

EVIDENCE REVIEW

How Strengthening Health System Capacity to Address Violence Can Improve Child, Adolescent and Maternal Health



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Acronyms and abbreviations

ACE	Adverse childhood experience
ADHD	Attention deficit hyperactivity disorder
DALY	Disability-adjusted life year
EASE	Early Adolescent Skills for Emotions
EQUIP	Ensuring Quality in Psychosocial and Mental Health Care
GBD	Global Burden of Disease
IASC	Inter-Agency Standing Committee
ICD-11	International Classification of Diseases, 11th Revision
ICVAC	International Classification of Violence against Children
LIVES	Listen, Inquire, Validate, Enhance safety and Support
LIVES CC	LIVES plus Child- and adolescent-friendly environments and Caregiver support
mhGAP	Mental Health Gap Action Programme
MHPSS	Mental health and psychosocial support
MNCAH	Maternal, Newborn, Child and Adolescent Health
PTSD	Post-traumatic stress disorder
STI	Sexually transmitted infection
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNODC	United Nations Office on Drugs and Crime
WHO	World Health Organization



Section 1.

Introduction and background

1.1 Rationale: Why violence is a health issue

Violence is a global public health problem as well as a human rights violation

The United Nations Children's Fund (UNICEF), the World Health Organization (WHO) and the United Nations have recognized violence against children and violence against women as human rights violations and global public health problems.^{1,2,3}

Violence against children, adolescents and caregivers is widespread

Globally, UNICEF estimates that two of every three (approximately 1.6 billion) children regularly experience psychological aggression or physical punishment by caregivers in the home, and one in four (around 610 million) children live with a mother who has experienced physical, sexual or emotional intimate partner violence in the past year.⁴ Analyses of Global Burden of Disease (GBD) data suggest that among individuals aged 15 and older who were alive in 2023, an estimated 1 billion had experienced some form of sexual violence during childhood.⁵ WHO estimates that almost one in three women and girls aged 15 and older have experienced physical and/or sexual intimate partner violence ever in life and/or non-partner sexual violence since turning age 15.⁶ Meanwhile, the number of children living in conflict zones has increased by an estimated 60 per cent since 2010.⁷

Violence has adverse health consequences for children, adolescents and caregivers

Violence against children and adolescents has serious consequences for physical, sexual, reproductive and mental health – both in the short term and through the life course.^{8,9,10,11} Child and adolescent exposure to violence against others, including community violence such as armed conflict¹² and intimate partner violence against women in the home,^{13,14} has been linked to similar negative health consequences. Meanwhile, growing evidence suggests that intimate partner violence during pregnancy¹⁵ and mistreatment of women and girls during maternity care¹⁶ may have adverse consequences for maternal and newborn health outcomes.

The health sector has the potential to prevent violence and mitigate health consequences

Global evidence and international guidance indicate that the health sector has an important role to play in violence prevention and response.¹⁷ Health workers are often among the first service providers to reach children and adolescents living in vulnerable situations, including those not in school. They have an opportunity to provide a beneficial first-line response, as well as an entry point for referrals to other sectors, such as child protection.^{18,19} Because violence contributes to negative physical and mental health outcomes⁸ and may pose a barrier to effective health programming (as explored in section 4), greater attention to violence may help clinical health services and community-based health programming achieve progress towards important health-related objectives.³

For all these reasons, strengthening health system capacity to address violence fits within UNICEF's core mission to protect the health, well-being and human rights of children, adolescents and women.²⁰

1.2 History of efforts to mobilize health system responses to violence

Over the past 30 years, the United Nations, WHO, UNICEF and other international organizations have increasingly called on health systems to play a greater role in preventing and responding to violence against children and adolescents, as well as violence against women and girls, as part of comprehensive multisectoral violence prevention and response. Annex A presents a timeline of select milestones in that effort, which shows clear progression in:

- recognizing violence as a public health problem and documenting health consequences for children, adolescents and women;^{21,22,23,24,25,26,27,28,29}

- calling for greater attention to health sector prevention and response strategies that include attention to intersections between violence against children and adolescents and violence against women and girls;^{30,31,32}
- translating evidence into clinical, health system and multisectoral guidance for preventing and responding to violence in more integrated, survivor-centred and gender-responsive ways;^{3,18,19,30,31,33,34,35,36,37,38}
- strengthening health systems capacity, implementation and accountability;^{17,39,40} and
- updating evidence-based frameworks for preventing and responding to violence against women and violence against children.^{41,42}

Despite this progress, there is still much to be done. For example, large gaps remain between evidence-based guidance and implementation, especially in low- and middle-income countries – both for violence against children^{39,43} and violence against women.⁴⁴ Governments, health systems, institutions and health workers often continue to view violence against children solely as a child protection matter, particularly as a social work concern, without considering the ways in which violence affects physical and mental health. Many countries lack clinical guidelines or protocols for responding to violence against children or national plans or policies that address violence as a strategic priority for the health sector.^{39,43,44,45} Resource constraints, lack of political will and evidence gaps about sustainable, effective health system responses also pose barriers,^{38,46} as do gaps in what is known about how health services should address intersections between violence against children and violence against women.⁴⁷

1.3 Purpose and scope of this review

In 2017, UNICEF's Child Protection Section developed a global [theory of change for preventing and responding to violence against children and adolescents](#) that included health systems and institutions as one component of multisectoral prevention and response (Annex B).² Building on that earlier work, this review summarizes evidence about why and how health systems should pay greater attention to violence as a **health issue**, with implications for all health-related programming, both clinical and community-based.



In keeping with UNICEF's priority focus on children and adolescents,⁴⁸ this review focuses on the implications of violence for the health of children and adolescents, including violence they experience directly and intersections with violence against women. It also covers violence against women and girls during pregnancy and maternity care, given evidence that maternal health has important consequences for pregnant adolescents, newborns and children, as well as UNICEF's long-standing commitment to improving the survival, health and well-being of pregnant women and new mothers.⁴⁸

This review encourages health systems to strengthen capacity to prevent and respond to violence, mitigate harm and protect health and human rights as part of a comprehensive, multisectoral response. It highlights evidence that strengthening health system capacity to prevent, respond to and integrate attention to violence across all health programming has the potential to improve the effectiveness of health programming – and therefore protect the health, well-being and human rights of children, adolescents and their families.

Intended audience and scope

This evidence review was written for UNICEF staff as a priority audience, but it may be helpful for anyone working in or in partnership with the health sector (*see Box 1*), particularly in low- and middle-income countries, including policymakers, programme managers, researchers and health workers. Given the importance of multisectoral collaboration for comprehensive violence prevention and response,^{37,49} this review may also be useful for those working in sectors such as child protection, education, social welfare and justice.

Box 1. Definitions of the health sector and health system

Health sector refers to all public and private entities and individuals whose primary purpose is to promote, restore or maintain health, including organizations, departments and ministries, programmes, community groups, professionals and health workers of all kinds. Examples include hospitals, emergency departments, clinics and primary health care facilities, community health workers, and clinical and public health programmes addressing child and adolescent health, maternal and newborn health, immunization, nutrition, hygiene, HIV, sexual and reproductive health and mental health.

Health system encompasses all health sector organizations, programmes and individuals described above, together with the broader arrangements through which they are governed, financed, regulated, resourced, supported and coordinated. These include the policies, regulations, governance, financing, infrastructure, community engagement, information systems and research that support them.

Source: Adapted from WHO⁵⁰ and UNICEF⁵¹ publications.

1.4 Methods used to develop this review

This report presents a narrative review of the global scientific journal literature and publications by international organizations, such as UNICEF and WHO. This review was based on a broad and structured, but not systematic, evidence search that prioritized systematic reviews, meta-analyses, large multi-country studies and other influential peer-reviewed journal articles published by July 2026 in English, French or Spanish. The search aimed to capture global evidence, with a priority focus on low- and middle-income countries. Annex C provides more details about the

search. Section 4 was also informed by personal communication with colleagues implementing or evaluating health programming in low- and middle-income countries.

1.5 Structure and content of this review

This review is divided into five sections:



Section 1

provides background information on violence as a health issue, including the rationale for this review, definitions of violence against children, prevalence estimates and relevance to Sustainable Development Goals.



Section 2

reviews evidence about the short- and long-term health consequences of violence against children and adolescents, child exposure to armed conflict and intimate partner violence against women, and violence against women and girls during pregnancy and delivery.



Section 3

summarizes lessons learnt about why and how health systems – including clinical services and community health programmes – can and should address violence, even in resource-constrained settings.



Section 4

explores opportunities to integrate greater attention to violence within specific areas of UNICEF's health programming, both to strengthen violence prevention and response and to improve the quality and effectiveness of programmes that aim to achieve other health-related outcomes.



Section 5

concludes by summarizing key points and calling for greater attention to violence throughout all health programming by using a systems approach, ensuring survivor-centred care and aligning protocols with international, evidence-based practice – grounded in a commitment to human rights, gender equality and protection of those living in vulnerable situations.

1.6 Definitions and conceptual frameworks

Violence includes physical, sexual and psychological acts, as well as deliberate neglect

Article 19 of the Convention on the Rights of the Child defines violence against children as “all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse”.¹ In keeping with the International Classification of Violence against Children (ICVAC),⁵² UNICEF classifies violence against children into six categories (see Box 2).



Box 2. International Classification of Violence against Children (ICVAC)⁵²

Violent killing	Any deliberate, unwanted and non-essential act that leads to death or intends to cause death
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Physical violence	Any deliberate, unwanted and non-essential act that uses physical force against the body of a child and that results in or has a high likelihood of resulting in injury, pain or psychological suffering
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Sexual violence	Any deliberate, unwanted and non-essential act of a sexual nature, either completed or attempted, that is perpetrated against a child, including for exploitative purposes, and that results in or has a high likelihood of resulting in injury, pain or psychological suffering
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Psychological violence	Any deliberate, unwanted and non-essential act, verbal and non-verbal, that harms or has a high likelihood of harming the development of a child, including long-term physiological harm and mental health consequences
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Neglect	The deliberate, unwanted and non-essential failure to meet a child's physical or psychological needs, protect a child from danger, or obtain medical, educational or other services when those responsible for the child's care have the means, knowledge and access to services to do so
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Other acts	Other acts of violence against a child not elsewhere classified
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Violence is a type of adverse childhood experience, with lifelong implications for health

Understanding the short- and long-term health consequences of violence for children and adolescents requires attention to the large body of evidence on violence as one type of adverse childhood experience (sometimes called an ACE), defined by researchers¹¹ as potentially traumatic or highly distressing experiences, such as:

- physical, sexual and psychological violence against children;
- child neglect;
- child exposure to intimate partner violence in the household;
- child exposure to armed conflict;
- caregivers with substance abuse or mental health conditions;
- separation from parents (e.g., due to divorce, incarceration, death, migration); and
- severe material deprivation (e.g., due to natural disasters).

More recently, researchers have argued for expanding the definition of adverse childhood experiences to include racial and ethnic discrimination.⁵³

Decades of evidence from high-income countries⁵⁴ and growing evidence from low- and middle-income countries⁵⁵ indicate that exposure to violence and other types of adverse childhood experiences may have profound and long-term negative physical and mental health consequences for children and adolescents – and that multiple adverse childhood experiences may have compounding and cumulative health effects.⁵⁶

1.7 Magnitude of violence

Violence against children and adolescents is widespread

Prevalence data on violence against children and adolescents remain fragmented. Many countries lack population-based surveys on prevalence; surveys often measure a limited set of acts, contexts or perpetrators; stigma and fear of retaliation pose barriers to disclosure; and many countries lack robust health surveillance systems.^{57,58} Population-based data for select types of violence are growing, however.^{59,60} For example, global estimates suggest the following findings:

- Two in three (1.6 billion children) regularly endure violent discipline by caregivers in the home, including psychological aggression and physical punishment.⁴
- Corporal punishment of children in schools remains widespread in many regions, with reported lifetime prevalence above 70 per cent of children in studies from Africa and Central America.⁶¹

- Almost one in three students aged 11–15 years (32 per cent) report having been bullied by peers in the past month.⁶²
- Among individuals aged 15 or older who were alive in 2023, about 1 billion had experienced sexual violence before age 18.⁵
- Around one in eight (more than 370 million) girls and women alive today experienced rape or sexual assault during childhood.⁵⁹
- Around 1 in 11 (between 240 and 310 million) boys and men alive today experienced rape or sexual assault during childhood.⁵⁹
- Among general or school populations, between 1 and 5 per cent of boys report child sexual exploitation (exchanging sex in return for money, drugs or necessities), with higher rates reported by boys living in vulnerable situations.⁶³
- WHO estimates that in 2023, almost one in six (16.0 per cent) ever-partnered adolescent girls aged 15–19 had experienced physical and/or sexual intimate partner violence in the past 12 months, as had more than one in five (23.3 per cent) ever in life.⁶
- WHO also found that the past-12-month prevalence of physical and/or sexual intimate partner violence was significantly higher among adolescent girls aged 15–19 and young women aged 20–24 than among women aged 45 years and older.⁶
- In 2024, verified grave violations against children in conflict reached their highest level since United Nations monitoring began in 2005, a 30 per cent increase from 2023; these include killing and maiming, recruitment by armed forces, rape and other forms of sexual violence, abduction, attacks on schools and hospitals, and denial of humanitarian access.⁷
- A systematic review and meta-analysis of data from 57 countries estimated that in those select countries with data, in the past 12 months, 12.5 per cent of internet-using children had experienced online sexual solicitation, 4.7 per cent had experienced online sexual exploitation (offers of money or goods in exchange for sexual images, videos or acts) and 3.5 per cent had experienced sexual extortion, with wide variations across studies.⁶⁴

Children and adolescents are often exposed to violence against others

For example:

- UNICEF estimates that one in four (approximately 610 million) children live with a mother who has experienced physical, sexual or emotional intimate partner violence in the past year.⁴
- In 2024, an estimated 520 million children (about 20.7 per cent of the global child population) lived within 50 km of an armed conflict – the highest number ever recorded, representing a 60 per cent increase since 2010.⁷

Violence against women and girls is also widespread

For example, estimates suggest:

- More than one in four (680 million) women and girls aged 15 and older have been subjected to physical and/or sexual intimate partner violence at least once in life.⁶
- Nearly one in three (840 million) women and girls aged 15 and older have experienced physical and/or sexual intimate partner violence ever in life and/or non-partner sexual violence since turning age 15.⁶
- About 9 per cent of ever-pregnant women and girls have experienced physical intimate partner violence during pregnancy,⁶⁵ with wide variations by country and region.⁶⁶
- Disrespect and mistreatment during labour and delivery by maternal care providers are widespread worldwide.^{67,68} Pooled estimates suggest that 37 per cent of those who give birth experience non-consented care and 28 per cent experience some form of physical mistreatment.⁶⁷

1.8 Variations by age, sex and situations of vulnerability

Prevalence and patterns of violence vary by age and sex

For example:

- Evidence suggests a bimodal age distribution of child homicide, with deaths concentrated in early childhood (ages 0–4) and adolescents aged 15 and older, with lower rates in middle childhood (ages 5–14).²⁸
- Young children are predominantly killed by family members, while adolescents are increasingly likely to be killed by someone outside the family as they get older, with adolescent boys particularly at risk from organized crime and gang-related violence.⁶⁹
- Homicide rates among girls and boys are similar in early childhood, but start to diverge around age 14, when rates among boys begin to rise rapidly relative to girls.⁶⁹
- An analysis of 2019 GBD data found that the mortality rate from interpersonal violence among young people aged 10–24 was almost six times higher among males than females (9.3 vs 1.6 per 100,000), whereas the burden of sexual violence was disproportionately borne by females, with over double the disability-adjusted life years (DALYs)ⁱ lost among females compared with males (DALYs: 42.8 vs 17.5 per 100,000).⁷⁰
- Globally, around 1 in 5 women aged 20–24 married or started cohabiting with a partner as children⁷¹ compared with around 1 in 37 men.⁷² Estimates suggest that child marriage raises girls' odds of lifetime intimate partner violence by approximately 42 per cent.⁷³

i DALYs represent a combined measure of premature death and years lived in ill health.

Children and adolescents living in situations of vulnerability face higher risks

Certain children and adolescents face a greater risk of violence due to situations of vulnerability,² such as:

- living with disabilities;⁷⁴
- in institutional care or deprived of liberty;²
- unaccompanied or separated from family;²
- on the move (e.g., migrants, refugees, asylum seekers and internally displaced persons);²
- living with HIV;⁷⁵
- girls who marry or cohabit with a partner before age 18;⁷³
- facing discrimination based on sexual orientation or gender identity;^{76,77}
- marginalized social or ethnic identities or national origin;⁷⁸ and
- other social or economic disadvantages.

Discrimination against children based on racial background, ethnic identity or national origin is itself sometimes considered a form of structural violence.⁷⁹ Evidence suggests it may increase the risk of poor health outcomes as well as other forms of violence, as highlighted by the Lancet commission on racism and child health.⁷⁸



1.9 Relevance to Sustainable Development Goals

Greater health system attention to violence could help countries make progress towards many Sustainable Development Goal targets – not only violence-reduction targets under Goals 5 and 16, but also health-related targets under Goal 3 (see Box 3).⁸⁰

Box 3. Select examples of Sustainable Development Goal targets relevant to violence



Goal 16. Peace, justice and strong institutions

Target 16.2 End abuse, exploitation, trafficking and all forms of violence against and torture of children.



Goal 5. Gender equality

Target 5.2 Eliminate all forms of violence against all women and girls in the public and private spheres, including trafficking and sexual and other types of exploitation.

Target 5.6 Ensure universal access to sexual and reproductive health and reproductive rights.



Goal 3. Good health and well-being

Target 3.1 Reduce the global maternal mortality ratio.

Target 3.2 End preventable deaths of newborns and children under 5 years of age.

Target 3.3 End the epidemics of AIDS ... hepatitis ... and other communicable diseases.

Target 3.4 Reduce by one third premature mortality from non-communicable diseases ... and promote mental health and well-being.

Target 3.5 Strengthen the prevention and treatment of substance abuse.





Section 2.

How violence affects child, adolescent and maternal health

2.1 Violence has profound consequences for child and adolescent health

Research on the consequences of violence for the health of children and adolescents has expanded rapidly in recent years, both globally and from low- and middle-income countries,⁸ as illustrated by the systematic reviews in Annex D. This evidence indicates that violence against children and adolescents (including neglect) often has profound, long-lasting negative effects on physical health, sexual and reproductive health, mental health, and child and adolescent development.^{8,9,10,11} Even when children and adolescents do not experience violence directly themselves, they often experience negative health consequences when exposed to violence against others, including armed conflict^{12,81,82} and intimate partner violence against women.^{13,14}

Health consequences of violence may be immediate and **direct**, such as physical injury, unintended pregnancy or psychological distress, as well as **indirect**, often occurring later in life, sometimes mediated by stress reactions to traumatic experiences, high-risk behaviours or intergenerational effects (see Figure 1). Long-term, adverse consequences through indirect pathways may include an increased risk of chronic disease, disability and even premature death later in life.^{11,56,83,84}

Non-lethal physical injuries

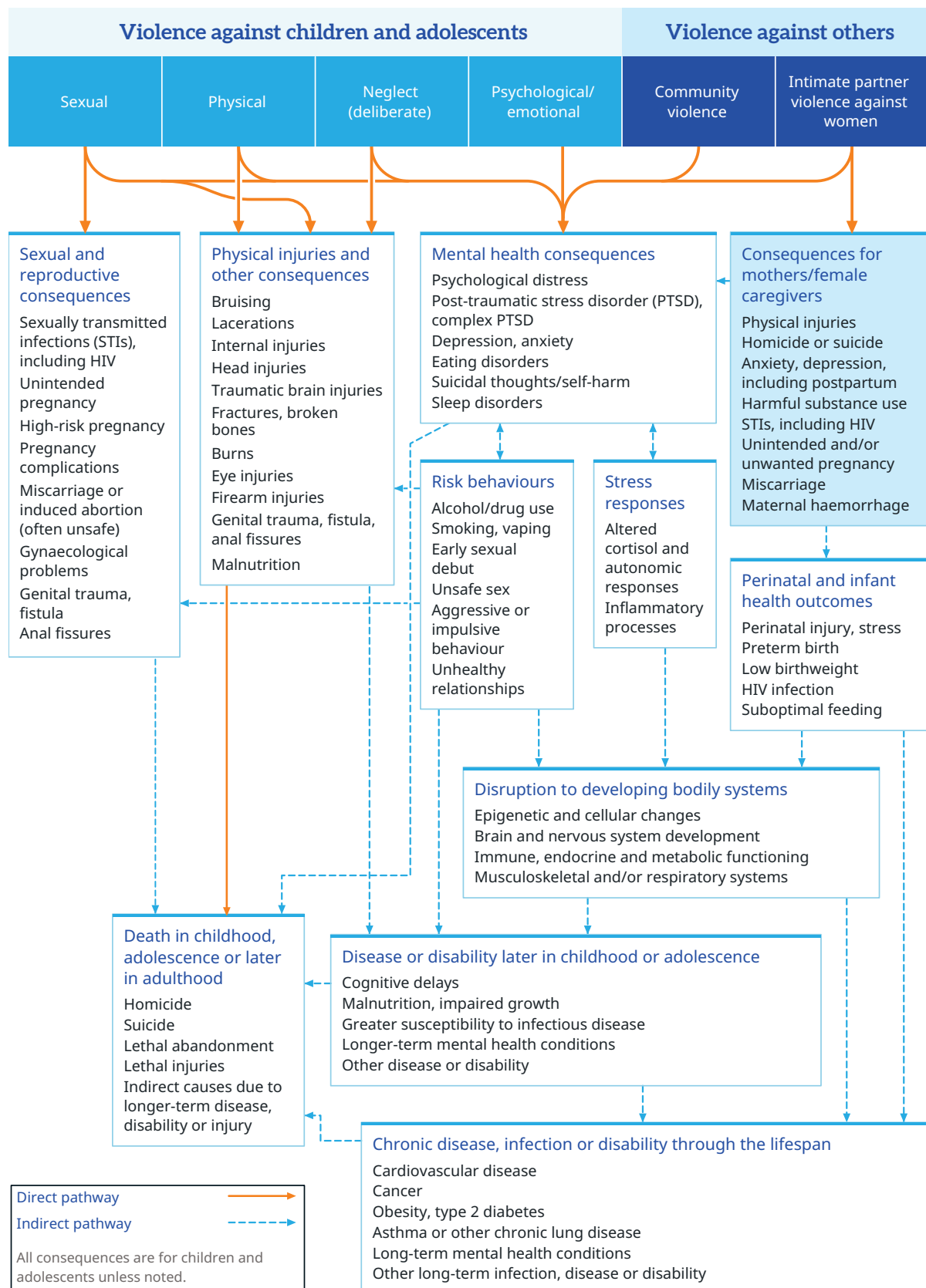
Physical violence may produce non-lethal physical injuries. For example:

