RISE UP POLICY FORUM

Making Child Protection a Winnable Battle

From commitments to coordinated, financed and scalable prevention

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THE SCALE OF THE CHALLENGE

Violence is not marginal.
It is a population-level issue.

1.6B

children

regularly endure violent punishment at home

370M+

girls & women

experienced rape or sexual assault before age 18

130K

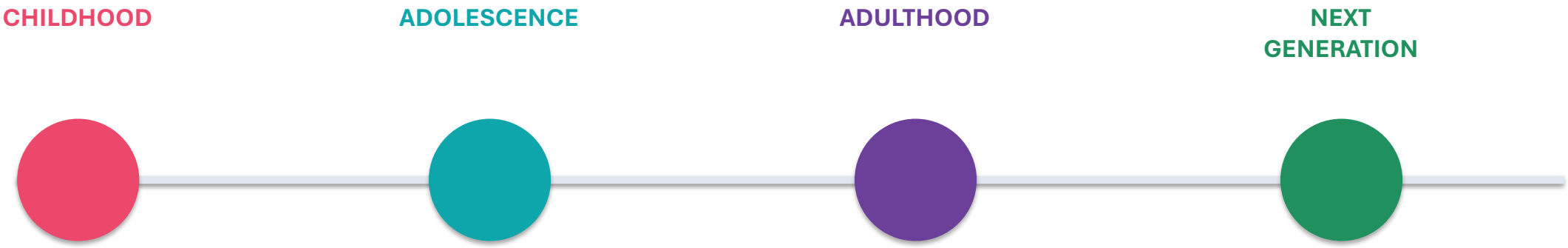
children & adolescents

die from violence each year on average

This is why prevention belongs in national health, education, social protection, justice and economic policy and coordinating this will save money and time.

UNICEF global estimates, 2024–2026

Childhood harm travels across the life course.



WHO reports that children exposed to violence have a 13% higher likelihood of not graduating from school.

Prevention protects the return on investments governments already make in health, education and human capital.

WHO Child Maltreatment Fact Sheet, May 2026

Child protection has built deep expertise in identifying and responding to harm.

But the scale of violence tells us that response alone cannot deliver the future we have promised children.

REACTIVE

Resources still concentrate after harm.

FRAGMENTED

Children cross systems that do not always connect.

UNDER-SCALED

Proven prevention rarely reaches everyone who could benefit.

How do we redesign the system so fewer children ever need a crisis response and when we have treatments we can ensure that they are working effectively for the child, family, and for our precious workforce?

WHO 2026; UNICEF 2024

We are already paying for violence — just too late.

The economic burden appears across ministries: health care, mental health, education, policing, justice, social welfare and lost productivity.

UP TO

8% **of global GDP**

has been estimated as the economic cost of violence against children.

A CURRENT COUNTRY EXAMPLE

Solomon Islands: 9.13% of GDP

Estimated economic cost of violence against children in 2021.

The policy choice is whether we invest upstream — or continue absorbing downstream costs.

UNICEF 2022; UNICEF Pacific 2025; UNICEF ESA 2025

THE GOOD NEWS

Prevention is possible — and the evidence base is growing.

SUPPORT PARENTS

Evidence-based parenting support reduces harsh parenting and maltreatment.

CHANGE NORMS

Non-violent norms, gender equality and safe environments change risk.

BUILD SKILLS

Education and life skills strengthen resilience and help-seeking.

STRENGTHEN INCOME

Economic security can reduce pressures that increase risk.

ENFORCE LAWS

Policy and legislation can shift environments and expectations.

RESILIENCE

Early recognition, care and healing reduce recurrence and consequences.

The challenge has shifted: from proving prevention can work → to financing, adapting and scaling what works.

WHO 2025–2026; WHO Parenting Guidelines 2023

A continuum — not a collection of projects.

