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Child Abuse & Neglect

journal homepage: www.elsevier.com/locate/chiabuneg

Ending violence against children: What can global agencies do in partnership?

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ARTICLE INFO

Keywords:

Violence against children

Child abuse and neglect

Prevention

Policy and practice

ABSTRACT

Globally, the range, scale and burden of all forms of violence against children (VAC) have visibly increased. Yet VAC as a physical, mental, public and social health concern is only recently gaining the prominence it deserves. Addressing VAC is critical. Violence experienced early in life can result in short, medium, long-lasting, and/or even inter-generational negative health outcomes. Ample evidence shows that VAC is widespread and the most common forms are usually perpetrated by people with whom children interact every day in their homes, schools and communities. We report on an innovative collaboration between global agencies, led by the International Society for Social Pediatrics and Child Health (ISSOP), the International Society for Prevention of Child Abuse and Neglect (ISPCAN), and the International Pediatric Association (IPA), who were galvanized to respond to VAC using a child-rights and public health lens. This collaboration led to a position statement on VAC with an implementation plan. The strength of the position statement was the explicit incorporation of a rights-based expansive understanding of VAC, with a description of typologies of violence pertinent to children globally, including child labor, children in armed conflict, trafficking of children and gender-based violence; and the identification of strategies both in preventing violence from occurring and ameliorating the effects in its aftermath. We report on the challenges and successes of our collaborative action at regional and supra-national levels, including opportunistic action.

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<https://doi.org/10.1016/j.chiabu.2020.104733>

Received 4 March 2020; Received in revised form 5 September 2020; Accepted 7 September 2020

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1. Introduction

Violence in all its forms is a global public health problem (Know Violence in Childhood, 2017; WHO, 2002). Violence against children (VAC) was traditionally framed in terms of abuse, neglect, maltreatment and exploitation, terms often used interchangeably. VAC is both a human-rights violation and a personal and public health problem that incurs huge costs for both individuals and society (Reading et al., 2009). Violence affects more than one billion children, in every country and every community, every year (Hillis, Mercy, Amobi, & Kress, 2016; Tew, 2017). The short, medium and long-term consequences (including intergenerational effects) of VAC are considerable (Gilbert et al., 2009; Maternowska & Potts, 2017; Moog et al., 2018); and there is evidence that exposure to violence increases a child's risk of further victimization and an accumulation of violent experiences (Pinheiro, 2006).

Child abuse and neglect has been the focus of the International Society for the Prevention of Child Abuse and Neglect (ISPCAN) for many years. Pediatricians and child advocates from the International Society for Social Pediatrics & Child Health (ISSOP) wanted to broaden this focus by including violence originating from societal and structural levels as a focal point for advocates and advocacy efforts. ISPCAN, ISSOP, and the International Pediatric Association (IPA), a global organization uniting hundreds of pediatric societies, formalized a partnership in 2016, recognizing the shared agenda for children globally. This tripartite agreement aimed to enhance advocacy and education directed at the protection of children's rights at both global and local levels.

The first part of the combined advocacy and education effort established by this tripartite collaboration, was to work on addressing VAC. The development of the VAC Working Group, the joint position statement that was developed, and the challenges encountered with implementing an ambitious global agenda, are outlined below.

2. Violence against children working group

The impetus to form a Working Group to combat VAC originated from the ISSOP 2015 conference focusing on the Sustainable Development Goals (SDG) in Geneva (Spencer, 2015). The recognition that the SDGs contained a specific target (SDG 16.2) to end all forms of violence against children, as well as several other targets addressing specific forms of violence and harm towards children, such as child marriage and female genital mutilation (target 5.3) and the eradication of child labor, including the recruitment and use of child soldiers (target 8.7) (Violence against children- related SDGs, 2015), suggested to the ISSOP Executive that this was a priority area of focused rights-based advocacy and action. We quickly realised that the only way forward was to build effective partnerships with ISPCAN and other global agencies working in this space. The memorandum of understanding between ISSOP, ISPCAN and IPA was finalised in 2016, in acknowledgement that the three organisations had shared visions and goals about ending violence against children. Specific actions agreed to within the tripartite agreement included: i) to enhance advocacy and education directed at the protection of children's rights at both global and local levels; ii) to highlight interdisciplinary cooperation in the prevention and response to VAC iii) to strengthen the knowledge base on violence against children through joint research. There was also an explicit commitment to sharing knowledge and skills to achieve the mutual goals through available global professional development platforms delivered by the three organisations. A Working Group came together specifically around ending VAC and was formalised at the IPA Congress in August 2016 in Vancouver, comprising pediatricians who were members of ISSOP, ISPCAN councillors, executive committee members of IPA; and invited representatives from United Nations Children's Fund (UNICEF), World Health Organization (WHO), GlobalChild, Know Violence in Childhood and the World Bank. The Working Group membership grew organically, largely through personal networks and word of mouth. In 2016, there were 23 members of the Working Group; members were from South Asia, the Middle East, Africa, Europe, the Americas and Oceania and their skill-set ranged from clinicians, public health specialists, researchers and policy makers.

