



HHS Public Access

Author manuscript

J Adolesc Health. Author manuscript; available in PMC 2025 May 27.

Published in final edited form as:

J Adolesc Health. 2025 March ; 76(3): 519–525. doi:10.1016/j.jadohealth.2024.12.001.

Improving Adolescent and Young Adult Health Through Knowledge and Action on Gender-Based Violence

Society for Adolescent Health and Medicine, Yvette Efevbera, Sc.D, M.Sc.,

SHE Thinks Group LLC, Lansing, Michigan

Romina L. Barral, M.D., M.S.C.R.,

Division of Adolescent Medicine, Children's Mercy Kansas City, University of Missouri-Kansas City School of Medicine, Kansas City, Missouri

Swati Bhawe, M.D., D.C.H.,

Adolescent Medicine, Dr D.Y. Patil Medical College, Erandawane Pune, Maharashtra, India

Alison J. Culyba, M.D., Ph.D., M.P.H.,

Division of Adolescent and Young Adult Medicine, UPMC Children's Hospital of Pittsburgh, University of Pittsburgh School of Medicine, Pittsburgh, Pennsylvania

Address correspondence to: Yvette Efevbera, Sc.D., M.Sc., Founder and Chief Executive Officer, SHE Thinks Group LLC, 405 W. Greenlawn Ave. #G11, Lansing, MI 48910. efevbera@post.harvard.edu (*Y. Efevbera*).

Lead Author

Yvette Efevbera, Sc.D, M.Sc.

SHE Thinks Group LLC, Lansing, Michigan

Authoring Committee Members

Romina L. Barral, M.D., M.S.C.R.

Division of Adolescent Medicine, Children's Mercy Kansas City, University of Missouri-Kansas City School of Medicine, Kansas City, Missouri

Swati Bhawe, M.D., D.C.H.

Adolescent Medicine, Dr D.Y. Patil Medical College, Erandawane Pune, Maharashtra, India

Alison J. Culyba, M.D., Ph.D., M.P.H.

Division of Adolescent and Young Adult Medicine, UPMC Children's Hospital of Pittsburgh, University of Pittsburgh School of Medicine, Pittsburgh, Pennsylvania

Nuray Kanbur, M.D.

Division of Adolescent Health & Eating Disorders Program, Children's Hospital of Eastern Ontario (CHEO), Department of Pediatrics, University of Ottawa, Ottawa, Ontario, Canada

Michele A. Kelley, Sc.D., M.S.W., M.A.

School of Public Health, Center of Excellence in Maternal and Child Health, The University of Illinois Chicago (UIC), Chicago, Illinois

Elizabeth Miller, M.D., Ph.D.

Division of Adolescent and Young Adult Medicine, UPMC Children's Hospital of Pittsburgh, University of Pittsburgh School of Medicine, Pittsburgh, Pennsylvania

Marissa Raymond-Flesch, M.D., M.P.H.

Division of Adolescent and Young Adult Medicine and the Philip R. Lee Institute of Health Policy Studies, University of California San Francisco, San Francisco, California

Sarah Stoddard, Ph.D., R.N., C.N.P.

University of Michigan School of Nursing, Ann Arbor, Michigan

Maria Veronica Svetaz, M.D., M.P.H.

Hennepin Healthcare, Department of Family and Community Medicine, Leadership Education for Adolescent Health Program, University of Minnesota, Minneapolis, Minnesota

Consultants

Tamera Coyne-Beasley, M.D., M.P.H.

Children's of Alabama Adolescent Health Center University of Alabama at Birmingham Heersink School of Medicine, Birmingham, Alabama

Conflicts of interest: The authors have no conflicts of interest to disclose.

Consultants

Tamera Coyne-Beasley, M.D., M.P.H., Children's of Alabama Adolescent Health Center, University of Alabama at Birmingham Heersink School of Medicine, Birmingham, Alabama

Nuray Kanbur, M.D.,

Division of Adolescent Health & Eating Disorders Program, Children's Hospital of Eastern Ontario (CHEO), Department of Pediatrics, University of Ottawa, Ottawa, Ontario, Canada

Michele A. Kelley, Sc.D., M.S.W., M.A.,

School of Public Health, Center of Excellence in Maternal and Child Health, The University of Illinois Chicago (UIC), Chicago, Illinois

Elizabeth Miller, M.D., Ph.D.,

Division of Adolescent and Young Adult Medicine, UPMC Children's Hospital of Pittsburgh, University of Pittsburgh School of Medicine, Pittsburgh, Pennsylvania

Marissa Raymond-Flesch, M.D., M.PH.,

Division of Adolescent and Young Adult Medicine and the Philip R. Lee Institute of Health Policy Studies, University of California San Francisco, San Francisco, California

Sarah Stoddard, Ph.D., R.N., C.N.P.,

University of Michigan School of Nursing, Ann Arbor, Michigan

Maria Veronica Svetaz, M.D., M.P.H. on behalf of Authoring Committee Members, Society for Adolescent Health and Medicine

Hennepin Healthcare, Department of Family and Community Medicine, Leadership Education for Adolescent Health Program, University of Minnesota, Minneapolis, Minnesota

