by developmental age.
- How to include a gender perspective throughout research and programming with adolescents.

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