2.1. Development of the violence against children position statement

The first task of the tripartite collaboration, was to build on the shared child rights-based and, public health vision by creating a comprehensive statement on VAC that would outline an implementation plan. We further engaged with other global agencies and processes that were also involved in advocacy towards ending VAC, including the Global Partnership to End Violence against Children, Know Violence in Childhood, UNICEF and WHO. A smaller working party comprising 15 members was formed to develop the position statement out of the VAC Working party. This working party was goal driven, comprised a mixture of clinicians, researchers in child rights and child protection, policy and advocacy specialists and represented all the major regions including Asia-Pacific, Europe, the Americas and Africa. Over an intense 18 month period between 2016 and 2017, the position statement working party explored the literature, thrashed out definitions of VAC, identified typologies of violence that were particularly relevant to children and young people globally, discussed intersectionality, and developed recommendations for prevention and amelioration of VAC that could be incorporated into an implementation plan.

3. Defining violence against children

We used both a child-rights and public health lens approach to defining violence, including acknowledging *structural violence*, particularly for children and young people from the majority world, and the root cause determinants of VAC (Farmer, 2004; Galtung, 1985).

- a) Drawing first on the World Health Organization (WHO) definition of 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”(WHO, 2002).
- b) Then the seminal United Nations Convention on the Rights of the Child’s (CRC) Article 19, which defines “violence” as “all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse” (Lee & Svevo-Cianci, 2011). The same terminology is used in the 2006 United Nations study on VAC (Pinheiro, 2006).
- c) Providing global impetus to this issue, the elimination of VAC is also called for in the 2030 Agenda for Sustainable Development, most explicitly in Target 16.2: “end abuse, exploitation, trafficking and all forms of violence against and torture of children”. Several other SDG targets address specific forms of violence and harm towards children, such as child marriage and female genital mutilation (target 5.3) and the eradication of child labor, including the recruitment and use of child soldiers (target 8.7) (*Violence against children- related SDGs, 2015*).

As stated in the CRC-General Comment 13, the evolution to a rights-based understanding of VAC “requires a shift toward 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” (Lee & Svevo-Cianci, 2011).

3.1. Specific typologies of VAC

A major benefit of the VAC Working Group was to be able to draw upon the experiences and expertise of a global panel of leaders and identify typologies of violence relevant to children and young people today. Guided by the *World Report on Violence and Health*, (Butchart, Harvey, Mian, & Fürniss, 2006; WHO, 2002) we explored violence categories according to the context in which it is committed: i.e., interpersonal, community, collective, practices based on tradition, culture, religion and superstition, and gender dimensions.

3.2. Interpersonal

3.2.1. Child maltreatment

Since the 1960s, when Henry Kempe described the battered child syndrome (Kempe, Silverman, Steele, Droegemueller, & Silver, 1962), this has become the most recognized form of VAC worldwide. Most definitions of CM found in the literature include four main types of maltreatment: physical abuse, sexual abuse, neglect and emotional abuse, which may occur in combination (Butchart et al., 2006; WHO, 2002). We highlighted the issue of poly-victimization, which is child and young people being exposed to high levels of multiple forms of violence and victimization across different contexts (Finkelhor, Ormrod, & Turner, 2007), (Finkelhor, Ormrod, & Turner, 2009; Finkelhor, Ormrod, & Turner, 2007; Leoschut & Kafaar, 2017), and the issue of children with disabilities being especially at-risk (Jones et al., 2012).

