Evidence for gender responsive actions to prevent violence

Young people's health as a whole-of-society response

World Health Organization

REGIONAL OFFICE FOR **Europe**

Abstract

The WHO Regional Office for Europe supports Member States in improving adolescent health by recommending comprehensive, multisectoral and evidence-informed adolescent health approaches; by delineating the critical contribution of the health sector; by fostering actions towards reducing inequalities; and by addressing gender as a key determinant of adolescent health. This publication aims to support this work in the framework of the *European strategy for child and adolescent health and development*, and is part of the WHO Regional Office for Europe contribution to the development of a new policy framework for Europe, *Health 2020*, for which the WHO Regional Office for Europe has been mandated by the 53 Member States.

The publication summarizes current knowledge on what works in preventing and managing violence. It is part of a series that includes social and emotional well-being, chronic conditions and disabilities, adolescent pregnancy, HIV/STIs, overweight and obesity, violence, injuries and substance abuse.

The publication assumes the position that young people's health is the responsibility of the whole society, and that interventions need to be gender responsive in order to be successful. It therefore looks at actions at various levels, such as cross-sector policies, families and communities actions, and interventions by health systems and health services. The publication does not prescribe nor recommend any particular course of action, which needs to be informed by the country specific context. It rather provides a basis to stimulate countries to further refine national policies so that they contribute effectively to the health and well-being of young people.

Acknowledgment

Foreword

In May 2011, the World Health Assembly adopted a resolution urging Member States to accelerate the development of policies and plans to address the main determinants of young people's health.

This series of publications, advocating a whole-of-society response to young people's health, and looking at the evidence for gender responsive actions, will be a timely resource for Member States as they implement both the resolution and the European strategy for child and adolescent health and development. The publications clearly show that not only are the health, education, social protection and employment sectors jointly responsible for the health of adolescents, but that effective interventions do exist. Ensuring that adolescents who are pregnant or have children can stay in or return to school, or enacting regulations to limit unhealthy snacks and soft drinks in school cafeterias are examples of policies that are beyond the mandate of health systems and yet generate health. By bringing evidence to the attention of policy-makers, these publications take a practical step toward achieving one of the core aims of the new European policy for health, Health 2020: to promote and strengthen innovative ways of working across sector and agency boundaries for health and well-being.

A common shortcoming of adolescent health programmes across the WHO European Region is that they often look at adolescents as a homogeneous cohort. Far too often programmes are blind to the fact that boys and girls differ in their exposure and vulnerability to health risks and conditions, such as depressive disorders, injuries, substance abuse, eating disorders, sexually transmitted infections, violence and self-inflicted injuries, including suicide. They are affected differently not only by the socioeconomic circumstances of their community and their ethnicity but also by gender norms and values. Research shows this, yet there is insufficient progress in transforming knowledge into policy action. I hope this publication will be a useful tool to facilitate this transformation.

Dr Gauden Galea
Director
Division of Noncommunicable Diseases
and Health Promotion

Introduction

The WHO Regional Office for Europe supports Member States in improving adolescent health in four main ways: by recommending comprehensive, multisectoral and evidence-informed adolescent health approaches; by delineating and supporting the critical contribution of the health sector, in-cluding the leadership role of ministries of health to influence other sectors, such as education, employment and social protection policies; by fostering actions towards reducing inequities in health both within and between countries; and by addressing gender as a key determinant of adolescent health.

By bringing together and coherently interconnecting knowl-edge and evidence on effective interventions and good practices for the better health, equity and well-being of young people, this publication aims to support this work us-ing the framework of the *European strategy for child and adolescent health and development*. It is also part of the WHO Regional Office for Europe's contribution to the development of a new policy framework for Europe, *Health 2020*, for which the WHO Regional Office for Europe has been mandated by the 53 Member States (resolution EUR/RC60/R5).

The publication summarizes current knowledge on what is effective in preventing and managing violence. It is part of a series that includes social and emotional well-being, chronic conditions and disabilities, adolescent pregnancy, HIV/STIs, mental health, overweight and obesity, violence, and injuries and substance abuse.

The publication includes two parts. The first part is a sum-mary table of effective interventions and good practices for preventing and managing violence. The table emphasizes intersectoral governance and accountability for young peo-ple's health and development, and takes a *whole-of society* approach to young people's health. It therefore looks at actions at various levels such as cross-sector policies, fami-lies and communities actions, and interventions by health systems and health services. It demonstrates that health

systems in general, and health ministries in particular, can work proactively with other sectors to identify practical policy options that maximize the positive health effects of other policies on young people's well-being, and minimize any negative effects. Interventions need to be gender responsive in order to be successful; the publication therefore looks at presented practices through a distinct gender perspective.

The second part explains the impact of gender norms, val-ues and discrimination on the health of adolescents relevant to prevention and management of violence. Through a re-view of the existing evidence, it looks at why is it important to look at gender as a determinant of adolescence health, what are the main differences between girls and boys in exposure to risk, norms and values and access to services, and what are the different responses from the health sector and the community. It complements the Gender Tool of the European strategy for child and adolescent health and development http://www.euro.who.int/__data/assets/pdf_file/0020/76511/ EuroStrat_Gender_tool.pdf. It gives the readers a deeper understanding of the gender dimension of actions listed in Part I.

The evidence base of this publication includes a review of existing literature, such as scientific and research articles and books, policy reviews, evaluations, and 'grey' literature. It needs to be emphasized that this is not a comprehensive and systematic review of the evidence in the area of preven-tion and management of violence, nor of approaches to support policies and their implementation. The publication does not rank presented interventions and good practices in any priority order, and does not assess them against the strengths of the evidences behind them. The publication does not prescribe nor recommend any particular course of action, which needs to be informed by country specific con-text. It rather provides a basis to stimulate countries to further refine national policies and strategies so that they contribute effectively to the health and well-being of young people.