Abstract

Gender-based violence (GBV) refers to a specific form of interpersonal violence that is rooted in gender inequities and unequal distribution of power. GBV is defined as any type of violence, including physical, sexual, psychological, and economic, perpetrated against individual(s) based on actual or perceived gender, gender identity, gender expression, sex or sex characteristics, sexual orientation, or divergence from social norms on masculinity and femininity. Cisgender (cis) and transgender (trans) women and girls of all ages, including adolescents and young adults (AYAs) of ages 10–24 years, disproportionately experience GBV. The Society for Adolescent Health and Medicine recognizes that GBV has been a long-standing threat, remains a public health crisis, and requires an urgent response to support the health and well-being of AYAs, especially cis and trans women and girls, worldwide. The Society for Adolescent Health and Medicine adopts the following positions: (1) GBV is a pervasive and harmful global health issue rooted in gender inequity; (2) An intersectionality framework that recognizes multiple layers of oppression should guide researchers, practitioners, and policymakers to address GBV among populations that are disproportionately affected; (3) Accurate and accessible data collection systems about GBV among AYAs should be established; (4) All AYA health service providers should be trained to deliver developmentally appropriate, healing-centered, culturally responsive, and evidence-informed GBV prevention and treatment strategies; (5) All AYAs should have equal access to developmentally appropriate education that disrupts gender inequality, a root cause of GBV; and (6) Governments should sign, ratify, adequately fund, and implement frameworks and policies to prevent and respond to GBV.

Society for Adolescent Health and Medicine Positions

1. Gender-based violence (GBV) is a pervasive and harmful global health issue rooted in gender inequity.
2. An intersectionality framework that recognizes multiple layers of oppression should guide researchers, practitioners, and policymakers to address GBV among populations that are disproportionately affected.
3. Accurate and accessible data collection systems about GBV among adolescents and young adults should be established.
4. All adolescent and young adult health service providers should be trained to deliver developmentally appropriate, healing-centered, culturally responsive, and evidence-informed GBV prevention and treatment strategies.
5. All adolescents and young adults should have equal access to developmentally appropriate education that disrupts gender inequality, a root cause of GBV.
6. Governments should sign, ratify, adequately fund, and implement frameworks and policies to prevent and respond to GBV.

Statement of the Problem

Gender-based violence (GBV) refers to a specific form of interpersonal violence that is rooted in gender inequities and unequal distribution of power [1]. GBV is defined as any type of violence, including physical, sexual, psychological, and economic, perpetrated against individual(s) based on actual or perceived gender, gender identity, gender expression, sex or sex characteristics, sexual orientation, or divergence from social norms on masculinity and femininity [1,2]. Examples of GBV include intimate partner violence (which can be physical, sexual, and/or psychological), femicide, honor killings, sexual violence, sexual harassment, child sexual abuse, sex trafficking, forced labor, coercion, school-related GBV, and technology-facilitated GBV [3,4]. Practices such as child marriage [5] and female genital mutilation [6] are increasingly recognized examples of GBV.

Cisgender (cis) and transgender (trans) women and girls of all ages, including adolescents and young adults (AYAs) of ages 10–24 years, disproportionately experience GBV and may not report it [3]. Globally, nearly 1 out of every 3 women experience physical or sexual violence from a male partner in their lifetime, and these experiences often begin during adolescence and young adulthood [3]. AYAs have myriad reasons they may not disclose experiencing GBV, such as on a screening form or directly to a provider, including fear of consequences, shame, and mistrust of the healthcare system [7]. Although global data on GBV among AYAs are limited, the prevalence, serious impacts, and escalation of GBV during war and public health emergencies highlight that GBV remains a critical challenge for public health promotion [8–10].

Methods

The author group is comprised of practitioners, scholars, and advocates with expertise in GBV and violence prevention; diversity, equity, and inclusion; and AYA health and well-being in multiple countries and diverse community contexts. We developed the stated positions and their supporting content through review and synthesis of reports and technical guidance from national and international organizations and consensus from AYA health and well-being specialists. The positions were then reviewed by external expert reviewers, and the paper was reviewed and approved by the Society for Adolescent Health and Medicine (SAHM) Publication Editorial Board and the SAHM Board of Directors. These positions and recommendations are situated within a framework of AYA development informed by the socioecological model, life course and developmental theories, and a health equity lens.

Positions and Recommendations

SAHM recognizes that GBV has been a longstanding threat, remains a public health crisis, and requires an urgent response to support the health and well-being of AYAs, especially for cis and trans women and girls, worldwide. Other populations, including other sexual and gender minority individuals, Indigenous populations, individuals affected by humanitarian crises, and people with disabilities, are also affected by GBV and belonging to multiple affected and marginalized communities can compound effects of GBV. This position paper focuses on GBV against cis and trans women and girls, underscoring the critical need to address gender inequities that drive GBV, and we acknowledge that the needs of other marginalized communities experiencing GBV are deserving of their own nuanced discussion beyond the scope of this position paper. The impact of GBV prevents optimal AYA health and well-being. Consequently, SAHM adopts the following positions.

