Violence against children of the world:
Burden, consequences and recommendations for action

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Abstract

Globally, the range, scale and burden of all forms of violence against children (VAC) are increasingly visible. Yet VAC as a physical, mental, public and social health concern is only recently gaining the prominence it deserves. Addressing VAC is critical as the outcomes of violence experienced early in life have long-lasting physical and mental health consequences throughout childhood, adolescence, adulthood—inter-generationally and for society as a whole. Negative health outcomes can result in the areas of maternal and child health, mental health, injury, non-communicable diseases, communicable diseases and risk behaviours. Ample evidence shows that violence is widespread and its most common forms are usually perpetrated by people with whom children interact every day in their homes, schools and communities. In this report, we define the problem, determine the burden and consequences of VAC, describe existing typologies of violence pertinent to children including child labour, children in armed conflict, trafficking of children and gender-based violence; and finally, identify what works both in preventing violence from occurring and ameliorating the effects in its aftermath. Our recommendations for action are aimed both at policy makers and practitioners at national, regional and supra-national levels.

1. Introduction

Violence in all its forms is a global public health problem.[1] While violence has always been part of human experience, its impact in terms of morbidity, mortality, sheer human cost of grief and pain and the effect on the most vulnerable populations, is incalculable. Violence against children (VAC), which incorporates the terms maltreatment, violence, exploitation and abuse—terms that are often used interchangeably—is both a human-rights violation and a personal and public health problem that incurs huge costs for both individuals and society.[2] From the best available data from high income countries (HICs), the burden and long-lasting consequences of VAC are considerable both to the children themselves and to society at large;[3-5] and these are likely to be magnified manyfold in low- and middle- income countries (LMICs). We know that in purely economic terms, the burden of child maltreatment (CM) in the Asia Pacific region is substantial,[6,7] affecting a vast number of children in this region. A broader focus will allow us to explore the burden of VAC to include family violence, community inter-personal violence, structural and institutional, and armed conflicts.

Exposure to early childhood abuse and trauma is not only associated with short and medium term consequences for the child, but can have long lasting detrimental effects. The adverse childhood experiences (ACE) study documented a strong graded relationship between the breadth of exposure to abuse or household dysfunction during childhood and multiple risk factors for several of the leading causes of death in adults.[8] Documented health consequences from ACEs have included increased risk of cancer, liver disease, skeletal fractures, chronic lung disease, ischemic heart disease, substance use, suicide, depression, obesity, alcoholism, teen pregnancy, sexual risk behaviours, and sexually transmitted infections. More recent explorations of the impact of ACEs have identified that early adversities are associated with poor early childhood mental health and chronic medical conditions,[9] chronic health and developmental problems in late childhood,[10] and that there are separate and cumulative effects of ACEs on adult health with exposure to violence in childhood having the most damaging effects.[11] Child maltreatment substantially contributes to child mortality and morbidity and has longlasting effects on mental health, substance misuse, risky sexual behaviour, obesity, and criminal behaviour.[3] Evidence over the past 30 years—from neuroscience, developmental psychology, social science and epidemiology—shows that VAC contributes to social, emotional and cognitive impairments and high risk behaviours leading to disease, disability, social problems and premature mortality.[12-14]

Since 1982, the International Society for Prevention of Child Abuse and Neglect (ISPCAN) has published data on child maltreatment (CM) every two years in their *World Perspectives on Child Abuse.* These publications are of great importance, not only for describing various forms of CM and identifying trends globally; but also in evaluating the differences in national policy, reporting systems and legislation. There is considerable variation over time and between cultures about what is deemed abusive to children. However, the unifying modern child protection movement which ISPCAN has been part of, stems from the acceptance of two inspiring ideas—that children are subjects of human rights and not objects of protection and, that children are psychological beings.[15]

The main purpose behind this statement is to make practitioners and policy makers think about VAC in much broader terms, recognize and respond to the myriad forms of violence and importantly, acknowledge the pressing urgency of the issue. We include children and young people up to 25 years in our exploration and offer a synthesized definition of VAC that integrates a child rights, clinical and public health-based approach. Our definition includes various types of violence and reflects the many places where violence can happen and manifest in children and young people's lives. A more contextualized understanding can help explain what drives different types of violations against children, including early marriage, commercial sexual or economic exploitation, to significantly increase vulnerability or exposure to violence.[2,16,17] Recent studies challenge child protection narratives focused on risk factors, which tends to obscure the social ecology and particularly the determinants of much of the harm that children experience.[18,19] From this shared understanding, we can make recommendations for establishing trans-disciplinary and inter-sectoral approaches to addressing VAC in the domains of prevention, treatment and rehabilitation.

2. Statement of the problem

2.1 Defining and clarifying the scope of violence against children

The World Health Organization defines violence as the "intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment or deprivation."[1] This definition includes violence at the personal, inter-personal and collective levels, as well as the use of threatened or actual power. It also includes neglect at the individual and societal levels, such as neglect of children or failure to prevent societal level violence. All forms of

VAC, ranging from armed conflict, physical or sexual abuse, trafficking and/or intergenerational transmission of trauma, may result in obvious physical harm and/or may cause less apparent psychological consequences, deprivation, altered development, or lack of wellbeing.

A rights-based approach to VAC requires a paradigm shift towards respecting and promoting the human dignity and the physical and psychological integrity of children as rights-bearing individuals rather than perceiving them primarily as "victims". The UN Convention on the Rights of the Child (CRC) provides the legislative framework for promoting and ensuring the rights of all children. Guided by General Comment (GC) 13 of the CRC, "violence" is understood to mean "all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse" as listed in article 19, paragraph 1, of the CRC. The use of this term is in keeping with the terminology used in the 2006 UN study on VAC, although the other terms used to describe types of harm (injury, abuse, neglect or negligent treatment, maltreatment and exploitation) carry equal weight.[20,21]

The most recent World Perspectives on Child Abuse, reported from their survey from 73 countries, that more than 90% of respondents regarded the following as also abusive to children: failure to provide adequate food, clothing or shelter, abandonment by a parent or caretaker, commercial sexual exploitation, exposing a child to pornography, child prostitution, children living on the streets, physical beating of a child by any adult, forcing a child to beg, child labour under age 12, and abuse or neglect occurring within foster care, educational settings, and detention facilities.[22] While there is greater congruence now across countries and geographical regions on what constitutes VAC, there is also evidence that reported violence is increasing. The scope of VAC globally therefore is considerable.

2.2 Estimating the burden and consequences of violence against children

The magnitude and devastating burden of VAC globally is hard to comprehend. Violence affects more than one billion children, in every country and every community, every year.[23,24] According to UNICEF,[25,26] globally children's experience of violence includes:

• ***Homicide***	— *In 2012, homicide took the lives of about **95,000 children and adolescents**—almost one in five of all homicide victims that year.*
• ***Physical punishment***	— *Around **six in ten** children between the ages of 2 and 14 are regularly subjected to physical punishment by their caregivers.*
• ***Bullying***	— *More than **one in three** students between the ages of 13 and 15 regularly experience bullying.*
• ***Forced sex***	— *Around **120 million girls** under the age of 20 (about one in ten) have been subjected to forced sexual intercourse or other sexual acts at some point in their lives.*
• ***Intimate partner violence (IPV)***	— ***One in three** adolescent girls aged 15–19 worldwide have been the victims of any emotional, physical or sexual violence committed by their husbands or partners at some point in their lives; 20% of adolescent girls are either married or in a union. **One in four children (176 million)** under the age of 5 live with a mother who has been a recent victim of IPV.*