Violence

PRIORITY	CROSS SECTOR ACTIONS		FAMILY & COMMUNITY ACTIONS	HEALTH SYSTEM ACTIONS	HEALTH SERVICES ACTIONS
	HEALTH IN ALL POLICIES	SCHOOL SETTING			
Prevent and manage violence, including bullying and sexual abuse	Improve disaggregated[1] data collection and information systems in order to identify vulnerable groups [27] Develop parenting programmes and programmes that develop children's life and social skills in early childhood [35] Implement comprehensive anti-trafficking policies, including multi-channel public awareness campaigns [28] Enact legal reforms that criminalize domestic violence [1] Limit unregulated employment and exploitation of girls under 16 in the form of domestic work [25] Enforce legislation encompassing all kinds of violence, including bullying, by and to minors [1, 4] Enact legislation which reduces access by minors, especially adolescent boys, to alcoholic beverages and to firearms [2, 26] Limit access of children and adolescents to violent material on television and on the web [3] Implement mandatory reporting of sexual abuse [5] Transform attitudes that condone or normalize violence against children, including stereotypical gender roles [27] Ensure that anti-violence policies and programmes are designed and implemented from a gender perspective [27] Increase youth employment [1] Promote social and gender equity and counteract poverty [1, 35]	Develop whole school interventions to improve school climate and ethos [6, 7] Adopt codes of conduct for staff and students that confront all forms of violence, taking into account gender-based stereotypes and other forms of discrimination [27] Implement sexual abuse prevention programme as part of sexual education programmes [8, 9] Implement school-based adolescent dating violence prevention programs [34] Set-up integrated[2] school-based specific anti bullying interventions with special focus on boys [10-14, 29, 30] Set-up gender-sensitive support programmes for victims of bullying [31] Help teachers to cope effectively with difficult situations without resorting to aggression, and increase training opportunities for teachers [32]	Develop community based interventions against violence, e.g. parental support, mediation activities, peer-led programs [15-18] Develop parenting programmes and programmes that develop children's life and social skills in early childhood [35] Implement programs which empower victims and offer readily available protection [15] Make available community services such as hotlines and shelters for victims of trafficking, primarily women and girls [28] Provide mediation facilities for victims of bullying [19] Develop gender-sensitive parent education programmes to orient parents towards nonviolent, constructive and positive forms of discipline [27] Set-up violence prevention programs for parents of young disruptive children [20] Develop restorative justice interventions [5, 21] Implement community-based adolescent dating violence prevention programs [34]	Implement hospital based surveillance of violence-related injuries [1, 22] Ensure proper referrals of victims within and between health care structures/community services [21] Develop specialized units or teams in the medical & psychosocial care of victims [23] Provide clinical restorative justice services [5, 21] Provide integrated services to prevent sexually abused young people from becoming abusers themselves [24]	Provide group therapy for victims of violence & bullying [15, 19] Promote equal referral for boys and girls and equal treatment when they have a similar pattern of impairment [33] Provide home visitation services by nurses and social workers to families at risk of maltreatment [27] Train parents on child development non-violent discipline and problem solving skills [27]

[1] data should be disaggregated by sex, age, urban/rural, household and family characteristics, education and ethnicity
[2] meaning that anti bullying interventions sould take into consideration other potential risk factor such as obesity and disability

References

1. *Preventing violence: a guide to implementing the recommendations of the World Report on Violence and Health.* Geneva, World Health Organization, 2004 (http://whqlibdoc.who.int/publications/2004/9241592079.pdf, accessed 20 December 2011).

2. Wallack L, Winett L and Lee A. Successful public policy change in California: firearms and youth resources. *J Public Health Policy,* 2005, 26:206-26.

3. Worthen MR. Education policy implications from the Expert Panel on Electronic Media and Youth Violence. *J Adolesc Health, 2007,* 41:S61-3.

4. Srabstein JC, Berkman BE and Pyntikova E. Antibullying legislation: a public health perspective. *J Adolesc Health,* 2008, 42:11-20.

5. Finkelhor D, Cross TP and Cantor EN. The justice system for juvenile victims: a comprehensive model of case flow. *Trauma Violence Abuse,* 2005, 6:83-102.

6. Patton GC et al. The Gatehouse Project: a systematic approach to mental health promotion in secondary schools. *Aust N Z J Psychiatry,* 2000, 34:586-93.

7. Catalano RFet al. The importance of bonding to school for healthy development: findings from the Social Development Research Group. *J Sch Health, 2004*, 74:252-61.

8. *Key Issues in the Implementation of Programmes for Adolescent Sexual and Reproductive Health.* Geneva, World Health Organization, 2004 (http://whqlibdoc.who.int/hq/2004/WHO_FCH_CAH_04.3_eng.pdf, accessed 20 December 2011).

9. Zwi KJ et al. School-based education programmes for the prevention of child sexual abuse. *Cochrane Database Syst Rev,* 2007, 3:CD004380.

10. Olweus D. Bullying at school: basic facts and effects of a school based intervention program. *J Child Psychol Psychiatry,* 1994, 35:1171-90.

11. *Violence Prevention: An Important Element of a Health-Promoting School.* Geneva, World Health Organization, 1999 (http://www.who.int/school_youth_health/media/en/sch_violence_prevention_en.pdf, accessed 20 December 2011).

12. Greene MB. Reducing violence and aggression in schools. *Trauma Violence Abuse,* 2005, 6:236-53.

13. Mytton J et al. School-based secondary prevention programmes for preventing violence. *Cochrane Database Syst Rev,* 2006, 3:CD004606.

14. Ryan W and Smith JD. Antibullying Programs in Schools: How Effective are Evaluation Practices? *Prev Sci,* 2009, 10:248-259.

15. Limbos MA et al. Effectiveness of interventions to prevent youth violence a systematic review. *Am J Prev Med,* 2007, 33:65-74.