Position 1: Gender-based violence is a pervasive and harmful global health issue rooted in gender inequity

GBV is pervasive among AYAs; however, rates of GBV in this population are likely underestimated given limited consistently reliable data on AYAs [3]. Available data reveal that cis and trans women and girl AYAs disproportionately experience GBV as measured through intimate partner violence [3], sexual violence [3], child sexual abuse, sex trafficking, forced labor, femicide, honor killings, sexual harassment, coercion, technology-facilitated violence, child marriage [5], and female genital mutilation [6]. One out of every four 15- to 19-year-old ever-married females report experiencing partner-perpetrated physical or sexual violence at least once [3]. Approximately 650 million girls and women alive today married before their 18th birthday, which is 5.6 times greater than the number of boys and men married before age 18 [11]. Furthermore, an estimated 200 million girls and women have had at least part of their female external genitalia removed for nonmedical reasons [6], with risk for complications of far greater magnitude than circumcision among boys and men [12].

GBV is harmful for AYAs, negatively impacting mental, physical, and sexual and reproductive health [13]. Intimate partner violence, one example of GBV, is strongly associated with poor mental health, including increased depression, post-traumatic stress disorder, anxiety, suicide/self-harm, sleep disorders, and poor self-perception. GBV is also

strongly associated with poor physical health, including functional health and chronic conditions among AYAs [14,15]. GBV also contributes to poor sexual and reproductive health outcomes for AYAs [3,16]. For AYAs who are childbearing, exposure to GBV impacts the health of the AYA's infant or child and their infant or child's development through both direct exposure to violence and exposure to the stress experienced by the AYA parent [16].

GBV is rooted in gender inequity [17]. AYAs' perspectives on gender attitudes, social expectations, and subsequently gender norms are shaped as early as 10–14 years of age [17]. This is in the context of masculine norms (e.g., strength, sexual dominance) and feminine norms (e.g., subservience, appearance) that create a power imbalance between men and women, negatively influencing GBV exposure, health behavior, healthcare access, healthcare systems, and health research, all of which impact health outcomes [17]. Endorsement of rigid gender norms (including homophobic and transphobic attitudes) is associated with increased use of and exposure to GBV, making it a modifiable factor for preventing GBV among AYAs. A review of 82 studies from 29 countries found that young adolescents across high-income countries and low- and middle-income countries accepted stereotypes of masculine and feminine behaviors and that there were fewer examples of boys challenging gender norms than girls [18]. Research demonstrates adolescent boys can be rewarded socially for adopting harmful behaviors that exert power over women and girls, creating a foundation for the acceptance of some forms of GBV [19].

Position 2: An intersectionality framework that recognizes multiple layers of oppression should guide researchers, practitioners, and policymakers to address gender-based violence among populations that are disproportionately affected

Researchers, practitioners, and policymakers should adopt an intersectionality framework, which recognizes multiple layers of oppression at individual and systemic levels that contribute to the disproportionate burden of GBV among different populations [20]. In research and practice, an intersectionality framework can help elucidate and address vulnerabilities based on overlapping marginalized identities, including, but not limited to, sexual and gender identity, racial and ethnic identity, physical and intellectual ability, and socioeconomic status [21–23]. Researchers should include participation and voices of diverse AYAs, especially persons with marginalized identities, in GBV research and interventions, not only as study participants but also as integral members of research teams [24,25]. For practitioners, an intersectionality framework may help to recognize the myriad social and structural challenges that some AYAs with multiple marginalized identities must navigate [26]. As healthcare delivery systems are increasingly embedding assessments of social determinants of health into clinical practice, practitioners can consider how food insecurity, housing instability, financial dependence, and discrimination can make AYAs more vulnerable to GBV [27–29]. Such social and structural stressors can increase economic dependence and social isolation and reduce access to community resources, increasing susceptibility for experiencing coercive and abusive situations and restricting ability to leave or seek help [30]. For policymakers, bringing an intersectionality framework to GBV reduction means creating policies that address social and structural inequities and historical marginalization [31]. New Zealand is one country that has outlined an intersectional approach to GBV prevention and response in *Te Aorerekura: The National Strategy for*

Eliminating Family Violence and Sexual Violence [32]. As the New Zealand example shows, an intersectional approach to addressing GBV can be strengthened across research, practice, and policy responses through co-creation with AYA survivors and community advocates [31,32].

Position 3: Accurate and accessible data collection systems about gender-based violence among adolescents and young adults should be established

There is a lack of accurate, accessible, and standardized AYA GBV data, which precludes precise tracking of trends and measurement of intervention effectiveness [33,34]. No single entity – for example, healthcare providers, social services, humanitarian response agencies, law enforcement – is solely responsible for the measurement and surveillance of the impact of GBV on AYAs. Data challenges include that definitions and measures of GBV vary, some forms of GBV are not regularly measured (e.g., psychological violence, technology-facilitated violence), GBV data are often collected from individuals at a single time point rather than following the same individuals over time (e.g., cross-sectional data rather than longitudinal data), data about perpetrators of GBV are limited (e.g., gender and age of partners), and data that are disaggregated by certain groups (e.g., early adolescence, disability, gender identity, sexual orientation) are lacking [3,34]. Moreover, researchers and practitioners collecting GBV data must ask survivors/victims for sensitive information safely and confidentially [34]. This can be especially challenging among AYAs due to ethical concerns because of their young age and concerns regarding the need to involve or report to child protection services [33].