3.2.2. Domestic/family violence

The term ‘domestic violence’ or family violence is used in many countries to refer to intimate partner violence (IPV), but the term can also encompass other forms of violence including child or elder abuse, or abuse by any member of a household. The overwhelming global burden of IPV is borne by women, and different forms of family violence co-occur. Children’s exposure to IPV is now recognized as a type of CM with levels of impairment similar to other types of maltreatment (MacMillan, Wathen, & Varcoe, 2013) and children can be at risk, both as victims and as witnesses (Thackeray & Randell, 2011).

3.3. Community violence

3.3.1. Schools: bullying, corporal punishment

Unfortunately, while schools are settings where children should be safe and happy, in many countries schools are where children face emotional and physical abuse from both fellow pupils and teachers. Bullying is repeated aggression via physical, verbal, relational or cyber forms in which the targets cannot defend themselves (Olweus, 1994). Technology provides a new medium for bullying; with the vastness and speed at which information can be shared via the Internet and on mobile devices, cyber-bullying has made way to an almost limitless platform for abuse.

Corporal punishment is the most common form of VAC. While over 50 states prohibit *all* corporal punishment of children, and over 125 states have prohibited corporal punishment in all schools, children may be lawfully subject to adult violence in all or some schools in remaining nations (*Global Initiative to End All Corporal Punishment of Children, 2017*). Evidence gathered from a range of settings including Africa where exposure to corporal punishment is very high, shows that children exposed to corporal punishment experience detrimental effects, including poor academic performance, low class participation, school dropout and declining psychosocial well-being (Knox, 2010; Olweus, 2013; Sherr et al., 2016).

3.3.2. Institutional violence

Children living in residential facilities are more likely to experience violence and sexual abuse than children living in family-based care (Jenney, 2013; Sherr, Roberts, & Gandhi, 2017). There has been a dramatic increase in the number of children and youth in institutional care, including those displaced by violence and war (Ferrara et al., 2016), and those in juvenile detention (Owen &

Goldhagen, 2016; Teplin, McClelland, Abram, & Mileusnic, 2005).

3.3.3. Child labor

Child labor is so ubiquitous that it is ignored; but it is one of the most serious forms of VAC and is underpinned by poverty and deprivation of education (Scanlon, Prior, Lamarao, Lynch, & Scanlon, 2002). Globally over 168 million children work, with more than half of them doing hazardous work (ILO, 2017). A particularly heinous form of child labor results from trafficking, with estimates suggesting that half of trafficked victims worldwide are children. Exploitative practices involving children include labor, domestic work, sexual exploitation, military conscription, marriage, illicit adoption, sport, begging and organ harvesting (UNICEF, 2005).

3.4. Collective violence

3.4.1. Armed conflict

Millions of children live in areas affected by conflict, and nearly one in three children living outside their country of birth is a refugee (Lake, 2015; UNICEF, 2015, 2016). Children are affected by armed conflict in a myriad of ways—caught in the crossfire, or directly targeted by combatants resulting in injury, illness, disability, psychological trauma and mortality (Rieder & Choonara, 2012; Shenoda, Kadir, Pitterman, & Goldhagen, 2018). Children exposed to armed conflict, are subject to multiple and intersecting forms of violence, including collective, community, interpersonal, and structural violence (Fig. 1). Forced displacement and separation from family lead to a broad range of downstream effects throughout the life course (Rieder & Choonara, 2012), while children being recruited into armed groups face devastating consequences in terms of health and long-term functioning (Betancourt et al., 2013; Guha-Sapir & D'Aoust, 2010; UNICEF, 2007).

3.5. Practices based on tradition, culture, religion or superstition

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 the child's community (International NGO Council on Violence Against Children, 2012). The report from the International NGO Council on Violence Against Children (2012) lists exhaustively practices from acid attacks, breast flattening, child marriage, dowry, to male circumcision, female genital mutilation (FGM) and honour killing. While traditional practices can affect both boys and girls, there is international consensus that harmful traditional practices based on patriarchal social values, act as root causes for violence against girls (Winter, Thompson, & Jeffreys, 2002).