16. Wright JL. and Cheng TL. Successful approaches to community violence intervention and prevention. *Pediatr Clin North Am,* 1998, 45:459-67.

17. Watson-Thompson J, Fawcett SB and Schultz JA. A framework for community mobilization to promote healthy youth development. *Am J Prev Med,* 2008, 34:S72-81.

18. Hawkins JD et al. Preventing adolescent health-risk behaviors by strengthening protection during childhood. *Arch Pediatr Adolesc Med,* 1999, 153:226-234.

19. Fleming M and Towey K, eds. Youth Bullying, in Educational Forum on Adolescent Health. Chicago, *American Medical Association,* 2002.

20. Tremblay RE. Prevention of youth violence: why not start at the beginning? *J Abnorm.Child Psychol,* 2006, 34:481-487.

21. Finkelhor D, Wolak J and Berliner L. Police reporting and professional help seeking for child crime victims: a review. *Child Maltreat,* 2001, 6:17-30.

22. Verhoek-Oftedahl W, Pearlman DN and Coutu Babcock J. Improving surveillance of intimate partner violence by use of multiple data sources. *Am J Prev Med,* 2000, 19:308-15.

23. Cunningham RM et al. Training emergency medicine nurses and physicians in youth violence prevention. *Am J Prev Med,* 2005, 29:220-225.

24. Bentovim A. Preventing sexually abused young people from becoming abusers, and treating the victimization experiences of young people who offend sexually. *Child Abuse Negl,* 2002, 26:661-78.

25. *Child Labour: Targeting the Intolerable.* Report submitted to the 86th Session of the International Labour Conference. Geneva, International Labour Office, 1998 (http://www.ilo.org/public/libdoc/ilo/1996/96B09_344_engl.pdf, accessed 20 December 2011).

26. Thurnherr J et al. Youths carrying a weapon or using a weapon in a fight: what makes the difference? *Health Educ Res,* 2009, 24:270-9.

27. *Report of the independent expert for the United Nations study on violence against children.* New York, United Nations, 2006.

28. *Somach S and Rubin D. Gender Assessment USAID/ Central Asian Republics.* United States Agency for International Development, 2010 (http://www.usaid.gov/our_work/cross-cutting_programs/wid/pubs/CAR_Gender_Assessment_Mar-2010_508.pdf, accessed 20 December 2011).

29. Griffiths LJ, Wolke D, Page AS and Horwood JP. Obesity and bullying: different effects for boys and girls. *Arch Dis Child,* 2006, 91:121-5.

30. *Study on Violence against Children.* United Nations Secretary-General's Report on Violence against Children. New York, United Nations, 2006 (http://www.unicef.org/violencestudy/reports/SG_violencestudy_en.pdf, accessed 20 December 2011).

31. Kepenekci YK and Cinkir S. Bullying among Turkish high school students. *Child Abuse Negl,* 2006, 30:193-204.

32. Khoury-Kassabri M. The relationship between staff maltreatment of students and bully-victim group membership. *Child Abuse Negl,* 2009, 33:914-23.

33. Novik TS et al. Influence of gender on attention-deficit/hyperactivity disorder in Europe–ADORE. *Eur Child Adolesc Psychiatry,* 2006, 15:I15-I24.

34. Foshee VA et al. Assessing the effects of the dating violence prevention program "safe dates" using random coefficient regression modeling. *Prev Sci,* 2005, 6:245-58.

35. *European Report on preventing violence and knife crime among young people.* Copenhagen, WHO Regional Office for Europe, 2010 (http://www.euro.who.int/__data/assets/pdf_file/0012/121314/E94277.pdf, accessed 20 December 2011).

Gender impacts on adolescent health with focus on violence management and prevention

"In order to ensure that women and men of all ages have equal access to opportunities for achieving their full health potential and health equity, the health sector needs to recognize that they differ in terms of both sex and gender. Because of social (gender) and biological (sex) differences, women and men face different health risks, experience different responses from health systems, and their health-seeking behaviour, and health outcomes differ."

Source: Strategy for integrating gender analysis and actions into the work of WHO. Geneva, World Health Organization, 2009.

Violence against adolescent girls and boys – what do we know?

Gender based violence is defined by the United Nations as "any act of…violence that results in, or is likely to result in, physical, sexual or mental harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life" (WHO, 2009b). Gender based violence "both reflects and reinforces inequities between men and women and compromises the health, dignity, security and autonomy of its victims" (UNFPA, 2005). Such violence is resultant of rigid gender norms that create inequalities and a patriarchal society; for example, domestic violence can be seen as resulting from gender norms which promote masculinity, male honour and aggression, and the subordination of women (Krug et al., 2002). These gender norms are also seen in adolescent relationships, however it can also be argued that the age of adolescents is also indicative of an unequal society, where a subordinate position has been created by both age and gender, as "girls marginalised gender reinforces the discrimination and lack of empowerment they experience as children" (Tefi, 2009).

Data on gender based violence is often categorized as being committed against women, women and girls, or just girls and is often not disaggregated by age groups, which means there is a lack of specific data on the prevalence of violence committed against adolescents, either by adults or by other adolescents. However it should be noted that studies have shown that gender norms are less rigidly fixed during adolescence, and therefore prevention and intervention strategies should not only take into account gender, but also the specificities of adolescence. It has been found that in violent teenage relationships, both partners are more likely to exhibit violent behaviours than in adult relationships. In the case of sexual violence, girls are more likely to perpetrate forced sexual acts, such as petting, fondling or kissing; while boys are more likely to attempt or complete forced penetration (Wekerle and Woolfe, 1999).

WHO estimates suggest that the rate of homicide of children in 2002 was twice as high in low-income countries than in high-income countries (2.58 v. 1.21 per 100,000 population). The highest child homicide rates occur in adolescents, especially boys, aged 15 to 17 years (3.28 for girls, 9.06 for boys) and among children 0 to 4 years old (1.99 for girls, 2.09 for boys) (WHO, 2006a). Economic development, status, age, sex and gender are among the many factors associated with the risk of lethal violence.