Government agencies and health systems can lead efforts at local, state, regional, and national levels to make accurate and accessible data available while research institutions and non-governmental agencies can help fill in gaps. Within governments, national statistics offices [34], law enforcement agencies [35,36], and child protection services [37] already collect representative data in countries like South Africa and across the 38 Organization for Economic Co-operation and Development countries about people and economic and social issues, including GBV. These entities can create a coordinating mechanism to consolidate data across agencies, such as Spain has done in its Government Office against GBV and should prioritize collecting and disaggregating GBV data by age and gender identity, with emphasis on historically excluded populations including early adolescence, sexual and gender minority individuals, Indigenous populations, and people with disabilities [34]. The World Health Organization, United Nations (UN) Women, and other UN partners have published tools and guidance for governments and researchers on how these data can be routinely collected and uniformly reported with common definitions [3]. GBV data and analyses generated by government agencies, research institutions, and other non-governmental agencies on AYA experiences must be accessible, disseminated, and translated in ways that program implementers, policy designers, and other collaborators can use [33]. Additionally, research and public health efforts to collect data on GBV among AYAs can apply best practices through the use of a decision tree to ensure the data are necessary, safely and ethically collected, and build on or utilize existing measures [38,39]. Several UN agencies have advocated for the use of a community of technical experts within and outside an organization to review GBV research plans to ensure rigor and reproducibility, such as

through establishing or engaging a technical advisory group or institutional review board, to improve data collection and accessibility efforts [38,39]. Expert groups should also include survivors/victims of GBV [34] and AYAs with lived experience [40], when discussing data about them.

Position 4: All adolescents and young adults health service providers should be trained to deliver developmentally appropriate, healing-centered, culturally responsive, and evidence-informed gender-based violence prevention and treatment strategies

Health service providers have an important role in supporting AYAs who have been exposed to GBV as well as offering anticipatory guidance to promote healthy relationships that can reduce the risk of GBV [7,41]. Providers need to be aware that some AYAs may be seeking care for physical and mental health consequences of such violence exposure, even in the absence of disclosure [41]. Health service providers should use developmentally appropriate, healing-centered, culturally responsive, and evidence-informed strategies to address trauma and promote healing, especially through centering survivors [7,41] and among populations who have inequitable access to resources [42]. One evidence-based universal approach is “CUES” – Confidentiality, Universal Education, Empowerment, and Support (see <https://ipvhealth.org/health-professionals/educate-providers/>). This approach has been evaluated in reproductive health, college health, women’s health, and adolescent health settings in the United States and Kenya, and has been shown to increase patients’ knowledge of resources and strategies for harm reduction, and to reduce reproductive coercion and abuse victimization among adolescents and young adult women [43–45].

Training for health professionals across disciplines (including students and trainees) should include skills building in how to implement healing-centered approaches in clinical settings including universal education to address GBV exposure [7]. This is a growing field with evidence-based curricula to address treatment and prevention of GBV (e.g., <http://ipvhealth.org> and <http://vawhealthresponse.org>). Other curricula have been published for undergraduate medical education and residency levels (e.g., <https://www.mededportal.org/action/doSearch?AllField=gender+based+violence>) with additional resources in disciplines such as social work and psychology (e.g., <https://aaswsw.org/wp-content/uploads/2016/01/WP15.pdf>). National and international consensus guidelines recommend that in-person and online GBV training should be integrated at all levels with training for entire clinical teams including support staff, not just clinicians.

Wrap-around support for caregivers and dependents is also critical, especially when there may be economic dependence on the person who is using violence [46]. In addition to safety planning, social work, and victim service advocacy, interventions also need to address basic needs such as housing, food insecurity, and financial support to reduce the impact of economic dependency on the AYA and family members that can place them at a greater risk for GBV [46]. Wherever victim service advocacy and social service resources exist, cross-sector collaboration and referral systems with the healthcare delivery system can be operationalized through formal partnership agreements [47]. Frontline health professionals such as physicians, nurses, and other healthcare providers should receive education and

routine updates on resources available to create these linkages to prevent GBV and support AYA survivors/victims of GBV [47].

Position 5: All adolescents and young adults should have equal access to developmentally appropriate education that disrupts gender inequality, a root cause of gender-based violence

Because gender attitudes, expectations, and norms are shaped by early adolescence, consistent access to quality education during adolescence – delivered through schools and other community programs – can be used to prevent GBV [18,19,48].

Evidence-based curricula delivered in primary schools, secondary schools, and university settings have been shown to reduce GBV in multiple high-income countries and low- and middle-income countries through targeting gender norms and power dynamics that perpetuate gender inequality [49]. Education ministries and departments can require schools to adopt curricula that teach children and AYAs of all genders about harmful gender stereotypes, how to develop and manage healthy relationships, and how to recognize abuse and violence (e.g., see La Strada Moldova’s Harmonious Family Relationships course or the Enhanced Assess, Acknowledge, Act Sexual Assault Prevention Intervention on an US university campus) [49,50]. Additionally, or alternatively, education ministries and departments can require schools to teach a comprehensive sexuality education curriculum, which has been shown to improve gender equity, reduce GBV, and improve sexual and reproductive health more broadly among school-going adolescents (e.g., see International Planned Parenthood Federation/MexFam in Mexico) [49]. Education institutions should also be aware of how the greater environment impacts classroom learning about GBV, including implementing protections such as after-school programs (e.g., see School Action Groups in Papua New Guinea) or school commute safety (e.g., see Walking School Bus initiative in Kwa-Zulu Natal, South Africa) [49].