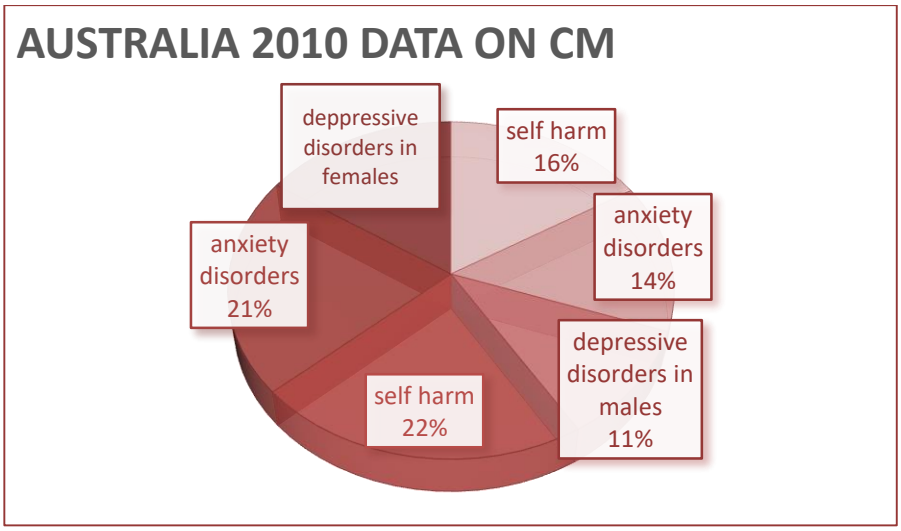
The short- and long-term health consequences of VAC are widely recognized.[21] They include: fatal injury; non-fatal injury (possibly leading to disability); physical health problems; cognitive impairment; psychological and emotional consequences (such as feelings of rejection and abandonment, impaired attachment, trauma, fear, anxiety, insecurity and shattered self-esteem); mental health problems; and health-risk behaviours (such as substance abuse and early initiation of sexual behaviour). Developmental and behavioural consequences can lead, inter alia, to deterioration of relationships, exclusion from school and coming into conflict with the law. There is evidence that exposure to violence increases a child's risk of further victimization and an accumulation of violent experiences, including later intimate partner violence.[27] Exposure to violence during childhood can impact on brain growth development with long-term negative consequences; emotional trauma during early childhood development in particular, may be much more difficult to treat than physical abuse.[28] Globally, despite the multiple data gaps and discrepancies in the type of data available, Pereznieto *et al* estimate that the global economic impacts and costs resulting from the consequences of physical, psychological and sexual VAC can be as high as $7 trillion; the annual costs of the worst

forms of child labour are approximately $97 billion, and those resulting from children's association with armed forces or groups up to $144 million. The authors who analysed the best available data to estimate the true cost of VAC for the Overseas Development Institute, suggest that global costs related to physical, psychological and sexual violence estimated by this study are between 3% and 8% of the global GDP.[29]

— ***High income countries***

While there is much better reporting and therefore data on CM and for homicide in HICs, there is substantial variation in definitions and reporting criteria. Even for HICs, there is not enough comparable data on all the typologies of violence we describe below. From the best available data from HICs, between 1.5% to 5% of children are reported to welfare authorities for CM concerns annually and approximately 1% of children have substantiated child protection concerns; neglect being the most common form reported in all countries with comparable data.[3] From self-reported maltreatment or parent-reported perpetration of violence, every year about 4–16% of children are physically abused, one in ten are neglected or psychologically abused, between 5% and 10% of girls and up to 5% of boys are exposed to penetrative sexual abuse, and up to three times this number are exposed to any type of sexual abuse. Exposure to multiple types and repeated episodes of maltreatment is associated with increased risks of severe maltreatment and psychological consequences. CM substantially contributes to child mortality and morbidity and has long-lasting effects on mental health, drug and alcohol misuse (especially in girls), risky sexual behaviour, obesity, and criminal behaviour, which persist into adulthood.[3] From Australian data, an estimated 24% of self-harm, 21% of anxiety disorders and 16% of depressive disorders burden in males; and 33% of self-harm, 31% of anxiety disorders and 23% of depressive disorders burden in females was attributable to CM in 2010.[4] CM was estimated to cause 1.4% (95% uncertainty interval 0.4–2.3%) of all disability-adjusted life years (DALYs) in males, and 2.4% (0.7–4.1%) of all DALYs in females in Australia (Chart 1).

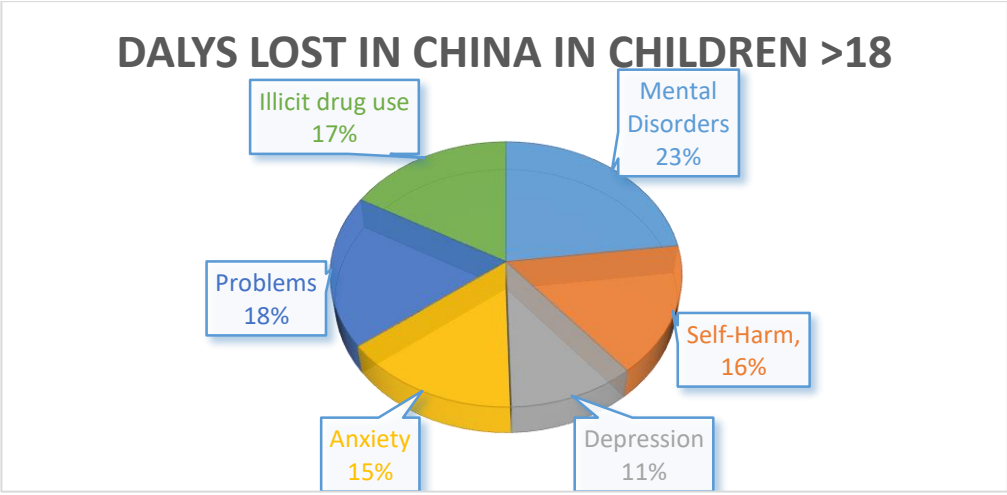
Chart 1



— ***Low and middle income countries***

Comparable data on the burden and health consequences of violence for children from low-resource settings is much less available. Pereznieto *et al* who did the global burden of VAC estimate, urge for there to be much more in-depth primary research on the different forms of VAC conducted in LMICs.[29] Fang et al systematically and comprehensively attempted to quantify the economic burden of VAC in the East Asia-Pacific region. They estimated the economic value of DALYs lost to VAC as a percentage of GDP, ranged from 1- 4 % across sub-regions, and the value of DALYs, in constant 2000 US$, lost to CM in the region totalled US $194 billion accounting for 2-3% of the region's GDP.[6] The best available data comes from China; from a meta-analyses of relevant studies Fang el al estimated that 27% of children under 18 years of age in China had suffered physical abuse, 20% emotional abuse, 9% sexual abuse and 26% neglect. They estimated that emotional abuse in childhood accounts for 26% of the DALYs lost because of mental disorders, 12% because of physical abuse linked to depression , 17% to anxiety, 21% drinking problems, 19% to illicit drug use and 18% of DALYs lost were to self-harm.[7] (Chart 2)

Chart 2



3. Specific Typologies of VAC

The typology presented in the *World report on violence and health*, divides violence categories according to the context in which it is committed; these include self-directed violence (including self-harm and suicide), interpersonal violence and collective violence.[1,30] We describe here the typologies pertinent to children and young people globally; we will not deal with self-directed violence in this statement. We acknowledge that no discussion about the typologies of violence, can ignore the importance of *structural violence*, particularly for children and young people from the majority world. Structural violence as described by Galtung and others refer to the impact of 'sinful' social structures characterized by poverty and steep grades of social inequality, including racism and gender inequality.[31] As distinct from direct violence, structural violence is violence exerted indirectly, systematically that is, by everyone who belongs to a certain social order and culminates in oppression.[32] There are several other contexts, conditions and risk factors that we cannot discuss in detail that increase or directly cause VAC, such as environmental threats, lesbian-gay-bisexual-transgender or gender fluid orientation, globalization and climate change.

3.1 Interpersonal

Interpersonal violence is divided into two subcategories in the WHO report[1] on violence and health.

- Family and intimate partner violence (IPV) – that is violence largely between family members and intimate partners, usually, though not exclusively, taking place in the home.

- Community violence – violence between individuals who are related, and who may or may not know each other, generally taking place outside the home.