Violence against boys and girls happens everywhere, in every country and society and across all social groups.

Extreme violence against children may hit the headlines but children say that daily, repeated small acts of violence and abuse also hurt them. While some violence is unexpected and isolated, most violent acts against children are carried out by people they know and should be able to trust: parents, boyfriends or girlfriends, spouses and partners, schoolmates, teachers and employers. Violence against children includes physical violence, sexual violence, psychological violence such as insults and humiliation, discrimination, neglect and maltreatment. Although the consequences may vary according to the nature and severity of the violence inflicted, the short- and long-term repercussions for children are very often grave and damaging (United Nations, 2006; WHO 2006b).

Gender based violence should be understood as violence perpetrated as a result of gender norms that promote behaviours that are seen as being masculine, such as aggression and strength, and have resulted in inequalities where women are seen as subordinate due to the construction of female gender. The majority of gender based violence is committed by men, against women and girls; however, it should be noted that adolescent boys (in particular young adolescent boys) are more at risk from gender based violence than their adult counterparts. Gender based violence can include, amongst others, domestic violence, physical abuse, sexual abuse, violence in pregnancy, psychological abuse, harmful traditional practices, forced prostitution and trafficking (Watts and Zimmerman, 2002).

Boys are at greater risk of physical violence than girls, while girls face greater risk of sexual violence, neglect and forced prostitution. WHO estimates that 150 million girls and 73 million boys under 18 experienced forced sexual intercourse or other forms of sexual violence (WHO, 2006a). In Europe, it is estimated that 46% of women and girls over the age of 15 have experienced violence in their lives, and 1 in 4 18-24 year olds have experienced violence in the previous year (IPPF European Network, 2009). In a study conducted by UNFPA, 99% of young women and adolescents in Azerbaijan believed that they had been abused (UNFPA, 2010). Social and cultural patterns of conduct and stereotyped roles, and socioeconomic factors such as income and education also play an important role (Krug et al., 2002).

Gender may interact with other social determinants of health in increasing the risk of suffering violence. Small-scale studies reveal that some groups of children are especially vulnerable to violence. These include children with disabilities, those from ethnic minorities and other marginalized groups, "street children" and those in conflict with the law, and refugee and other displaced children.

The occurrence of sexual violence in the home is increasingly acknowledged. An overview of studies in 21 countries (mostly developed) found that 7-36 per cent of women and 3-29 per cent of men reported sexual victimization during childhood, and the majority of studies found girls to be abused at 1.5-3 times the rate for males. Most of the abuse occurred within the family circle (Finkelhor, 1994). Studies have shown that in all countries, between 40-60% of sexual assaults committed in the family are perpetrated against girls aged 15 or younger (UNICEF, 2000). It has been found that in Germany girls who are sexually abused before the age of 16, are twice as likely to be victims of domestic violence and four times as likely to be victims of further sexual abuse after the age of 16 (MIGS, 2009). In the Netherlands it was found that 45% of familial sexual abuse victims were under 18, and most were girls (UNICEF, 2000).

Similarly, a multi-country study by WHO, including both developed and developing countries, showed that between 1 and 21 per cent of women reported to have been sexually abused before the age of 15, in most cases by male family members other than the father or stepfather (WHO, 2008). In both community and clinical based studies, adult women who have been sexually abused as children report suffering from depression, anxiety, eating disorder, phobias, post-traumatic stress disorder, substance abuse, sexual disturbances and difficulties in relationships with both men and women. These women often make suicide attempts and display self-destructive behaviour (Lundqvist, Svedin and Hansson, 2004).

The absence of a legally established minimum age for sexual consent and marriage in some countries may expose children to partner violence. Eighty-two million girls are estimated to marry before the age of 18 (Bruce, 2002). A significant number are married at much younger ages, frequently coercively, and face a high risk of violence, including forced sex.

Sexual and gender-based violence also occurs in educational settings. Much is directed against girls, by male teachers and classmates. Violence is also increasingly directed against lesbian, gay, bisexual and transgendered young people in many States and regions. Sexual and gender-based violence is facilitated by Government's failure to enact and implement laws that provide students with explicit protection from discrimination.

A study conducted in Israel, presents the prevalence of students' reports of physical and emotional maltreatment by school staff and examines the differences between these reports according to the students' category of involvement in school bullying (only bullies, only victims, bully-victims, and neither bullies nor victims). It also examines the interaction of students' gender, nationality (Jewish vs. Arab students) and school level (junior high vs. high school student) with physical and emotional maltreatment. Significant results were found for gender (boys more than girls), nationality (Arabs more than Jews) and bully-victim group membership for both emotional and physical maltreatment. Post hoc follow-up analyses revealed that bully-victims reported significantly more staff maltreatment than other students, followed by bullies and victims. Students who were not involved in bullying reported the lowest levels of staff maltreatment. In addition, the interaction analysis revealed that differences in bully-victim subgroup membership vary by gender, nationalities and school level in both physical and emotional maltreatment (Khoury-Kassabri, 2009).

Millions of children, particularly boys, spend substantial periods of their lives under the control and supervision of care authorities or justice systems, and in institutions such as orphanages, children's homes, care homes, police lock-ups,

prisons, juvenile detention facilities and reform schools. Girls in detention facilities are at particular risk of physical and sexual abuse, mainly when supervised by male staff (United Nations, 1999).