In addition, out-of-school community programs can deliver developmentally appropriate education. Skills building around healthy relationships, for AYAs themselves as well as intra-family relationships they may have observed, is a research-informed approach to GBV prevention [51]. Education strategies that have strong evidence for addressing GBV at the interpersonal, community, and societal levels include edutainment, parent programs, couples programs, and community mobilization [51]. For example, SASA!, a community education and mobilization project that shifts norms of “men’s power over women as the root cause of” GBV in 30 countries, and MTV Shuga, a TV series that successfully used its edutainment program to reduce men’s reporting of perpetrating violence against female partners in Nigeria, have shown creative approaches to educational programming that address root causes of GBV against cis and trans women [51]. Community educational strategies for children and AYAs should counter acceptance of GBV, help ensure all individuals do not perpetuate intergenerational gender discrimination, and work against passively accepting GBV [19]. Governments, research agencies, and other non-governmental agencies should fund, test, adapt, and refine these interventions for different situations and contexts [49,51], and ensure that children, AYAs, and GBV survivors/victims are listened to, included, and supported in such programmatic responses

[52]. Such interventions to address GBV can help to both reduce GBV and increase protective factors to mitigate the impacts of GBV, supporting AYAs on positive health, economic, and developmental trajectories [53].

Position 6: Governments should sign, ratify, adequately fund, and implement frameworks and policies to prevent and respond to gender-based violence

GBV is a human rights violation, thus governments and civil society play an important role toward preventing and responding to GBV [54,55]. Governments can and have signed onto numerous international frameworks that provide guidance related to GBV and AYAs, including the UN Convention on the Elimination of All Forms of Discrimination against Women (1979) [56]; the UN Convention on the Rights of the Child (1989) [57]; Beijing Declaration and Platform for Action (1995) [58]; the UN Sustainable Development Goals (2015) [59]; the World Health Organization global plan of action to strengthen the role of the health system within a national multisectoral response to address interpersonal violence, particularly violence against women, girls, and children [60]; the Council of Europe Convention on Preventing and Combating Violence Against Women and Domestic Violence (2017) [61]; the International Labor Organization Convention 190 on reducing violence and harassment at work [62]; and the Call to Action on Protection from GBV in Emergencies Road Map (2021) [63]. Civil society organizations worldwide advocate for governments to endorse these frameworks to demonstrate their commitment to addressing GBV [64].

To implement these international frameworks, governments must set their own goals and adopt a strategic, coordinated, whole-of-government approach to address GBV [31]. Governments should establish an office responsible for coordinating across multiple government agencies and incorporate a diverse set of collaborators in the setting of frameworks, policies, and systems [34]. For example, in Kenya, the Office of the President leads the initiative to end all forms of GBV, including child marriage and female genital mutilation, and coordinates across other government agencies and non-governmental partners to implement GBV laws and policies; scale-up and finance GBV data collection, research, and evidence-based prevention; scale up and finance services for GBV survivors/victims including medical and psychological services; and create mechanisms to coordinate with non-governmental partners [65]. In Canada, a whole-of-government approach led to the development of the federal GBV strategy, which commits to several prevention efforts, support for survivors/victims and their families, and improvements to legal and justice systems through coordinating and funding work at seven federal agencies [66]. Governments should integrate the perspectives of and address explicitly the needs of AYAs who have experienced GBV, cis and trans women and girls, Indigenous populations, and other historically under-represented individuals in their national frameworks and in decision-making spaces [34,65,66].

Summary

GBV impacts AYAs of all genders and sexual orientations, and cis and trans women and girls disproportionately experience such violence. GBV has increased amid other global

health and sociopolitical crises, yet actions and resources for supporting GBV survivors remain insufficient. SAHM recognizes that GBV has been a longstanding threat, remains a public health crisis, and requires an urgent response to support the health and well-being of AYAs, especially cis and trans women and girls, worldwide. To comprehensively address GBV among AYAs, SAHM endorses these six positions which can guide efforts to prevent and address GBV and promote overall AYA health and well-being.

