The health of children is compromised by armed conflict, complex political emergencies, political upheaval, and forced migration. Children and young people comprise a significant proportion of the population in many countries, and often predominate in refugee or internally displaced settings. These environments expose them to risky situations over which they have limited control. An international symposium in Manila1 drew attention to these issues.

Debate in The Lancet has highlighted the tremendous challenges of achieving the Millennium Development Goals (MDGs), of applying best practice in child-health interventions, and of assuring children's rights and voices.2–5 Conflict and instability are significant impediments to achieving the MDGs: in many countries they have reversed earlier gains from childhood interventions and undermine livelihoods, leading to greater poverty and adverse health. Addressing this challenge to child health is urgent.

Children under 5 years of age have the highest mortality rates in conflict-affected settings.6,7 In some situations, when childhood interventions have been disrupted for periods, older children are similarly affected.8 Diarrhoeal diseases, acute respiratory infections, measles, malaria, and severe malnutrition are the most common causes of death in the early phases of conflict-related emergencies.9–11 In addition, outbreaks of other infectious diseases such as pertussis, typhoid, and meningococcal meningitis, can contribute substantially to childhood morbidity and mortality.8 Little is known about the effect on children of chronic conditions (eg, tuberculosis), or of neglected diseases (eg, visceral leishmaniasis, African trypanosomiasis) in such settings.

Traditionally we approach health problems through emergency responses, ad-hoc medical services, and vertical disease-specific programmes, often targeted, on those aged under 5 years. Although these programmes are successful in decreasing mortality in camp settings, more comprehensive programmes, such as the Integrated Management of Childhood Illness, have potential for greater impact and sustainability but are rarely implemented fully.9

The disruption and displacement of families and communities during armed conflict often results in children adopting new roles. They may take on more responsibility in seeking health care for themselves, or as carers for others. Girls in their early teens may themselves be mothers. Children who were previously at school, or had been at home or working in the fields, might need to find paid work taking them away from family for long periods. Within the home, children might be more responsible for obtaining and preparing food, overseeing hygiene and collecting water, washing younger children, and collecting firewood, most of which may be done unsupervised and often in situations which put them at risk.

In Nepal, the Maoist insurgency and resultant instability has exposed children to risks of HIV/AIDS and other infectious diseases, trafficking, and psychosocial stressors.10–12 An increasing number of children are homeless and unaccompanied, yet we know little about them, including whether, or how, they access services.

In northern Uganda, children leave their villages at nightfall and head to nearby towns to seek safety from abduction and violence.13 They make decisions affecting health every day: where and what to eat, where to sleep, and in what circumstances they can find safety. They decide what to do if their brother or sister has a fever. They decide which health-related resources to use: traditional healer, clinic nurse, non-governmental...
organisation, or government clinic. They decide whom to talk to or be with; they decide whom to trust.

Technical interventions exist for dealing with almost all childhood illnesses in conflict settings; these are particularly attuned to delivery in refugee camp settings. Public-health practice typically adopts top-down control strategies for infectious disease, seeking to get interventions underway quickly. We may not have the time or the skills to find out what is already being done or what is working, and what strategies have been developed at a household or community level. We adopt technical solutions driven by health professionals. Although such solutions require active participation by the community, insufficient attention is given to how health programmes interface with, or engage, the community. We typically do not elicit perspectives on service acceptability, accessibility, or responsiveness. Little emphasis is placed on understanding the circumstances in which community members will trust health services and service providers, or how and why distrust lingers in fractured communities.

Public-health practice prides itself on being consultative and participatory. Health promotion, prevention and control of infectious disease, and epidemic preparedness and response depend on extensive community participation and acceptance, and on understanding how people react to threats to their health. Appreciating and being responsive to the cultures, beliefs, and practices of community members underpin the effectiveness of public-health interventions, but are often neglected in emergencies. Even where consultation is present, health promotion and information sessions are structured around the needs of mothers, not those of the many children also affected. In being protective and seeking to shelter children and young people, we deny them the opportunity to shape the nature and form of health services and health promotion activities in their own communities.

Despite substantial exposures and vulnerabilities, children often exhibit strength and resilience; they may actively respond to threats to their health. They take action to shape their environment. Do we talk with them? Do we hear their experiences and insights? Do we know how they make choices? The answer, in most cases, is “no.”

Debate in The Lancet has amplified the need to hear their voices and learn. Other disciplines are developing models for engaging with children in vulnerable situations. These approaches differ greatly from more conventional practice, which relies on adults, usually parents and teachers, to convey children’s perspectives. Innovative approaches show that children, if appropriately facilitated, can share important insights into their lives and their environment, and that such insights may differ substantially from those of adults. In East Timor at present, better understanding of the perceptions and perspectives of children and young people should help shape future services and programmes.

Public-health practice must take seriously the right of children to participate in health decisions that affect them and in research that seeks to benefit them. A first step is to engage researchers in education, anthropology, and the social sciences with experience of undertaking child-centred research and evaluations. We should seek answers to questions such as which children are most affected by conflict and displacement? How do experiences differ by age, gender, and social class? What health risks do children perceive and how do they respond? Are these responses health-promoting or health-threatening? What more do we learn from directly engaging and talking with children.

We need, simultaneously, to attend to the important ethical issues raised such as ensuring that children are not pressured to participate, or that advice on issues that are particularly sensitive is followed by enquiry in settings where privacy and confidentiality can be better achieved.
Consideration and negotiation around offering some tangible benefits for participants is central.

Taking forward this work will challenge assumptions about children’s roles, responsibilities, skills, and competencies as they relate to health research and the promotion, prevention, and treatment of health problems. Inviting children’s genuine participation in health research, including providing opportunities to act as co-investigators and to help shape the research agenda, involves a shift in power. We must be prepared to listen to and be led by young people—to hear the unexpected and most importantly to act on what we find. This investment is challenging but ultimately worthwhile. It will examine risks to children’s health and reveal the resilience and resourcefulness that children and young people show in the face of adversity.

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We declare that we have no conflict of interest.