Although research on intimate partner violence among adults has dramatically expanded over the past 30 years, comparatively little is understood about partner violence among adolescents, Among the few national data sources on dating violence among adolescents, homicide data show girls to be at much higher risk than boys for the most extreme form of partner violence (Hickman, Jaycox and Aronoff, 2004).
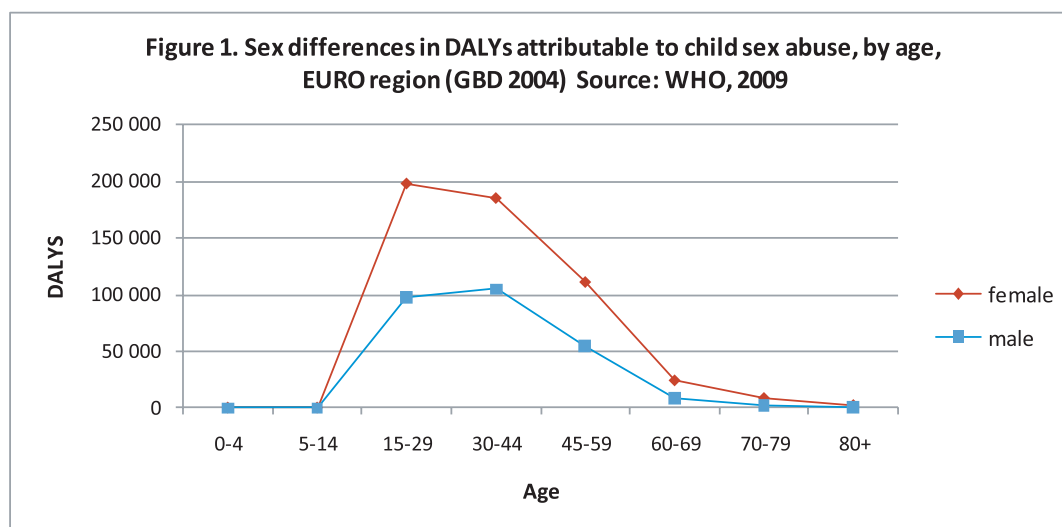
The most prevalent form of gender based violence in domestic violence, yet statistically not much is known about this sort of violence in teenage relationships. Although a charity in the United Kingdom has estimated that between 1 in 4 and 1 in 5 teenage girls have experienced intimate partner violence (Women's Aid). Studies have shown that adolescent girls are more at risk from receiving injuries caused by their partners than boys are. They have also shown that being victim to, or committing partner violence as a teenager, is often a precursor for suffering from or perpetrating such violence as an adult (Wekerle and Woolfe, 1999).

Trafficking and Forced Prostitution are also acts of gender based violence that affect adolescents. Around 250 000 people are estimated to be trafficked in Europe each year, with an estimated 120 000 women and children being trafficked through the Balkans. Victims include people trafficked from outside the EURO zone, inside the EURO zone and those trafficked domestically. Information gathered has identified an upward trend in the percentage of children trafficked each year, with 4% of the total victims considered children in 2003, and 11% being considered children in 2008. The majority of victims are trafficked for sexual exploitation purposes, although some are trafficked to become forced labourers. The vast majority of trafficking victims are female (UNODC, 2009).

Harmful traditional practices affect children disproportionately and are generally imposed on them at an early age by their parents or community leaders. According to the Special Rapporteur on traditional practices affecting the health of women and the girl child, female genital mutilation, which, according to WHO, is carried out on increasingly younger girls, is prevalent in Africa, and also occurs in some parts of Asia and within immigrant communities in Europe, Australia, Canada and the United States of America. It is estimated that there are 500 000 women and girls living in Europe who have been subjected to Female Genital Mutilation (FGM). In the United Kingdom (England and Wales), it is thought that 65 800 women and girls over the age of 15 are victims of FGM. This number not only reflects women who have arrived in the country who have already suffered from FGM, but also girls who are being sent from Europe to their home country for the procedure, and girls who have undergone the procedure inside Europe. Another harmful traditional practice which affects adolescents is that of forced marriages. In the United Kingdom, in 85% of forced marriages it is the girl or woman who is forced to marry, compared to 15% for boys or men. Most victims of forced marriages are aged between 13 and 30, and 30% are under 18 (IPPF European Network, 2009).

According to the 2004 data for EURO region on disability adjusted life years (DALYs) the greatest sex differences attributable to child sex abuse can be found for adolescent and young adults (Fig. 1). Regarding violence (attributable to alcohol abuse) a big gap can be found among adolescents and young adults, with boys and men in general, accounting for the majority of the DALYs (Figures 2) (WHO, 2009).

Figure 1. Sex differences in DALYs attributable to child sex abuse, by age, EURO region (GBD 2004) Source: WHO, 2009

Figure 2. Sex differences in DALYs lost to violence*, by age, EURO region (GBD 2004) Source: WHO, 2009

* attributable to alcohol abuse
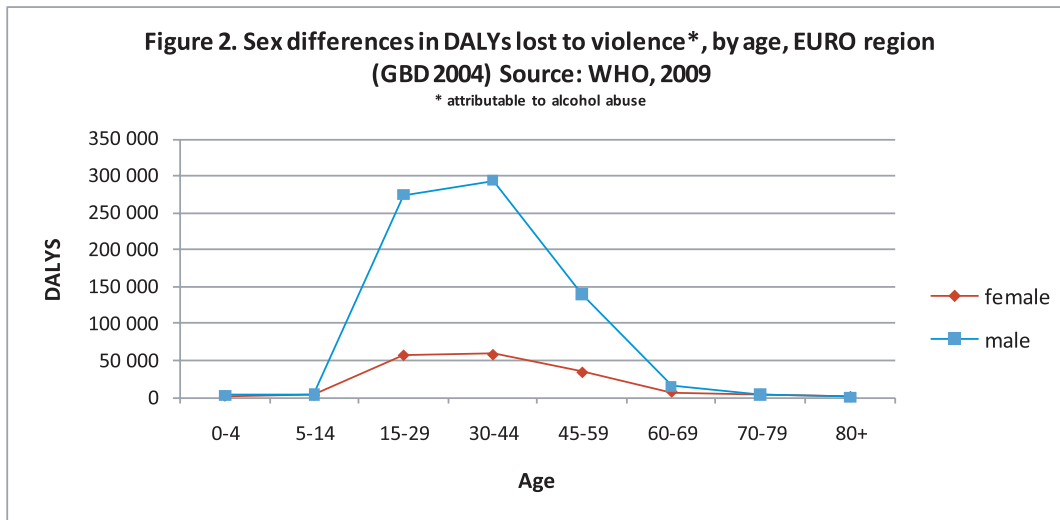
Weapon carrying among adolescents is an ongoing matter of concern. Violent offenses committed with a weapon are the most dangerous offenses, often leading to serious injury, disability or death. The Health Behaviour in School-Aged Children survey reported a prevalence of weapon carrying in the preceding 30 days ranging from 10 to 22% for boys and from 2 to 5% for girls in five European countries, the United States and Israel (Pickett et al., 2005).