References

- [1]. United States strategy to prevent and respond to gender-based violence globally 2022. U.S. Department of State. Available at: <https://www.state.gov/reports/united-states-strategy-to-prevent-and-respond-to-gender-based-violence-globally-2022/>. Accessed October 9, 2024.
- [2]. Declaration on the elimination of violence against women. OHCHR. Available at: <https://www.ohchr.org/en/instruments-mechanisms/instruments/declaration-elimination-violence-against-women>. Accessed July 15, 2022.
- [3]. World Health Organization. Violence against women prevalence estimates. 2018. Available at: <https://www.who.int/publications-detail-redirect/9789240022256>. Accessed March 19, 2024.
- [4]. UN Women's, Generation Equality. Commitment to the action coalition on gender-based violence, progress report. 2022. Available at: <https://forum.generationequality.org/sites/default/files/2023-10/GBV-AC-Progress-Report-2022.pdf>. Accessed July 4, 2024.
- [5]. Efevbera Y, Petroni S, Hastings MB, et al. The child marriage learning partners consortium: Connecting data and evidence for action. *J Adolesc Health* 2021;69:S4–5. [PubMed: 34809899]
- [6]. Female genital mutilation (FGM) statistics - UNICEF data. Available at: <https://data.unicef.org/topic/child-protection/female-genital-mutilation/>. Accessed March 8, 2024.
- [7]. Kulkarni SJ, Bell H, Rhodes DM. Back to basics: Essential qualities of services for survivors of intimate partner violence. *Violence Against Women* 2012;18:85–101. [PubMed: 22411300]
- [8]. Li Y, Marshall CM, Rees HC, et al. Intimate partner violence and HIV infection among women: A systematic review and meta-analysis. *J Int AIDS Soc* 2014;17:18845. [PubMed: 24560342]
- [9]. Measuring the shadow pandemic: Violence against women during COVID-19. UN women data hub. Available at: <https://data.unwomen.org/publications/vaw-rga>. Accessed July 15, 2022.
- [10]. Sexual violence in Port-au-Prince: A weapon used by gangs to instill fear. OHCHR. Available at: <https://www.ohchr.org/en/documents/country-reports/sexual-violence-port-au-prince-weapon-used-gangs-instill-fear>. Accessed March 19, 2024.
- [11]. Towards ending child marriage. UNICEF data. 2021. Available at: <https://data.unicef.org/resources/towards-ending-child-marriage/>. Accessed July 15, 2022.
- [12]. Evans M Circumcision in boys and girls: Why the double standard? *BMJ* 2011;342:d978. [PubMed: 21325390]
- [13]. Ellsberg M, Madrid B, Vyas A, et al. In: Violence against adolescent girls: Falling through the cracks? Background paper. Ending violence in childhood global report. New Delhi: Know Violence in Childhood; 2017.
- [14]. Dillon G, Hussain R, Loxton D, Rahman S. Mental and physical health and intimate partner violence against women: A review of the literature. *Int J Family Med* 2013;2013:313909. [PubMed: 23431441]
- [15]. Longitudinal associations between teen dating violence victimization and adverse health outcomes | Pediatrics | American academy of pediatrics. Available at: <https://publications.aap.org/pediatrics/article/131/1/71/30768?autologincheck=redirected?nfToken=00000000-0000-0000-0000-000000000000>. Accessed September 10, 2022.
- [16]. Walker-Descartes I, Mineo M, Condado LV, Agrawal N. Domestic violence and its effects on women, children, and families. *Pediatr Clin North Am* 2021;68:455–64. [PubMed: 33678299]
- [17]. Heise L, Greene ME, Oppen N, et al. Gender inequality and restrictive gender norms: Framing the challenges to health. *Lancet* 2019;393:2440–54. [PubMed: 31155275]

- [18]. Kågesten A, Gibbs S, Blum RW, et al. Understanding factors that shape gender attitudes in early adolescence globally: A mixed-methods systematic review. *PLoS One* 2016;11:e0157805. [PubMed: 27341206]
- [19]. Amin A, Kågesten A, Adebayo E, Chandra-Mouli V. Addressing gender socialization and masculinity norms among adolescent boys: Policy and programmatic implications. *J Adolesc Health* 2018;62(3 Suppl):S3–5.
- [20]. CDC's health equity guiding principles for inclusive communication. Centers for Disease Control and Prevention. 2022. Available at: https://www.cdc.gov/healthcommunication/Health_Equity_Lens.html. Accessed September 10, 2022.
- [21]. Coulter RWS, Mair C, Miller E, et al. Prevalence of past-year sexual assault victimization among undergraduate students: Exploring differences by and intersections of gender identity, sexual identity, and race/ethnicity. *Prev Sci* 2017;18:726–36. [PubMed: 28210919]
- [22]. Hackett M Domestic violence against women: Statistical analysis of crimes across India. *J Comp Fam Stud* 2011;42:267–88.
- [23]. Crenshaw K “Demarginalizing the intersection of race and sex: A Black feminist critique of antidiscrimination doctrine, feminist theory and antiracist politics,” *University of Chicago Legal Forum*: Vol. 1989: Iss. 1, Article 8. Available at: <http://chicagounbound.uchicago.edu/uclf/vol1989/iss1/8>. Accessed December 23, 2024.
- [24]. Anyon Y, Bender K, Kennedy H, Dechants J. A systematic review of youth participatory action research (YPAR) in the United States: Methodologies, youth outcomes, and future directions. *Health Educ Behav* 2018;45:865–78. [PubMed: 29749267]
- [25]. Ozer EJ, Abraczinskas M, Duarte C, et al. Youth participatory approaches and health equity: Conceptualization and integrative review. *Am J Community Psychol* 2020;66:267–78. [PubMed: 32969506]
- [26]. Issue 15: Intersectionality - learning network - Western University. Available at: https://gbvlearningnetwork.ca/our-work/issuebased_newsletters/issue-15/index.html. Accessed July 4, 2024.
- [27]. Laster M, Kozman D, Norris KC. Addressing structural racism in pediatric clinical practice. *Pediatr Clin North Am* 2023;70:725–43. [PubMed: 37422311]
- [28]. Andermann A Screening for social determinants of health in clinical care: Moving from the margins to the mainstream. *Public Health Rev* 2018;39:19. [PubMed: 29977645]
- [29]. Health and public health recommendations for the gender-based violence national action plan. Futures without violence. Available at: https://policy.futureswithoutviolence.org/resource_center/health-and-public-health-recommendations-for-the-gender-based-violence-national-action-plan/. Accessed October 9, 2024.
- [30]. Health Partners on IPV + Exploitation. Healing centered approaches to screen and intervene for social determinants of health including intimate partner violence (a paper). Available at: <https://healthpartnersipve.org/resources/healing-centered-approaches-to-screen-and-intervene-for-sdoh-including-ipv-a-paper/>. Accessed October 9, 2024.
- [31]. Beck C, Cretsinger M, Frey V, et al. Systems and legal frameworks to address gender-based violence. In: OECD, ed. *Joining forces for gender equality: What's holding us back?* Paris: OECD Publishing; 2023.
- [32]. Te Kāwanatanga o Aotearoa | New Zealand Government. Te Aorerekura: National strategy to eliminate family violence and sexual violence. Wellington: The Board for the Elimination of Family Violence and Sexual Violence; 2021. Available at: <https://tepunaonui.govt.nz/national-strategy/#download>. Accessed July 3, 2024.
- [33]. Engel D, Vyas S, Chalasani S, et al. Violence against adolescents: Prevention must cross the divide between children and women. *BMJ* 2022;379:e067682.
- [34]. OECD. Types of administrative data collected by countries at the national level to estimate incidences of GBV. Organisation for economic co-operation and development; 2023. Available at: https://www.oecd-ilibrary.org/governance/types-of-administrative-data-collected-by-countries-at-the-national-level-to-estimate-incidences-of-gbv_56c8fd01-en. Accessed July 3, 2024.