- Physical violence against children and adolescents may result in bruising, lacerations, internal injuries, head injuries, eye injuries, burns, fractures and broken bones.⁸
- Cutaneous injuries such as bruises are common clinical signs in confirmed cases of child physical abuse in high-income settings.^{85,86}
- Data from low- and middle-income countries are more limited, but hospital and forensic studies from India,⁸⁷ Malaysia,⁸⁸ Mozambique⁸⁹ and South Africa⁹⁰ similarly report that bruises and other soft-tissue injuries, as well as fractures and head injuries, are common in cases of confirmed or suspected physical child abuse.
- Traumatic brain injury is an important physical sequela of violence against children and adolescents,⁸ but accurate estimates of its magnitude are challenging, because it mimics injuries from unintentional causes and has non-specific symptoms that are easy to overlook or misdiagnose.^{85,86}
- Abusive head trauma is a medical diagnosis of a brain injury caused by violent shaking, blunt impact or both.⁹¹ Studies suggest it is a leading cause of serious head injuries in children under 2 years of age, with peak incidence around 2 months of age.⁹² Children who survive are often left with lifelong neurological, visual or developmental impairment.⁹¹
- The magnitude of physical injuries from violence can be difficult to estimate, in part because health workers cannot always rely on children, adolescents or caregivers to report causes of injury when a perpetrator is close to the victim, and many injuries are likely misattributed to unintentional causes.^{85,86}

Physical injuries may also result from sexual violence and neglect. For example:

- Sexual violence against girls may cause genital trauma, while sexual violence against boys and girls may cause bruising and anal injuries, sometimes severe enough to require intensive care or surgery – as documented in hospital-based studies from settings as diverse as Canada and Mozambique.^{89,93}
- Childhood neglect has been linked to physical injuries, untreated illness, poor oral health, malnutrition and impaired growth; however, this is an understudied issue, and most studies come from high- or middle-income countries.⁹⁴

Figure 1. Examples of direct and indirect pathways by which violence leads to negative health consequences for children and adolescents



Lethal consequences (homicide, suicide and indirect causes of death)

Violence, including deliberate neglect, may have direct and immediate lethal consequences for children and adolescents due to homicide and fatal injuries.^{95,96} Violence may also contribute to premature mortality later in life through indirect pathways, including long-lasting consequences of injuries, damaging effects of stress on developing bodily systems during childhood, mental health conditions, chronic disease and disability, risk behaviours and suicide.^{5,97,98} For example, estimates suggest:

- Globally, approximately 71,600 children under 18 were victims of homicide in 2021, and the majority (67 per cent) were boys.⁶⁹
- Homicide is among the top four causes of death among adolescents globally, with males accounting for more than 80 per cent of both victims and perpetrators.⁹⁹
- In 2019, homicide accounted for about 1 in 10 deaths among children and adolescents in Latin America and the Caribbean; it was the leading cause of death among adolescents aged 10–19.¹⁰⁰
- Between 1995 and 2015, more than 10 million deaths among children younger than age 5 worldwide could be attributed to armed conflict, largely through indirect pathways.¹²
- In 2024, self-harm was the leading global cause of death among adolescent girls aged 15–19 and the third leading cause among boys aged 15–19.¹⁰¹
- Interpersonal violence and self-harm are among the leading global causes of injury-related deaths and DALYs among adolescents aged 15–19.⁹⁶ In the Eastern Mediterranean, they were **the** leading cause among children and adolescents aged 0–19 in 2017.¹⁰²
- Mortality rates and DALYs attributed to self-harm and interpersonal violence among children and adolescents increased in many countries between 1990 and 2019, even as those from unintentional injuries declined.⁹⁶
- A meta-analysis found that individuals who have a history of child maltreatment have nearly twice the odds of subsequent mortality compared with those who do not.⁹⁸

Mental and emotional health consequences

Systematic reviews, including evidence from low- and middle-income countries, indicate that all forms of violence in childhood and adolescence may have adverse emotional, mental, developmental and behavioural consequences, both in the immediate aftermath of violence and later in life, including:

- psychological distress;¹⁰³
- acute stress reactions and post-traumatic stress disorder (PTSD) (*see Box 4*);^{103,104}
- depression and anxiety;^{8,103,104,105,106}
- eating disorders;^{8,105}
- behavioural disorders and other externalizing problems;^{103,105}
- sleep problems;¹⁰⁷

- harmful alcohol, tobacco and drug use;^{8,105} and
- suicidal ideation, planning and attempts.^{8,105,108,109}

An analysis of 2021 GBD data estimated that bullying (peer violence) and childhood sexual abuse accounted for a substantial global burden of DALYs among adolescents and young adults, attributable to major depressive disorder, anxiety and alcohol-use disorders.¹¹⁰ In 2023, among males and females aged 15 years and older, sexual violence in childhood accounted for an estimated 6.71 million DALYs from self-harm and 3.93 million from major depressive disorder.⁵

Exposure to violence against others has also been linked to adverse mental health outcomes. For example, a systematic review found that child and adolescent exposure to community and gang violence, armed conflict and bullying were associated with a greater risk of substance abuse, externalizing behaviours, depression, anxiety and PTSD.¹¹¹ Similarly, a systematic review and meta-analysis found that on average, 29.4 per cent of young people aged 10–24 exposed to war-related traumatic events experienced PTSD, with heterogeneity across studies.¹¹²

Even when symptoms do not meet diagnostic criteria for a mental health condition, distress caused by violence can shape a child's thoughts, feelings and behaviours, affecting a range of lifelong outcomes, including relationships, coping strategies and executive function.¹¹³ However, evidence suggests that support from caring adults and communities can buffer the effects of potentially traumatic experiences.¹¹⁴

Box 4. WHO definitions of stress reactions and traumatic stress disorders

- **Acute stress reactions** include emotional, somatic, cognitive or behavioural symptoms, such as sadness, anxiety, anger, despair and social withdrawal, as well as substance use and risk-taking in adolescents. These symptoms may subside within a short time after the traumatic event(s). These reactions are not classified as a mental disorder.
- **PTSD** is marked by symptoms that last at least several weeks after the traumatic event(s) and includes re-experiencing the event(s) in the present, deliberate avoidance of reminders, a heightened sense of current threat and significant impairment in functioning.
- **Complex PTSD** includes symptoms of PTSD as well as severe difficulties regulating emotions, persistent negative beliefs about oneself, difficulties sustaining relationships and significant impairment in functioning. Children and adolescents are particularly vulnerable to complex PTSD when exposed to severe, prolonged or repeated traumatic events, including chronic child abuse.

Source: *Clinical Descriptions and Diagnostic Requirements for ICD-11 Mental, Behavioural and Neurodevelopmental Disorders*, WHO, Geneva, 2024.¹¹⁵

Stress responses to traumatic experiences

Growing evidence suggests that stress responses to traumatic experiences may affect multiple bodily systems during sensitive periods of child development,¹¹⁶ sometimes weakening immune systems, increasing susceptibility to infection and possibly altering brain architecture and nervous system development.¹¹⁷ For example, systematic reviews and meta-analyses have found associations between childhood adversity, including violence, and physiological changes such as:

- altered stress-response and cortisol activity;¹¹⁸
- increased inflammatory activity;^{119,120}
- altered immune functioning;¹²¹
- changes in brain development and functioning;¹¹⁷
- metabolic changes;¹²²
- epigenetic changes and accelerated cellular ageing;¹²¹ and
- cumulative strain across cardiovascular, immune, metabolic and stress-response systems.¹²²

Responses to stress are one possible mechanism by which violence in childhood may affect long-term physical and mental health into adulthood.¹¹ Evidence suggests that stress responses to traumatic experiences may have cumulative effects, with dose-response gradients and greater harm associated with multiple or prolonged periods of stress.⁸⁴ Researchers emphasize, however, that these are population-level findings, and a history of childhood violence does not determine how an individual child or adolescent will respond to adversity, especially when supportive caregivers and communities are available to buffer the effects.⁸⁴

Early childhood social/emotional and cognitive development

A growing number of studies from low- and middle-income countries have documented associations between many different types of violence and children's social, emotional and cognitive development. For example, a multi-level meta-analysis of 189 studies from 92 low- and middle-income countries¹²³ found that physical punishment and verbal aggression by caregivers were significantly associated with outcomes such as:

- mental health problems;
 - worsened parent-child relationships;
 - substance use;
 - impaired social-emotional development;
 - negative academic outcomes; and
 - externalizing behaviour problems.
- "Violence can be particularly detrimental in ... early years due to the rapid and context-dependent development of the brain and key skills, including executive function and self-regulation."
– Draper et al., 2024¹²⁴

Similarly, an analysis of national data from 49 low- and middle-income countries found that children who were physically punished by caregivers were about 24 per cent less likely to be

developmentally on track than other children.¹²⁵ Even widely accepted acts such as spanking have been associated with elevated neural responses, similar to more severe forms of maltreatment.¹²⁶ Negative impacts on cognitive and social-emotional outcomes have also been found for corporal punishment,¹²⁷ as well as on learning outcomes from corporal punishment in schools, including by UNICEF's longitudinal research in Ethiopia, India, Peru and Viet Nam.¹²⁸

Risk behaviours

Evidence suggests that violence against girls and boys, including physical, sexual and emotional violence, as well as neglect, is significantly associated with increased risk-taking and other externalizing behaviours in adolescence and adulthood.^{129,130,131,132,133} Findings vary by type of violence, sex and setting; however, global systematic reviews, meta-analyses and multi-country studies from low- and middle-income countries find significant associations between violence in childhood (including child maltreatment and sexual abuse) and high-risk behaviours later in life, among both males and females (unless noted), including:

- smoking, harmful alcohol use or drug use;^{130,132}
- early sexual debut;¹³¹
- multiple sexual partners, transactional sex and unprotected sex;^{131,134,135}
- perpetrating violence against others;^{129,133,136}
- women experiencing physical and/or sexual intimate partner violence;^{137,138} and
- men perpetrating physical and/or sexual intimate partner violence.¹³⁸

Risk behaviours may lead to other negative physical, mental and sexual health outcomes described in this section.⁵⁶

Sexual and reproductive consequences

Sexual violence against children and adolescents may have sexual and reproductive consequences, including anal injuries (among girls and boys), genital trauma (among girls)^{89,93} and sexually transmitted infections, including HIV. Adolescent girls who experience sexual violence face the risk of unintended pregnancy, gynaecological problems and – compared with boys and older women – a heightened risk of HIV infection, in part due to the biology of the developing cervix.^{139,140,141}

Sexual and reproductive consequences may result **directly** from sexual violence. For example, an analysis of Violence against Children Survey data from five countries (Haiti, Malawi, Nigeria, Uganda and Zambia) found that among the 10–18 per cent of adolescent girls and young adult women who had experienced forced or pressured sex, 13–37 per cent reported becoming pregnant as a result of their first or most recent experience.¹⁴² Sexual and reproductive consequences may also result **indirectly** from many types of violence, often mediated by mental health conditions and risk-taking behaviours such as unsafe sex or increased vulnerability to experiencing or perpetrating sexual violence later in life.⁵⁶

Adolescent pregnancy

Between 2000 and 2021, the birth rate among girls aged 15–19 fell by about 34 per cent.¹⁴³ Nonetheless, estimates suggest:

- In 2019, approximately 21 million pregnancies occurred among adolescent girls aged 15–19 in low- and middle-income countries; about half were unintended; and 55 per cent of those unintended pregnancies ended in abortion, often under unsafe conditions.¹⁴⁴
- Globally in 2024, out of an estimated 12.4 million live births to adolescent girls aged 10–19,¹⁴⁵ 4.7 million occurred among girls younger than age 18, with 340,000 among girls younger than age 15.¹⁴⁶
- The majority of adolescent births occur in low- and middle-income countries,¹⁴³ and in 2023, more than half of all adolescent births occurred in sub-Saharan Africa.¹⁴⁷

What proportion of adolescent pregnancies can be attributed to violence and/or harmful practices such as child marriage is unknown, but violence against girls is clearly associated with an increased likelihood of adolescent pregnancy, including unintended pregnancy.^{148,149} These links may be direct, for example, when forced sex leads to unintended pregnancy.¹⁴² Links may also be indirect; for example, researchers have found that histories of physical and/or sexual violence before age 18,¹⁵⁰ as well as child exposure to community violence,¹⁵¹ are associated with a greater likelihood of adolescent pregnancy, both in high-income¹⁵² and low- and middle-income settings.¹⁴⁸

Maternal and perinatal risks associated with adolescent pregnancy

Studies from low- and middle-income settings, including large multi-country and pooled analyses, have found that when compared with women in their 20s, pregnant adolescents and their newborns face a greater risk of adverse maternal and newborn outcomes such as:

- eclampsia, puerperal endometritis and systemic infections;^{153,154}
- severe neonatal conditions;¹⁵³
- preterm birth, low birthweight and small-for-gestational-age birth;^{154,155}
- perinatal and neonatal mortality,¹⁵⁴ highest among girls aged 10–14;¹⁵⁵
- maternal mortality,¹⁵⁴ and
- possibly obstetric fistula in some settings.¹⁵⁶

WHO estimates that in 2021, maternal conditions were among the leading causes of disease burden for girls aged 15–19 globally.^{157,158} A separate research team that used Bayesian modelling estimated that maternal conditions were the second leading cause of death among girls aged 15–19 in 2024, after self-harm.¹⁰¹ Elevated risks of adolescent childbearing may reflect incomplete physiological maturation, higher nutritional demands during adolescence, socioeconomic disadvantages and barriers to maternal health care.^{153,155}

Chronic disease and disability

A large body of evidence suggests that adverse childhood experiences, including violence, are significantly associated with higher risks of chronic disease and disability later in life, such as cardiovascular, liver, digestive and respiratory diseases, and mental health conditions.^{11,56,83} Conversely, living with a disability may be associated with an elevated risk of violence.⁷⁴ The 2023 GBD study estimated that sexual violence against children alone accounted for 32.2 million DALYs,⁵ based on associations with 14 different health outcomes, including type 2 diabetes, HIV/AIDS, harmful alcohol and drug use, anxiety disorders, bipolar disorder, bulimia nervosa, schizophrenia, asthma and major depressive disorder.

Adverse childhood experiences may have cumulative and compounding effects

A large body of evidence, including a growing number of studies from low- and middle-income countries,⁵⁵ suggests that multiple adverse childhood experiences may have cumulative and compounding effects.^{11,56,83} For example:

- An analysis of pooled, nationally representative data from five sub-Saharan African countries found strong graded relationships between cumulative exposure to adverse childhood experiences and outcomes such as adverse mental health and substance use.¹³⁶
- Analyses of nationally representative data from Honduras¹⁵⁹ and Lesotho¹⁶⁰ found dose-response associations between the number of adverse childhood experiences and outcomes such as mental distress, self-harm/suicidality, HIV risk behaviours, smoking and other health risks.
- Research from Uganda found that girls and boys who witnessed intimate partner violence **and** experienced violence directly had around twice the odds of mental health difficulties compared with those who had experienced violence themselves but had not witnessed intimate partner violence.¹⁶¹
- A 2026 systematic review and meta-analysis of 56 studies found a clear dose-response relationship between cumulative adverse childhood experience exposure and mental disorders, with risk increasing steadily as the number of adverse childhood experiences rose from one to four or more.¹⁶²
- A systematic review and meta-analysis found that adults who had experienced four or more adverse childhood experiences (including physical, sexual and/or emotional abuse) had approximately 30 times the odds of attempted suicide compared with adults who reported no adverse childhood experiences.⁵⁶

2.2 Health consequences of intimate partner violence

Consequences of intimate partner violence for the health of women and girls

Intimate partner violence against women and girls may have both short- and long-term negative health consequences, and GBD analyses suggest it was a major contributor to the global burden of ill health in 2023.⁵ That analysis attributed 18.5 million DALYs lost among women and girls aged 15 and older to intimate partner violence. It was the fourth leading risk factor for all DALYs among women and girls aged 15–49 years, based on associations with outcomes such as anxiety disorders, major depressive disorder, physical injuries and homicide, self-harm, HIV/AIDS, abortion, miscarriage, maternal haemorrhage and drug-use disorders.

Consequences of intimate partner violence for maternal and perinatal health outcomes

Systematic reviews and multi-country analyses highlight associations between intimate partner violence and adverse maternal health outcomes such as:

- inadequate antenatal care;¹⁶³
- lack of skilled care during labour and delivery;¹⁶³
- miscarriage and induced abortion;^{105,164,165}
- preterm delivery;^{164,166}
- maternal haemorrhage;⁵
- hypertensive disorders, such as gestational hypertension and pre-eclampsia;^{164,167} and
- anxiety and depression during pregnancy and/or postpartum.^{168,169}

Research also suggests that maternal stress during pregnancy – including stress from intimate partner violence – may be associated with physiological changes among newborns, including telomere length and other epigenetic markers, with implications for perinatal and infant neurodevelopment.^{170,171} This evidence suggests a possible intergenerational biological pathway by which intimate partner violence against mothers has implications for newborn health, as well as health consequences later in life.

Consequences of intimate partner violence for children of survivors

Although evidence is still emerging, systematic reviews and other studies have found evidence that children of intimate partner violence survivors have a significantly higher likelihood of many adverse health outcomes compared with other children.

Early childhood morbidity and mortality

- (In some settings) increased risk of child mortality^{14,172}
- Increased risk of diarrhoeal disease and acute respiratory infection among children under age 5¹⁴

Mental health and developmental consequences in childhood and adolescence

- Depression, anxiety and psychological distress^{173,174,175}
- PTSD and other stress reactions^{174,176}
- Emotional and behavioural issues;^{13,174}
- Aggression towards peers^{177,178}
- Poorer cognitive development and functioning (with some mixed findings)^{174,176,179}

Consequences for child nutrition and growth

Studies have found associations between intimate partner violence and adverse nutrition-related outcomes among infants and children, likely through multiple pathways, including:

- low birthweight;^{164,166}
- suboptimal breastfeeding and infant-feeding practices;^{180,181} and
- impaired linear growth, including stunting.^{14,181,182}

Intimate partner violence may affect child health through complex pathways

Researchers have proposed numerous possible pathways by which intimate partner violence may affect the health and development of children, including:

- **Girls experiencing intimate partner violence directly:** WHO estimates that in 2023, more than one in five (23.3 per cent) ever-partnered adolescent girls aged 15–19 had ever been subjected to physical and/or sexual intimate partner violence, as had 16.0 per cent in the previous 12 months.⁶
- **Maternal stress, depression and anxiety:** Studies have found that intimate partner violence is associated with maternal depression, stress and anxiety,^{168,169,183} possibly contributing to harsh or less responsive parenting,^{184,185} or – when it occurs during pregnancy – adverse newborn outcomes such as low birthweight and preterm birth.^{186,187}
- **Maternal alcohol and other substance use:** Intimate partner violence may increase substance use during pregnancy, posing a risk of impaired foetal growth and adverse newborn outcomes.¹⁸³ In a South African cohort, substance use was found to mediate associations observed between women's experience of intimate partner violence and infant growth at birth.¹⁸⁸
- **Paternal harmful alcohol use:** Men's harmful use of alcohol is consistently linked with an increased likelihood of perpetrating intimate partner violence,¹⁸⁹ has been proposed as a

possible shared risk factor for intimate partner violence and violent child discipline^{31,190,191} and has been linked to adverse child outcomes such as behavioural disorders.¹⁹²

- **Coercive control, economic abuse and social isolation:** Researchers theorize that these may contribute to adverse child outcomes by undermining survivors' economic security, mobility and social support, all of which are needed to care for their children.^{193,194}
- **Barriers to health care:** Intimate partner violence, including controlling behaviour, may pose barriers to antenatal care and skilled delivery care, potentially contributing to adverse maternal and newborn health outcomes.^{163,195}
- **Disrupted feeding:** Intimate partner violence may interfere with optimal breastfeeding and other child-feeding practices, potentially contributing to impaired growth;^{181,196} impaired growth may in turn contribute to poor early childhood development outcomes.¹⁹⁷
- **Quality of maternal caregiving:** Some studies^{198,199} suggest that intimate partner violence may undermine the quality of maternal caregiving. However, findings are mixed,^{187,200} and evidence suggests that survivors often go to great lengths to protect their children.²⁰¹ Moreover, a systematic review²⁰² identified caring maternal relationships as an important factor that may protect children from adverse effects.
- **Quality of paternal caregiving:** Some evidence suggests that men who abuse their partners are more likely to use harsh discipline against their children¹³⁸ and less likely to provide parental stimulation, with adverse consequences for child development.¹⁹⁹
- **Co-occurring violence against children:** Evidence suggests that children in households affected by intimate partner violence are more likely to experience violent discipline than other children,^{191,203} which is a known correlate of negative child health and development outcomes.⁶⁰
- **Child and adolescent stress and distress:** Exposure to intimate partner violence may generate chronic fear and stress among children, with adverse emotional, developmental and behavioural consequences.^{175,187,204}

2.3 Health outcomes of mistreatment during maternity care

Mistreatment of women and girls by maternity care workers may have adverse consequences for maternal and newborn health outcomes,¹⁶ with pregnant adolescent girls and girls from marginalized groups at particular risk.^{205,206} In addition to a violation of rights, this mistreatment has been linked to elevated risks of prolonged labour, postpartum haemorrhage, physical injuries, disrupted newborn bonding and negative psychological consequences such as PTSD and depression.^{207,208,209,210} Fear of mistreatment is an important reason why pregnant girls and women avoid facility-based care and seek out less skilled birth attendants in some settings, contributing to poorer maternal and perinatal outcomes.^{210,211}

2.4 Health consequences of violence have high economic costs

Morbidity and mortality from violence impose heavy economic costs on societies in low-, middle- and high-income settings. For example, researchers estimated that the annual economic burden of DALYs lost due to violence against children totalled US\$151 billion in the East Asia and the Pacific region, nearly 2 per cent of gross domestic product,²¹² and US\$13.5 billion in South Africa, around 4.3 per cent of gross domestic product²¹³ – not including costs incurred by governments and societies for health care and other services responding to violence. A study from Colombia that did estimate the costs of these services found that physical intimate partner violence alone accounted for at least 16 per cent of overall health costs among women and girls aged 13–24.²¹⁴



Section 3.