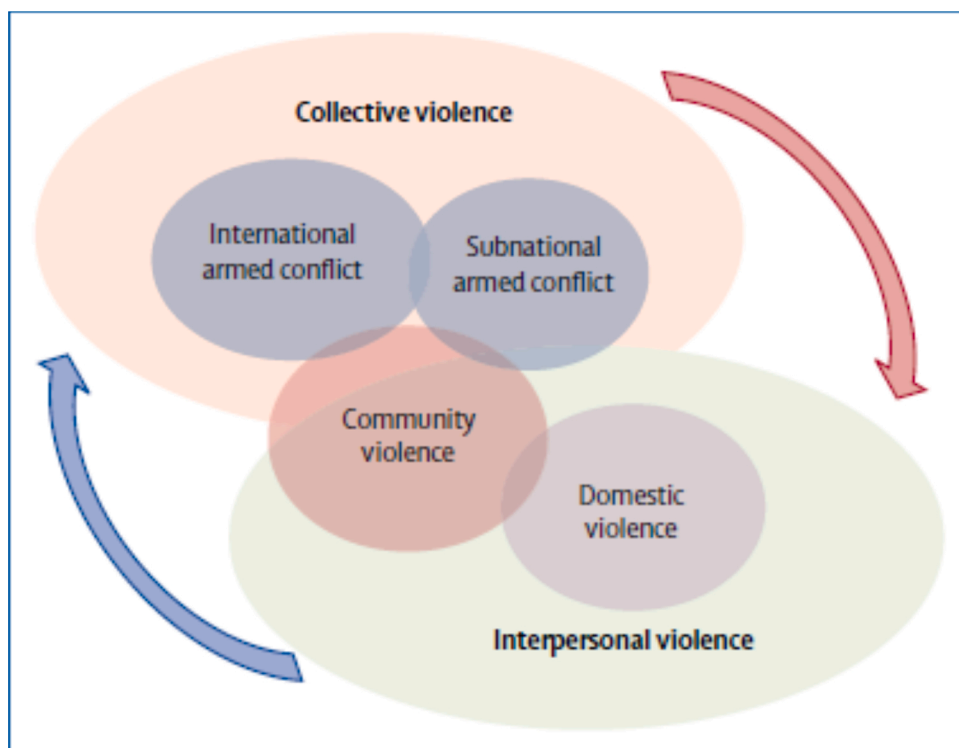


Fig. 1. Armed conflict and violence against children— Intersections.

3.6. Gender dimensions

A key recommendation of the United Nations Report on VAC was to address the gender dimensions, which necessitates critical examination of norms around masculinity and femininity (Pinheiro, 2006). There are certainly specific types of violence that disproportionately affects girls, particularly in low- and middle-income countries (LMICs) (UNICEF, 2009), including — female infanticide/feticide due to son preference (Sahni et al., 2008), early and forced marriage (Hampton, 2010), honour killings, neglect of the girl child (Fikree & Pasha, 2004), domestic labor and FGM (Kimani, Muteshi, & Njue, 2016). Children and young people who are gay, bisexual or transgender face unacceptable rates of bullying and victimization leading to high rates of depression and suicidal ideation especially among males (Russell, Ryan, Toomey, Diaz, & Sanchez, 2011).

4. What works in preventing violence against children?

Know Violence in Childhood was a key partner in the Working Group developing the VAN policy statement. Know Violence in Childhood reviewed and synthesized evidence from around the world, especially from LMICs (Know Violence in Childhood, 2017). Based on the best available evidence from their report; the following broad-based and integrated prevention strategies were identified (Fig. 2):

- i) **Enhancing individual capacities**, especially those of *caregivers* to manage aggression and relationship conflict, reduce stress, and nurture children, as well as those of *children* by empowering them through programs that build children's capacities, promote equitable gender norms and non-discrimination. The best examples of enhancing caregiver capacities include home visitation, group parenting programs, community mobilization and economic empowerment (especially of women), and cash transfer programs. Successful initiatives aimed at empowering children include quality preschool programs, respectful relationships programs delivered via school curricula and services such as child help-line.



Fig. 2. Prevention of childhood violence.