- [35]. U.S. Office of Public Affairs. Justice department highlights initiatives to prevent and address gender-based violence. 2023. Available at: <https://www.justice.gov/opa/pr/justice-department-highlights-initiatives-prevent-and-address-gender-based-violence>. Accessed July 3, 2024.
- [36]. Mpako A, Ndoma S. South Africans see gender-based violence as most important women's-rights issue to address. Afrobarometer Dispatch; 738. 2023. Available at: <https://www.afrobarometer.org/publication/ad738-south-africans-see-gender-based-violence-as-most-important-womens-rights-issue-to-address/>. Accessed July 3, 2024.
- [37]. National child abuse and neglect data system (NCANDS). 2024. Available at: <https://www.acf.hhs.gov/cb/data-research/ncands>. Accessed July 3, 2024.
- [38]. UN Women Headquarters Office. Decision tree: Data collection on violence against women and COVID-19. 2020. Available at: <https://www.unwomen.org/en/digital-library/publications/2020/07/decision-tree-data-collection-on-violence-against-women-and-covid-19>. Accessed September 10, 2022.
- [39]. UN Women. Measuring the shadow pandemic: Collecting violence against women data through telephone interviews. An evidence-based technical guidance. UN Women data hub. 2021. Available at: <https://data.unwomen.org/publications/measuring-shadow-pandemic-collecting-VAW-data-guidance>. Accessed September 10, 2022.
- [40]. Call for experts – global action for measurement of adolescent health (GAMA) advisory group (AG). Available at: [https://www.who.int/news-room/articles-detail/call-for-experts—global-action-for-measurement-of-adolescent-health-\(gama\)-advisory-group-\(ag\)](https://www.who.int/news-room/articles-detail/call-for-experts—global-action-for-measurement-of-adolescent-health-(gama)-advisory-group-(ag)). Accessed July 3, 2024.
- [41]. Munro-Kramer ML, Dulin AC, Gaither C. What survivors want: Understanding the needs of sexual assault survivors. *J Am Coll Health* 2017;65:297–305. [PubMed: 28358265]
- [42]. French BH, Lewis JA, Mosley DV, et al. Toward a psychological framework of radical healing in communities of color. *Couns Psychol* 2020;48:14–46.
- [43]. Miller E, Goldstein S, McCauley HL, et al. A school health center intervention for abusive adolescent relationships: A cluster RCT. *Pediatrics* 2015;135:76–85. [PubMed: 25535265]
- [44]. Miller E, Jones KA, McCauley HL, et al. Cluster randomized trial of a college health center sexual violence intervention. *Am J Prev Med* 2020;59:98–108. [PubMed: 32362510]
- [45]. Uysal J, Boyce SC, Undie CC, et al. Effects of a clinic-based reproductive empowerment intervention on proximal outcomes of contraceptive use, self-efficacy, attitudes, and awareness and use of survivor services: A cluster-controlled trial in Nairobi, Kenya. *Sex Reprod Health Matters* 2023;31:2227371. [PubMed: 37594312]
- [46]. Matjasko JL, Niolon PH, Valle LA. The role of economic factors and economic support in preventing and escaping from intimate partner violence. *J Policy Anal Manage* 2013;32:122–8. [PubMed: 29853729]
- [47]. Promoting cross-sector collaborations to address intimate partner violence in health care delivery systems using a quality assessment tool - PubMed. Available at: <https://pubmed.ncbi.nlm.nih.gov/33666518/>. Accessed July 4, 2024.
- [48]. Chawla SA, Solomon J, Sarnquist C. A review of evidence-based dating violence prevention programs with behavioral change outcomes for adolescents and young adults. *Trauma Violence Abuse* 2024;25:3315–31. [PubMed: 38671574]
- [49]. Maruo M, Arango DJ, Grossi A, Contreras-Urbina MA. Addressing gender-based violence to accelerate gender equality. Gender thematic policy notes series: Issues and practice note. Washington: World Bank; 2023. Available at: <http://hdl.handle.net/10986/40469>. Accessed December 23, 2024.
- [50]. Acceptability and feasibility of implementing the Enhanced Assess, Acknowledge, Act (EAAA) sexual assault prevention intervention on a U.S. university campus: Themes from qualitative interviews and written reflections. *J Am Coll Health* 2024;72:3583–90. [PubMed: 38754093]
- [51]. Brief 3: Evidence-based programmes to prevent violence against women. Prevention Collaborative. Available at: <https://prevention-collaborative.org/wp-content/uploads/2022/03/Prevention-Essentials-Brief-3.pdf>. Accessed July 4, 2024.