Why and how health systems should address violence

3.1 State of the evidence

Despite global recognition that violence against children and adolescents is a health issue,¹⁷ governments, international organizations, health institutions and health workers often question how health systems can address violence, especially in settings with severe resource constraints. Health workers often express concerns that they do not have the knowledge, skills, time, resources or institutional support to respond to violence; that referral services in the community are inadequate; and/or that reporting cases of violence to authorities may cause harm.^{43,215,216}

Evidence about health system responses to violence against women

Evidence about why and how to strengthen health service capacity to address intimate partner violence began to emerge several decades ago, primarily from high-income countries²¹⁷ but also from low- and middle-income settings,^{218,219,220,221} and it has continued to expand, albeit slowly.^{222,223} One early lesson from all sectors, including health, was that positive, sustainable change requires more than training; changes are needed across broader institutional and workplace environments.²²⁴ In the health sector, that includes changes to normative frameworks, leadership and governance, financing, coordination and referral networks, institutional resources for service delivery, health workforce development, physical infrastructure and supplies, and information systems.²²⁵ This finding has been confirmed many times,²²³ including by recent evidence reviews.⁴¹

Evidence about health system responses to violence against children

Systematic and scoping reviews suggest that evidence about health system capacity to address violence against children and adolescents in low- and middle-income countries remains fragmented.^{43,216,226} The 2026 review of reviews,⁴² designed to update the 2016 INSPIRE framework,³⁰ included a new category of health care-based programmes in the search and found a lack of evidence, especially in low- and middle-income countries, with some exceptions such as evidence for the effectiveness of parenting support programmes and cognitive behavioural therapy for child survivors.

WHO has produced evidence-based guidance for responding to child maltreatment¹⁸ and sexual abuse of children and adolescents.¹⁹ However, the evidence reviews carried out to inform both the child maltreatment guidelines³⁸ and the sexual abuse guidelines²²⁷ found limited evidence – especially from low- and middle-income settings. One review of literature on health system responses to child and adolescent sexual abuse concluded:

“Most glaring is the under-representation of low- and middle-income (LMIC) settings in the research literature. While expert clinicians and program implementers in LMICs possess a wealth of knowledge on good practices in LMICs, much of this knowledge is tacit or written in records and program reports that are not widely available in peer reviewed publications.”
– Broaddus-Shea et al., 2021²²⁷

Those reviews found particularly limited evidence about how to strengthen supportive health systems and enable clinical environments to address child maltreatment and sexual abuse, for example through training, supervision, staff well-being, intersectoral coordination or integrated service delivery models.^{38,227} Perhaps as a result, at the time of writing, WHO has not yet published a manual for managers to strengthen whole-organization capacity to address violence against children, similar to one WHO produced for violence against adult women.⁵⁰

In high-income settings, a large body of research exists on health systems and paediatric service responses to adverse childhood experiences, including violence.^{228,229} This includes substantial attention to whole-organization frameworks such as trauma-informed care,^{230,231,232} but that framework has had limited reach in low- and middle-income countries^{43,226} and has generated debates, as discussed later in this review.

Despite these fragmented bodies of research, there is substantial and growing evidence about **WHY** and **HOW** health systems should integrate greater attention to violence, even in low-resource settings, as summarized in the rest of this section. In particular, five key themes emerge from international evidence and guidance about **HOW** to strengthen health system capacity to address violence, even in resource-constrained settings, each of which is described in later sub-sections, including:

- Implement WHO recommendations to help whole health systems address violence.
- Use a systems approach to strengthen capacity of health services.
- Align health protocols and practices with international, evidence-based guidelines.

- Ensure rights-based, gender-responsive, survivor-centred care.
- Address intersections between violence against children and violence against women.

3.2 Why health systems should pay greater attention to violence

- **To ensure that health workers do no harm:** Health workers may encounter children, adolescents and caregivers who present signs of or spontaneously disclose violence, even when staff do not ask.^{18,19,233} Health workers need basic knowledge, skills, training and institutional support to ensure that they do not cause additional harm or distress, for example by misdiagnosing health conditions, minimizing abuse, blaming victims, expressing discriminatory attitudes (e.g., based on gender or ethnic identity), breaching confidentiality or alerting perpetrators that survivors disclosed violence or sought help.²²⁵ When health systems prepare staff to respond appropriately to disclosures of violence, health workers are more likely to achieve the most basic principle of medicine: **DO NO HARM**.
- **To ensure that survivors receive appropriate first-line, survivor-centred support:** Even when community services are limited, evidence suggests that survivors and non-offending caregivers may benefit from an appropriate, empathetic first response from health workers.^{18,233,234} WHO developed evidence-based recommendations for first-line responses to violence, called LIVES (Listen, Inquire, Validate, Enhance safety and Support) for intimate partner violence and sexual violence against women²³³ and LIVES CC (LIVES plus Child- and adolescent-friendly environments and Caregiver support) for child maltreatment,¹⁸ which are described later in this review. These recommendations were designed to be survivor-centred and feasible in low-resource settings. When possible, international guidance also recommends that child and adolescent survivors and their families receive additional basic psychosocial support and referrals,¹⁸ including in emergency settings.^{40,235,236}
- **To increase opportunities for early identification, response and referrals:** Health workers play an important role in early identification and response to violence against children and adolescents^{18,19} and intimate partner violence against women.³³ Multi-country research from Africa, Asia and Latin America found that most children and adolescents who experienced violence did not tell anyone, and only 11 per cent received formal services.²³⁷ Access to post-rape care is severely limited, especially in low- and middle-income settings,^{238,239,240} even though timely access is essential.¹⁹ The role health workers play in early identification and response is especially important for children and adolescents who do not regularly interact with service providers, including those not in school or those living in vulnerable situations such as emergency contexts.

"Health care is often the first and sometimes only encounter that children and adolescents who have experienced violence have with care and support professionals ... It is important for the health system to have organizational policies and procedures in place that are: consistent with WHO evidence-based guidelines; supported by training, supervision, and adequate personnel and supplies."

– WHO, *INSPIRE Handbook: Action for implementing the seven strategies*, 2018, p. 202⁴⁹

- **To improve the quality of health services:** Growing evidence suggests that greater attention to the broader context of children's and adolescents' lives, including adverse childhood experiences such as violence, can improve quality of care in clinical settings.^{230,241,242} WHO global standards for adolescent health services explain that high-quality health care requires recognizing that exposure to "traumatic events such as violence, poverty or discrimination – will have an impact on individual physical, emotional and mental health as well as ability to feel safe while seeking health care".²⁴³ Similarly, Forkey and colleagues say: "... the complete assessment of child and adolescent behavioural, developmental, emotional, and physical health requires consideration of trauma as part of the differential diagnosis to improve diagnostic accuracy and appropriateness of care".²⁴¹
- **To improve the quality and effectiveness of community-based health programmes:** As highlighted in section 4 of this review, evidence suggests that diverse types of community-based health sector programming may be more effective when they integrate attention to the implications of violence, including deliberate neglect. This includes community health workers, school-based health services and nurse-led home-visiting programmes focused on maternal and newborn health, adolescent health, HIV prevention and caregiver support.
- **To ensure that health workers have the support and resources, they need to address violence:** A consistent finding from research is that to address violence as a health issue, health workers need supportive managers and workplace environments.^{215,244} This is what WHO calls "a supportive and enabling service delivery environment" (p. 17).³⁸ Without institutional support, health workers may not have the skills, knowledge, resources and confidence they need to address violence.^{244,245} Health workers may face complex decisions about mandatory reporting of child abuse, often fearing that it could do more harm than good, threaten their personal safety or get them entangled in legal disputes.^{43,216} Health workers need support to manage these challenges, provide high-quality care and protect their own safety and well-being.

"A consistent theme in published literature and reports is the lack of awareness and confidence among health professionals on how to handle these cases and the fear and discomfort with reporting to authorities."

– Wirtz et al., 2017²⁴⁴

- **To protect the safety and well-being of health workers:** Health systems, institutions and programmes that are fully committed to preventing and responding to violence will take steps to ensure that workplaces are free of abuse and reflect values of respect for human rights, gender equality and non-discrimination.²²³ This may require policies and initiatives to prevent and respond to physical, sexual and psychological violence and harassment against health workers,²⁴⁶ to reduce power imbalances between managers and front-line staff, to address discriminatory attitudes within the workplace and to prevent vicarious trauma and burn-out by supporting the well-being of health workers.^{247,248}
- **To contribute to comprehensive, multisectoral violence prevention and response:** Health systems could help advance public health and human rights by contributing to more comprehensive violence prevention and response, in collaboration with sectors such as justice, education, social welfare and child protection.^{3,49} Health systems can contribute to primary prevention by integrating social norms change strategies into home-visiting, parenting support and community-based health programmes;^{30,37,41,42} to secondary prevention through early identification, appropriate first-line responses and referrals to specialized services;^{18,19,225} and to tertiary prevention by mitigating consequences and facilitating long-term recovery, for example through cognitive behavioural therapy for children exposed to violence (*see Box 5*).⁴²

Box 5. Levels of prevention

Primary prevention:

Prevents violence before it occurs by addressing root causes.

Secondary prevention:

Intervenes to mitigate short-term harm and prevent recurrence.

Tertiary prevention:

Mitigates long-term harm and facilitates recovery.

Source: Adapted from UNICEF^{249,250} and Prevention Collaborative²⁵¹ publications.

- **To generate data to build political will for multisectoral prevention and response:** By strengthening health surveillance and epidemiologic research on violence, health systems can document violence as a public health problem and a risk factor for negative child and adolescent health outcomes.²⁵² High-quality data on the magnitude and health consequences of violence can reframe and raise attention to violence as a public health issue and build political will to address the problem at global, national and local levels.^{3,49,253}

3.3 How whole health systems can address violence



The 2016 WHO [*Global Plan of Action to Strengthen the Role of the Health System within a National Multisectoral Response to Address Interpersonal Violence, in Particular against Women and Girls, and against Children*](#)³ called for strengthening health system capacity to address interpersonal violence across four areas: leadership and governance; health service capacity; preventive health programming; and information systems. World Health Assembly resolution WHA74.17 (2021) [*Ending Violence against Children through Health Systems Strengthening and Multisectoral Approaches*](#)¹⁷ called on Member States to take actions to address violence against children specifically (see Box 6).

Box 6. Examples of WHO recommendations for strengthening health system responses to violence against children

Strengthen leadership and governance:

- Build high-level political commitment within the health system and across government.
- Establish a national strategy that includes health sector actions to address violence against children.
- Establish an interministerial coordination process that includes the health sector.
- Create or designate a unit or focal point within the ministry of health to lead work on violence against children and liaise with other sectors, including child protection.
- Strengthen and implement legislative and policy frameworks related to violence against children, sensitive to age, gender, disability and other situations of vulnerability.
- Allocate adequate budgets and mobilize resources to address financing gaps.
- Establish policies, accountability mechanisms and reporting procedures for all organizations and personnel who come in contact with children.
- Involve children and adolescents, according to their evolving capacities, in advocacy, policy development, implementation and monitoring.

Strengthen the capacity of health services and health workers to respond to violence:

- Improve service infrastructure, referral pathways and intersectoral coordination.
- Improve the accessibility, affordability, acceptability, availability and quality of care.
- Ensure continuity of mental health services during emergencies.
- Integrate identification, first-line support and referral into relevant health services.

Box 6. Continued

- Ensure that health services do not cause harm and are free from discrimination.
- Equip health workers to recognize signs and consequences of violence against children.
- Prepare providers to offer evidence-based, trauma-informed first-line support, reporting and referral, with the best interests of the child as a primary consideration.
- Ensure child- and adolescent-friendly, gender-sensitive services for violence.
- Give particular attention to children in vulnerable situations, including emergencies.
- Strengthen health worker training, supervision, institutional support and accountability.

Strengthen health programming to prevent violence against children:

- Adapt and implement INSPIRE³⁰ and, where relevant, RESPECT Women³⁷ strategies.
- Identify children and families at heightened risk and link them to preventive support.
- Integrate violence prevention into relevant health promotion programmes.
- Strengthen capacity of community health workers,²⁵⁴ families and communities.
- Address harmful gender and social norms.
- Address intersections between violence against children and violence against women.
- Partner with other sectors to ensure multisectoral prevention of violence against children.

Improve health information and evidence on violence against children:

- Support epidemiological research on violence, including population-based surveys.
- Improve routine as well as age- and sex-disaggregated data collection.
- Strengthen epidemiological surveillance systems.
- Establish measurable national and programme-level targets.
- Monitor implementation of laws, policies and response frameworks.
- Strengthen monitoring and evaluation, as well as research, on effective interventions.

Source: World Health Assembly¹⁷ and WHO.³

3.4 How a systems approach can strengthen capacity of health services

Researchers have repeatedly found that broad changes to systems and institutions, rather than narrow efforts to train health workers, are needed to achieve positive, sustainable change in health system responses to violence.^{41,43,49,50,223,225,245} In contrast to narrow policy changes or individual provider efforts, a systems approach involves changes across whole systems, institutions and programmes,^{43,50,232} with the aim of creating what WHO calls “an enabling environment”.³⁸ As a qualitative meta-synthesis of the international evidence explained, health workers need system-wide changes:

"... providers cannot integrate attention to violence ... into health services for women and children through training alone, without ... support through leadership, policies, protocols, champions, infrastructure, environments, data systems for feedback and a supportive culture. This is the first step needed in any process of reform, so we are not setting up practitioners to fail."

– Hegarty et al., 2020²⁴⁵

A systems approach is relevant for strengthening whole-of-system responses to violence, as well as individual health facilities and programmes.⁴⁹ A systems approach also aligns with UNICEF's commitment to systems strengthening within health, child protection and other sectors.⁴⁸

What are the key components of a systems approach to addressing violence?

A systems approach to improving health system capacity to address violence against children and adolescents, as well as violence against women, has numerous components, described below (see Box 7 and Figure 2). This framework builds on six original WHO building blocks for strengthening health systems (service delivery; health workforce; health information systems; medical products, vaccines and technologies; financing; and leadership and governance),²⁵⁵ adapted and expanded to address violence, based on research,^{223,225,226} WHO resolutions and action plans,^{3,17} WHO guidance,^{38,50} the INSPIRE package⁴⁹ and UNICEF sources.^{20,48,51}

Figure 2. Key components of a systems approach



Source: Adapted from the 2017 WHO manual for managers, p. 3.⁵⁰

Box 7. Components of a systems approach to health service readiness to address violence

Legal and policy frameworks

Legal, policy and planning frameworks that align with international frameworks, evidence-based guidelines and human rights standards, including laws, policies, regulations, guidelines, protocols, minimum standards, codes of conduct and plans of action – at national, subnational and system levels,^{3,43} as well as in institutions and programmes.²²³ Normative frameworks need to include specific considerations for children, especially with regard to informed consent and assent,²⁴³ mandatory reporting,²¹⁶ child protection considerations, laws about sexual age of consent and clinical considerations.¹⁹

Leadership and governance

Leadership and governance that support health system responses to violence. This includes political will and a commitment to support health sector efforts to prevent and respond to violence by policymakers and programme managers at national, subnational and institutional levels.^{17,223}

Financing and budgets

Adequate budgets and funding to strengthen health service capacity to respond to violence. This includes resources to fund the implementation of national plans relevant to health sector responses to violence, resources for putting national protocols into practice⁴³ and resources for strengthening service infrastructure, health worker training, service delivery and information systems^{3,17,223} – not simply adding new responsibilities to staff working in overstretched, underfunded services.²²⁵

Operational resources for high-quality service delivery

Operational resources that enable health services and health workers to provide high-quality care. This includes protocols and policies that align with evidence-based guidance;^{43,49} physical infrastructure and secure records systems to protect survivors' privacy, confidentiality and safety; and other equipment, supplies and resources.^{223,225}

Organizational management and culture

Health managers and institutional cultures that give health workers the support they need to address violence. This includes managers who are willing and able to help staff integrate attention to violence as a health issue, teams that provide mentorship and supervision, and a workplace culture that respects human rights and gender equality.^{223,245} It also includes policies, procedures and support mechanisms to protect the safety and well-being of health workers, by ensuring reasonable workloads, preventing and responding to workplace violence, including sexual harassment,¹⁶ and reducing the risk of compassion fatigue and vicarious trauma.²⁴⁸

Health workforce capacity

A workforce prepared to identify and respond to violence. Health workers need knowledge, awareness, skills, attitudes and values to provide appropriate first-line support.¹⁸ They also need to understand how adverse childhood experiences may affect child and adolescent health and how to provide care without discrimination based on sex, ethnicity, sexual orientation or other situations of vulnerability.²⁴³ Preparing the health workforce may require pre-service or in-service education, sensitization and training, and supportive supervision.^{49,223,245} In some settings, this has included changes to recruitment and hiring practices to reinforce gender-equitable values.²¹⁵

Community engagement and survivor participation

Community engagement and meaningful child and adolescent participation. Children, adolescents and families affected by violence should be included in the design, implementation and monitoring of health programmes,²⁵⁶ according to their evolving capacities.²⁴³ Health programmes should also engage communities in dialogue and awareness-raising about violence to build trust, address stigma and harmful norms, improve service acceptability and uptake, and ensure that services respond to the needs of survivors and families.²²³

Box 7. Continued

Health information systems

Administrative data, surveillance, epidemiological research, and monitoring and evaluation related to violence. At national and subnational levels, this includes surveillance and epidemiological data collection on violence as a health issue,³ which can mobilize stronger health system responses.²⁵⁷ Within health systems and programmes, it includes data collection for monitoring, evaluation and continuous quality improvement.²⁵⁸ It also includes facility-based information systems designed to protect survivors' privacy, confidentiality and safety.²²⁵ In some settings, child death reviews can combine health and other sectoral data to identify service gaps and inform improvements in child health and protection.^{259,260}

Coordination with other sectors and referral systems

Collaboration with other sectors and referral systems to appropriate, safe, and timely services, including specialized health services such as post-rape care,¹⁹ as well as social welfare, child protection and justice across public, private and community systems.¹⁸ Coordination requires clear referral and accountability mechanisms to monitor service access and quality,⁵⁰ with particular attention to the safety and timeliness of referrals.²³⁴ Health services for children should also be prepared to refer adult caregivers who need services, just as services for women should be prepared to refer children affected by violence.