- ii) Embed violence-prevention in institutions and services, especially those that serve the needs of women and children. Such institutions include schools and hospitals /health services. Strong action is required to prevent institutionalization of all kinds, support processes of deinstitutionalization of children and promote alternative family-based care. School cultures can be transformed to become centers of nonviolence with a no-tolerance approach to bullying and victimization. Ensuring online safety is critical in the 21 st century. Online systems have been used proactively to promote children’s safety, and online technology has been used by girls and women to map and create alerts about rape. Finally healthcare professionals and health systems have a critical role to play in preventing violence, since children come into contact with them even before they are born. Frontline health professionals can be trained to screen and arrange appropriate referral and treatment if they detect exposure to violence and trauma. Health systems are more effective in preventing violence when services offer links to safe spaces for women and children.
- 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. Targeted multi-component strategies that address all aspects of fragility—social, economic and civic—can play a role in reducing levels of violence. There is ample evidence of strategies that reduce violence by strengthening systems of formal justice supplemented with community-based mediation. Reshaping the physical environment to create safe public spaces can also help reduce violence.

While evidence for interventions is highly skewed towards high-income countries, there are promising interventions aimed at preventing gender-based violence in low- and middle-income countries, including group training for women and girls, community mobilisation interventions, skill-building to enhance voice/agency, and social-network expansion (Ellsberg et al., 2015; Yount, Krause, & Miedema, 2017).

5. What works in ameliorating the consequences of violence against children?

- i) Health-worker training can improve knowledge of CM reporting laws, accuracy in recognizing CM, and clinical expertise in reporting (Alvarez et al., 2010; Narayan, Socolar, & Claire, 2006).
- ii) Risk assessment and behavioural interventions in pediatric clinics (such as the Safe Environment for Every Kid (SEEK) model) can help in reducing abuse and neglect outcomes for young children (Selph, Bougatsos, Blazina, & Nelson, 2013).
- iii) Cognitive behaviour therapy may have a positive impact on the sequelae of child sexual abuse (Macdonald., Higgins, & Ramchandani, 2007).
- iv) Early placement of maltreated children in stable foster care can improve outcomes, compared with young people who remain at home or those who reunify from foster care (MacMillan et al., 2009).
- v) Integration of empirically validated substance abuse and trauma treatments into IPV interventions shows some promise and manualised child trauma treatments are effective in reducing child symptoms secondary to IPV (Stover, Meadows, & Kaufman, 2009).
- vi) Specifically targeted and tailored parenting programs such as the ‘Incredible Years’ can contribute to improvements in parenting practices (Letarte, Normandeau, & Allard, 2010), the Positive Discipline in Everyday Parenting is a promising anti-punitive parenting program (Durrant et al., 2014), and the ACT Raising Safe Kids Program is an evidence-based intervention that teaches caregivers positive parenting skills and prevents violence (Pontes, Siqueira, & Williams, 2019).

6. Launch of the VAC policy statement and recommendations for action

Given our key collaborators were Know Violence in Childhood and we were part of the Global Partnership to end Violence against children, we advocated a child-rights-based approach as the core plank of any action on VAC, and we also ensured that our recommendations were complementary to and in synergy with, other global and regional efforts. In 2016, the WHO along with the End Violence Against Children Partnership launched INSPIRE, the seven strategies to end VAC globally (WHO, 2016). The strategies with the cross-cutting activities of inter-sectoral coordination and monitoring and evaluation, include:

- i) Implementation and enforcement of laws;
- ii) Norms and values;
- iii) Safe environments;
- iv) Parent and caregiver support;
- v) Income and economic strengthening;
- vi) Response and support services; and
- vii) Education and life skills.

Our position statement “Violence against children of the world: Burden, consequences and recommendations for action” was fittingly launched at the first ever South Asia Regional Conference on Child Rights (Raman, Kadir, Seth et al., 2017). We made recommendations for action requiring commitments at the global, regional and national levels. We stressed that all international professional bodies representing health, education, justice and social welfare professionals working with children such as the IPA and ISPCAN need to endorse and ensure mandatory VAC training at the national level, available as part of the core curriculum in their professional streams. Our call to action to end all VAC suggested the following as priorities:

- *Addressing children living in humanitarian contexts:* As the majority of displaced and refugee children live in low resource settings and two thirds of displaced children reside within their country of origin (UNHCR, 2010), international agencies and international professional associations should 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.
- Given the intersections between violence against women and VAC (Guedes, Bott, Garcia-Moreno, & Colombini, 2016) and 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, 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 including the education sector, NGOs and research bodies.
- At the policy level, inter-sectoral action across all levels— can contribute to the generation of relevant and effective public policy.