There are little data on violence against child workers, especially those in the informal sector. The largest employment category for girls under 16 is domestic work which often takes the form of unregulated employment and exploitation (ILO, 1998).

For some children, the journey to and from school may be their first independent exposure to the community; it may also be their first exposure to its risks. Others are exposed to violence when carrying out domestic tasks, such as when fetching water, fuel, food or fodder for animals. These tasks, which may involve walking considerable distances, are usually assigned to girls in rural areas of the developing world (World Vision, 2001).

A sudden, steep increase is noticeable in the rates of violence (both victimization and perpetration), particularly among boys at around age 15, indicating that some factors come together at adolescence to make peer violence more common. Available data indicates that in most parts of the world, homicide rates among boys aged 15 to 17 are at least three times greater than among boys aged 10 to 14. Gender differences in adolescent homicide rates suggest that male socialization and norms of masculinity contribute to violence.

Refugee and other displaced children experience significant violence. In the cases of forced displacement, women and girls in particular can be exposed to protection problems related to their sex, gender issues, including their cultural and socio-economic position, and their legal status, which means that they may be less likely than men and boys to be able to exercise their rights.

Risk factors for weapon carrying include being male, a history of substance use, living in unsafe surroundings, witnessing violence, having been a victim of violence, having high availability of weapons, a history of delinquency other than carrying a weapon and poor academic performance (Kodjo, Auinger and Ryan, 2004). Additionally, previous studies have shown an association between risk behaviours including violence and weapon carrying and behaviours such as being tattooed and sensation seeking (Carroll et al., 2002).

What are the explanations behind the differences in violence among adolescent girls and boys?

The imbalance in the sex ratio between girls and boys in some regions suggests that girls are at particular risk of neglect, as well as violence. Neglect, including a failure to meet children's physical and emotional needs, protect them from danger, or obtain medical or other services when needed contributes to mortality and morbidity in young children. Disability also increases the risk of neglect. Disabled children may be abandoned, a practice which is sometimes accepted and encouraged (United Nations, 2005).

Factors associated with females perpetrating violence are, being a victim of physical violence and sensation seeking at the individual level. In males, practicing unsafe sex, sensation seeking, being a victim of physical violence, having a poor relationship with parents, being depressed, and living in a single-parent household at the individual level; violence and antisocial acts at the classroom level; and being in a vocational school at the school level showed a correlation with violence perpetration (Thurnherr et al., 2008).

A study conducted with the aim of characterizing weapon-carrying adolescents and to assess whether weapon carriers differ from weapon users among school-based adolescents in Switzerland, showed that for both sexes, delinquent behaviour and being victims of physical violence were associated with weapon carrying. For males, quarrelling while intoxicated, being an apprentice, being sensation seekers, having a tattoo, having a poor relationship with parents and practicing unsafe sex were also related to weapon carrying. Compared with weapon carriers, female weapon users were more likely to be regular smokers. Male weapon users were foreign born, urban and apprentices; had poor school connectedness; practiced unsafe sex and quarrelled while intoxicated. Carrying a weapon is a relatively frequent behaviour among youths in Switzerland and a sizeable proportion of weapon carriers have used it in a fight (Thurnherr et al., 2009).

Boys experience overt bullying victimization more often than girls. Gender differences are also reported in relational victimization before adolescence in the USA but not in European studies. Boys are more often victims of physical bullying if they are physically weaker, while recent evidence also suggests that overweight and obese adolescent boys are more likely to be perpetrators of bullying than their average weight peers. For girls, appearance and the lack of close friendships may increase their exposure to victimization. Obesity is predictive of bullying involvement for both boys and girls. Preadolescent obese boys and girls are more likely to be victims of bullying because they deviate from appearance ideals. Other obese boys are likely to be bullies, presumably because of their physical dominance in the peer group (Griffiths et al., 2006).

Fewer girls than boys are referred for ADHD treatment, but they have a similar pattern of impairment and receive similar treatment. Compared with boys, girls had significantly more parent-rated emotional symptoms and prosocial behaviour and were more likely to be the victim of bullying and less likely to be the bully. Girls and boys had similar levels of co-existing psychiatric and physical health problems, and received the same type of treatment. (Novik et al., 2006).

A study conducted in Turkey, showed that there were clear gender differences, with boys consistently experiencing more physical bullying including kicking-slapping, assault with a knife, rude physical jokes, and more verbal bullying including name calling and insulting-swearing. Among the four types of bullying, the most common forms of bullying faced by girls and boys were the same in order: pushing (58.1% girls/63.5% boys) and name-calling (44.1%/61.8%). About one-third of the students stated that they did not get any help in coping with bullying. The main reason for bullying was pretending to be strong (43.1%) (Kepenekci and Cinkir, 2006).

Are policies and programmes that address risk for violence gender sensitive?

Research shows that child maltreatment can be prevented, however, efforts to address violence against children are frequently reactive, focusing on the symptoms and consequences and not on the causes. Strategies tend to be fragmented, rather than integrated, and insufficient resources are allocated to measures that seek to address the problem. The need to increase investment in prevention is urgent and global. Promising strategies include reducing unintended pregnancies; improving access to high-quality pre- and post-natal care; reducing harmful levels of alcohol and illicit drug use during pregnancy and by new parents; providing home visitation services by nurses and social workers to families at risk of maltreatment, and training parents on child development, non-violent discipline and problem-solving skills. Child protection measures and services should be made available alongside preventive strategies.