- [52]. School-related gender-based violence: Achieving systemic, sustainable change - with youth and for youth - UNESCO digital library. Available at: <https://unesdoc.unesco.org/ark:/48223/pf0000386209>. Accessed July 3, 2024.
- [53]. Patton GC, Olsson CA, Skirbekk V, et al. Adolescence and the next generation. *Nature* 2018;554:458–66. [PubMed: 29469095]
- [54]. Kanbur N, Barral R, Efevbera Y, et al. Call to action against femicide: Illuminating a shadow pandemic as a global public health emergency. *J Adolesc Health* 2021;68:443–6. [PubMed: 33431250]
- [55]. UN Office of the High Commissioner for Human Rights. Women's rights are human rights. New York and Geneva: United Nations; 2014.
- [56]. General recommendation No. 35. On gender-based violence against women, updating general recommendation No. 19 (1992) | OHCHR. 2017. Available at: <https://www.ohchr.org/en/documents/general-comments-and-recommendations/general-recommendation-no-35-2017-gender-based>. Accessed July 3, 2024.
- [57]. Convention on the rights of the child. OHCHR. Available at: <https://www.ohchr.org/en/instruments-mechanisms/instruments/convention-rights-child>. Accessed July 3, 2024.
- [58]. Commission on the status of women/59 Beijing+20 (2015). UN women – headquarters. Available at: <https://www.unwomen.org/en/csw/previous-sessions/csw59-2015>. Accessed July 3, 2024.
- [59]. UN Department of Economic and Social Affairs. SDG actions platform. Available at: <https://sdgs.un.org/partnerships>. Accessed July 3, 2024.
- [60]. Global plan of action to strengthen the role of the health system within a national multisectoral response to address interpersonal violence, in particular against women and girls, and against children. World Health Organization. Available at: <https://www.who.int/publications/i/item/9789241511537>. Accessed July 3, 2024.
- [61]. The Council of Europe convention on preventing and combating violence against women and domestic violence (Istanbul Convention). Available at: <https://www.coe.int/en/web/gender-matters/council-of-europe-convention-on-preventing-and-combating-violence-against-women-and-domestic-violence>. Accessed July 3, 2024.
- [62]. Convention C190 - violence and harassment convention, 2019 (No. 190). International Labor Organization. Available at: https://normlex.ilo.org/dyn/normlex/en/f?p=NORMLEXPUB:12100:0::NO::P12100_ILO_CODE:C190. Accessed July 3, 2024.
- [63]. Call to action on protection from gender based violence in emergencies. Available at: <https://www.calltoactiongbv.com>. Accessed July 3, 2024.
- [64]. Rana B, Perrie V. CEDAW: A tool for addressing violence against women a tool for addressing violence against women. In: Aneel S, Haroon U, Niazi I, editors. 70 Years of development: The way forward. Islamabad: Sustainable Development Policy Institute. Available at: <https://www.jstor.org/stable/resrep24393.12>. Accessed July 3, 2024.
- [65]. Generation equality forum: Kenya's roadmap for advancing gender equality and ending all forms of gender-based violence and female genital mutilation by 2026, UN WOMEN. Available at: https://www.icrw.org/wp-content/uploads/2021/06/GEF_Kenya_GBV_roadmap-05.21-web.pdf. Accessed July 4, 2024.
- [66]. Women and Gender Equality Canada. The federal gender-based violence strategy. Ottawa: Government of Canada. 2024. Available at: <https://www.canada.ca/en/women-gender-equality/gender-based-violence/gender-based-violence-strategy.html>. Accessed July 3, 2024.

Comment

YE was an employee of the Bill & Melinda Gates Foundation during the preparation of this manuscript, however, the views expressed do not necessarily represent the views of the Gates Foundation. EM receives royalties for writing content for UpToDate, Wolters Kluwer. MVS has support through the Eliminating Health Disparities Initiative grant from the Minnesota Department of Health.