WHO resources for strengthening system- and organization-wide capacity

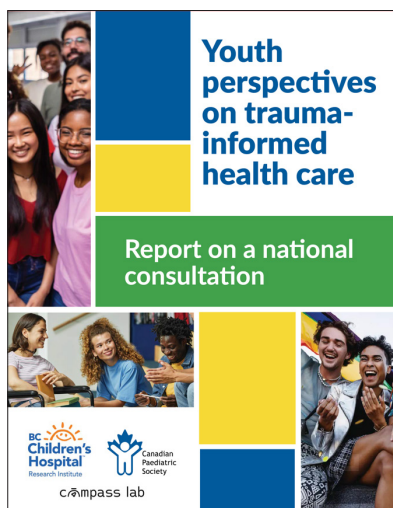
WHO has produced resources for strengthening whole system and organizational capacity to address violence against children and violence against women, such as:

2016	A global plan of action, with a priority focus on violence against women and violence against children	<i>Global Plan of Action to Strengthen the Role of the Health System within a National Multisectoral Response to Address Interpersonal Violence, in Particular against Women and Girls, and against Children</i> , WHO, Geneva, 2016
2017	A manual for health managers focused on violence against women	<i>Strengthening Health Systems to Respond to Women Subjected to Intimate Partner Violence or Sexual Violence: A manual for health managers</i> , WHO, Geneva, 2017
2018	A chapter on responses to and support for violence against children	'Response and support', in <i>INSPIRE Handbook: Action for implementing the seven strategies for ending violence against children</i> , pp. 187–234, WHO, Geneva, 2018
2019	A good practice statement about enabling service delivery environments focused on child maltreatment	'Creating a supportive and enabling service-delivery environment for health-care providers', in <i>WHO Guidelines for the Health Sector Response to Child Maltreatment: Technical report</i> , pp. 66–67, WHO, Geneva, 2019
2021	A World Health Assembly resolution calling on Member States to strengthen health systems to respond to violence against children	World Health Assembly Resolution WHA74.17: <i>Ending Violence against Children through Health Systems Strengthening and Multisectoral Approaches</i> , WHO, Geneva, 2021
2021	Training sessions for health managers focused on violence against women	Sessions 14–16 (for health managers), in <i>Caring for Women Subjected to Violence: A WHO training curriculum for health care providers</i> (revised edition, 2021), WHO, Geneva, 2021

Trauma-informed care: An example of a whole-organization framework

WHO^{17,19,38,261,262} and UNICEF^{263,264} publications often call for “trauma-informed” practices, often without defining what this term means. In contrast, WHO clinical guidelines for responding to child maltreatment¹⁸ and many mental health and psychosocial support (MHPSS) resources from WHO,^{265,266} UNICEF²⁶⁷ and partner agencies⁴⁰ do not mention trauma-informed care, possibly due to various concerns and debates (see Box 8).

Within paediatric health services research, trauma-informed care usually refers to an organization-



wide framework for strengthening health service capacity to address adverse childhood experiences, including violence,²³⁰ building on a framework formalized by the United States of America's Substance Abuse and Mental Health Services Administration.²⁶⁸ Trauma-informed care has arguably become one of the more influential models for strengthening paediatric health service responses to violence in settings such as Australia,²⁶⁹ Canada,^{256,270} the United Kingdom of Great Britain and Northern Ireland^{271,272} and the United States.²⁴¹ In low- and middle-income countries, formal use of this framework is not widespread, but a scoping review found programmes aligned with trauma-informed care in 39 low- and

middle-income countries.²²⁶

Key elements of trauma-informed care for children and adolescents

- It is an organization-wide framework, not an individual, trauma-focused intervention.²⁶⁸
- It aims for changes across whole organizations, including leadership, policies, the physical environment and workforce development,²³² similar to a systems approach to strengthening health service responses to violence against women.²²⁵
- It encourages health workers to pay greater attention to how adversity, including violence, affects child and adolescent physiological, developmental and mental health.²⁴¹
- It prioritizes a set of key principles, including safety, trustworthiness, transparency, peer support, collaboration, empowerment, voice, choice and attention to cultural, historical and gender issues²⁶⁸ – similar to WHO's vision of adolescent-centred care.²⁴³
- It aims to change the way that services are delivered to all children, adolescents and families, whether or not they disclose violence, and can be implemented as a universal rather than a targeted approach.²⁷³ It therefore complements and expands on, but does not substitute for, survivor-centred care.
- It aims to ensure that health services protect the safety and well-being of children, adolescents, families and staff members at every point of contact.²³⁰

Box 8. Debates about trauma-informed care

Trauma-informed care has generated various debates and concerns, including the following:

- **Concerns about trauma as a dominant framework for understanding emotional distress.** Some voice concern that the framework's overly broad conception of trauma includes almost any distress.²⁷⁴ Research has found that even in situations of armed conflict, most people do not develop traumatic stress disorders,²⁷⁵ and emotional distress is often temporary.⁴⁰
- **Concerns about overemphasizing child traumatic stress.** As a UNICEF paper explains, the field has tried to move away from an overmedicalized view of child trauma towards an emphasis on resilience, recognizing that adversity does not always lead to traumatic stress,²⁷⁶ especially with support from caring adults and communities.¹¹⁴
- **Concerns about inconsistent implementation or insufficient evidence of effectiveness.** Critics suggest that trauma-informed care has been implemented in many different ways, making it hard to compare across sites^{277,278,279,280} and/or that the framework's rapid scale-up in high-income settings has outpaced evidence of its effectiveness.^{231,280,281}
- **Concerns that some programmes have screened children for adversity, without evidence that benefits outweigh harm.** Systematic reviews and other research have found insufficient evidence to recommend universal screening for adverse childhood experiences, a component of some trauma-informed programmes.²⁸²
- **Concerns about what the framework contributes beyond what is already known about good practice.**^{277,283}
- **Concerns that focusing on violence exposure as a mental health issue could stigmatize survivors or distract from ongoing threats to survivor safety.** This was an early lesson learnt by health programmes serving survivors of intimate partner violence, who told programme evaluators they did not want to be offered mental health treatment without first being offered resources to protect themselves and their families from ongoing violence; as a survivor from Peru explained: "I'm not crazy, he is."²⁸⁴ Similarly, paediatric WHO mental health guidance for non-specialized settings calls for attention to signs of ongoing abuse and other threats to safety and well-being before trying to diagnose or treat mental health conditions.²⁸⁵

It is worth noting that the name 'trauma-informed care' suggests a priority focus on mental health, but guidance on paediatric trauma-informed care usually prioritizes child safety and protection before assessing specialized mental health needs.²⁴¹ This raises the question: Would some concerns be alleviated if the framework were renamed and refocused on adversity-informed care?

Reconciling conflicting opinions about trauma-informed care is beyond the scope of this review, but more discussion is warranted given the framework's prominence in the paediatric health literature, conflicting messages from international guidance and the pressing need for child- and adolescent-centric frameworks for strengthening health system capacity to address violence in low- and middle-income settings.

3.5 How to align health protocols and practices with international guidelines

Countries, health systems, institutions, programmes and services need normative frameworks to guide health system responses to violence aligned with international, evidence-based guidelines. These include laws, policies, regulations, plans of action, codes of conduct, orders, guidelines and care protocols. UNICEF has the potential to play an important role in helping governments and health systems ensure that normative frameworks, including care protocols, reflect evidence-based guidelines published by WHO, UNICEF and other partners (see Box 9) as well as international standards from child protection, such as *Minimum Standards for Child Protection in Humanitarian Action*²⁸⁶ and *Minimum Standards for Gender-Based Violence in Emergencies Programming*.²³⁴

Box 9. Examples of guidelines relevant to violence against children and adolescents

Child maltreatment	<i>Responding to Child Maltreatment: A clinical handbook for health professionals</i> , WHO, Geneva, 2022
Sexual violence against children and adolescents	<i>Responding to Children and Adolescents Who Have Been Sexually Abused: WHO clinical guidelines</i>, WHO, Geneva, 2017 <i>Strengthening the Medico-Legal Response to Sexual Violence</i>, WHO, Geneva, 2016 <i>Caring for Child Survivors of Sexual Abuse Guidelines</i>, 2nd ed., UNICEF and International Rescue Committee, New York, 2023
Intimate partner violence and sexual violence against women and girls	<i>Health Care for Women Subjected to Intimate Partner Violence or Sexual Violence: A clinical handbook</i>, WHO, Geneva, 2014 <i>Clinical Management of Rape and Intimate Partner Violence Survivors: Developing protocols for use in humanitarian settings</i>, WHO, Geneva, 2020

At minimum, protocols for health sector staff should provide guidance to:

- understand their legal obligations.
- respect the rights of children, adolescents and women.
- address evolving capacities of children and adolescents to make their own decisions.
- identify potential signs and symptoms of violence and neglect.
- provide first-line support using the LIVES and/or LIVES CC approach (see Box 10).
- assess safety and conduct safety planning.
- protect survivors' safety, privacy and confidentiality.
- address the safety and well-being of non-offending caregivers.
- recognize links between violence and other health issues.
- provide specialized health care if applicable and feasible.
- make referrals to specialized services as needed.

Box 10. Prepare health workers to provide first-line support using LIVES and LIVES CC

WHO recommends that health sector staff use LIVES CC¹⁸ for responding to suspected or disclosed cases of violence against children and adolescents and LIVES²³³ for first-line support to adult women who disclose intimate partner violence or sexual violence. LIVES and LIVES CC are designed to be practical, survivor-centred, empathetic and feasible in resource-constrained settings. The acronyms refer to:

Listen closely with empathy and without judging in a private space.

Inquire: Assess and respond to needs and concerns, emotional, physical, social and practical.

Validate: Show that you understand and believe them and that they are not to blame.

Enhance safety: Discuss safety plans to protect them from further harm.

Support: Facilitate access to formal and informal services and support.

Child- and adolescent-friendly environments, with staff trained in survivor-centred care.

Caregiver support for non-offending caregivers to support the child or adolescent.

Ensure that health protocols respect the evolving capacities of children and adolescents

Children and adolescents have the right to participate in decisions about their lives, according to their developing capacities, based on age and developmental stage.²⁴³ Health sector efforts to prevent and respond to violence should ensure that children and adolescents receive information appropriate for their age, developmental stage and capacity, along with the opportunity for informed consent or – among young children – assent. As WHO child maltreatment guidelines explain:

"In some instances, ... care can be provided without involving the caregivers or legal guardians when it is assessed to be in the best interests of the child or adolescent ... in line with WHO guidance for adolescent health services and national legislation, and ... human rights standards."¹⁸

– WHO, *Responding to Child Maltreatment: A clinical handbook for health professionals*, 2022, p. 11

While ethical guidelines about adolescent confidentiality, privacy, safeguarding and age-appropriate consent protocols are important for all health programmes that serve adolescents, they are essential for preparing health services to respond to violence against children and adolescents.

Translate normative frameworks into practice

Normative frameworks are only effective if they are implemented.⁴⁹ A systematic review of national health sector guidelines and protocols for responding to child survivors of violence and neglect in Latin America and the Caribbean found that about half (22 of 43) of all countries in the region had such protocols; those that did addressed topics such as how to identify violence-related injuries, how to provide patient-centred care and how to manage and refer cases.⁴³ However, health staff were often unaware of these protocols or lacked training, resources and institutional support to put them into practice. These findings highlight that effective national protocols need to be accompanied by investments across whole systems and institutions, including training and supportive supervision. For this reason, the *INSPIRE Handbook* repeatedly emphasizes the need for health budgets to include costs of implementing protocols and guidelines.⁴⁹



Box 11. Mandatory reporting of violence against children

Many countries require health workers and other professionals to report known or suspected cases of child abuse to child protection or law enforcement agencies, including low- and middle-income countries such as Brazil, China, Guatemala, India, Malawi, South Africa, Uganda and the United Republic of Tanzania.^{43,216,287,288} Evidence reviews suggest:

- Mandatory reporting policies aim to ensure that children who are experiencing or at risk of violence receive protection from recurrence, escalation and further harm.^{288,289}
- These policies may also prevent institutions, including health programmes, from enabling or concealing child abuse perpetrated by their own staff.^{289,290}
- Policies vary in terms of who must report; to whom; which types, circumstances and thresholds of abuse trigger reporting; and penalties for non-compliance.^{216,288,289}
- Health workers often do not comply due to lack of training, clear reporting mechanisms or inter-agency collaboration, or fear of putting children at risk of additional harm.²¹⁶
- Evidence needed to assess whether benefits outweigh risks (or vice versa) is limited, even in high-income settings.^{38,291}
- Potential risks and ethical dilemmas of mandatory reporting may include:^{38,216,287,288,291,292}
 - perceived breaches of confidentiality and loss of trust;
 - overburdened, under-resourced child protection systems that cannot respond;
 - secondary harm from interacting with police or child protection agencies;
 - challenges in navigating the evolving capacities of adolescents;
 - reduced willingness of adolescents or caregivers to seek health care;
 - retaliation by perpetrators, stigma, family conflict or social exclusion; and
 - unwarranted, biased or discriminatory reporting of suspected cases.

UNICEF and WHO recommendations

UNICEF²³⁶ and WHO³³ acknowledge that mandatory reporting of violence against adult women can undermine women's right to autonomy and increase the risk of retaliation.²⁹³ For violence against children, however, those concerns must be balanced against their right to protection.²³⁶ While calling for more evidence about whether benefits outweigh risks, UNICEF²³⁶ and WHO^{18,19} provide guidance for implementing mandatory reporting of violence against children, where required, in ways that protect children's rights and best interests:

- **Policymakers:** Design policies and invest in child protection systems and referral services that protect and support children and non-offending caregivers.
- **Health systems and institutions:** Train staff to understand their legal obligations and provide the institutional resources they need to comply (e.g., protocols).
- **Health managers:** Design procedures that clarify who must report, to whom and under what circumstances; what information should be shared, when, how and with whom; how to protect confidentiality and other rights; and legal implications of not reporting.
- **Health workers:** Understand legal reporting obligations. Consider children's rights, best interests and evolving capacities. Inform children and caregivers about reporting obligations and limits of confidentiality.
- **Health researchers:** Expand the evidence base on risks, benefits and accountability mechanisms to inform better policies and prevent harm.

3.6 How to ensure rights-based, gender-responsive and survivor-centred care

International guidelines for strengthening health service responses to violence^{37,38,49,294} call for health policies and programmes to be grounded in a commitment to key principles related to human rights, gender equality and the needs of those who live in vulnerable situations, including the following:

- **Recognize violence as a public health and a human rights issue.** Health systems need to recognize that violence is both a public health and a human rights issue. This ensures that policies, programmes and health workers do not justify violence, blame victims, re-victimize survivors, dismiss violence as outside the purview of the health sector or miss opportunities to address the health implications of violence.
- **Ensure survivor-centred care.** Survivor-centred care prioritizes the rights, needs, autonomy and wishes of violence survivors,²⁹⁵ including the right to:
 - dignity and respect;
 - freedom from fear and violence;
 - self-determination, meaning the right to make their own decisions;
 - the highest attainable standard of health;
 - non-discrimination;
 - privacy and confidentiality; and
 - information.

These principles were originally developed for responding to violence against women, rooted in a commitment to empowering women to exercise autonomy and make their own decisions.²⁹⁶ Health services for child and adolescent survivors of violence are encouraged to adopt these principles, balanced with considerations for the evolving capacities of children and adolescents and the best interests of the child – especially in situations of ongoing violence by caregivers.²³⁶

- **Promote gender equality and the empowerment of girls and women.** Harmful gender norms often devalue girls and women, increase their vulnerability to violence, justify male dominance and aggression, blame and stigmatize survivors and prioritize reputations of perpetrators, families and institutions over survivors' well-being.^{31,297} Boys subjected to sexual violence often face discrimination and barriers to care that may be distinct from those faced by girls, including from health workers with negative attitudes towards male victims and/or males who have sex with males.^{63,298} UNICEF is committed to promoting gender equality and the empowerment of women and girls across all programming, including the health sector. When possible, this should include not only responding to gender inequality but seeking to transform it.²⁹⁴
- **Commit to non-discrimination and protection of children living in vulnerable situations.** As noted in section 1, certain children and adolescents face a greater risk of violence, including

those with disabilities,⁷⁴ living with HIV⁷⁵ and/or facing discrimination for their sexual orientation or gender identity.^{76,77} Health sector organizations need to acknowledge and mitigate these risks, ensure that children and adolescents from all backgrounds have access to services, and protect those living in vulnerable situations from secondary victimization by working to transform discriminatory attitudes and behaviours among staff.²⁹⁷

3.7 How to address intersections between violence against children and violence against women

Historically, violence against children and violence against women were treated as separate issues, with different funding streams, lead agencies, rights treaties, clinical guidance and bodies of research.³¹ Growing evidence indicates a need to bridge those gaps. For example, evidence suggests that preventing and responding to intimate partner violence against women may have important benefits for children's health, rights and well-being.²⁹⁷ Similarly, preventing violence against children may contribute to long-term prevention of violence against women by interrupting intergenerational cycles of violence.⁴¹

[World Health Assembly resolution WHA74.17](#) acknowledged that child exposure to intimate partner violence against women may have mental and physical health consequences similar to child maltreatment, that violence against children and against women often occur in the same households and that these forms of violence may have shared risk factors.¹⁷ That resolution also called on Member States to address intersections, common risk factors and co-occurrence in the household as a prerequisite to long-term violence prevention.

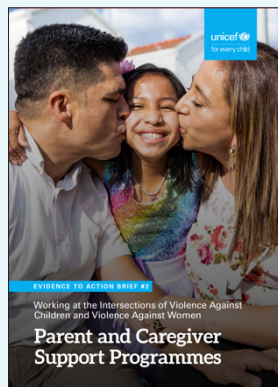
UNICEF has produced a series of evidence briefs exploring intersections between violence against children and violence against women, which include many recommendations relevant to the health sector (see *Box 12*).



Box 12. UNICEF evidence briefs about intersections between violence against children and violence against women



Evidence Brief 1: *Why it matters for children's protection and well-being*²⁹⁹



Evidence Brief 2: *Parent and caregiver support programmes*³⁰⁰



Evidence Brief 3: *Adolescent programming to prevent violence*³⁰¹

Forthcoming Evidence Brief 4: *Improving coordination of response and support services for victim-survivors of violence*³⁰²

These UNICEF briefs note that evidence about integrated responses to intimate partner violence against women and violence against children remains limited in low- and middle-income countries.⁴⁷ Nonetheless, studies have begun to explore how both facility- and community-based health programmes can integrate greater attention to intersections between violence against children and violence against women.^{47,303} Health systems can address key intersections based on these briefs and other evidence reviews and guidelines (see Box 13).^{18,19,47,303,304}

Box 13. Examples of how health systems can address key intersections

Key intersections ³¹	Implications for health systems
Shared risk factors: Violence against children and violence against women have shared risk factors, including weak institutional responses and gender inequality.	Incorporate violence against children and violence against women prevention strategies into child, adolescent and maternal health services – for example, by linking families to parenting support, promoting gender equality, and addressing caregiver mental health, harmful use of substances and other risks shared by violence against children and violence against women.
Social norms: These often condone both violence against children and violence against women and discourage help-seeking.	Ensure that health workers do not reinforce social norms that justify violence, blame survivors or discourage disclosure; conversely, health workers can promote respect for human rights, non-violence, gender equality, equitable relationships and help-seeking in cases of violence.
Co-occurrence: Child maltreatment and intimate partner violence often co-occur. Children in households affected by intimate partner violence are more likely to be subjected to caregiver violence themselves.	Train front-line health workers who care for children to identify signs and provide appropriate first-line responses when female caregivers disclose intimate partner violence. ¹⁸ Conversely, train health workers who care for women subjected to intimate partner violence to address the needs of children who may have witnessed or been subjected to violence themselves. Health workers should also be prepared to support the safety and well-being of both children and non-offending caregivers, without placing responsibility for perpetrators' violence on non-offending caregivers.

Box 13. Continued

Intergenerational effects: Both violence against children and violence against women can produce intergenerational effects.

Invest in early, trauma-informed support for children, adolescents and caregivers, including parenting interventions and services for adolescents to reduce long-term harm and interrupt the intergenerational cycles of violence.

Common and compounding consequences: Violence against children and violence against women may have common and compounding health consequences across the lifespan.

Ensure that health organizations and health workers understand and respond to the potential health consequences of violence and other adverse childhood experiences, including polyvictimization (multiple forms of violence), and exposure to all types of violence in the household rather than addressing each incident or family member in isolation.

Adolescence: This is a time of heightened vulnerability to intimate partner violence and non-partner sexual violence; meanwhile, adolescents often fall through the gaps between services for children and services for adults.

Strengthen health system capacity to deliver adolescent-centred care that is accessible, confidential, rights-based, gender-responsive, age-appropriate and survivor-centred. Health services need to ensure that adolescent girls do not fall through the gaps. This includes attention to age-appropriate protocols for first-line support for intimate partner violence and sexual violence, as well as access to sexual and reproductive health care services that consider the evolving capacity, legal and human rights, and specific needs of adolescents that may be distinct from younger children or older adults.





Section 4.

Why and how specific UNICEF health programme areas can integrate greater attention to violence

4.1 Introduction

This section highlights examples of why and how specific areas of UNICEF's health programming can integrate greater attention to violence against children, adolescents and women. UNICEF's 2026–2029 Strategic Plan included Impact Result 4, which was dedicated to violence (350 million children are protected from violence).²⁰ However, because this review focuses on health, this section presents evidence about why and how greater health system attention to violence could contribute to Impact Result 1 (10 million child lives saved and at least 500 million children healthy, well-nourished and developmentally on track), informed by UNICEF's 2025 Gender Equality Action Plan.²⁹⁴

Specifically, this section examines entry points and opportunities for UNICEF to address violence and thereby strengthen primary health care, maternal health and child survival, adolescent health, immunization programmes, HIV treatment and prevention, MHPSS, malnutrition treatment and prevention, and early childhood development and parenting support services.