Research also suggests the need to reflect on and modify the type of childrearing and socialization patterns that are promoted in males so that they will favour the development of skills oriented towards warm interpersonal relations, nonaggressive communication, positive social behaviours, internal control of anger and empathy. Research also suggest including supplementary modules for males when designing interventions to prevent violence (Garaigordobil et al., 2009).

As was discussed above, gender based violence is a result of socialised norms of female and male behaviours and positions in society; in addition to gender, the age of adolescent also creates further inequalities, disempowerment, and subordination. Thus, when addressing such violence policies and programmes need to be aware of this. It should also be noted that the construction of these norms has lead to a degree of acceptance of violence against women and girls in some countries; in a study, 64% of young women in Azerbaijan aged 15-24, 45% of Turkish women aged 15-24, and about 25% of young women from Armenia and the Republic of Moldova in the same age group believed that abuse is justified in certain circumstances, such as arguing, refusing sex and in burning dinner (UNFPA, 2010).

Factors that are likely to be protective in the home as well as other settings include good parenting, the development of strong attachment bonds between parents and children and positive non-violent discipline. Factors that are likely to protect against violence at school include school-wide policies and effective curricula that support the development of non-violent and non-discriminatory attitudes and behaviours. High levels of social cohesion have been shown to have a protective effect against violence in the community, even when other risk factors are present. Research has identified several factors that appear to facilitate resilience in children who have experienced violence. These resilience factors include secure attachment of the child to an adult family member, high levels of paternal care during childhood, a warm and supportive relationship with a non-abusing parent; as well as supportive relationships with peers who do not engage in substance abuse or criminal behaviours (WHO, 2002).

Some studies have evaluated programs for adolescents designed to prevent dating violence, and the results show promising results about the efficacy of school and community-based programs (Foshee et al., 2005). Evaluations suggest that programmes can influence knowledge and attitudes, but their effectiveness at reducing violence is less well established (WHO, 2010).

Interventions at the classroom level as well as an explicit school policy on violence and other risk behaviours should be considered a priority when dealing with the problem of

youth violence and prevention should take into account gender differences (Thurnherr et al., 2008; Thurnherr et al., 2009; WHO, 2010).

Few countries have a policy at the central level to deal with bullying. The findings of the previously mentioned studies emphasize the need to invest more efforts in helping bully-victims that were found at highest risk of staff maltreatment. Furthermore, it is essential to support teachers to help them cope effectively with difficult situations without resorting to aggression. To achieve this goal, training opportunities for teachers need to be expanded. This intervention should be designed and implemented from a "whole school" approach that includes students, school staff, and parents.

Regarding violence among youths, evaluations suggest that it can be prevented. The evidence supporting interventions that reduce risk factors and strengthen protective factors in young people early in life is much stronger than that for measures that seek to reduce violent behaviour once it has already emerged. Effective early interventions are also cost effective, and can have much broader benefits including improved school performance, reduced substance use and crime, and better employment outcomes. More evaluative research is needed in Europe including studying the cost benefits of youth violence prevention measures (WHO, 2010).

References

Bruce (2002). *Married adolescents girls; human rights, health and development needs of a neglected majority.* New York, United Nations Special Session on Children.

Carroll ST et al. (2002). Tattoos and body piercings as indicators of adolescent risk-taking behaviors, *Pediatrics,* 109:1021-1027.

Finkelhor D. (1994). The international epidemiology of child sexual abuse. *Child Abuse Negl,* 18:409-417.

Foshee VA et al. (2005). Assessing the effects of the dating violence prevention program "safe dates" using random coefficient regression modeling. *Prev Sci.* 6:245-58. Garaigordobil M et al.(2009). Gender differences in socioemotional factors during adolescence and effects of a violence prevention program. J Adolesc Health, 44:468-477.

Griffiths LJ et al. (2006). Obesity and bullying: different effects for boys and girls. *Arch Dis Child,* 91:121-125.

Heise L, Ellsberg M and Gottmoeller M (2002). A global overview of gender-based violence. *International Journal of Gynecology and Obstetrics,* 78:S5-S14

Hickman LJ, Jaycox LH and Aronoff J (2004). Dating violence among adolescents: prevalence, gender distribution, and prevention program effectiveness. *Trauma Violence Abuse,* 5:123-142.

ILO (1998). *Child Labour: Targeting the Intolerable. Report submitted to the 86th Session of the International Labour Conference.* Geneva, International Labour Office (http://www.ilo.org/public/libdoc/ilo/1996/96B09_344_engl.pdf, accessed 20 December 2011).

IPPF European Network (2009). *Choices: Gender-based violence in Europe.* Brussels, International Planned Parenthood Federation European Network (http://picum.org/picum.org/uploads/file_/ippfchoices2009_web.pdf, accessed 20 December 2011).

Kepenekci YK and Cinkir S (2006). Bullying among Turkish high school students. *Child Abuse Negl,* 30:193-204.

Khoury-Kassabri M (2009). The relationship between staff maltreatment of students and bully-victim group membership. *Child Abuse Negl,* 33:914-923.

Kodjo CM, Auinger P and Ryan SA (2004). Prevalence of, and factors associated with, adolescent physical fighting while under the influence of alcohol or drugs. *J Adolesc Health, 35:346.*

Krug EG et al., eds.(2002). *World Report on Violence and Health.* Geneva, World Health Organization, 2002 (http://whqlibdoc.who.int/publications/2002/9241545615_eng.pdf, accessed 20 December 2011).

Lundqvist G, Svedin CG and Hansson K (2004). Childhood sexual abuse. Women's health when starting in group therapy. *Nord J Psychiatry,* 58:25-32.