UNIVERSAL safe norms • parenting support • schools • digital safety • social protection

TARGETED early identification • family support • community coordination • risk reduction

SPECIALIST trauma-informed response • protection • justice • healing • reintegration

MULTISECTORAL GOVERNANCE + DATA + WORKFORCE + FINANCING + MORE FOCUS ON PREVENTION UPSTREAM

THE RISE UP PUBLIC HEALTH PILLARS

Six levers for moving from commitment to system change.

1 COORDINATION

Create effective multisectoral governance.

2 LAWS + POLICY

Build legislation and policy that enable prevention.

3 DATA

Measure the problem and use evidence to choose solutions.

4 CONTINUUM

Connect community prevention, response and healing.

5 INVEST + SCALE

Fund national plans and proven approaches.

6 PARTICIPATION

Build child, survivor and community voice into assurance.

No single pillar is enough. The work is in the connections between them.

Children experience one life. Governments support children and families via many systems.

HEALTH | EDUCATION | SOCIAL | JUSTICE | DIGITAL

↓

SHARED OUTCOMES • SHARED DATA • CLEAR ACCOUNTABILITY • COORDINATED FINANCING

Multisectoral coordination at a national level provides oversight, coordination of resources, efforts and harnesses infrastructure by design.
It means roles, resources and accountability are designed to work together from the start.

Move from project funding to prevention infrastructure.

TODAY

- Short grants
- Pilot projects
- Crisis response
- Single-sector budgets

TOMORROW

- Costed national plans
- Core prevention services
- Blended cross-sector investment
- Scale + implementation capacity

WHO evidence reviews found LMIC parenting-program delivery costs ranging from US$5–500 per family, with a median around US$40 (approx. 2015 prices).

WHO parenting guidance; UNICEF violence prevention dividend

WHAT TODAY IS FOR

Not another conference.
A working community of practice.

SHARE THE REAL CHALLENGE

What is blocking implementation in your country?

LEARN LATERALLY

What has another country solved that you do not need to solve alone?

CONNECT EVIDENCE + POLICY

What do researchers and practitioners know that can improve your next decision?

LEAVE WITH A NEXT MOVE

What can you advance in the next 90 days?

Progress accelerates when countries can be candid about what is not working — and generous about what is.

A SIMPLE TEST

Five questions for every national child-protection strategy.

1. Do we know where harm is happening — and to whom?
2. Are we investing before harm, not only after?
3. Can a child move through the system without falling between sectors?
4. Are children, survivors and communities shaping the solution?
5. Do we know what we will scale — and how we will pay for it?

Do we have national level multi-sectoral coordination with authority and budget?

THE AMBITION

Fewer children harmed.
Earlier support.
Stronger families.
Systems that learn.

Child protection can be a winnable battle — if prevention becomes how the system works.

Use advocacy to turn evidence into political will.

The ISPCAN Advocacy Toolkit is designed to help child-protection leaders make a case that decision-makers can act on.

1 FRAME

Define the problem in terms the audience values.

2 TARGET

Identify who has authority, influence and resources.

3 TRANSLATE

Connect child safety to each ministry's mandate.

4 ASK

Make one specific, feasible and time-bound request.

Political will grows when the issue is visible, solvable, aligned with priorities — and backed by a credible coalition.

ispcan.org/rise up policy forum

Speak the language of the ministry you need to move.

HEALTH — **Preventable burden**

Mental health • injury • NCD risk • maternal/child health • health-system cost

EDUCATION — **Learning outcomes**

Attendance • attainment • school safety • teacher capacity • human capital

FINANCE — **Return on investment**

Avoided downstream costs • productivity • fiscal sustainability • scalable investment

JUSTICE — **Safety + rule of law**

Prevention • access to justice • diversion • recidivism • coordinated case pathways

SOCIAL PROTECTION — **Family stability**

Early support • poverty stress • parenting • disability inclusion • social safety nets

DIGITAL / TECH — **Safe-by-design**

Duty of care • platform accountability • online harms • digital citizenship

Same child. Same evidence. Different entry point.

ISPCAN Advocacy Framework; WHO INSPIRE

WHY HEALTH CAN LEAD

The Health or Lead Minister can advocate to make violence prevention a whole-of-government priority.