4.2 Strengthen primary health care systems

"A comprehensive, multisectoral approach to child survival and development, grounded in resilient, inclusive primary health care (PHC), is critical to saving children's lives and ensuring they are healthy, well-nourished and developmentally on-track. Integrated service delivery across the life course promotes children's rights to survival, health, nutrition, education and protection, and is essential to achieving universal health coverage."

– Paragraph 53, UNICEF Strategic Plan, 2026–2029⁴⁸

Why primary health care, especially maternal and child health services, should address violence

Primary health care systems should integrate greater attention to violence for many reasons already mentioned in sections 2 and 3:

- Both violence against children and exposure to violence against women may contribute to child morbidity and mortality.^{8,14}
- Violence against children and adolescents can have wide-ranging adverse effects on physical and mental health and development through direct and indirect pathways.^{8,11}
- Intimate partner violence during pregnancy is associated with adverse maternal and newborn outcomes¹⁶⁴ and lower use of antenatal care and skilled delivery care.¹⁶³
- Primary health workers are often among the first service providers to interact with children and adolescents who experience violence, especially those not in school.
- Health workers play a critical role in providing a first-line response and helping survivors access specialized care and services from other sectors, such as child protection, social welfare and justice.

For all these reasons, primary health services, maternal and child health programmes, and community health workers should be prepared to recognize signs and respond to disclosures of violence (including neglect) in ways that at minimum do no harm; ideally, they should provide a beneficial first-line response by helping children and non-offending caregivers access appropriate services as needed.^{18,19,233} To safeguard survivor safety and confidentiality, however, health systems and organizations need to give health workers the key institutional resources and support described previously in this review, such as training, supervision, protocols and referral resources, before asking them to take on new responsibilities.

Examples of how maternal and child health care services can respond to violence

Earlier recommendations are particularly salient for primary health care systems, including a systems approach to prepare primary health care organizations to provide first-line support to survivors, with care protocols aligned with international, evidence-based guidance. Primary health services also need to be prepared to promote gender equality and attention to the needs of

children and adolescents living in vulnerable situations. Examples below suggest that maternal and child health programmes may be able to mitigate harm from violence through early identification and referral to services, by integrating greater attention to mental health care services within clinical care settings and, more generally, by addressing the implications of violence for health services, including barriers to care. Specific examples are described in the rest of this section.



4.3 Advance maternal health and child survival

“UNICEF will support governments in strengthening primary health care systems to advance maternal and child survival. This includes improving antenatal, perinatal, and postnatal care – particularly in high-burden and humanitarian settings – by expanding access to skilled birth attendance, emergency obstetric care, and adolescent pregnancy prevention.”

– Paragraph 55, 2025 Theory of Change, UNICEF Strategic Plan, 2026–2029⁴⁸

Why maternal and newborn health programmes should ensure respectful care

Ensuring access to high-quality maternity care is a core strategy for reducing preventable maternal and newborn morbidity and mortality.¹⁶ Research suggests that mistreatment of pregnant women and girls within maternal and newborn health services is common, as documented in low-, middle- and high-income settings (*see Box 14*).⁶⁷ Such mistreatment erodes trust in the formal health services and contributes to adverse maternal and perinatal outcomes.^{207,208,209,210,305} Moreover, health workers who themselves mistreat patients are unlikely to be able to provide appropriate first-line support for pregnant women and girls who disclose intimate partner violence.



Box 14. Disrespect and mistreatment of women and girls during maternity care

Global systematic reviews and meta-analyses estimate that worldwide, a majority of women and girls who give birth experience some form of mistreatment or disrespectful care during labour and delivery.^{67,68} Pooled estimates for specific forms include 37 per cent who experienced non-consented care and 28 per cent who experienced some form of physical mistreatment such as slapping, pushing, pinching or refusal of pain control measures.⁶⁷ Evidence of widespread mistreatment comes from virtually all regions of the world, including Latin America and the Caribbean,^{306,307,308} South Asia,^{309,310} sub-Saharan Africa^{311,312} and high-income settings such as the United States.³¹³ Widely documented^{16,206,305,312} forms of mistreatment in maternity care include:

- physical abuse (e.g., slapping) and/or rough handling;
- refusing pain control requests;
- verbal and emotional abuse (e.g., shouting, insults, humiliation and threats);
- stigma and discrimination (e.g., based on age, ethnicity or socioeconomic status);
- use of restraints without consent, compromising women's autonomy and dignity;
- non-consensual, painful and/or medically unnecessary procedures (e.g., vaginal exams);
- episiotomies performed without informed consent;
- failure to provide clear information about care and treatment options;
- denial of companion of choice during labour and childbirth;
- violations of privacy and confidentiality;
- neglect or abandonment of patients;
- delays in care during labour, childbirth or obstetric emergencies; and
- detention of mothers or newborns due to inability to pay.

Women and girls sometimes describe mistreatment during labour as a form of sexual violence. As a qualitative review³¹⁴ explained, "Participants often said that they felt raped on the delivery table with everyone watching and no one offering to help ... They felt violated, humiliated, and stripped of their dignity."

Examples of how to strengthen respectful maternal and newborn care

UNICEF, WHO and other international organizations have called on countries and programmes around the world to ensure respectful maternal and newborn care to protect human rights, increase access to high-quality care and improve maternal and perinatal health outcomes.^{16,315} Ensuring such care is the first recommendation in WHO's guidance about intrapartum care for a positive childbirth experience.³¹⁶ Respectful care is also a milestone in the WHO/UNICEF roadmap for ending preventable newborn deaths and stillbirths and reducing disability by 2030.³¹⁷

Respectful maternal and newborn care is defined as care organized for and provided to all women and newborns in a manner that maintains their dignity, privacy and confidentiality, ensures freedom from harm and mistreatment, and enables informed choice and continuous support during labour and childbirth.¹⁶

Evidence suggests that mistreatment during maternity care is often driven by a lack of resources and difficult work environments, including low pay, high workloads, inadequate pain management supplies and lack of supportive supervision, especially for front-line midwives and nurses.^{16,318} Research also suggests that some of this mistreatment reflects low regard for women and girls, a broader lack of respect for women's rights, prejudices against unmarried adolescent girls and discrimination based on ethnic identity or national origin.^{205,312} As a result, reducing mistreatment during maternity care likely requires improving the work environment as well as health worker attitudes and beliefs about women and vulnerable groups.³¹⁸ Global reviews^{318,319} and international guidance¹⁶ suggest that the most promising approaches involve multiple levels of the health care system, echoing the systems approach described previously.

Implement strategies for strengthening respectful maternal and newborn care

In 2025, UNICEF, WHO and other partners published a compendium that highlighted key elements for ensuring respectful maternity and newborn care.¹⁶ The compendium and global systematic reviews^{318,319} suggest the following approaches show promise:

- Institutional policies and resources to:
 - ensure confidentiality and informed consent;
 - ensure privacy (e.g., curtains, partitions between beds);
 - allow women and girls to have a companion of their choice during labour;
 - prevent and respond to workplace violence against staff members; and
 - provide dispute resolution and complaint mechanisms when abuse occurs.
- Institutional support for staff, especially front-line midwives and nurses, such as:
 - adequate pay and reduced staff shortages;
 - peer support and mentorship;
 - higher-quality supervision;
 - quality improvement measures; and
 - protection from workplace abuse.
- Staff training on:
 - norms, values and attitudes;
 - stigma and discrimination;
 - interpersonal communication skills; and
 - the rights of pregnant women and girls.
- Community engagement efforts to:
 - educate women and girls about their rights; and
 - participate in programme design and reduce barriers to access.



Key resource: [*Compendium on Respectful Maternal and Newborn Care*](#), WHO, Geneva, 2025.

Why maternal health programmes should integrate attention to violence

Evidence indicates that violence against pregnant women and adolescent girls poses a barrier to maternal health care, as well as risks to perinatal and infant health.¹⁶⁴ A systematic review found that, compared with other women, women and girls who experienced intimate partner violence had 25 per cent decreased odds of adequate antenatal care and 20 per cent decreased odds of skilled delivery.¹⁶³ Another global analysis found that maternal histories of abuse were significantly associated with preterm delivery and low birthweight.³²⁰

“Domestic and gender-based violence (GBV) during pregnancy puts women, infants and others in the household in danger ... Violence increases the risks for miscarriage, infection, premature birth and injury or death of the baby. It can contribute directly to emotional and mental health problems in the woman, such as depression, anxiety and post-traumatic stress disorder, which can affect the development of the baby.”

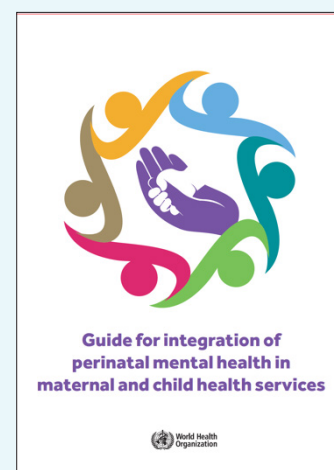
– WHO, *Guide for Integration of Perinatal Mental Health in Maternal and Child Health Services*, 2022, p. 39³²¹

Examples of how maternal health programmes can address intimate partner violence

Integrate greater attention to violence and mental health within maternal and newborn health services, with particular attention to pregnant adolescents

WHO's 2022 *Guide for Integration of Perinatal Mental Health in Maternal and Child Health Services*³²¹ identifies “domestic and gender-based violence” during pregnancy as risk factors for adverse maternal and newborn health outcomes. The guide recognizes pregnant adolescents as a cohort at elevated risk of mental health conditions as well as physical and sexual abuse, and it recommends that maternal health services:

- provide adolescent-friendly care;
- ensure privacy, build trust and provide information appropriate for adolescents;
- provide counselling for adolescents in distress;
- ensure that adolescents have a supportive adult of their choice who can accompany and support them during pregnancy, childbirth and beyond;
- determine whether abuse contributed to the pregnancy when it is unintended;
- train maternal health workers to provide caring, non-judgemental support to girls experiencing violence;
- manage health consequences of violence, including injuries and sexually transmitted



infections, and provide information about available support services;

- do not pressure girls to report abuse or leave a partner if it could increase danger; and
- provide or refer to counselling, psychosocial and legal services when appropriate.

Overall, the guide provides a model for integrating attention to violence into prenatal care through adolescent-friendly, confidential care; recognition of violence-related vulnerability; supportive first-line responses; and established referral pathways, rather than treating violence as a separate service. It does not, however, recommend routine enquiry for violence among all pregnant adolescents.

Source: *Guide for Integration of Perinatal Mental Health in Maternal and Child Health Services*, WHO, Geneva, 2022.

Strengthen the capacity of maternal and newborn health services to respond to intimate partner violence against pregnant women and new mothers

A growing number of maternal care programmes in middle-income settings have expanded attention to intimate partner violence with promising results. A 2020 systematic review found evidence from five middle-income countries (India, Kenya, Nigeria, Peru and South Africa) that integrating supportive counselling and/or routine enquiry and referrals into maternal health services significantly reduced recurrence of intimate partner violence in two studies and increased family support in one study; studies also found some evidence of improved quality of life, increased safety planning and use of support services, and reduced maternal depression.³²² Better maternal health outcomes may contribute to positive child outcomes. Even in resource-constrained settings, maternal health programmes should be prepared to do no harm when responding to disclosures of violence, by aligning protocols and practices with international guidance, including WHO's 2014 [*Health Care for Women Subjected to Intimate Partner Violence or Sexual Violence*](#).²³³

4.4 Promote adolescent health

To drive progress towards Impact Result 1, UNICEF will focus on expanding access to life-saving interventions for children and pregnant women; immunization; HIV treatment; mental health and psychosocial support; nutrition interventions to address malnutrition among children, including adolescents. – Paragraph 36, 2025 Theory of Change, UNICEF Strategic Plan, 2026–2029⁴⁸

Adolescent girls are often excluded from health planning and funding, especially in humanitarian settings. Each year, 23 million adolescent girls become pregnant, yet few of them have access to specialized maternal services. Maternal conditions remain a leading cause of death for girls aged 15–19 years, and adolescent girls account for 70 per cent of new HIV infections in their age group. Globally, only one in eight girls is protected from cervical cancer through human papillomavirus ... vaccination. – Paragraph 16, UNICEF [*Gender Equality Action Plan, 2026–2029*](#)²⁹⁴

Why health systems should integrate greater attention to violence against adolescents

- **Because prevalence of violence against adolescents is high, and many adolescents have histories of adverse childhood experiences** (as described in section 1).
- **Because violence contributes to substantial adolescent morbidity and mortality.** GBD estimates suggest that interpersonal violence was the fifth leading cause of DALYs among young people aged 10–24 in 2019.³²³ Child sexual abuse and other forms of violence contribute to adolescent depression, anxiety and alcohol-use disorder.^{5,110}
- **Because violence is associated with a greater likelihood of early and higher-risk adolescent pregnancy.** Systematic reviews and meta-analyses – including evidence from low- and middle-income countries – indicate that both sexual and physical abuse during childhood increase the risk of adolescent pregnancy,^{148,149,150} likely through direct and indirect pathways.
- **Because WHO guidance calls for adolescent health services to integrate attention to violence and other adverse childhood experiences.** WHO's *Global Standards for Quality Health Care Services for Adolescents*²⁴³ calls for attention to violence, saying:

"Health services must recognize that an adolescent's background – for example, traumatic events such as violence, poverty or discrimination – will have an impact on individual physical, emotional and mental health as well as ability to feel safe while seeking health care."
– WHO, *Global Standards for Quality Health Care Services for Adolescents*, 2025, p. 24

- **Because adolescents' needs and rights are often distinct from those of younger children and adults.**²⁴³ Adolescent girls often fall into the gaps between the child protection system focused on younger children and services designed for adults.³⁰¹ For this reason, researchers have called on gender-based violence prevention and response programmes in low- and middle-income countries to assess adolescent girls' needs, barriers and service entry points, and include adolescents in programme design and monitoring.³²⁴
- **Because there are critical gaps in post-rape care for adolescents.** International guidance calls on health services to provide age-appropriate, first-line support for adolescents who experience rape or sexual assault.¹⁹ However, research from low- and middle-income countries documents critical service delivery gaps.³²⁵ These include resource constraints, lack of trained staff, disruptions in supplies, poor documentation and lack of support for health workers called to give legal testimony.³²⁶ It also includes health workers' rape-myth beliefs and negative attitudes about rape survivors, adolescent girls' sexuality and abortion.^{238,327} These gaps compound barriers to access related to survivors' fear of stigma and consequences of disclosure.¹⁹ Adolescent boys who experience sexual violence and/or sexual exploitation often face distinct barriers such as health workers who do not recognize boys as survivors or who have stigmatizing attitudes about males who have sex with males.^{63,328}
- **Because pregnant adolescents are often living in situations of violence, and antenatal care provides an opportunity to respond.** A systematic review from sub-Saharan African countries found that 8–41 per cent of pregnant adolescents had experienced violence by

an intimate partner during pregnancy, and this violence was significantly associated with symptoms of depression and anxiety.³²⁹ An analysis of nationally representative data from 57 low- and middle-income countries estimated that 7 per cent of ever-pregnant adolescent girls aged 15–19 had experienced physical violence by a partner during pregnancy, which was significantly higher than among older cohorts of women.³³⁰

- **Because adolescence offers an important window of opportunity for health promotion programmes to contribute to violence prevention.** A UNICEF review³⁰¹ explained:

"... early adolescence offers an important window for intervention, given adolescents' increased neuroplasticity and maturation. Prevention programmes can create spaces for boys and girls to critically reflect on and question inequitable gender norms, as well as helping them build skills that support healthy, respectful and non-violent relationships."
– UNICEF, *Working at the Intersections of Violence against Children and Violence against Women: Adolescent programming to prevent violence*, 2026, pp. 12–13

Examples of how health programmes can integrate greater attention to the implications of violence for adolescent health

Implement recommendations from WHO global standards for adolescent health services

WHO's 2025 *Global Standards for Quality Health Care Services for Adolescents* provides a framework for improving the accessibility, effectiveness, safety and quality of health services for adolescents aged 10–19 years. The standards integrate attention to violence and other adverse childhood experiences. They also echo the systems-oriented and trauma-informed approaches described earlier in this review, by emphasizing the need to integrate attention to adversity, not just within clinical encounters, but also within policies, workforce development, the service environment, referral systems and quality monitoring.



The following recommendations in the framework illustrate attention to violence:

- **Standard 1. Adolescent-centred care:** Let adolescents' own needs and priorities guide care, including concerns such as safety and housing. Provide additional support and referrals when needed.
- **Standard 3. Inclusive, confidential, respectful and safe care:** Recognize that violence and other adverse experiences can affect adolescents' health and their ability to feel safe seeking care. Create physically and emotionally safe, supportive environments; protect confidentiality; train staff to understand the effects of adverse childhood experiences; assess broader psychosocial needs; and design procedures for responding to distress.

- **Standard 4. Family and community engagement:** Educate families and communities about sensitive issues including child maltreatment. Build links with schools, community organizations and other services that can support adolescents' wider needs.
- **Standard 5. Competent workforce:** Equip health workers to manage safety concerns, confidentiality, privacy, consent, and conflicts between adolescents and caregivers, including when there are concerns that an adolescent may be at risk of ongoing harm.
- **Standard 6. Comprehensive care and referral:** Ensure that adolescent services can identify and respond to violence and establish clear referral pathways to mental health, sexual and reproductive health, legal, welfare, housing, and other relevant services.
- **Standard 7. Data-informed and youth-engaged practice:** Involve adolescents in designing, monitoring and improving services. Use age- and sex-disaggregated data and adolescent feedback to identify gaps in access and quality.
- **Standard 8. Welcoming physical environment:** Provide private, accessible and welcoming spaces where adolescents feel safe discussing sensitive concerns.

Help adolescents access high-quality post-rape care

Adolescents and children subjected to non-consensual sexual intercourse need access to timely, high-quality post-rape care, within 72 hours for post-exposure HIV prophylaxis and within 120 hours (five days) for emergency contraception depending on the circumstances.¹⁹ Health programmes, including clinical services and community-based programmes, should be prepared to help children and adolescents access services (either directly or by referral) that align with international guidelines.^{19,236} High-quality post-rape care may include emergency contraception and sexually transmitted infection prophylaxis, and in some settings and cases, hepatitis B vaccination and HIV testing, counselling, and prophylaxis.¹⁹

Key resources:

[*Responding to Children and Adolescents Who Have Been Sexually Abused*](#), WHO, Geneva, 2017¹⁹

[*Working with Adolescent Girl GBV Survivors on the Move: A guide for service providers*](#), UNICEF Latin America and Caribbean Regional Office and VOICE, Panama, 2020³³¹

[*Supporting Young Male Refugees and Migrants Who Are Survivors or at Risk of Sexual Violence: A field guide for frontline workers in Europe*](#), UNICEF Regional Office for Europe and Central Asia and the Women's Refugee Commission's Sexual Violence Project, Geneva, 2021³³²

Strengthen access to post-rape services for adolescents in humanitarian settings

A global review of adolescent girls' uptake of sexual and reproductive health care found emerging evidence of promising strategies for expanding access to post-rape services in humanitarian settings.³³³ Evidence of effectiveness is still limited, but examples of innovative strategies include:

- mobile sexual and reproductive health care camps;
- free transportation to clinics for severe cases;
- adolescent-friendly service corners in sexual and reproductive health care camps; and
- task-shifting care to community health workers and traditional birth attendants.

Related resources:

[*Caring for Child Survivors of Sexual Abuse Guidelines*](#), 2nd ed., UNICEF, New York, 2023

[*The Inter-Agency Minimum Standards for Gender-Based Violence in Emergencies Programming*](#), United Nations Population Fund (UNFPA), New York, 2019

[*Clinical Management of Rape and Intimate Partner Violence Survivors: Developing protocols for use in humanitarian settings*](#), WHO, Geneva, 2020

Invest in research, prevention and response to injuries resulting from self-harm and interpersonal violence against adolescents

Evidence about effective injury prevention programmes for adolescents in low- and middle-income countries is still limited.³³⁴ However, WHO reviewed evidence about the effectiveness of 21 youth violence prevention strategies in low- and middle-income countries, where youth violence rates are highest.³³⁵ That review highlighted the need for multisectoral, multi-level strategies to prevent injuries associated with interpersonal violence among adolescents; it also emphasized the role of health systems in public health prevention, community-based programmes, health service responses to violence-related injuries and data collection on violence-related injuries, to build national political will to address youth violence as a public health issue.



4.5 Strengthen national immunization systems

"Support for supply chain management, outbreak preparedness, and social and behaviour change ... strategies will help to strengthen national immunization systems. These efforts will prioritize zero-dose children, including those in humanitarian settings and children with disabilities, and contribute to the eradication of wild polio. UNICEF will work to ensure that immunization remains high on the global health agenda and is integrated with broader areas of work such as efforts towards universal health coverage, improved nutrition and gender equality."