MIGS (2009). *Prevention of Gender-based Violence among Adolescents in Cyprus and Europe: Research and Educational Practices. Seminar Report.* Mediterranean Institute of Gender Studies (http://www.medinstgenderstudies.org/calendar/prevention-of-gender-based-violence-among-adolescents-in-cyprus-and-europe-research-and-educational-practices/, accessed 20 December 2011).

Novik TS et al. (2006). *Influence of gender on attention-deficit/hyperactivity disorder in Europe–ADORE. Eur Child Adolesc Psychiatry,* 15:I15-I24.

Pickett W et al. (2005). Cross-national study of fighting and weapon carrying as determinants of adolescent injury. *Pediatrics,* 116:e855-e863.

Somach S and Rubin D (2010). *Gender Assessment USAID/ Central Asian Republics.* United States Agency for International Development (http://www.usaid.gov/our_work/cross-cutting_programs/wid/pubs/CAR_Gender_Assessment_Mar-2010_508.pdf, accessed 20 December 2011).

Tefi N (2009). The Synthesis of Age and Gender: Intersectionality, International Human Rights Law and the Marginalisation of the Girl Child. *The International Journal of Children's Rights,* 17:345.

Thurnherr J et al. (2008). Violent adolescents and their educational environment: a multilevel analysis. *J Dev Behav Pediatr,* 29:351-359.

Thurnherr J et al. (2009). Youths carrying a weapon or using a weapon in a fight: what makes the difference? *Health Educ Res,* 24:270-279.

UNFPA (2005). *State of world population 2005.* New York, United Nations Population Fund (http://www.unfpa.org/swp/2005/english/ch1/index.htm, accessed 20 December 2011).

UNFPA (2010). *Epidemic of Gender-based Violence in Eastern Europe and Central Asia.* New York, United Nations Population Fund.

UNICEF (2000). *Domestic Violence against Women and Girls.* Florence, Innocenti Research Centre for the United Nations Children's Fund (http://www.unicef-irc.org/publications/pdf/digest6e.pdf, accessed 20 December 2011).

United Nations (1999). *Report of the Special Rapporteur on violence against women on the mission to the United States of America on the issue of violence against women in state and federal prisons (E/CN.4/1999/68/Add.2).* New York, United Nations.

United Nations (2005). *Study on Violence against Children, Regional Desk Review: Violence against Children in West and Central Africa.* New York, United Nations Secretary-General.

United Nations (2006). *Report of the independent expert for the United Nations study on violence against children.* New York, United Nations.

UNODC (2009). *Trafficking in Persons; Analysis on Europe,* Vienna, UNODC (http://www.unodc.org/documents/human-trafficking/Trafficking_in_Persons_in_Europe_09.pdf, accessed 20 December 2011).

Watts C and Zimmerman C (2002). Violence against women: global scope and magnitude. *The Lancet,* 359:1232-1237

Wekerle C and Woolfe DA (1999). Dating Violence in mid-adolescence: theory, significance, and emerging prevention strategies. *Clinical Psychological Review,* 19:435-456.

WHO (2006a). *Global Estimates of Health Consequences due to Violence against Children. Background paper for the United Nations Study on Violence against Children.* Geneva, World Health Organization.

WHO (2006b). *Preventing child maltreatment: a guide to taking action and generating evidence,* Geneva, World Health Organization (http://whqlibdoc.who.int/publications/2006/9241594365_eng.pdf, accessed 20 December 2011).

WHO (2008). *Multi-Country Study on Women's Health and Domestic Violence.* Geneva, World Health Organization (http://www.who.int/gender/violence/who_multicountry_study/en/, accessed 20 December 2011).

WHO (2009a). *Global health Risks. Mortality and burden of disease attributable to selected major risks.* Geneva, World Health Organization.

WHO (2009b). *Violence against Women.* Factsheet no. 239, 2009b, at (http://www.who.int/mediacentre/factsheets/fs239/en/, accessed 20 December 2011).

WHO (2010). *European Report on preventing violence and knife crime among young people.* Copenhagen, WHO Regional Office for Europe ((http://www.euro.who.int/__data/assets/pdf_file/0012/121314/E94277.pdf, accessed 20 December 2011).

World Vision (2001). *Every Girl Counts. Development, Justice and Gender. Girl Child Report,* Canada, Ontario, World Vision (http://www.worldvision.com.au/Libraries/3_3_1_Gender_and_Development/Every_Girl_Counts_Development_Justice_and_Gender.pdf, accessed 20 December 2011).

All topics in the series

Young people's health as a whole-of-society response.
Evidence for gender responsive actions:

mental health

overweight and obesity

violence

chronic conditions

adolescent pregnancy

HIV/AIDS and STIs

injuries and substance abuse

well-being

The WHO Regional Office for Europe

The World Health Organization (WHO) is a specialized agency of the United Nations created in 1948 with the primary responsibility for international health matters and public health. The WHO Regional Office for Europe is one of six regional offices throughout the world, each with its own programme geared to the particular health conditions of the countries it serves.

Member States

Albania
Andorra
Armenia
Austria
Azerbaijan
Belarus
Belgium
Bosnia and Herzegovina
Bulgaria
Croatia
Cyprus
Czech Republic
Denmark
Estonia
Finland
France
Georgia
Germany
Greece
Hungary
Iceland
Ireland
Israel
Italy
Kazakhstan
Kyrgyzstan
Latvia
Lithuania
Luxembourg
Malta
Monaco
Montenegro
Netherlands
Norway
Poland
Portugal
Republic of Moldova
Romania
Russian Federation
San Marino
Serbia
Slovakia
Slovenia
Spain
Sweden
Switzerland
Tajikistan
The former Yugoslav
Republic of Macedonia
Turkey
Turkmenistan
Ukraine
United Kingdom
Uzbekistan

**World Health Organization
Regional Office for Europe**