DECLARE

Frame violence against children as a preventable public-health crisis.

CONVENE

Bring Health, Education, Finance, Justice and Social Protection around shared outcomes.

MEASURE

Use health and population data to expose burden, inequity and preventable cost.

INVEST

Protect upstream prevention in budgets and cost national action plans.

INTEGRATE

Embed identification, referral, parenting support and trauma-informed care in health systems.

CHAMPION

Use ministerial authority to build public support and sustain political attention.

Health does not need to own every intervention. It can own the mandate to make prevention measurable, coordinated and unavoidable.

WHO's 2026 Council of Champions demonstrates a health-led model for high-level action on ending violence against children.

Success is no longer measured by survival alone.

Mortality still matters — profoundly.

But as more children survive, the policy question expands:

THEN

Did the child survive?

Mortality

NOW

Can the child thrive?

Mortality + morbidity + functioning + well-being

Since 2000, the global under-five mortality rate has fallen 51% — a historic achievement that makes health after survival increasingly central.

UN IGME/UNICEF 2026; WHO Global Health Estimates

A child can survive — and still lose years of healthy life.

YLL

Years of life lost to premature death

YLD

Years lived with disability or ill health

DALY

YLL + YLD = total health burden

WHO's Global Health Estimates explicitly track both death and disability to guide policy and resource allocation.

For adolescents alone, WHO estimated 69 million years lived with disability in 2019.

WHO Global Health Estimates; WHO AA-HA! adolescent health

As mortality falls, non-fatal burden becomes impossible to ignore.

69M

adolescent YLDs globally in 2019

>50%

of adolescent NCD-related disability burden is substantial

2.1M

deaths ages 5–24 in 2024

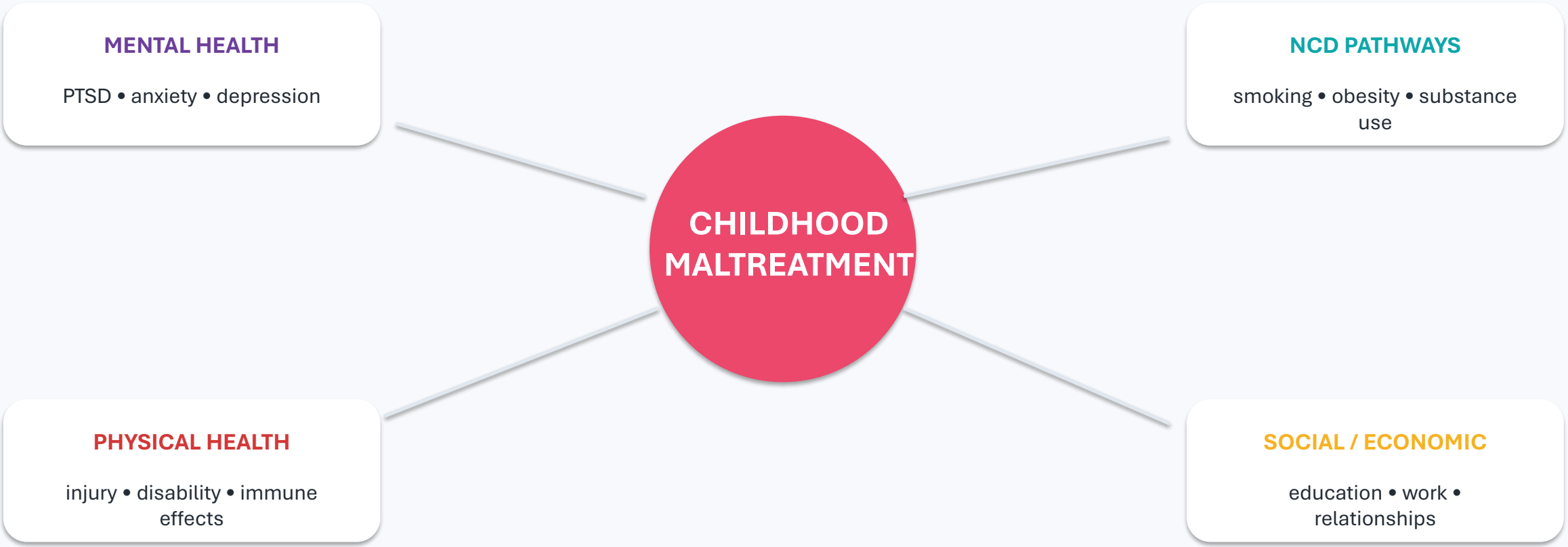
Older children and adolescents face a changing burden:

- mental-health conditions
- injury and interpersonal violence
- chronic and noncommunicable disease
- substance use and other risk pathways

THE POLICY IMPLICATION

A nation can improve survival while still carrying a large and preventable burden of poor health.

Maltreatment is a morbidity issue across the life course.



WHO explicitly links child maltreatment to lifelong physical and mental health, NCD risk factors, educational outcomes and economic costs.

WHO Child Maltreatment Fact Sheet, 8 May 2026

THE HEALTH MINISTER'S NEW DASHBOARD

Measure the health children gain — not only the deaths we prevent.

SURVIVAL

mortality • life expectancy

HEALTHY LIFE

DALYs • YLDs • functioning

MENTAL HEALTH

depression • anxiety • self-harm

SAFETY

violence • injury • maltreatment exposure

DEVELOPMENT

learning • school completion • participation

EQUITY

who carries the burden • who reaches care

This is where Health can lead government: make prevention visible in the national health metrics, then align ministries around reducing the burden.

Mortality tells us who we lost. Morbidity tells us what children are living with — and what prevention can change.

WHO Global Health Estimates; UNICEF adolescent health data

Mastermind sessions turn the room into a problem-solving resource.

Not presentations about perfect systems — structured conversations about the difficult work of changing real ones.

1

REAL CHALLENGE

A government or partner puts an implementation problem on the table.

2

MULTISECTOR LENS

Policy, practice, research and lived experience examine it together.

3

TRANSFERABLE LEARNING

The room surfaces what has worked elsewhere — and why.

4

NEXT MOVE

Ideas become options that can be adapted, tested and taken home.

The expertise is not only on the stage. It is distributed across the governments and disciplines in the room.

THE SIX PILLARS ARE THINKING TOOLS

They help us diagnose why progress stalls — and where to intervene.

DATA

What do we know?

POLICY

What enables action?

GOVERNANCE

Who coordinates?

CONTINUUM

Where is prevention?

SCALE

What will we fund?

PARTICIPATION

Whose voice shapes it?

A policy problem may actually be a financing problem. A service gap may actually be a governance problem. The pillars help us see the system.

Evidence informs implementation. Implementation improves evidence.

The most useful evidence for government = public health implementation +assurance loops

Governments should not have to solve these problems alone.

Rise Up connects countries over time so experience becomes shared capacity.

COUNTRY → COUNTRY
Peer learning across political and system contexts.

REGION → REGION
Adapt lessons rather than copy models.

EXPERT → GOVERNMENT
Bring research and practice to live policy challenges.

GOVERNMENT → FIELD
Tell the field what evidence and tools are actually needed.

The aim: a living network where countries can bring a problem, find experience, test a solution and return with what they learned.

FROM LEARNING TO PUBLIC-HEALTH INFRASTRUCTURE

The goal is not more activity. It is a smarter system that learns and improves.

MEASUREMENT

Data identifies burden, risk and inequity.

PREVENTION

Evidence informs population and targeted interventions.

IMPLEMENTATION

Practice reveals what works in context.

POLICY + FINANCE

Government creates authority, accountability and scale.

EVALUATION

Outcomes feed back into decisions.

RESEARCH ↔ PRACTICE ↔ POLICY ↔ COMMUNITIES

Rise Up can help governments build the learning architecture around the child-protection system — so public health structures become adaptive, evidence-driven and sustainable.