7. Progress with implementation of recommendations and advocacy

As interdisciplinary cooperation and training in the prevention and response to VAC was a core deliverable of the tripartite agreement between ISSOP, ISPCAN and IPA, we undertook a series of plenary presentations and training workshops in regional and global conferences between 2017 and 2019. ISPCAN regional conferences in Europe and the Arab region served to promote the global position statement (Raman, Kadir, Aa et al., 2017, 2017b), and we got further global traction from the editorial in The Lancet group (Raman, Muhammad et al., 2018). Targeted and contextually tailored training workshops were delivered: a) in Bali for pediatricians from the Asia-Pacific region (Raman, 2018) in Guwahati for Indian sub-continent pediatricians (Raman, 2019c), and 2019c) in Panama City for pediatricians from Latin America (Raman, Rubio, & Guys, 2019). A major strength of the position statement was highlighting various typologies of violence and specific areas of concerted action, therefore we developed specialised training modules. Professional development on gender-based violence for inter-disciplinary child health and welfare professionals was provided in Prague (Raman, Bennett et al., 2018), and for Pacific healthcare professionals in Port Moresby (Raman, 2019a). Since a major focus of our collaborative action on VAC was on children living in humanitarian circumstances, we held a special Child Protection and Promotion in Armed Conflicts workshop, as part of the ISSOP conference “Children in Armed Conflict” in Beirut (Raman, 2019b). All the training workshops were evaluated, with very positive feedback. All advocacy efforts and training activity have involved an equal partnership between the three organisations. Although impact at a community or population level is not measurable, a tangible flow on effect of this collaboration has been the ongoing commitment by ISSOP, ISPCAN and IPA to joint advocacy and action on key issues such as children on the move, children living in humanitarian contexts and most recently a child rights and equity response to COVID-19. The Budapest Declaration on children and youth on the move was supported and endorsed widely (Goldhagen, Kadir, Fouad, Spencer, & Raman, 2018); the Beirut conference on Children in Armed Conflict had strong involvement of the tripartite collaboration and the COVID-19 research and advocacy working group has already developed an editorial (Raman et al., 2020), a declaration, a position statements and research repository.

There have been challenges with pursuing a focused advocacy agenda to end VAC however. Principally, health professional organisations (e.g. Pediatric societies) may not view VAC as a health issue, or may not give the issue the priority it is due, given the many other priorities in child health globally. Getting professional development and training workshops on VAC into Pediatric conferences has taken a lot of negotiation and has not been easy. Pharmaceutical companies that invest huge resources into medical conferences are not likely to support workshops on VAC. Professionals dealing with children on the margins also have many competing priorities. For example those working with street and working children may focus on providing them much needed healthcare and nutrition, health professionals working with refugee children and those exposed to conflict may focus principally on nutrition and infectious diseases. Using the language of rights can be seen as needlessly “political”. Broadening the definition and conceptual framework of violence against children also has been challenging. However, we cannot underestimate the sheer power of child health and welfare professionals, policy makers and researchers coming together across geographical boundaries on a shared platform and speaking the same language.

8. Ending violence against children: a call to action

As we have stated at the outset, violence against children is universal and widespread – it occurs in all countries, rich or poor. Violence also features in every stage of childhood, from prenatal to age 18 years. There is a moral imperative to end VAC and we have shown that it is possible for disparate groups and agencies to work together using a child-rights based approach, towards this goal. The research exists, the recommendations are clear – we need governments at all levels to shift their lens to acknowledge all typologies of VAC in all forms, so that resources can be allocated and integrated into their policies and implementation plans to end VAC now. In the words of the immortal Gabriel Mistral “Many of the things we need can wait... the child cannot wait.” We need to continue to work together on a shared agenda to end VAC within a generation—this agenda must resonate in the corridors of homes, schools, hospitals, communities and governments. The benefits of ending VAC are paramount in resolving so many long-term conditions afflicting communities globally. By making this a focus today, we will be preserving and ensuring a prosperous tomorrow, for children are those to whom we entrust the future.

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