– Paragraph 57, 2025 Theory of Change, UNICEF Strategic Plan, 2026–2029⁴⁸

Why immunization programmes should integrate attention to violence

In some parts of the world, researchers have found evidence that women's empowerment and intimate partner violence may be associated with childhood immunization-related outcomes. For example, a study from 17 sub-Saharan African countries found that an index of women's empowerment (including attitudes about wife-beating) was a significant predictor of full childhood immunization, even after controlling for other factors.³³⁶ Another study from India found that emotional (but not physical or sexual) intimate partner violence against mothers was associated with incomplete child immunization.³³⁷

Another body of research suggests that proximity to armed conflict³³⁸ and urban violence³³⁹ can undermine immunization uptake. One study found that conflict-affected children (primarily in Africa and the Eastern Mediterranean) were over 20 per cent less likely to receive vaccines such as polio and diphtheria, tetanus, and pertussis than other children, and effects often persisted for years post-conflict.³³⁸ Similarly, a systematic review of qualitative studies from Latin America found that fear of crime and gang-related violence limited access to health facilities and undermined vaccination efforts in Colombia, Ecuador, El Salvador and Honduras.³⁴⁰ A UNICEF study from Maré in Rio de Janeiro, Brazil,³³⁹ found that active police operations related to armed urban violence suppressed daily vaccination uptake by up to 82 per cent, even when clinics remained open, likely due to caregiver fear and restricted mobility.³³⁹

Examples of opportunities for immunization programmes to address violence

It is not clear whether addressing intimate partner violence can improve child immunization rates. However, staff who provide child and adolescent immunization services are often service providers who have regular interaction with new mothers, young children and adolescents, especially in vulnerable situations. Therefore – similar to primary care providers – they should be prepared to identify signs of violence, provide appropriate first-line responses to disclosures and make referrals for additional support when appropriate and feasible, as described previously.

Meanwhile, UNICEF and international partners have developed resources for helping health services, including immunization programmes, continue to operate in emergency contexts, including armed conflict.³⁴¹ Some programmes have aimed to help health services avoid disrupted immunization services in settings affected by urban armed violence, as described below.

Support health services operating in settings affected by urban violence: The Access (Acesso) programme

In 2009, the International Committee of the Red Cross launched a programme in Rio de Janeiro in collaboration with municipal and state agencies for essential services, including the Municipal Health Secretariat of Rio de Janeiro. In 2016, this evolved into the Safer Access to Essential Public Services Programme, now known as the Acesso programme. The programme equips health, education and social welfare personnel working in communities affected by urban armed violence to analyse context and risks, develop contingency and crisis-response procedures, and manage work-related stress. The aim is to enable essential services – including health facilities – to continue operating safely in the context of urban armed violence. According to programme reporting, by June 2026, Acesso had trained more than 62,000 essential-service professionals, and approximately 2,478 public service facilities were implementing the programme across eight Brazilian municipalities.³⁴² An evaluation found that the programme helped strengthen service providers' capacity to manage risks associated with proximity to urban armed violence and supported more systematic decision-making during crises, though the evaluation design did not permit causal conclusions about programme impact.³⁴³



4.6 Expand HIV/AIDS prevention, testing and treatment

"To support the elimination of paediatric HIV and improve survival outcomes, the organization will offer technical assistance to governments and foster partnerships to expand early diagnosis and antiretroviral therapy ... coverage for children, particularly in sub-Saharan Africa."
– Paragraph 58, 2025 Theory of Change, UNICEF Strategic Plan, 2026–2029⁴⁸

Why HIV prevention, testing and treatment should integrate attention to violence

Violence has important implications for HIV transmission, testing, treatment and prevention. For example:

- **Sexual violence poses a risk of HIV transmission.** Adolescent girls face particular risks, in part due to the biology of the developing cervix and reproductive system.^{140,141}
- **Sexual violence has been linked to elevated risks of HIV.** Longitudinal studies^{344,345} and cross-sectional studies^{346,347} from high-prevalence settings have found associations between HIV and histories of sexual violence among children, adolescents and young adults, including forced sexual debut; attempted or completed forced vaginal, anal or oral sex; and/or exploitative sex with minors involving money, gifts or goods.
- **Some evidence suggests that women and girls subjected to intimate partner violence have an elevated risk of HIV, though findings are mixed.** Longitudinal studies from South Africa³⁴⁸ and Uganda³⁴⁹ have suggested a link. A pooled analysis of nationally representative data from six sub-Saharan African countries found that ever-partnered women and girls aged

15 and older who had experienced physical or sexual intimate partner violence in the past 12 months were three times as likely to have had a recent HIV infection compared with other women and girls,³⁵⁰ though global reviews find mixed results.¹³⁹

- **Studies suggest multiple possible pathways by which violence may increase the risk of HIV.** These include forced/non-consensual sex, as well as longer-term high-risk sexual exposures such as reduced ability to negotiate condom use or refuse sex, age-disparate partnerships between adolescent girls and older men, sexually transmitted infections and higher HIV prevalence and higher-risk sexual behaviours among men who perpetrate violence.^{350,351,352}
- **In many settings, HIV services for child and adolescent survivors of sexual violence have gaps and challenges.** These include a lack of pre- and post-test counselling and low rates of return visits for adherence counselling and follow-up testing for child and adolescent survivors placed on post-exposure prophylaxis.^{239,353,354}
- **Children and adolescents living with HIV often experience discrimination and violence, including neglect.** This includes stigma and discrimination,⁷⁵ abandonment and neglect from caregivers, partners and other family members,³⁵⁵ and physical and sexual violence³⁵⁶ – all of which may undermine their health, well-being and sometimes survival. Violence and discrimination against those living with HIV pose barriers to HIV testing, treatment, adherence and prevention of onward transmission.^{357,358}
- **Studies find persistently sub-optimal or inconsistent rates of antiretroviral therapy adherence among children and adolescents living with HIV.** Studies from sub-Saharan Africa identify stigma, discrimination, inadequate caregiver support and violence including neglect as important factors that undermine adolescent adherence, while family, peer, psychosocial and material support facilitate adherence and retention.^{355,356,359} Medical neglect, including persistent caregiver failure to secure or administer treatment, remains a barrier to paediatric HIV adherence.³⁶⁰ Evidence from Eastern and Southern Africa suggests this risk may be higher for children whose primary caregivers are not their biological parents.³⁶¹
- **Intimate partner violence may increase the risk of vertical transmission.** Research from South Africa³⁶² and Zambia³⁶³ found that intimate partner violence may increase the risk of vertical transmission by reducing maternal adherence to HIV treatment and other prevention of mother-to-child transmission measures. In Zambia, women living with HIV who reported violence by their current partner had 74 per cent reduced odds of adherence to HIV treatment during pregnancy, 89 per cent reduced odds of adherence postpartum and 91 per cent reduced odds of recommended infant prophylaxis compared with women who reported no violence.³⁶³ That study also found evidence of a dose response, whereby each additional violent episode in the past year reduced odds of adherence. One modelling study estimated that past-year intimate partner violence against women and girls aged 15–49 years accounted for around one in eight (over 22,000) paediatric HIV infections in sub-Saharan Africa in 2022, with the population attributable fraction highest among girls aged 15–19 years, at 20 per cent (8–33 per cent) – ranging from 4 per cent (2–7 per cent) in the Niger to 28 per cent (13–43 per cent) in Uganda.³⁶⁴

Examples of how HIV programming can address violence, including deliberate neglect

Given the elevated risks of violence (including neglect) and discrimination against children, adolescents and women living with HIV,^{357,358} HIV prevention, testing, treatment and care programmes have an opportunity and an obligation to integrate attention to violence, as highlighted in the examples below.

Integrate attention to violence and neglect into adolescent HIV care: Zvandiri, Zimbabwe

Zvandiri is a service delivery model for children and adolescents living with HIV in Zimbabwe. Young people living with HIV are trained as Community Adolescent Treatment Supporters and work alongside health services to provide clinic-based counselling, support groups, home visits, telephone and text support, and referrals.³⁶⁵ Support is tailored to adolescents' clinical and psychosocial needs. Exposure to or risk of abuse or neglect was explicitly identified as a reason for implementing enhanced support, along with psychological distress, treatment difficulties and other vulnerabilities. Enhanced care includes more frequent contact, counselling and referral. Adolescents identified as being at risk of harm are referred to clinic staff and social services. In a randomized controlled trial involving 496 adolescents aged 13–19 years attending 16 public health facilities, Zvandiri reduced the combined outcome of virological failure or death at 96 weeks compared with standard HIV care (25 per cent vs 36 per cent), although the trial did not include specific outcomes related to abuse or neglect.³⁶⁶ According to programme reports,³⁶⁷ the model has been scaled up across many districts in Zimbabwe and adapted and scaled up in 15 countries.

Integrate attention to violence within HIV services for young people: Project YES!, Zambia

Project YES! (Youth Engaging for Success) tested a peer-mentoring intervention for adolescents and young adults aged 15–24 years attending four HIV clinics in Zambia. Young adults living with HIV were trained and employed as peer mentors within health facilities, providing individual and group support aimed at strengthening HIV self-management and reducing internalized stigma.³⁶⁸ The programme incorporated a violence and mental health safety and referral protocol, whereby young people reporting severe violence or suicidal thoughts during assessments or peer-mentor sessions were referred to designated health care providers, with referral to outside services where needed.³⁶⁹ This addressed substantial unmet need. Among participants, 78 per cent reported lifetime violence victimization, and 45 per cent were referred at least once for severe violence and/or suicidal thoughts during the course of the programme. Sexual violence was the most common reason for a first referral.³⁷⁰ A randomized controlled trial found reduced internalized HIV stigma across study sites

and improved viral suppression among participants attending intervention paediatric HIV clinics.³⁶⁸ The lessons learnt from implementation highlighted a need for improved provider training and stronger referral networks to integrate violence and mental health responses effectively into HIV care.³⁶⁹

Integrate attention to violence within home-visiting programmes for HIV-affected families

Innovative examples of health programmes for HIV-affected families with children have demonstrated positive health outcomes by integrating attention to violence into home-visiting programmes for HIV-affected families. For example, in Rwanda, the **Family Strengthening Intervention** for families affected by HIV used social workers based in health centres to identify caregivers living with HIV. Families were offered home-based sessions to strengthen family communication, positive parenting and coping; reduce harsh punishment and violence; and connect families with services. An evaluation found promising preliminary evidence that such an approach may have the potential to reduce caregiver alcohol use, decrease rates of intimate partner violence and family conflict, and improve child mental health outcomes.³⁷¹

The approach subsequently evolved into **Sugira Muryango** (Strengthen the Family), a home-visiting programme for highly vulnerable families with young children that was designed with a trauma-informed lens to address mental health challenges facing parents and other caregivers, such as those related to family violence, social isolation and chronic illness. Delivered by trained community workers and linked to Rwanda's social protection system, it promotes responsive parenting, paternal engagement, conflict resolution, non-violent discipline, nutrition and child health. A cluster-randomized trial of more than 1,000 families found reductions in harsh discipline and intimate partner violence; it also found improvements in paternal engagement and child mental health and development outcomes one year later.³⁷² A four-year follow-up study found sustained improvements in parenting and decreased harsh discipline, although effects on intimate partner violence and child developmental outcomes were no longer evident.³⁷³



4.7 Expand mental health and psychosocial support services

"UNICEF will advocate for national mental health strategies and promote the integration of mental health and psychosocial support (MHPSS) into health, education, and protection systems. These services will be inclusive of children and adolescents with disabilities and tailored to the unique needs of adolescent girls. Greater coordination and coherence among humanitarian action, development, and peace will ensure continuity of care in fragile contexts."
– Paragraph 58, 2025 Theory of Change, UNICEF Strategic Plan, 2026–2029⁴⁸

Why mental health services for children and adolescents should address violence

- **Violence has serious mental health consequences for children and adolescents and contributes to the global burden of ill health.** Violence may have consequences such as psychological distress, PTSD, depression, anxiety, behavioural and other externalizing problems, harmful alcohol and drug use, self-harm, and suicidal thoughts and attempts.^{8,103,104,105,107,108,109,111} Violence contributes to a substantial proportion of the global burden of DALYs due to adolescent depression, anxiety and self-harm.^{5,8,110,374} In 2024, self-harm was the leading cause of death among adolescent girls aged 15–19 and the third leading cause of death among boys aged 15–19.¹⁰¹
- **Globally, access to mental health care for children and adolescents is highly limited.** A 2023 meta-analysis estimated that only 38 per cent of children and adolescents who met diagnostic criteria for a mental health condition in the included studies received treatment services.³⁷⁵ WHO and UNICEF suggest that unmet need can approach 100 per cent in many low- and middle-income settings.²⁶⁶
- **Mental health services have an opportunity to identify and respond to violence.** Research suggests that mental health services should integrate attention to child maltreatment, sexual abuse and other adverse childhood experiences to ensure they do not miss opportunities to identify and provide an appropriate first-line response to children and adolescents subjected to violence, who often show a wide range of non-specific presentations, similar to other conditions.²⁴²
- **Child and adolescent reactions to violence often overlap with symptoms of other mental health and behavioural conditions, posing a risk of misdiagnosis.** Children and adolescents often react to violence and other adverse childhood experiences with a range of presentations that often overlap with conditions such as depression, attention deficit hyperactivity disorder (ADHD), disruptive behaviour disorders^{376,377} and PTSD,³⁷⁸ posing a risk of misdiagnosis. For this reason, the 2016 Mental Health Gap Action Programme (mhGAP) Intervention Guide 2.0ⁱⁱ instructed health workers to consider whether emotional, behavioural or developmental problems might be reactions to child maltreatment or other forms of violence against children and adolescents before confirming these types of diagnoses or initiating pharmacological treatments.²⁸⁵

ii As of August 2026, the mhGAP Intervention Guide 3.0 was not publicly released.

- **Despite this evidence, mental health services and international guidance do not always integrate attention to violence, especially in low- and middle-income settings.** For example, a systematic review of evidence from low- and middle-income countries found few examples of mental health services or interventions that addressed child maltreatment or exposure to intimate partner violence; authors described violence and mental health services as “typically siloed, when available”.³⁷⁹ Notably, the most recent WHO 2023 mhGAP Guideline²⁶⁵ does not include any mention of violence against children or adolescents under age 18 when instructing non-specialized health workers on how to diagnose and treat children with conditions such as PTSD and ADHD, even though 2016 mhGAP resources noted that child and adolescent reactions to potentially traumatic events such as child maltreatment and sexual abuse can complicate diagnosis and treatment of these conditions.²⁸⁵
- **Evidence about how to support children and adolescents subjected to violence remains limited.** The Lancet commission on adolescent health and well-being³⁸⁰ and WHO³⁸¹ have called for more research on mental health services and psychosocial support for adolescents exposed to violence in low- and middle-income countries, with attention to the possibility that universal MHPSS initiatives designed for the general adolescent population might avoid the risk of stigmatizing or otherwise harming adolescent survivors compared with targeted approaches.³⁸¹

Examples of ways to expand access to mental health services that address violence

UNICEF and partners such as WHO have led efforts to expand and improve mental health services for children and adolescents in low- and middle-income countries, especially in emergency settings.⁴⁰ UNICEF is therefore well positioned to help countries improve mental health responses to violence, informed by the examples described below.



Expand community-based mental health services with capacity to address violence against children and adolescents

In 2024, WHO and UNICEF published joint service guidance to expand and strengthen community-based mental health care for children and young people aged 5–24, based on literature reviews, existing standards, consultations and selected country examples.²⁶⁶ Several themes from this guidance are particularly relevant for improving the capacity of mental health services to address the needs of children and adolescents who experience violence, as listed below.

Integrate mental health services into existing health programmes. Because of widespread service gaps, especially in low-resource settings, the guidance recommends expanding mental health services integrated into primary health care, community health worker programmes, maternity care for pregnant adolescents, HIV services for adolescents and other community-based programmes.

Strengthen mental health service capacity to care for children and adolescents affected by violence while protecting their safety, rights and well-being. The guidance includes detailed standards for mental health care, such as:

- Protect children and adolescents from exploitation, violence and abuse.
- Eliminate coercive practices such as seclusion and restraint.
- Respect confidentiality, privacy, non-discrimination and inclusion.
- Establish child protection policies, procedures and reporting mechanisms.
- Train service providers to recognize, respond to and report child abuse.
- Empower children and young people to speak up about safety concerns.
- Establish referral processes to child protection and other community services.
- Involve caregivers while respecting adolescents' evolving capacities and autonomy.
- Ensure that health workers act in the best interests of the child or young person.
- Involve children, adolescents and families in service design and evaluation.

Strengthen the broader community-based mental health system. For example, in the following areas:

- **Leadership and governance:** Strengthen mental health-related legislation and policy.
- **Participation:** Involve families, children and adolescents in policy development.
- **Financing:** Secure adequate funds for the mental health care system.
- **Workforce:** Expand and strengthen the specialist and non-specialist workforce.
- **Information systems:** Strengthen monitoring, research and quality assurance.



Implement recommendations from the Inter-Agency Standing Committee's Mental Health and Psychosocial Support Minimum Service Package

With UNICEF and WHO in leading roles, the Inter-Agency Standing Committee (IASC) developed the [*Mental Health and Psychosocial Support Minimum Service Package*](#) for use in humanitarian settings.⁴⁰ The package recommends integrating MHPSS across sectors, including clinical health services. It calls for attention to violence against children and adolescents, reflecting a systems approach, including the following recommendations:

- **Integrate MHPSS within clinical care for child and adolescent survivors** of sexual violence and intimate partner violence against girls.
- **Recognize the mental health and psychosocial consequences of violence.** Ensure that services have staff with appropriate child- and adolescent-specific competencies, including capacity to inquire appropriately about suspected violence and respond safely to disclosures.
- **Address children's and adolescents' need for safety as well as mental health support.** Recognize that mental health interventions may have limited impact when violence is ongoing, highlighting the need for coordination with protection services.
- **Map services and maintain coordinated referral pathways.** Link MHPSS, health, child protection and gender-based violence services through humanitarian coordination mechanisms. Review available services as humanitarian responses evolve.
- **Strengthen case-management systems.** These should address mental health and protection needs together and avoid unnecessary duplication of assessments.
- **Support non-offending caregivers, particularly following sexual violence.**
- **Adapt services for children and adolescents at heightened risk.** This includes children and adolescents who are unaccompanied, separated or otherwise face heightened protection risks and barriers to care.



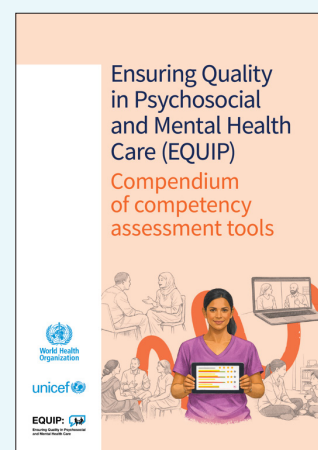
Expand family-inclusive MHPSS interventions in complex humanitarian settings

UNICEF and partners in the Syrian Arab Republic developed two complementary programmes that offer family-inclusive MHPSS interventions for children and caregivers in complex humanitarian settings.³⁸² Developed with input from communities, caregivers, front-line workers and other stakeholders, Sawa (Together) is for children aged 6–17 and Sanadi (My Rock) is for caregivers. The programmes are delivered through structured group sessions that emphasize relational well-being and the connections between child and caregiver mental health. Sawa uses play, art, role-play and storytelling to build children's emotional regulation, social connectedness and coping skills. Sanadi is designed to support caregivers by focusing on child development, non-violent discipline, stress management and peer exchange. Run in parallel, the two programmes form a family-inclusive model

that serves children and caregivers simultaneously – addressing a persistent limitation of humanitarian MHPSS programmes, which have often served children and caregivers separately. After the programmes were endorsed by the government in 2023 and 2025, they were implemented across all governorates in the country, reaching over 250,000 children and 100,000 caregivers by 2025. A mixed-methods evaluation using pre- and post-surveys and qualitative reports found evidence of promise across key domains, including emotional regulation, social connectedness, help-seeking and non-violent parenting, with participants reporting sustained use of skills beyond the sessions. Further research into the sustainability of these reported results is needed.

Expand use of EQUIP (Ensuring Quality in Psychosocial and Mental Health Care)

EQUIP is a joint WHO/UNICEF initiative that aims to strengthen psychosocial and mental health care competencies in low-resource and humanitarian settings.³⁸³ EQUIP addresses general mental health care, but also explicitly includes attention to identifying and responding to violence-related psychological harm among children, adolescents and adults in a person-centred way. EQUIP helps programmes identify skill gaps early, target support efficiently, and maintain accountable child-facing services through ensuring safe, ethical and observable helping skills that reduce avoidable harm to children, adolescents and adults.

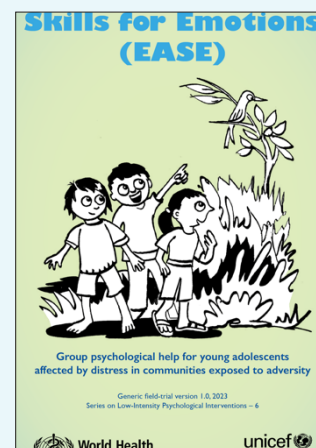


The initiative has developed resources for training and supervising non-specialists and specialists so they can deliver more effective psychological support to adults, adolescents and children. The online platform provides competency assessment tools, role-play scripts, training videos and e-learning tools on how to use the EQUIP platform and resources.³⁸⁴ As of March 2024, EQUIP's digital platform had been used by more than 10,000 users across 794 training programmes in over 100 countries.³⁸³

In Lebanon, a proof-of-concept study found that non-specialists trained using EQUIP demonstrated higher competency scores than those receiving training as usual, though the sample was small (n=24).³⁸⁵ A randomized controlled trial in Nepal comparing EQUIP-based training with routine training had been registered but not yet published when the search for this review was carried out.