The former group includes forms of violence such as child abuse, IPV and abuse of the elderly. The later includes youth violence, random acts of violence, rape or sexual assault by strangers, and violence in institutional settings such as schools, workplaces, prisons and nursing homes.

3.1.1 Child maltreatment

Since Henry Kempe described the battered child syndrome in 1962,[33] the medical profession and society at large has come to recognize CM. In 1999, the WHO Consultation on child abuse, came up with the following holistic definition:[34] ‘‘Child abuse or maltreatment constitutes all forms of physical and/or emotional ill-treatment, sexual abuse, neglect or negligent treatment or commercial or other exploitation, resulting in actual or potential harm to the child’s health, survival, development or dignity in the context of a relationship of responsibility, trust or power.’’ This form of VAC, clearly involves the perpetration of violence predominantly by caregivers. In the most recent edition of the World Perspectives on Child Abuse, the most common behaviours across all or most regions and country income categories were physical abuse by parents or caregivers (97%) and sexual abuse (96%). Other parental behaviours mentioned comprising CM by 90% of all respondents included failure to provide adequate food, clothing or shelter; commercial sexual exploitation; and emotional abuse. The majority of respondents (90%) identified “social conditions” such as physical beating of a child by any adult, child prostitution, infanticide and child labour as CM. Most respondents considered emotional abuse, psychological neglect and children’s witnessing IPV or domestic violence as CM. There is the least consensus on the use of physical discipline (53%) by a parent, and whether this is considered CM. We know that physical discipline is common across high-, middle-, and low-income communities,[35] and despite the considerable evidence of it harming children, it remains a normative practice in many countries. Other behaviours less often viewed as CM included: parent mental illness affecting the child (49%), female circumcision/ female genital mutilation (60%) and children serving as soldiers (66%); with wide variation across regions. Some behaviours and conditions in spite of being devastating for children were not considered CM by all or most respondents; these included slavery, abandonment, prostituting a child, forcing a child to beg. It is possible that the responses reflect what legal systems consider CM, rather than acceptance of such conditions.[22]

Most definitions of CM found in the literature include four main types of maltreatment: physical abuse, sexual abuse, neglect and emotional abuse. Although any of the forms of CM may be found separately, they often occur in combination. In the WHO documents,[1,30] physical abuse of a child is defined as the intentional use of physical force that results in—or has a high likelihood of resulting in—harm to the child's health, survival, development or dignity. Key principles in the definition include that it is non-accidental behaviour with physical injury; when a caregiver is involved in the injury, this behaviour is considered abuse regardless of the intention to hurt. Sexual abuse is defined as the involvement of a child in sexual activity that he or she does not fully comprehend, is unable to give consent to, or for which the child is not developmentally prepared, or else that violates the laws or social taboos of society.[1,30] The WHO definition of child neglect is (a) inattention or omission by the caregiver to provide for the child: health, education, emotional development, nutrition, shelter & safe living conditions; (b) in the context of resources reasonably available to the family or caretakers; (c) and causes, or has a high probability of causing harm to the child's health or physical, mental, spiritual, moral or social development.[34] It includes the failure to properly supervise and protect children from harm. Emotional abuse includes the failure of a caregiver to provide an appropriate and supportive environment, and includes acts that have an adverse effect on the emotional health and development of a child.[1] Such acts include restricting a child's movements, denigration, ridicule, threats and intimidation, discrimination, rejection and other nonphysical forms of hostile treatment.

More recent explorations of abuse in children and young people have identified that multiple forms of abuse occur together and over time. The term poly-victim refers to those children who experience high levels of multiple forms of violence and victimization; these young people also experience victimization in different contexts.[36] These children have high levels of psychological distress, some of the most serious victimization profiles, and vulnerability for further victimization.[37,38] In a recent study from South Africa, almost two-thirds of school-going children experienced poly-victimization;[39] these children were significantly more likely to be urban, living in single-parent households, whose parents abused substances, were absent from the home due to prolonged illness and were children who themselves used substances and engaged in risky sexual behaviours.

3.1.2 Domestic/family violence

The term 'domestic violence' or family violence is used in many countries to refer to IPV but the term can also encompass other forms of violence including child or elder abuse, or abuse by any

member of a household. It is important to be aware of all the contexts of violence within the home including the abuse of animals and exposure to violent media including television, internet and violent video games. The WHO defines IPV as "any behaviour within an intimate relationship that causes, physical, or sexual harm to those in the relationship".[1] The overwhelming global burden of IPV is borne by women. Although women can be violent in relationships with men, often in self-defence, and violence sometimes occurs in same-sex partnerships, the most common perpetrators of violence against women are male intimate partners or ex-partners.

Several studies have found that different forms of family violence co-occur. Renner and Slack in exploring inter-generational connections, found that that three of four forms of childhood violence (physical abuse, sexual abuse, and witnessing IPV) are highly predictive of adulthood IPV victimization.[40] Domestic violence can be physical, emotional, sexual, verbal, or financial, or can involve restricting contact of family members with people outside of the home. Domestic violence has a substantial effect on all family members, especially children. Children's exposure to IPV is now recognized as a type of CM with levels of impairment similar to other types of abuse and neglect.[41] Children represent a special population of those at risk of IPV; both as victims of abuse and as witnesses to it.[42] Children who witness domestic violence grow up in an environment that is unpredictable, filled with tension, anxiety and dominated by fear. This can lead to significant emotional and psychological trauma, similar to that experienced by children who are victims of child abuse. Instead of growing up in an emotionally and physically safe, secure, nurturing and predictable environment, these children are forced to worry about the future. It is well established that exposure to domestic violence has a significant negative impact on children's development, affecting their emotional, social and cognitive functioning and interfering in their ability to learn. Each child is unique and may respond differently to abuse, but there are common short- and long-term effects that can impact a child's day-to-day functioning.[43]

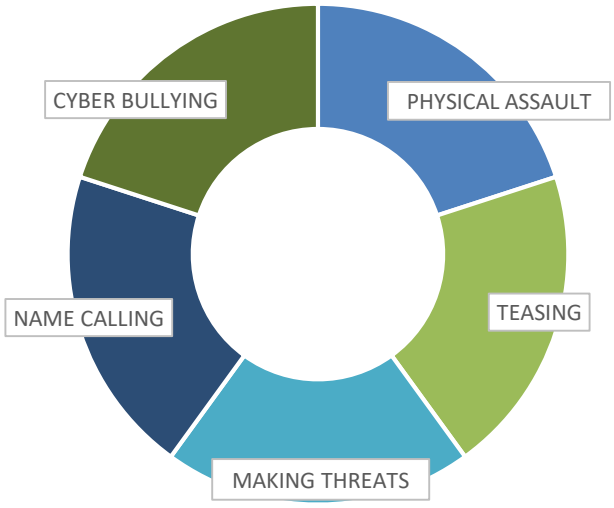
Short-term effects can include academic and behavioural problems, sleep disturbances and/or difficulty concentrating. Long-lasting effects can persist into adulthood, like difficulty trusting others and establishing relationships or ongoing depression. The emotional responses of children who witness domestic violence may include fear, guilt, shame, sleep disturbances, sadness, depression, and anger. Physical responses may include stomachaches and/or headaches, bedwetting, and loss of ability to concentrate. Some children may also experience physical or sexual abuse or neglect. Others may be injured while trying to intervene on behalf of their mother or a sibling. The behavioural

responses of children who witness domestic violence may include acting out, withdrawal, or anxiousness to please. These children may exhibit signs of anxiety and have a short attention span which may result in poor school performance and attendance. They may experience developmental delays in speech, motor or cognitive skills. They may also use violence to express themselves displaying increased aggression toward peers or parents, and can become self-injuring. Apart from the emotional, physical, social and behavioural damage abuse creates for children, domestic violence can also become a learned behaviour.[44]

3.1.3 Community violence

Schools: bullying, corporal punishment

Bullying is a relatively recent addition to the violence literature. While there is no legal definition of bullying, it is usually defined as intentional and repeated behaviour which is intended to hurt someone either emotionally or physically, and is often aimed at certain people because of their race, religion, gender, sexual orientation or any other aspect such as appearance or disability.[45] Bullying is repeated aggression via physical, verbal, relational or cyber forms in which the targets cannot defend themselves.[46]Bullying can take many forms including:



School is a place where children should be safe, secure and happy and where the threat of violence is non-existent. Sadly, in many countries it is a place where children face emotional and physical abuse from both fellow pupils and from teachers. Globally, more than one in three teenagers between 13 and 15 are regularly bullied and in some countries such as Latvia and Romania, nearly 6 in 10 admit

to bullying others.[27] While little is known about bullying in low resource settings, data from the UNICEF Multi-Country Study involving adolescents from Ethiopia, India, Peru and Vietnam,[47] shows that indirect bullying, such as measures to humiliate and socially exclude others and verbal bullying are more prevalent; boys are at greater risk than girls of being physically and verbally bullied while girls are more likely to be bullied indirectly. Forms of violence perpetrated by children and young people include bullying, sexual and gender-based violence, schoolyard fighting, gang violence, and assault with weapons. Technology provides a new medium for bullying using the Internet and mobile phones, and has given rise to new terms such as "cyber-bullying".