Expand initiatives such as Early Adolescent Skills for Emotions (EASE)

Early Adolescent Skills for Emotions (EASE), developed by WHO and UNICEF, is a brief, group-based psychological intervention for adolescents aged 10–15 years with internalizing symptoms such as stress, anxiety and depression in communities exposed to adversity, including armed conflict.²⁶⁷ EASE combines seven adolescent group sessions with three caregiver sessions and is designed for delivery by trained, supervised, non-specialist helpers, making it suitable for emergency and other resource-constrained settings where children exposed to violence may not have access to specialist care for mental health. EASE is not a violence-specific intervention, but it addresses common emotional consequences of adverse childhood experiences, including exposure to violence. It teaches skills adapted from cognitive behavioural therapy, including stress management, behavioural activation and caregiver support. In a randomized trial with Syrian refugee adolescents in Jordan, EASE reduced caregiver-reported adolescent internalizing symptoms and caregiver distress, suggesting its value as a scalable approach for mitigating some mental health consequences of violence, displacement and other stressors, though these effects were not sustained at 12-month follow-up relative to usual enhanced care.^{386,387} Similarly, a cluster-randomized controlled trial found evidence that EASE reduced psychosocial distress among adolescents in low-resource public schools in Pakistan.³⁸⁸ A 2025 systematic review noted that EASE produced a small but favourable effect on internalizing symptoms and was found to be acceptable and feasible, albeit with some challenges such as uneven caregiver engagement.³⁸⁹





4.8 Prevent and treat malnutrition among children, adolescents and women

"A life-course approach will guide the scale-up of early childhood nutrition packages, school-based nutrition education, and maternal nutrition programmes. These interventions aim to prevent stunting, anaemia, and other forms of malnutrition in 1.2 billion children and women, with a focus on adolescent girls and women of reproductive age."

– Paragraph 59, 2025 Theory of Change, UNICEF Strategic Plan, 2026–2029⁴⁸

Why nutrition programmes should integrate attention to violence, including neglect

Evidence suggests that certain types of violence, including deliberate neglect, are associated with a greater risk of malnutrition among children and adolescents.⁹⁴ Research, including an analysis of nationally representative data from 42 low- and middle-income countries, has also found significant associations between maternal experiences of physical and/or sexual intimate partner violence and stunting among their children, after controlling for other factors.¹⁸²

Numerous studies,^{390,391} including an analysis of national data from 51 low- and middle-income countries,¹⁸⁰ have found that women subjected to intimate partner violence are less likely to breastfeed according to recommended practices, such as early initiation of breastfeeding or exclusive breastfeeding in the first six months. A [rapid evidence assessment](#)¹⁸¹ summarized in a UNICEF brief³⁹² examined child nutrition outcomes among children of women experiencing intimate partner violence in fragile settings and identified 15 studies exploring links between intimate partner violence and breastfeeding, suggesting that violence is a barrier to optimal breastfeeding practices, with implications for infant and early childhood nutrition.

Meanwhile, a global review suggests links between undernutrition, violence and harmful practices among adolescent girls, including emerging evidence that child marriage and early pregnancy are associated with and may exacerbate undernutrition among adolescent girls in low-resource settings.³⁹³ Conversely, emerging evidence from low- and middle-income settings suggests that food insecurity may sometimes increase the risk of physical intimate partner violence.³⁹⁴

Evidence linking poor child growth with intimate partner violence against caregivers¹⁸² and with child neglect⁹⁴ suggests that high-quality management of undernutrition among children, adolescents and pregnant women would benefit from addressing intimate partner violence against caregivers and deliberate child neglect as possible risk factors for malnutrition and stunting, as well as the possibility that food insecurity may increase the likelihood of violence.³⁹⁴

Examples of how nutrition programmes can address violence

Integrate attention to intimate partner violence against women within breastfeeding programmes

The [rapid evidence assessment](#) summarized in the previously mentioned UNICEF brief,³⁹² subsequently published as a journal article,¹⁸¹ concluded that actions to proactively identify and mitigate the risk of intimate partner violence could help make early childhood nutrition programming more effective. Specifically, the UNICEF brief³⁹² suggested that nutrition programmes should undertake steps that echo a systems approach to improve their capacity to address violence, as described earlier, including the following:

- Conduct safety audits to identify and address violence-related risks at nutrition facilities.
- Train nutrition staff to respond appropriately to disclosures of intimate partner violence.
- Advocate for policies that create safe and supportive environments for breastfeeding.
- Disseminate information about available response services for violence against women.

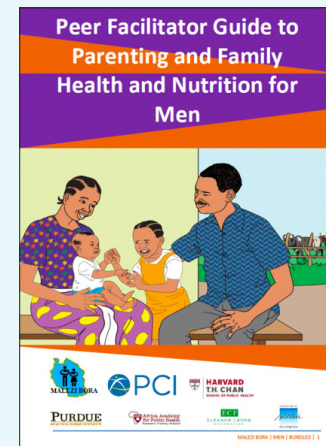


Bundle positive parenting support into community-based child nutrition interventions

The Engaging Fathers for Effective Child Nutrition and Development in the United Republic of Tanzania (EFFECTS) trial was a cluster-randomized 2×2 factorial trial (plus a standard-of-care control) conducted across 80 villages in northern areas of the United Republic of Tanzania.³⁹⁵ Between October 2018 and May 2019, 960 households with a child under 18 months were enrolled, and 80 villages were randomly assigned to one of five arms: 1) standard of care (routine community health worker services); 2) nutrition content delivered to mothers; 3) nutrition content delivered to couples; 4) bundled nutrition-and-parenting content delivered to mothers; 5) bundled nutrition-and-parenting content delivered to couples. Community health workers delivered 18 biweekly peer-group sessions. After a four-month disruption caused by the COVID-19 pandemic, the remaining six sessions were delivered as biweekly home visits.^{395,396}

Between baseline and endline, the proportion of mothers reporting intimate partner violence in the prior three months fell from 67 per cent to 42 per cent in the bundled nutrition-and-parenting arms and from 60 per cent to 47 per cent in the nutrition-only arms. Adjusted differences between the two groups were statistically significant for any intimate partner violence and for sexual intimate partner violence. Differences in reductions in physical and emotional intimate partner violence were suggestive but not statistically significant.

Notably, engaging couples rather than mothers alone did not have a significant independent effect on maternal reports of intimate partner violence. Instead, the added reduction appeared to be associated with the parenting content rather than paternal engagement.³⁹⁵ Authors described this as an unexpected finding and suggested that responsive-caregiving and positive-discipline content may have had broader effects on family violence, beyond parent-child relationships.³⁹⁵ Compared with nutrition-only interventions, bundled interventions also produced small but significant improvements in children's cognitive and receptive language development and a reduction in paternal parenting distress.



Home-visiting programmes that integrate attention to parenting and maternal depression within programmes to address undernutrition

Some home-visiting programmes designed to detect and treat child undernutrition in low- and middle-income countries have integrated attention to parenting and maternal depression. For example, the Philani programme in Cape Town, South Africa, was a community-based, nutrition-focused home-visiting programme that integrated attention to topics such as nurturing caregiving, maternal depression and gender dynamics in the household.³⁹⁷ Mentor Mothers were trained to identify and address undernutrition; recognize signs of abuse, child neglect and maternal depression; assist mothers experiencing depression; support mother–child bonding; and develop referral strategies for intimate partner abuse and other psychosocial problems. A later evaluation found positive results in child growth outcomes³⁹⁸ and more harmonious mother–child interactions when children were aged 3 years, at least among mothers without antenatal depression.³⁹⁹



4.9 Strengthen early childhood services and parenting support

"UNICEF will generate and use evidence to inform programming, engage families and communities to promote positive nutrition practices, and strengthen inclusive national systems that integrate early stimulation, parenting support, and inclusive childcare – especially for children with disabilities."

– Paragraph 59, 2025 Theory of Change, UNICEF Strategic Plan, 2026–2029⁴⁸

Why parenting support services should address violence, including neglect

Nearly 30 years ago, researchers found longitudinal evidence that home visits to new mothers by nurses had the potential to prevent child maltreatment.⁴⁰⁰ Since then, parenting support programmes in low-, middle- and high-income countries have increasingly integrated attention to responsive caregiving, positive child discipline, caregiver stress, coping and mental health, and other caregiver support. More recently, integrated strategies have shown preliminary promise for preventing or reducing both child maltreatment and intimate partner violence.^{47,304}

The 2026 systematic review⁴² carried out to update the INSPIRE framework³⁰ concluded that across low-, middle- and high-income countries, parenting support delivered through home visits or community settings had the strongest evidence of any strategy for reducing child maltreatment and preventing re-victimization, with some promise for reducing co-occurring intimate partner violence against women. Similarly, the 2025 systematic review⁴¹ carried out to update RESPECT Women³⁷ identified parenting support as a promising strategy for long-term prevention of violence against women, by reducing child maltreatment and disrupting intergenerational cycles of violence.

Systematic reviews suggest parenting support programmes have the potential to:

- prevent or reduce violence against children:
 - by reducing harsh parenting, physical violence and psychological aggression by caregivers.^{304,401,402}
- strengthen protective factors and reduce risk factors for violence:
 - by improving parent–child relationships and interactions.^{403,404}
 - by increasing responsive, positive and non-violent parenting.^{304,404}
 - possibly by improving caregiver mental health, including symptoms of depression, anxiety and/or stress.^{304,401}
- possibly prevent or reduce intimate partner violence against caregivers:
 - by reducing or preventing co-occurring intimate partner violence and violent discipline.^{47,304}
- improve child and adolescent mental health, development and well-being:
 - by reducing symptoms of internalizing problems (e.g., anxiety, depression or stress).^{401,403,405}
 - by reducing behavioural and externalizing problems (e.g., aggression, conduct problems or hyperactivity).^{403,404,405}
 - by improving cognitive, language and motor development.^{404,406}
 - by improving social-emotional development.⁴⁰⁴

In settings affected by armed conflict, displacement and other humanitarian crises, children face heightened risks of acute psychosocial distress and long-term mental health and psychosocial challenges.^{407,408} Growing evidence suggests that parenting support programmes can reduce physical and psychological violence against children and improve caregiver mental health.⁴⁰¹ Children in these settings are better able to adapt and recover when they have positive caregiver relations, non-violent and responsive parenting, and supportive community environments.^{409,410} Studies from Afghanistan⁴¹¹ and the Syrian Arab Republic⁴¹² found evidence that caregiver well-being (and distress) plays a central role in shaping child outcomes in those settings. Strengthening caregiver well-being and positive parenting may therefore mitigate the negative mental health impacts of conflict-related stress.⁴¹³

Examples of parenting support programmes in the health sector that address violence

WHO and UNICEF have published many resources with recommendations for and examples of parenting support programmes that integrate attention to violence, such as:

- [*The Role of the Health Sector in Supporting Parents and Caregivers to Meet Their Parenting Potential*](#), WHO, Geneva, 2025;⁴¹⁴
- [*WHO Guidelines on Parenting Interventions to Prevent Maltreatment and Enhance Parent-Child Relationships with Children Aged 0–17 Years*](#), WHO, Geneva, 2022;⁴¹⁵

- [*Working at the Intersections of Violence against Children and Violence against Women: Parent and caregiver support programmes*](#), UNICEF, Florence, 2024;³⁰⁰
- [*UNICEF's Vision for Elevating Parenting: A strategic note*](#), UNICEF, New York, 2021;⁴¹⁶ and
- [*Designing Parenting Programmes for Violence Prevention: A guidance note*](#), UNICEF, New York, 2020.⁴¹⁷

The health sector can help families access positive parenting interventions by integrating these programmes within health services, by partnering with social service organizations running these programmes or by referring families to these programmes in the community. Select examples of health sector-based parenting programmes are profiled below.

Integrate positive parenting and parenting support into routine child and adolescent health services

WHO's 2025 brief, [*The Role of the Health Sector in Supporting Parents and Caregivers to Meet Their Parenting Potential*](#),⁴¹⁴ summarizes:

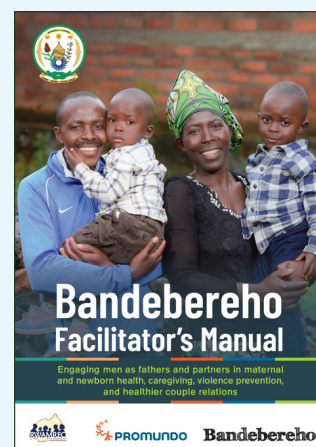
- why the health sector should support parents and caregivers;
- types of support that parents need and which health services can provide; and
- key building blocks of an effective health sector response to parenting support.

The brief encourages health systems to integrate parenting support into routine health services throughout childhood and adolescence; to promote positive, non-violent parenting; to recognize signs of harsh parenting, maltreatment and neglect; to address caregiver mental health and support caregivers' psychosocial well-being; and to connect families with specialized services, such as mental health services and services from other sectors including social welfare – as needed. The brief also describes how to tailor key elements of parenting support for different stages of child development.



Integrate gender-responsive parenting support with strategies to improve couple relationships

In Rwanda, Bandebereho (Role Model) began as a programme for expectant fathers and fathers of children under 5 years of age and their partners, with participatory group sessions on gender roles and power, fatherhood and caregiving, couple communication and relationships, and men's involvement in reproductive, maternal, newborn and child health.⁴¹⁸ Originally implemented by the Rwanda Men's Resource Centre, Bandebereho was subsequently scaled up through the Rwandan health system, delivered by community health workers in collaboration with the Rwanda Biomedical Centre.⁴¹⁹ At 21 months, a randomized controlled trial found positive impacts on intimate partner violence, physical child punishment, maternal health-seeking and couple relations.⁴¹⁸ A six-year follow-up evaluation found lasting reductions in intimate partner violence and physical child punishment, as well as positive effects related to caregivers' depressive symptoms, harmful alcohol use, maternal health-seeking, paternal engagement, more equal division of labour and shared decision-making.⁴²⁰



Integrate violence prevention and response into multisectoral child development programmes: Chile Crece Contigo

Chile Crece Contigo (Chile Grows with You) is a nationwide early childhood development programme in Chile that combines universal services with targeted support for families living in vulnerable situations, from pregnancy through early childhood. It is managed jointly by ministries of health, education and social development, with the health system as the primary entry point, enrolling families at mothers' first prenatal appointment and using routine contacts (prenatal visits, well-child check-ups, immunizations) to monitor child development, screen for psychosocial risk and connect families to services. Chile Crece Contigo includes parenting support delivered through public health centres, including Nadie es Perfecto (Nobody is Perfect) for families with children aged 0–5 and the Programa de Apoyo a la Salud Mental Infantil (Child Mental Health Support Programme) for families of children aged 5–9. Nadie es Perfecto features content designed to prevent both child maltreatment and domestic violence, including positive discipline and caregiver self-care. Families experiencing violence are identified and referred to additional services. Evaluations have found positive effects on child development,⁴²¹ significant increases in positive parenting practices and non-significant



reductions in negative discipline.⁴²² A 2023 UNICEF-commissioned evaluation found that the programme strengthened access to mental health care for children aged 5–9, though challenges remain, illustrating the real-world difficulty of multisectoral collaboration, even in well-established, legally mandated programmes.⁴²³

Health sector support for adolescent mothers: Mama Ambassador Program, Uganda

The Mama Ambassador Program in Uganda provides group-based psychosocial and parenting support to adolescent mothers from the third trimester of pregnancy through the first year after birth. The programme addresses maternal mental health, responsive caregiving and child development, social support, and sexual- and gender-based violence, including referral pathways for survivors.^{424,425} Developed by the Babies and Mothers Alive Foundation in collaboration with Uganda's Ministry of Health, the programme is delivered by trained community health workers drawn from the existing government community health workforce, with supervision from health-facility midwives. Over time, the intervention has expanded violence-response components, adding counselling and social work support, building links with legal and district authorities, engaging male partners, and addressing alternatives to corporal punishment.⁴²⁵ A quasi-experimental evaluation found improvements in maternal mental well-being and infant development, though it did not specifically examine violence-related outcomes.^{424,425}





Section 5. Conclusions

This global review describes the fragmented but rapidly expanding knowledge base about why and how to strengthen health system capacity to address violence against children, adolescents and caregivers. Key findings include the following.

Violence is a health issue

- **Violence against children and adolescents is widespread.** Evidence about magnitude and variations by age, sex and situations of vulnerability is fragmented, especially in low- and middle-income countries, but it is growing rapidly.
- **Violence has profound consequences for child and adolescent health.** Violence against children and adolescents, child exposure to armed conflict and intimate partner violence, and violence against women and girls during pregnancy are major contributors to the global burden of mortality and morbidity.
- **Violence is a type of adverse childhood experience.** The health consequences of violence cannot be fully understood without considering the large body of evidence on violence as a type of adverse childhood experience. Children and adolescents often experience multiple and/or prolonged types of adversity, including violence, which may have cumulative, compounding and/or long-lasting consequences.
- **Violence affects child and adolescent health through direct and indirect pathways.** Consequences may be immediate and direct, such as physical injury, unintended pregnancy or psychological distress, or indirect, often occurring later in life, sometimes mediated by stress reactions to traumatic experiences, high-risk behaviours or intergenerational effects.

- **Stress responses to traumatic experiences are an indirect pathway by which violence may affect health.** Chronic or severe stress responses may affect multiple bodily systems during sensitive periods of child development, sometimes weakening immune systems, increasing susceptibility to infection, and possibly altering brain architecture and nervous system development.

There is growing evidence about why and how health systems should respond

- **Evidence on health system responses to violence against children is fragmented.** Global reviews suggest a need for more research in low- and middle-income countries about how to strengthen the capacity of health systems to prevent and respond to violence. There are also major divides between health services research and programmes in higher- versus lower-income settings.
- **Evidence and international guidance for the health sector are expanding rapidly.** International organizations such as WHO and UNICEF have translated evidence into plans of action, as well as clinical, health system and multisectoral guidance for preventing and responding to violence in more integrated, survivor-centred and gender-responsive ways. Large gaps remain, however, in the effort to ensure that those international guidelines are put into practice.
- **However, most children and adolescents who experience violence do not receive services.** Evidence suggests that most do not tell anyone, and few receive formal services or support. Access to post-rape care is severely limited, especially in low- and middle-income settings.
- **Health services have a distinct, but not stand-alone, role in prevention and response.** Health workers are often among the first service providers to identify violence against children, adolescents and caregivers, but effective responses require coordination with other sectors, including child protection, social welfare, education and justice.
- **Health sector organizations should ensure that their staff are prepared to respond safely to signs or disclosures of violence.** That requires evidence-based protocols, confidentiality and safety protections, first-line support, appropriate referral pathways, and attention to children's and adolescents' health, rights and evolving capacities.
- **A systems approach is needed; training health workers is not enough.** Health systems, organizations and programmes need to make changes across whole systems and organizations, including normative frameworks, leadership and governance, financing, protocols, infrastructure, workforce development, supervision, staff well-being, information systems, community engagement and intersectoral coordination.
- **Health systems should integrate attention to violence within health programming.** Rather than limiting their role to identification, response and referral, health systems should consider the health implications of violence and other forms of adversity when designing and implementing all types of health programming. They also need to involve survivors in programme design and evaluation.

- **Health systems should address intersections between violence against women and violence against children.** Historically, these have been addressed as separate issues, but evidence suggests a need to bridge the gaps. Instead of treating each form of violence or each family member in isolation, expand opportunities for integrated service responses and address co-occurring violence against children and violence against women in the same household.

Greater attention to violence within specific areas of health programming is needed

- **Primary health care:** Primary health care provides an entry point for health workers to identify violence against children and caregivers, respond safely to disclosures and link children, adolescents and caregivers to appropriate support and referrals.
- **Maternal and newborn services:** Respectful maternity care is an important and promising area of work. Evidence suggests this has the potential to protect the rights of pregnant women and girls while also improving maternal and newborn health outcomes.
- **Adolescent health services:** Adolescent girls and boys face substantial violence-related health risks. Their needs and rights may be distinct from younger children or adults, but they often fall into the gaps between child- and adult-focused services. Adolescent-centred care offers a model for ensuring that pregnant adolescents and adolescent survivors of violence can access confidential, age-appropriate and survivor-centred care.
- **Immunization programmes:** Evidence suggests these programmes could benefit from greater attention to violence. This includes strategies for mitigating challenges around delivering care in proximity to armed conflict and urban violence.
- **HIV prevention, testing and treatment:** These could all benefit from greater attention to the ways in which violence, neglect, stigma and discrimination can increase HIV risk and undermine treatment adherence. Meanwhile, health programmes that serve adolescents and families affected by HIV have found that integrating appropriate responses to and support for violence and other psychosocial issues into their services shows promise.
- **MHPSS services:** Violence is a major contributor to child and adolescent mental health conditions. Evidence suggests that integrating attention to violence within these programmes is essential for quality of care.
- **Nutrition programmes:** Emerging intervention evidence suggests that integrating parenting and violence-related support into nutrition programmes may produce benefits for families and children.
- **Parenting support programmes:** These are a highly promising strategy for violence prevention and response. Evidence is particularly strong for reducing child maltreatment, with growing promise for reducing intimate partner violence. An expanding body of international guidance is now available from WHO, UNICEF and other partners.

The way forward for UNICEF: Translating evidence into action

UNICEF is well positioned to help strengthen health system responses to violence worldwide. The organization has a long history of working with governments to strengthen systems in many sectors, including health. UNICEF works across many different health areas, including primary health care, maternal and child health, nutrition, HIV, early childhood development, adolescent health and humanitarian programming.