Being bullied has been found to have a significant impact on children's physical and mental health, psychosocial well-being and educational performance, with lasting effects into adulthood on health, well-being and lifetime earnings.[48] Children who are bullied are more likely to experience: depression and anxiety, increased feelings of sadness and loneliness, changes in sleep and eating patterns, and loss of interest in activities they used to enjoy; health complaints; decreased academic achievement, and school participation. A very small number of bullied children might retaliate through extremely violent measures. In 12 of 15 school shooting cases in the 1990s, the shooters had a history of being bullied. Some children are particularly vulnerable to bullying: those from minority ethnic groups, those from low socio-economic background, those with language delay or learning difficulties, and children who are gay or transgender. And yet, bullying is highly preventable.[49] Training of teachers is essential and the building of a culture where violence is unacceptable and diversity is applauded are necessary components of an inclusive, pro-child school community. Paediatricians have a key role in supporting anti-bullying approaches in schools.

Corporal punishment in schools

"Can anything be more anti-educational than deliberately using violence to discipline children?" (Paulo Pinheiro)

There is growing progress towards universal prohibition of this most common form of VAC: 52 states have prohibited all corporal punishment of children, including in the family home.[50] As of 2015, there are 126 states where corporal punishment is prohibited in all schools but still 73 states where children may be lawfully subject to adult violence in all or some schools: including India, Jamaica, Lebanon, Singapore, Egypt and many African states. Proponents argue that it is an effective

and non-harmful means of instilling discipline, respect and obedience into children. The evidence suggests otherwise. Children exposed to corporal punishment experience detrimental effects, including poor academic performance, low class participation, school dropout and declining psychosocial well-being.[51] Corporal punishment is highly prevalent, despite prohibition. Data from the UNICEF Multi-Country Study on the Drivers of Violence Affecting Children,[52] shows that over half of eight year old children in Peru and Vietnam, three quarters in Ethiopia and over nine in ten in India reported witnessing a teacher administering corporal punishment in the last week.Violence in school is the most important reason children give for disliking school; and boys and children from disadvantaged backgrounds are significantly more likely to experience corporal punishment. While research especially from low-resource settings is sparse, there is evidence from the UNICEF Multi-Country Study that corporal punishment in schools is associated with lasting effects on children's cognitive development.[53]

Corporal punishment in the home, the hitting, smacking or beating of children by teachers, models violence and counters the rights of the child, which can lead to serious injuries and does not help to reduce behaviour problems or facilitate learning. Forms of violence found in schools are both physical and psychological, and usually occur together.[27] Forms perpetrated by teachers and other school staff, include not just corporal punishment but other cruel and humiliating forms of punishment, sexual and gender-based violence, and bullying. Paediatricians and health professionals have an important role in ending corporal punishment in school by making it clear that this is unacceptable and by helping to educate parents in alternative approaches to discipline. The Uganda Government has published a useful handbook for promoting positive discipline which is applicable globally.[54]

Institutional violence

Tens of millions of children in the world live and develop for varying lengths of time in institutional care.([27Chapter 5]) Given the dramatic increase in the number of children currently being displaced by violence and war,[55] children and youth who are separated from their families are increasingly finding themselves 'institutionalized' by governments. Children living in residential facilities are more likely to experience violence and sexual abuse than children living in family-based care.[49] Incarcerated youth are at even greater risk, and also experience psychological trauma secondary to their confinement itself, in particular children exposed to solitary confinement.[56,57] Children with disabilities, both physical and mental, are at the greatest risk regardless of the venue of the institutional care.[58] In a recent systematic review, researchers attempted to quantify institutional violence globally, and found that overall abuse experiences of children in institutions were poorly recorded.[59] The authors concluded that despite the paucity of studies, violence and abuse, by commission or omission is prevalent in institutions, has an effect on child well-being and is amenable to intervention.

Globally, there are many reasons why children become institutionalized. Some have lost their relatives and are without extended families or foster care placements to care for them. The pandemic of AIDS in Africa, compounded by extreme poverty, resulted in profound demographic shifts in this regard. Some have physical and mental health conditions that require institutional care. Still others are caught-up in juvenile justice systems that have little regard for the health and well-being of the children and youth they are expected to protect. Although a relatively small number, militaries that conscript children constitute another form of institutionalization.

The physical and psychological trauma associated with institutionalization affects children across their life course into adulthood. Beyond the immediate effects of physical, sexual and psychological trauma, children experience developmental delays, depression, post-traumatic symptoms, anxiety disorders and increased rates of suicide, homicide and criminality. For children conscripted into military forces, the impact of violence may be more extreme, resulting in death, dismemberment or permanent developmental and psychological disabilities.

A number of human rights instruments, most importantly the UN CRC,[60,61] address the rights of children and youth living outside of the family environment. Key articles specifically address the obligation of States to protect children from abuse and neglect by those responsible for the care of the child (Article 19), and to provide special protection for a child deprived of the family environment (Article 20). Other articles emphasize the rights of children to live with their families (Article 9) unless the child's best interests dictate otherwise (Article 3). Article 10 articulates the right to family reunification if the child is forced to leave his/her country, and Article 22 requires special protection to refugee children or children seeking refugee status. In particular, it requires States to co-operate with *competent* organizations to provide protection and assistance. Article 23 addresses the right of 'disabled' children to special care, education and training to ensure a life lived with dignity and with the greatest degree of self-reliance and social integration.

The CRC also specifically address the rights of children detained through juvenile justice systems to be protected from torture and deprivation of liberty (Article 37), to be treated with dignity and respect in the system (Article 40) and to be protected from being directly engaged in armed conflicts and from the impact of conflict (Article 38). With respect to each of these and other related rights, special attention must be focused on ensuring the rights of children are fulfilled for those that are institutionalized for whatever reason.