The evidence reviewed here points to a broad opportunity to integrate attention to the health implications of violence for child, adolescent and maternal health across all health system strengthening and health programming, rather than treating violence as a separate concern. This has the potential to help health systems fulfil their responsibility to protect health and human rights, strengthen multisectoral efforts to prevent and respond to violence and enable children and adolescents not simply to survive, but to be healthy, safe, well-nourished and developmentally on track.



Annex A.

Milestones in global efforts to mobilize health sector responses to violence

1996 The World Health Assembly adopts resolution WHA49.25 declaring violence a leading worldwide public health problem and calling for public health action to address its causes, consequences and prevention.²¹

1998 The Adverse Childhood Experiences Study finds a graded relationship between potentially traumatic experiences in childhood (including violence) and later health risks and causes of death in adulthood.²²

2002 WHO publishes the *World Report on Violence and Health*, emphasizing the role of public health in prevention, surveillance, services for survivors and multisectoral action.²³

2005 WHO publishes findings from the WHO Multi-Country Study that gathered evidence on the prevalence and health outcomes of violence against women and girls in 15 sites across 10 countries.²⁴

2006 The United Nations Secretary-General publishes global studies on violence against children and violence against women, and calls for coordinated, multisectoral action, including from the health sector.^{25,26}

2009 International partners, including UNICEF, launch Together for Girls, which has coordinated Violence against Children Surveys in more than 20 countries as of 2026.²⁷

2013 WHO publishes clinical and policy guidelines on responding to intimate partner violence and sexual violence against women, establishing evidence-based clinical recommendations for health care providers.³³

2014 UNICEF's report *Hidden in Plain Sight* presents global data on violence against children from 190 countries, making the scale of violence against children and adolescents more visible.²⁸

2015 Sustainable Development Goals and targets elevate violence prevention as a priority for global public health and development, including targets on ending violence against women and girls (Target 5.2) and violence against children (Target 16.2).²⁹

2015 United Nations agencies publish the *Essential Services Package for Women and Girls Subject to Violence*, defining key responses to violence across health, justice and social service sectors.³⁴

2016 The article 'Bridging the Gaps' highlights evidence of six intersections between violence against children and violence against women: shared risk factors, social norms, co-occurrence, intergenerational effects, common and compounding consequences, and adolescents who face heightened risks yet often fall through gaps between services for children and adults.³¹

2016 WHO, UNICEF and other partners launch *INSPIRE: Seven strategies for ending violence against children*, with multiple strategies (e.g., response and support services) relevant for the health sector.³⁰

2016 In partnership with the United Nations Office on Drugs and Crime (UNODC), WHO publishes a toolkit for *Strengthening the Medico-Legal Response to Sexual Violence*, which contains material relevant for children as well as adults.³⁵

2016 The World Health Assembly endorses the *Global Plan of Action to Strengthen the Role of the Health System within a National Multisectoral Response to Address Interpersonal Violence, in Particular against Women and Girls, and against Children*.³

2017 WHO publishes *Responding to Children and Adolescents Who Have Been Sexually Abused: Clinical guidelines*, aimed at front-line health workers in low-resource settings.¹⁹

2019 UNICEF's *Gender-Based Violence in Emergencies: Operational guide* calls for health programmes to provide survivor-centred gender-based violence services, post-rape care, psychosocial crisis support, case management, safety services, referral pathways and risk mitigation.³⁶

2019 United Nations agencies launch RESPECT Women,³² which frames violence against women as a public health priority and advocates for preventing violence against children as a way of disrupting intergenerational transmission.

2019 WHO publishes *Guidelines for the Health Sector Response to Child Maltreatment*, which presents evidence reviews later used to inform 2022 clinical guidance.³⁸

2020 WHO, UNICEF and other partners publish a global status report showing uneven progress implementing INSPIRE strategies to prevent and respond to violence against children in 155 countries.³⁹

2021 The World Health Assembly calls for ending violence against children through multisectoral approaches and by strengthening health systems.¹⁷

2022 IASC's *Mental Health and Psychosocial Support Minimum Service Package* calls for integrating MHPSS into general health care in emergencies and strengthening first-line support, psychosocial support, clinical care and referral pathways for survivors of violence.⁴⁰

2022 WHO publishes *Responding to Child Maltreatment: A clinical handbook for health professionals*.¹⁸

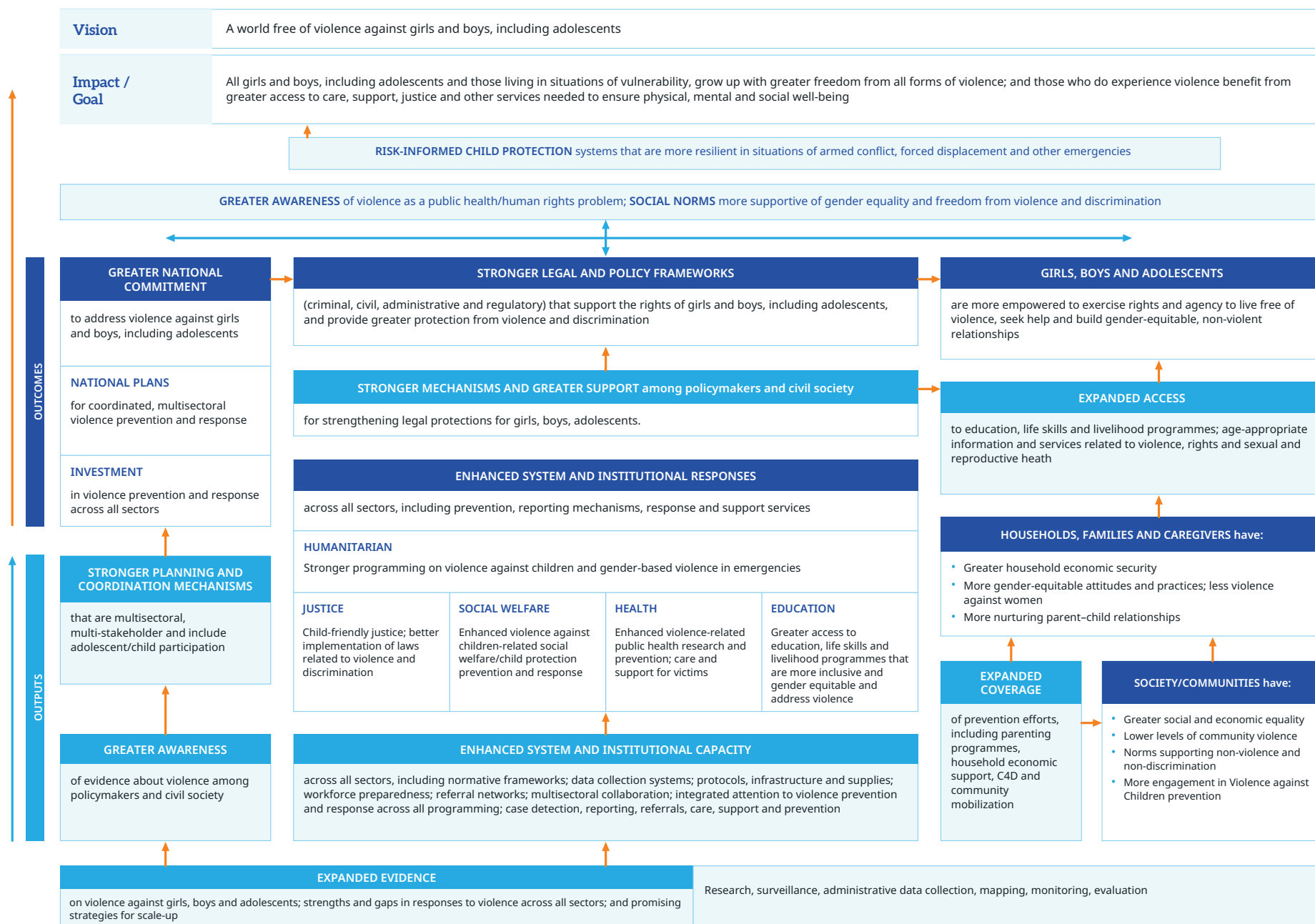
2025 WHO publishes *Clinical Management of Rape and Intimate Partner Violence in Emergencies: A training curriculum for health workers, facilitator guide*.²³⁵

2025 Researchers publish a global review of reviews⁴¹ to update the RESPECT Women framework,³⁷ in which preventing violence against children is theorized as a way to disrupt intergenerational transmission.

2026 Researchers publish a global review of reviews⁴² to update the 2016 INSPIRE framework,³⁰ including a new search category for health care-based violence programmes.

Annex B.

UNICEF's 2017 theory of change for preventing and responding to violence against children and adolescents



Vision	A world free of violence against girls and boys, including adolescents.
Impact/ Goal	All girls and boys, including adolescents and those living in situations of vulnerability, grow up with greater freedom from all forms of violence; and those who do experience violence benefit from greater access to care, support, justice and other services needed to ensure physical, mental and social well-being.
Cross-cutting Outcomes	• Policies and programmes across all results areas are more risk-informed and supportive of resilience at individual, family, community and system levels, so child protection strategies continue seamlessly across humanitarian and development cycles, including in situations of armed conflict, forced displacement and other emergencies. • Policymakers, professionals, leaders, community members, caregivers, girls, boys and adolescents have greater awareness of violence against children as a human rights and public health problem and greater agreement with social norms that support freedom from violence, harmful practices, gender inequality and discrimination, particularly against vulnerable groups.

All outcomes contribute to impact/goal but also influence one another across the results chain. In other words, the chain of results flows horizontally and vertically.

	National, multisectoral action	Legal/policy frameworks	Systems and institutions: prevention, reporting mechanisms and response services across all sectors (including but not limited to sectors listed below)					Society/ communities	Families and caregivers		Girls, boys and adolescents
OUTCOMES	Countries have strengthened national commitment to fund and implement comprehensive, evidence-based, multisectoral, coordinated plans, policies and actions to prevent and respond to violence against girls, boys and adolescents.	Countries have strengthened legal and policy frameworks (as written and implemented) to protect girls and boys, including adolescents, from violence and discrimination, in accord with international norms (e.g. CRC and CEDAW).	Whole systems and institutions have improved the quality, coverage, access to and multisectoral coordination of violence prevention, reporting mechanisms and response services .					Communities are more engaged in: • Protecting the right of all girls and boys to grow up free of violence and discrimination, regardless of age, sex, disability or any other social or economic disadvantage • Creating safer environments for girls, boys and adolescents.	Households/ families have greater social and economic stability and security, more gender-equitable attitudes and practices, and lower levels of violence against women in the home.	Mothers, fathers and caregivers have built more nurturing parent-child relationships and have improved positive parenting and gender-equitable attitudes, skills and practices.	Girls, boys and adolescents are more empowered to exercise and advocate for rights and agency to live free of violence; seek help when violence occurs; build healthy, gender-equitable, non-violent relationships; and postpone marriage and childbearing until adulthood.
		Justice sector systems and institutions have improved access to child-friendly justice and enforcement of laws that protect girls, boys and adolescents from violence and discrimination.	Social welfare systems , including child protection, have strengthened access to high-quality prevention and responses to violence against girls, boys and adolescents, especially the most vulnerable.	Health systems and institutions have strengthened violence-related public health research, prevention and case detection, as well as care and support for girls, boys and adolescents who experience violence.	Education systems and institutions provide greater access to safe, inclusive, gender-equitable education, life skills and livelihood programmes that are responsive to all forms of violence against girls, boys and adolescents.	Humanitarian/ emergency actions have improved access to and quality of prevention and responses to violence against children and gender-based violence against women and children.					
OUTPUTS	Countries have strengthened the: • Capacity of multi-stakeholder, multisectoral planning and coordination mechanisms • Evidence base about violence against children (research, mapping, surveillance and monitoring) • Awareness of evidence for informed policies and planning.	Countries have strengthened: • Mechanisms to monitor and reform laws and policies in accord with international norms • Public and policymaker support for legal reform and children's rights • Justice sector capacity to implement laws.	Each sector has strengthened the capacity of whole systems and institutions to address violence against girls, boys and adolescents in accord with a systems approach, including: • Normative frameworks for addressing violence and child protection, e.g. policies, regulations, guidelines, protocols, minimum standards, codes of conduct and plans of action (developed with child participation, adopted, costed, funded, implemented and monitored). • Evidence and data collection systems related to violence and child protection, including research, mapping, surveillance, administrative data systems, monitoring and evaluation. • System and institution-wide resources such as infrastructure, supplies, policy and protocol implementation, workforce strengthening and data systems. • Workforce preparedness of duty-bearers, professionals and paraprofessionals, e.g. number, qualifications, training, knowledge, skills, attitudes, awareness, etc. • Referral networks, multisectoral collaboration and community outreach. • Integration of attention to violence against children across all policies and programming. • Investment in: • Case detection, responses, referrals, monitoring, care, support and documentation • Dedicated, evidence-based initiatives to prevent and respond to violence against children and adolescents in accord with international good practices (including INSPIRE strategies).					Communities and community-based organizations have greater awareness of children's rights, including the right of girls and boys to grow up free of violence and discrimination, regardless of age, sex, disability or any other social or economic disadvantage.	Vulnerable households have greater access to social and economic support programmes that integrate attention to gender equity, family violence prevention and safe transitions to adulthood.	Mothers, fathers and caregivers have greater: • Access to higher higher-quality parenting support services • Awareness of positive parenting and child development.	Girls, boys and adolescents have greater access to: • Education, life skills, livelihood and violence prevention programmes • Age-appropriate information about sexuality and healthy relationships • Knowledge about rights and where to seek help for violence.

Note: Violence against children includes all forms of physical, sexual and emotional abuse, including violent discipline and sexual abuse and exploitation of girls and boys, including adolescents, in all settings (e.g. home, school, community, online). Girls and boys in situations of vulnerability include those with disabilities, in institutional care, deprived of liberty, in extreme poverty, unaccompanied/separated from family, and affected by HIV or any other social or economic disadvantage.

Source: Schematic illustration from page 16 of *Preventing and Responding to Violence against Children and Adolescents: A theory of change*, UNICEF, Child Protection Section, New York, 2017.

Annex C.

The search for evidence to inform this narrative review

A broad, structured but not systematic search was carried out to produce this narrative report. The search prioritized systematic reviews, meta-analyses and other influential peer-reviewed journal articles, as well as guidance and reports by international organizations, such as UNICEF and WHO, that were published by July 2026. The search was designed to capture global evidence, with a priority focus on low- and middle-income countries. Section 4 was also informed by personal communication with colleagues implementing or evaluating specific examples of health sector programming.

Specifically, the search included:

- a search for peer-reviewed journal articles using PubMed, maintained by the United States National Library of Medicine, Google Scholar, and hand-searches of key international reports and reference lists; and
- a search for international guidance and reports through Google Scholar and the online platforms of key international organizations, including WHO, UNICEF, Together for Girls, UN Women and other relevant agencies.

Search terms included: child/children/childhood, adolescent/adolescents/adolescence, girls and boys combined with violence, abuse, maltreatment, homicide, suicide, physical violence, corporal punishment, physical punishment, violent discipline, child maltreatment, sexual violence, sexual abuse, sexual exploitation, forced sex, coerced sex, sexual coercion, psychological violence, emotional abuse, verbal aggression, neglect, child exposure to community violence, armed conflict, spousal violence, intimate partner violence, dating violence and adverse childhood experiences.

Search terms also included women and girls combined with sexual violence, rape, violence against women, spousal abuse, domestic violence, mistreatment/abuse/disrespect during maternity care, respectful maternal care, obstetric violence, interpersonal violence, intersections between violence against women and violence against children, and child exposure to intimate partner violence.

Additional search terms included: prevalence, risk factors, health consequences, physical health consequences, sexual and reproductive health consequences, mental health consequences, suicide, self-harm, risk behaviours, traumatic stress, maternal health outcomes, perinatal health outcomes, intentional injury, trauma-informed care, INSPIRE strategies, and RESPECT Women, as well as specific search terms for outcomes listed in the figure in section 2 and terms related to each UNICEF programme area in section 4. All search terms were used with and without combined terms such as review, systematic review, and low- and middle-income countries.

Annex D.

Select reviews of health consequences of violence

Multiple forms of violence	Flor, Luisa S., et al., ' Health Effects Associated with Exposure of Children to Physical Violence, Psychological Violence and Neglect: A burden of proof study ', <i>Nature Human Behaviour</i> , vol. 9, no. 6, June 2025, pp. 1217–1236.
Violent killing	Kim, Bitna, Alida V. Merlo and Yeonghee Kim, ' Intrafamilial Child Homicide: An umbrella review of systematic reviews ', <i>Journal of Family Violence</i> , vol. 39, no. 6, August 2024, pp. 995–1012.
Physical violence	Burghart, Matthias and Sophia Backhaus, ' The Long-Term Consequences of Family Violence Victimization: An umbrella review of longitudinal meta-analyses on child maltreatment and intimate partner violence ', <i>Journal of Family Violence</i> , vol. 41, July 2026, pp. 999–1009. World Health Organization, ' Corporal Punishment of Children: The public health impact ', WHO, Geneva, 2025.
Sexual violence	Grose, Rose G., et al., ' Sexual and Reproductive Health Outcomes of Violence against Women and Girls in Lower-Income Countries: A review of reviews ', <i>Journal of Sex Research</i> , vol. 58, no. 1, January 2021, pp. 1–20. Hailes, Helen P., et al., ' Long-Term Outcomes of Childhood Sexual Abuse: An umbrella review ', <i>Lancet Psychiatry</i> , vol. 6, no. 10, October 2019, pp. 830–839. Moss, Corinne, et al., ' A Global Systematic Scoping Review of Literature on the Sexual Exploitation of Boys ', <i>Child Abuse & Neglect</i> , vol. 142, part 2, August 2023, 106244.
Psychological violence/ emotional abuse	Dube, Shanta R., et al., ' Childhood Verbal Abuse as a Child Maltreatment Subtype: A systematic review of the current evidence ', <i>Child Abuse & Neglect</i> , vol. 144, October 2023, 106394. Korolevskaia, Anastasiia and Svetlana Yampolskaya, ' The Consequences of Childhood Emotional Abuse: A systematic review and content analysis ', <i>Families in Society</i> , vol. 104, no. 2, April–June 2023, pp. 167–178.
Neglect	Kobulsky, Julia M., Howard Dubowitz and Yanfeng Xu, ' The Global Challenge of the Neglect of Children ', <i>Child Abuse & Neglect</i> , vol. 110, part 1, December 2020, 104296. Jackson, Annette L., et al., ' Childhood Neglect and Its Implications for Physical Health, Neurobiology and Development: A scoping review of the literature ', <i>Developmental Child Welfare</i> , vol. 4, no. 2, June 2022, pp. 114–135.
Adverse childhood experiences	Kim, Bitna and Meghan Royle, ' Annual Research Review: Mapping the multifaceted approaches and impacts of adverse childhood experiences – An umbrella review of meta-analyses ', <i>Journal of Child Psychology and Psychiatry</i> , vol. 66, no. 4, April 2025, pp. 399–416. Bhutta, Zulfiqar A., et al., ' Adverse Childhood Experiences and Lifelong Health ', <i>Nature Medicine</i> , vol. 29, no. 7, July 2023, pp. 1639–1648. Hughes, Karen, et al., ' The Effect of Multiple Adverse Childhood Experiences on Health: A systematic review and meta-analysis ', <i>Lancet Public Health</i> , vol. 2, no. 8, August 2017, pp. e356–e366. Oh, Debora Lee, et al., ' Systematic Review of Pediatric Health Outcomes Associated with Childhood Adversity ', <i>BMC Pediatrics</i> , vol. 18, no. 1, February 2018, 83.

Community violence	Bendavid, Eran, et al., ‘The Effects of Armed Conflict on the Health of Women and Children’, <i>Lancet</i>, vol. 397, no. 10273, February 2021, pp. 522–532. Kadir, Ayesha, Sherry Shenoda and Jeffrey Goldhagen, ‘Effects of Armed Conflict on Child Health and Development: A systematic review’, <i>PLOS ONE</i>, vol. 14, no. 1, January 2019, e0210071.
Child exposure to intimate partner violence	Holmes, Megan R., et al., ‘Nearly 50 Years of Child Exposure to Intimate Partner Violence Empirical Research: Evidence mapping, overarching themes, and future directions’, <i>Journal of Family Violence</i>, vol. 37, no. 8, November 2022, pp. 1207–1219.
Perinatal intimate partner violence	Pastor-Moreno, Guadalupe, et al., ‘Intimate Partner Violence and Perinatal Health: A systematic review’, <i>BJOG: An International Journal of Obstetrics & Gynaecology</i>, vol. 127, no. 5, April 2020, pp. 537–547.

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About us

UNICEF, the United Nations agency for children, works to protect the rights of every child, everywhere, especially the most disadvantaged children and in the toughest places to reach. Across more than 190 countries and territories, we do whatever it takes to help children survive, thrive, and fulfil their potential.

UNICEF Office of Strategy and Evidence – Innocenti accelerates progress for children by working to ensure that policies and programming are informed by high-quality evidence. As the global custodian of child-related official statistics, it works closely with governments and partners to strengthen national statistical systems. Through world-leading data, research and foresight, it underpins UNICEF's global leadership on children's rights and serves as the organization's hub for setting strategy and monitoring programmes. With the active engagement of young people and other partners, it supports advocacy and dialogue aimed at improving the lives of children everywhere.

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