Child labour

"Child labour" is defined as work that deprives children of their childhood, their potential and their dignity, and that is harmful to their physical and mental development.[62] From a rights based perspective, there can be no excuse for the existence of child labour. Child labour is a global phenomenon; around 168 million children work, many full-time worldwide. More than half of them, 85 million, are still in hazardous work. Asia and the Pacific still has the largest numbers (almost 78 million or 9.3% of the child population), but Sub-Saharan Africa continues to be the region with the highest numerals of child labour (59 million, over 21%).[62]

Child labour is so ubiquitous that it often gets ignored; but it is one of the most serious forms of VAC. In many low-income countries, it is essentially a socio-economic problem, inextricably linked to poverty and illiteracy. It not only prevents children from acquiring the skills and education they

need for a better future, it also perpetuates poverty and affects national economies through losses in competitiveness, productivity and potential income. A particularly heinous form of child labour comes as a result of trafficking. While there are no exact estimates of the numbers of trafficked children at this time, estimates suggest that 50% of trafficking victims worldwide are children; human trafficking is one of the fastest growing transnational crimes. Children are trafficked into a range of exploitative practices including labour, domestic work, sexual exploitation, military conscription, marriage, illicit adoption, sport, begging and organ harvesting.[63]

One way of responding to the problem of child labour is to use the language of CRC to guide the recognition, response and targeted advocacy campaigns against it. Many governments have taken proactive steps to tackle the problem of child labour through strict enforcement of legislative provisions along with simultaneous rehabilitative measures.[64] The International Labour Organization's (ILO) International Program on the Elimination of Child Labour (IPEC) is currently is the largest program globally (operational in 88 countries). IPEC has worked to achieve this in several ways: through country-based programmes which promote policy reform, build institutional capacity and put in place concrete measures to end child labour; and through awareness raising and mobilization intended to change social attitudes and promote ratification and effective implementation of ILO child labour Conventions.[62]

Withdrawing children from labour, providing them with education and assisting their families with training and employment opportunities contribute directly to creating decent work for adults. Besides education and health care, transforming economies for quality growth and quality jobs has been the main theme in the discussion on the current development framework, setting the stage for the Sustainable Development Goal (SDG) #8 to "promote sustained, inclusive and sustainable economic growth, full and productive employment and decent work for all".[65]

3.2 Collective

3.2.1 Armed conflict

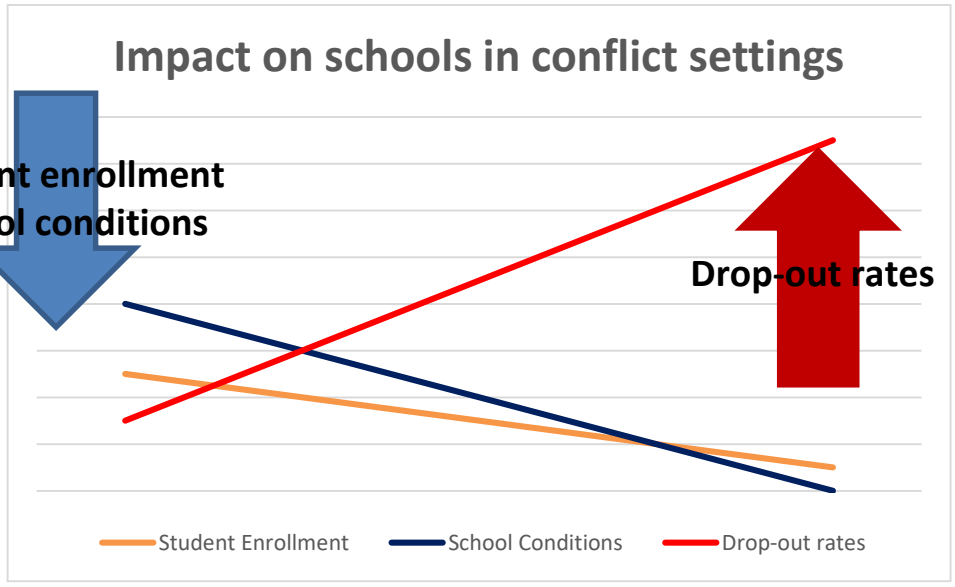
An estimated 246 million children live in areas affected by conflict, more than one in ten children globally.[66,67] Children account for one fourth of the 65 million forcibly displaced people worldwide[68] and half of the world's 21 million refugees.[69] In spite of these extraordinary numbers, our

understanding of the scale of the impact of armed conflict on child health is limited. Even basic mortality estimates do not provide age-disaggregated data, with the result that children are simply not counted.[70,71]

The ways in which armed conflict affects children are at once diverse and pervasive. Children may be caught in the crossfire or directly targeted by combatants, resulting in physical injury, illness, disability, psychological trauma and mortality.[72] Newborns in areas of active conflict have higher rates of stillbirth, low birth weight, prematurity and perinatal mortality when compared with those born during peacetime or in peaceful areas of the same country.[73-75] Forced displacement, separation from family, environmental exposures (e.g. contamination of water supplies, unexploded ordinance, and chemical weapons), and the destruction of health, public health, educational and economic infrastructure leads to a broad range of downstream effects on child health that follow children throughout the life course.[72] Food is used as a weapon of war, with sieges, destruction of crops, and attacks on food supply chains leading to high rates of micronutrient deficiencies and acute malnutrition.[76] As these children grow up, they face barriers in access to basic necessities for several generations, resulting in the continuing violation of children's rights long after cessation of hostilities. The medium- and long-term health effects of armed conflict on the growing child are poorly understood due to disruption of health information systems and constraints in the collection of longitudinal data in this vulnerable group.[70]

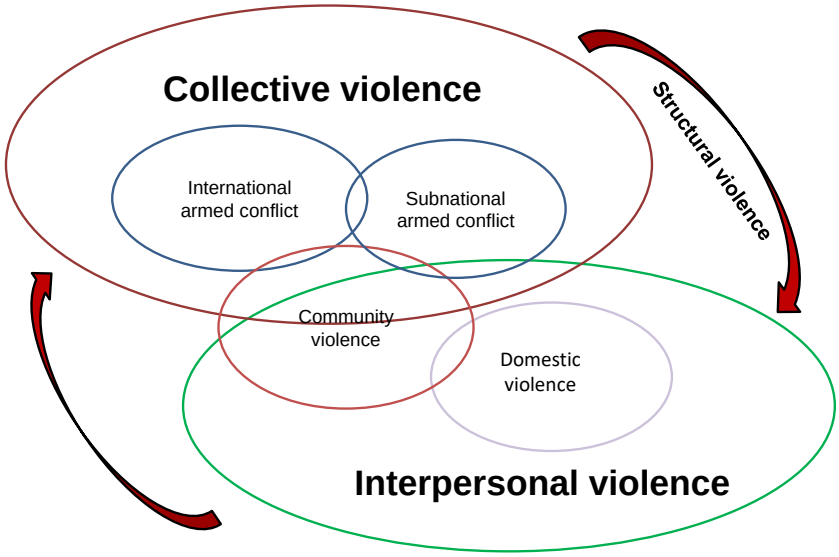
Increasingly, schools and health facilities have come under attack.[77,78] Attacks on health facilities not only result in the injury and death of child patients, but also create barriers in access to health care by destroying health facilities and reducing the health workforce, many of whom are killed in the line of duty, and many more who flee in search of safety.[79] Children are both recruited and forced into armed groups, with devastating consequences for their health, socialization and long-term functioning.[80-82] Schools are also often used as recruiting grounds, and children are attacked and abducted on their way to and from school.[78] In 2016, nearly 500 attacks and threats on schools were either documented or verified in 18 conflict-affected areas.[26] Not surprisingly, in conflict settings, fewer children enroll in school, drop-out rates are higher, school conditions are poorer, and schools close.[78] (Chart 3)

Chart 3



The violence that conflict brings into the lives of children does not only take place at the societal level. Exposure to armed conflict has been associated with higher rates of mental health disorders in caregivers,[83] which in turn places these children at risk for physical abuse.[84] The children of deployed armed forces personnel are known to be at higher risk for both physical abuse and neglect, and this risk occurs both during and after parental return from deployment.[85-87] Children exposed to armed conflict, whether directly or remotely, are therefore subject to multiple and intersecting forms of violence, including collective, community, interpersonal, and structural violence (Figure 1).

Figure 1: Armed conflict and violence against children— Intersections



3.3 Practices based on tradition, culture, religion or superstition

All violations of children's rights can legitimately be described as harmful practices, but the common characteristic of the violations here are that they are based on tradition, culture, religion or superstition and are perpetrated and actively condoned by the child's parents or significant adults within the child's community.[17] Within the international human rights community, there has been a concern for many decades about 'harmful traditional practices' (HTPs) which violate the human rights of women and girls, culminating in the comprehensive UN Fact Sheet "Harmful Traditional Practices Affecting the Health of Women and Children".[88] The report from the International NGO Council on Violence against Children,[17] lists exhaustively various practices from acid attacks, breast flattening, child marriage, dowry, to male circumcision, female genital mutilation (FGM) and honour killing. There are criticisms of the UN approach to HTPs, in particular that the practices condemned are for the most part only those practiced in non-western societies.[89] There is now international consensus that harmful traditional values and practices based on long upheld patriarchal social

values, act as root causes for discrimination and violence against girls.[89] Traditionally condoned forms of discrimination and violence against girls include son preference, early and forced marriage and FGM. Apart from their shared designation as injurious, the reasons for considering early marriage and FGM together are that they respond to common cultural logics and are often linked in practice.[90] Despite many or most HTPs such as child marriage and FGM being prohibited by law in most countries, the practices are maintained by powerful social forces, sometimes with the active consent of girls and women. We need to therefore acknowledge that interventions to promote changes in practice that do not consider the underlying logics and all the potential effects for those involved, are unlikely to achieve their aims and may even bring about resistance and unintended adverse consequences.

3.4 Intersections between Violence against Children and Violence against Women

Violence against women (VAW) and VAC are acknowledged globally as human rights and public health problems. Unsurprisingly, both VAW and VAC share common antecedents and pathways. Those working at the intersection of VAW and VAC have wrestled with this divide, with increasing recognition for strategic integration of programming and services.[91,92] Moving forward with integrated strategies is likely to be more effective if policy makers and practitioners fully consider the historical and political influences that created this gender-age divide. Scholars working in this field identified and reviewed six intersections between VAW and VAC.[93] These include:

- VAC and VAW have many shared risk factors;
- Social norms often support VAW and VAC and discourage help-seeking;
- CM and partner violence often co-occur within the same household;
- Both VAC and VAW can produce intergenerational effects;
- Many forms of VAC and VAW have common and compounding consequences across the lifespan;
- VAC and VAW intersect during adolescence, a time of heightened vulnerability to certain kinds of violence.

As with the rest of the evidence-base, much of the research used by Guedes *et al* relied on studies from HICs, mostly involving CM and IPV. The authors acknowledged that there were important intersections among other forms of violence, including sexual violence by non-partners. A recent important qualitative study from Uganda identified four potential patterns that suggest how IPV and

VAC co-occur and intersect within the family, triggering cycles of emotional and physical abuse: bystander trauma, negative role modelling, protection and further victimization, and displaced aggression especially from the mother.[94]

3.5 Gender dimensions

One of the key recommendations of the UN study on VAC was to address the gender dimensions of violence, specifically to understand the different forms of violence meted out against girls in the home and family.[27] There are multiple structures that put girls and women at risk of violence; however problems of gender are not confined to females. Adopting a gender perspective to address VAC necessitates critical examination of norms around masculinity and femininity. In many societies, boys learn that it is socially acceptable to control and dominate, and girls learn to accept this as the norm. There are certainly specific types of violence that disproportionately affects girls, particularly in LMICs.[95] These include — female infanticide/feticide due to son preference,[96] early and forced marriage,[97] honour killings, neglect of the girl child,[98] domestic labour, FGM.[99] The widespread and systematic neglect of responding to the health and social needs of girls have resulted in documented differences in immunization coverage, home food allocation, seeking medical care for childhood ailments and proportion of household healthcare expenditures allocated to them.[100] Girls and women are also particularly vulnerable in war and conflict situations.[101] Experiences of children across the globe vary tremendously with a complex combination of factors including age, stage of life, socio-economic status, religion, ethnicity, colour, caste, sexual orientation, health, minority status, citizenship and status as an asylum seeker or refugee coming into play.[95]

Violence, as it is understood here therefore, includes an array of factors that are not necessarily linear and include sorting through the meaning of different types of violence (emotional, physical and sexual), happening in different places (the home, school and community), at different levels of a child's social ecology (the structural, institutional, community, interpersonal and individual), while keeping issues of age, gender and power relations figuring prominently in our understanding.[19] Within all these variables, it is also essential to consider the dynamics of children's lives (that is that they are changing and growing), making the task for pediatricians and other who often bear direct responsibility for children's well-being a large, a difficult but not insurmountable task with increased understanding and coordination.

4. What works? The evidence base

4.1. What works in preventing violence against children?

In 2016, ten major international organizations and campaigns launched INSPIRE, an evidence-based resource package of strategies to end VAC. The seven prioritised strategies include (Box 1):

- Implementation and enforcement of laws;
- Norms and values;
- Safe environments;
- Parent and caregiver support;
- Income and economic strengthening;
- Response and support services;
- Education and life-skills.

It is widely recognized that adaptations of these strategies to national and local contexts is critical and that weaving together several strategies in a multi-sectoral manner is an essential element to success. For these reasons, INSPIRE emphasizes two important cross-cutting activities that help connect and strengthen the seven strategies. These are: inter-sectoral activities and coordination; emphasizing the roles of multiple sectors—including front line ministries as well as civil service organizations with different skills sets, coming together to develop an integrated platform of concerted actions to end violence. The foundation of any of the INSPIRE activities is appropriate monitoring and evaluation to track progress and ensure effective investments.

The implementation of INSPIRE draws on some of the more recent findings in the field of violence prevention and promotes a multi-pronged implementation plan that incorporates several of the INSPIRE strategies simultaneously. The Multi Country Study on the Drivers of Violence Affecting Children, suggests, for example, that working in the field of violence prevention requires the understanding that little is linear or predictable. While scholars and practitioners agree that prevention requires an understanding of all the factors that influence violence, too frequently these factors are ascribed to one level or another in the model creating a static, if not simplistic interpretation of a very complex social phenomenon. As a result, in the research to policy and

practice transfer, researchers, policy-makers and programmers often do not address the complexity that may influence the way violence manifests in children's lives—*at all levels.* Failing to account for this complexity has created a fractured approach to violence prevention, with the tendency to develop interventions stripped of critical and dynamic contextual factors.[102]

Box 1: INSPIRE

Know Violence in Childhood, a global learning initiative launched in 2014, reviewed and synthesized evidence from around the world, especially from LMICs.[103] Although there are gaps in the evidence base, there are many examples of promising strategies and programmes in place in diverse countries of the world. The Know Violence report *Ending Violence in Childhood*, highlights the importance of broad-based and integrated prevention strategies that can be adapted and implemented in different contexts. These promising strategies are clustered into three broad types of action (Figure 2):

Figure 2: Prevention of childhood violence

Source: Know Violence in Childhood 2017.

i) Enhancing individual capacities, especially those of *caregivers* to manage aggression and relationship conflict, reduce stress induced by economic factors, and nurture children appropriately, as well as those of *children* through age-appropriate programmes that promote equitable gender norms and promote non-discrimination. There are many examples of effective programmes that promote social-emotional learning, life-skills, and comprehensive sex education from different parts of the world. Evidence-based interventions aimed at parents include home visitation programmes, individual and group parenting programmes, community mobilization and economic empowerment of women combined with gender equality training, and cash transfer programmes. Children-who need to be at the heart of violence prevention efforts can be empowered by well-designed and structured preschool and school programmes and respectful relationship programmes. Services such as child helplines can provide confidential support and counselling to vulnerable children and youth.

ii) Embed violence-prevention in institutions and services, especially those that serve the needs of women and children. Such institutions include schools, where transforming the overall culture of a school can have long-lasting impacts both on ending violence and improving the quality of education. The Good School Toolkit in Uganda is an example of a "whole school" approach that integrates children, parents and educators in a way that strengthens positive behaviours and fosters positive outcomes.[104] Bullying-prevention programmes have also been implemented in many parts of the world, as are peer violence programmes.[105] While much more evaluation is required of these diverse programmes,[106] there is significant potential to adapt and scale up such programmes and integrate them into schooling systems across the world.

Health systems around the world can play a significant role in violence prevention – especially as they are the first service that a child encounters in her life, and are a critical point of connection for women's well-being, especially during pregnancy but also beyond. There are many ways in which health systems can play a role – including identification of violence, referral and counselling – across primary, secondary and tertiary services, and integrating mental health services. While some lessons have emerged from efforts linked to ending VAW, more needs to be done to strengthen the role of paediatricians in reducing VAW and children.

Other important areas where services, service providers, and institutions need to be strengthened include ending online violence. Children's exposure to the internet can be positive, rewarding and empowering – but it is often a source of exposure to great vulnerability to bullying and sexual exploitation. Prevention strategies aimed at both supporting children to avoid such exposure and also working with online service providers to detect, report and prevent abuse are necessary and possible, as examples from different parts of the world show.

Finally, children who are placed in large residential institutions in the absence of appropriate family care are at risk of exposure to cognitive harm and all forms of abuse and exploitation. Strong action is required to support processes of deinstitutionalization and promote investment in alternative family-based care.

iii) Eliminating the root cause of violence, especially in fragile, at-risk communities, and promoting positive social norms while challenging adverse ones, are necessary to end violence. Fragile communities can concentrate grave violence including gang violence leading to homicide especially among adolescents and young boys as well as sexual violence against girls. Targeted multi-component strategies that address all aspects of fragility—social, economic and civic—can play a role in reducing levels of violence. Community-oriented policing, supportive justice systems and programmes for children, such as after-school programmes, can all play a critical role in addressing risks in a multi-pronged approach.

Improving the design of public spaces through proper lighting, mixed commercial and residential use, better transportation amongst others, can also improve the quality of public spaces for women and children, in particular.

Finally, the role of community-wide communications strategies to change adverse social norms is critical. Violence in childhood is often deeply embedded in social norms, including patriarchal norms that perpetuate gender inequality and underpin CM. Such norms can be addressed in part by communications strategies, ranging from mass media campaigns to training and capacity development, and in part by progressive legislation that promotes gender equality and women's rights and freedoms. The implementation of such laws can go a long way in shifting norms and related attitudes and behaviours.

The global report concludes that there are three overarching strategies that can provide an enabling framework for public action. These include breaking the silence around violence, investing in quality data and evaluation research; and investing in violence prevention systems that can integrate strategies across the different sectors that need to play a role in ending violence.

4.2 What works in ameliorating the effects/consequences of violence against children?

While the research on prevention of violence is still in its infancy, the evidence-base for what works in reducing or alleviating harm in children and young people is sparse. Increasingly, evidence is

being made available from low-resource settings but more needs to be done. A major concern is the lack of recognition of CM; much less the broader sphere of VAC.

Health professionals have a key role to play along with other sectors in responding to VAC. Health-worker training can improve knowledge of CM reporting laws, accuracy in recognizing CM, and clinical expertise in reporting.[107] While there are a great range of training programs for health professionals, there is an absence of rigorous evaluation of their impact;[108] mandatory clinical experiences in CM has been shown to improve the preparedness of paediatricians to identify and evaluate children for abuse and neglect.[109] We know that there is evidence for risk assessment and behavioural interventions in paediatric clinics (such as the Safe Environment for Every Kid (SEEK) model) in reducing abuse and neglect outcomes for young children..[110] The Cochrane systematic review on child sexual abuse concluded that cognitive behaviour therapy may have a positive impact on the sequelae of abuse, but most results were statistically non-significant.[111] Home visitation for at-risk families has the best evidence for preventing CM, but not all types of programs are equally effective. Two specific home-visiting programmes—the Nurse-Family Partnership and Early Start—have been shown to prevent CM and associated outcomes such as injuries. Some parent-training programs may prevent the recurrence of physical abuse; no intervention has yet been shown to be effective in preventing recurrence of neglect. A few interventions for neglected children and mother-child therapy for families with IPV show promise in improving behavioural outcomes. Foster or alternative care placement especially stable and early placement for children who have been maltreated, can lead to benefits compared with young people who remain at home or those who reunify from foster care.[112] Integration of empirically validated substance abuse and trauma treatments into IPV interventions show some promise and manualised child trauma treatments are effective in reducing child symptoms secondary to IPV.[113] Although the evidence-base is small, there is potential for improved coherence between IPV and CM programmes, which requires equal attention to the needs of women and children, and the involvement of fathers when it is safe to do so.[114] Specifically targeted and tailored parenting programs such as the ‘Incredible Years’ can contribute to improvements in parenting practices and in parents' perception of their child's behaviour.[115]

5. Recommendations for action on violence against children

Despite the enormity of the problem, and the substantial costs and the disproportionate burden of VAC for those in LMICs, we know that in 2015 the total development assistance spent to address this area was less than US$1.1 billion, i.e., less than 0.6% of spending.[24] A child-rights-based approach is at the core of any action on VAC. Children's rights as laid out in the UN CRC provide a framework for understanding the range of violence, harm, and exploitation of children at the individual, institutional, and societal levels. The greatest strength of an approach based on the UN CRC is that it provides a legal instrument for implementing policy, accountability, and social justice, all of which enhance public-health responses.[2] Addressing VAC necessarily requires a multi-sectoral approach and involves not only prevention, but also treatment and rehabilitation of the effects of VAC. Approaches need to be integrated such that services and programs are supported by community systems that are in turn supported by public policies. The Integrated Child Centred Framework for Violence Affecting Children,[116] an application of the socio-ecological model, provides an innovative way to make visible what is known about a type/place of violence, using existing nationally-generated evidence. Findings plotted onto this prevention framework helps make clear the different and varied stakeholders, disciplines and responses needed to translate evidence into action in the form of improved interventions and policies.

Recommendations for action require commitments at the global, regional and national levels. Coordination will be critical, so too will key topical areas of concern.

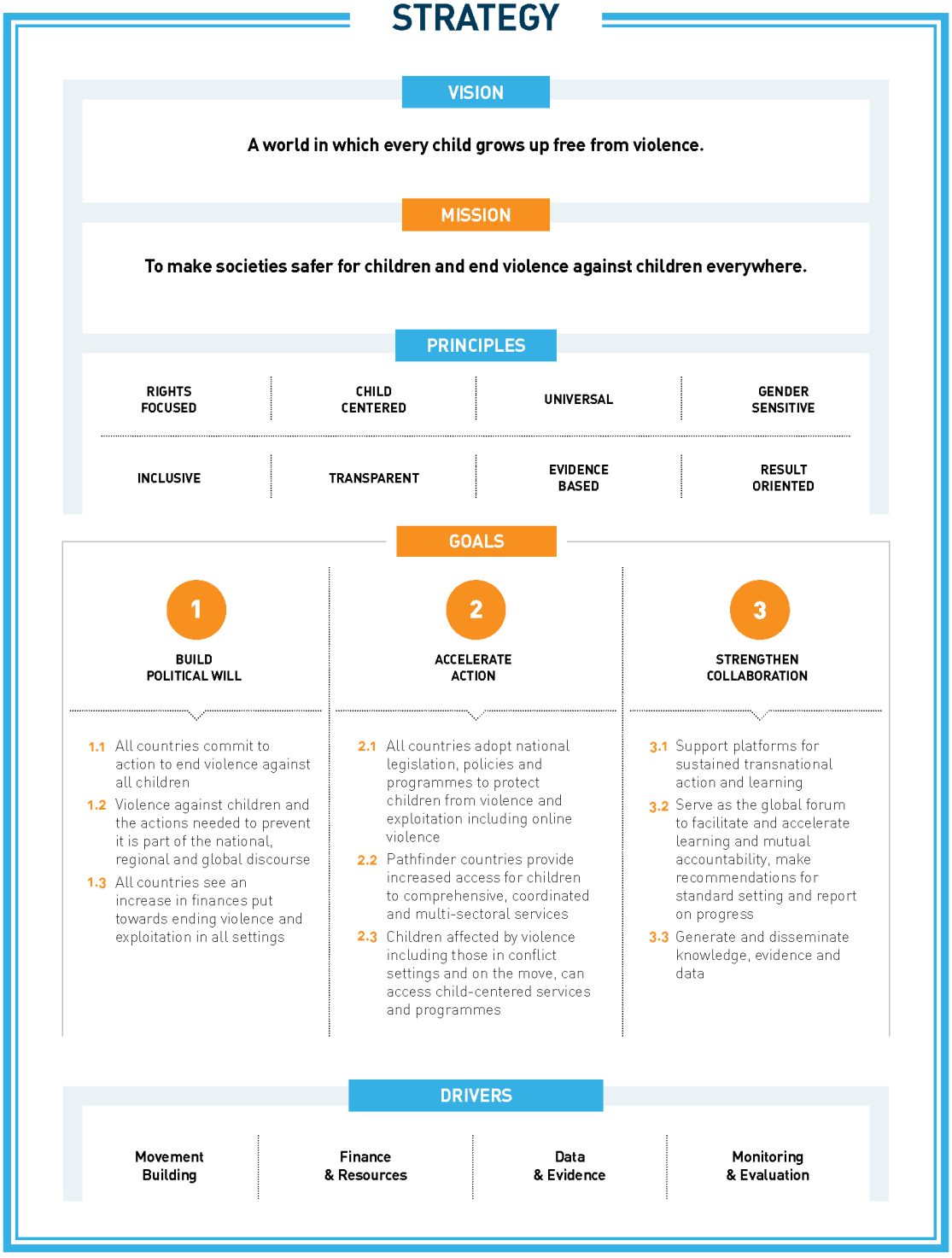
5.1 Global coordination

Global coordination strategies to enhance progress in reducing VAC include:

- Global agencies such as ISPCAN, IPA, UNICEF and WHO have recently joined together in a collaborative endeavour—the Global Partnership to End Violence in Childhood (Box 2). The Global Partnership provides the learning and technical platform for improved collaboration to support evidence-based primary, secondary and tertiary prevention approaches nationally, regionally and globally. The partership has an end violence strategy based on the following principles— rights focused; child centered; universal; gender sensitive; inclusive; transparent; evidence-based; result oriented. Efforts like these designed to coordinate agency and government approaches to end violence should be fully endorsed.

- Careful and sustained attention needs to be given to the effects of armed conflict on children, understanding that the dimensions of everyday violence can be exacerbated under these conditions. Specifically, global agencies should take on a leading role to monitor the effect of armed conflict on children and make this data and its translation into policy and practice available for public health praticitioners and clinicians working with these children.
- Global agencies addressing violence must agree, to move beyond the narrow focus of risk factors acknowledging the inter-connectedness of children's social ecology. The term '**drivers**' refers to factors at the institutional and structural levels that create the conditions in which violence is more likely to occur. While '**risk and protective factors'** reflect the likelihood of violence occurring due to characteristics most often measured at the individual, interpersonal, and community levels,'**drivers'** refer to macro-level (structural) factors and meso-level (institutional) factors that influence a child's risk of, or protection from, violence.[18]
- Multi-disciplinary professionals at the global level, including clinicians, child rights advocates and researchers can contribute to the growing state of evidence on violence in childhood, by providing decision-makers with multiple types of knowledge and demonstrating how findings can be translated into effective practice in different contexts. Depending on national needs, this could include: information on prevalence, consequences and impact of violence for advocacy, and more in-depth, relational analyses required to understand the inter-relationships of both the drivers, risk and protective factors of VAC. The continued and careful documentation of proven and promising practices that acknowledge national needs, with sound measures aligned to the SDGs, will be critical to success in combating violence.
- All international professional bodies representing health, education, justice and social welfare professionals working with children (such as the International Pediatric Association) need to endorse and ensure mandatory VAC training at the national level, available as part of the core curriculum in their professional streams. This should be broader than the usual singular focus on CM.

Box 2: Global Partnership to End Violence Against Children



5.2 Regional coordination

In order to achieve progress both at global and national levels, building strategic regional partnerships and promoting regional governance structures underpinned by a child-rights based approach is critical. The following regional approaches need promoting:

- The establishment and implementation of specific regional frameworks that help countries set national agendas for addressing VAC.
- Leaders serving as regional drivers of initiatives, promoting the implementation of agreed upon protocols for data collection, implementation of interventions and evidence generation that can produce regional understandings of change. These can be achieved through incorporating the INSPIRE strategies agreed upon and promoted by the Global Partnership to End Violence and its many partners, such as the WHO, responsible for its implementation.
- Promotion of comprehensive regional studies to capture national developments aiming at the prevention and elimination of VAC, and identifying areas where the process of national follow-up could be further enhanced to respond to uniquely regional issues.
- Promote cross-regional learning to accelerate progress on the 2030 Agenda for Sustainable Development.

5.3 National coordination

- All national governments must uphold their obligations to have reliable systems for gathering data as mandated by the UN CRC to ensure the acquisition, dissemination and analysis of high quality, robust, reliable, valid, social, and epidemiological data on VAC.
- Goverments must acknowledge the inter-connectedness of different factors and therefore call upon stakeholders, most notably from the multiple front-line ministries needed to address VAC. Structural and institutional drivers of violence such as poverty, gender inequity and ineffective legal structures and systems work in potent combination with risk factors at the community, interpersonal and individual levels. These drivers cannot be addressed alone by ministries of social welfare and/or ministries of women and gender, typically responsible for the oversight of children's well-being. Acknowledging this complexity and ensuring a multi-sectoral and multi-disciplinary approach to interventions is mandatory.

- Training in child protection issues for all professionals dealing with children, including but not limited to health, social welfare, education and justice should be part of on-going professional development and be linked to credentialing of professionals. Furthermore, introduction of basic violence prevention principles into curricula of these fields should be mandated.

5.4 A Call to Action: Prioritising VAC

Children everywhere are at risk of violence but efforts to change the conditions in which children live, learn, sleep and play can be made safe: this is utlimately the new global mandate. Paediatricians and front-line professionals working with children have a role in this work and it is significant. Research is needed to identify how to effectively respond at the individual, systemic and policy levels. The INSPIRE package of seven strategies builds on growing evidence that VAC is preventable and on a growing public consensus that it can no longer be tolerated. The role of the health sector in the provision of these services—along with those in justice, welfare, education and other child-related domains is essential. Pediatricians also play a critical role in educating parents around these initiatives. Specifically, we call for coordinated efforts in the following as priorities:

- *Addressing children living in humanitarian contexts:* As the majority of displaced and refugee children live in LMICs and two thirds of displaced children reside within their country of origin, [117] international agencies and relevant international professional associations such as the International Pediatric Association should collaborate to assist governments in responding to the needs of these especially vulnerable children by improving access to trauma-informed rehabilitative care, safety and prevention programmes.
- A public health model incorporating population-based studies, better monitoring and surveillance as well as prevention responses should be advocated widely.
- Drawing on the experience of the women's health and violence prevention movement, more effective integration between the common concerns of the two distinct, yet similar concerns of VAW and VAC must occur.
- At the program and systems levels, hospitals and other health care facilities and schools can serve as useful settings for interventions. The design and implementation of community level interventions related to VAC should be enhanced—including advancing the close cooperation

of the health sector with other sectors concerned with violence including the education sector, NGOs and research bodies.

- At the policy level, inter-sectoral action across all levels—from individual providers to professional societies, public health professionals and policy makers—can contribute to the generation of relevant and effective public policy.

6. Summary

We believe that the time *has* come to end VAC — achieving this globally and within a single generation. Increased investment in preventive and therapeutic strategies to address VAC at all ages and at all levels, ranging from domestic violence to armed conflict is needed. Investing in violence prevention can greatly increase the returns on investments in health, education and welfare. Recognizing that violence is a fluid and shifting phenomenon in children's lives as they move between the places where they live, play, sleep and learn is important. Research is needed to identify how to effectively respond at the individual, systemic and policy levels. Agreement on frameworks for expressing the complexity and multi-sectoral and disciplinary approaches must be advocated for and applied across all types of interventions to ensure a holistic approach to violence prevention—addressing factors that influence violence from the structural to the individual. We reiterate that VAC is preventable and that public health has a crucial role to play in addressing its causes and consequences. Most importantly, supported by the language of rights, we must all take up the mantle of a shared agenda to end VAC within a generation—this agenda must resonate in the corridors of homes, schools communities and governments.

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