Responding to child maltreatment:

a clinical handbook for health professionals

World Health Organization

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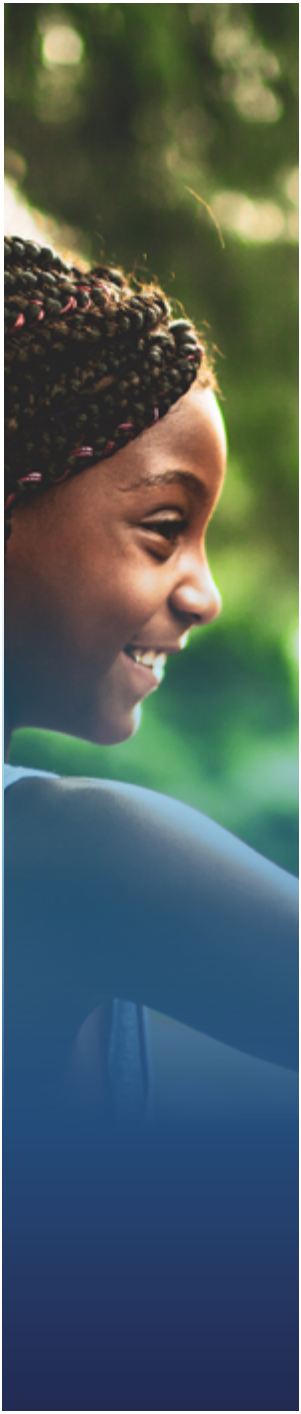

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Who this handbook is for

This handbook is intended primarily for front-line health care providers who are likely to see children (among other clients) in their day-to-day practice. These may include general practitioners, nurses, midwives, gynaecologists, paediatricians, mental health professionals, first responders and staff in emergency care.

Other professionals who may find it useful include social workers, those working in social welfare institutions, providers of psychosocial support, and those working in child care facilities and the education system.

Further, the content will benefit the work of policy-makers and managers to enable and support provision of clinical care to children experiencing, or who have experienced, child maltreatment.

The content of this handbook is based on the following WHO Guidelines and will be regularly updated, when new guidelines emerge:

WHO Guidelines for the health sector response to child maltreatment (2019) [1]
https://www.who.int/publications/m/item/who-guidelines-for-the-health-sector-response-to-child-maltreatment

Responding to children and adolescents who have been sexually abused: WHO Clinical Guidelines (2017) [2]
https://apps.who.int/iris/bitstream/handle/10665/259270/9789241550147-eng.pdf

Part I:
Understanding child maltreatment

In Part 1 of this handbook you will learn why child maltreatment is often hidden, how many children are affected globally, and about the possible health and social consequences faced by the children who experience it. You will also learn about important principles of working with children experiencing maltreatment and their caregivers, and about why it is important to know the legal regulations that apply to the context in which you work.

What is child maltreatment?

Child maltreatment includes the perpetration of physical, sexual and psychological/emotional violence and neglect of infants, children and adolescents aged 0–17 years by parents, caregivers and other authority figures, most often in the home but also in settings such as schools and orphanages. It is a significant public health problem and a violation of fundamental human rights, including the right to life, right to protection from all forms of violence, and the right to enjoy the highest attainable standard of health. Child maltreatment can have serious and often lifelong negative consequences for mental and physical health, sexual and reproductive health, academic performance and social life.

Physical abuse

This includes causing injury or harm to a child by the parent or caregiver, for example by hitting, kicking or beating; using a hot object, substance or flame to burn the body; or pushing, punching or inflicting hurt with an object.

Emotional abuse

Emotional abuse involves isolated incidents as well as a pattern of failure over time on the part of a parent or caregiver to provide a developmentally appropriate and supportive environment. It can include many types of behaviours, such as parents or caregivers:

- telling a child or adolescent they wished he/she had never been born or that they were dead;
- telling a child or adolescent that he/she is not loved or does not deserve to be loved;
- threatening to hurt or kill the child or adolescent;
- telling the child or adolescent that he/she is stupid or useless.

Sexual abuse

Sexual abuse refers to the involvement of a child or an adolescent in sexual activity into which he or she has been forced or tricked; which they may not understand is wrong; and about which they may be afraid to tell someone.

Sexual abuse involves the intent to gratify or satisfy the needs of the perpetrator or another third party, including that of seeking power over the child. It includes:

- non-contact sexual abuse (e.g. threats of sexual abuse, verbal sexual harassment, sexual solicitation, indecent exposure, exposing the child to pornography);
- contact sexual abuse involving sexual intercourse (i.e. sexual assault or rape);
- contact sexual abuse excluding sexual intercourse but involving other acts such as inappropriate touching, fondling and kissing.

Child sexual abuse is often carried out without physical force, but rather with some type of emotional manipulation. Children can be sexually abused by both adults and other children who are – by virtue of their age or stage of development – in a position of responsibility or trust or power over the survivor.

Neglect

Neglect includes a caregiver's failure to provide for the development and well-being of the child or adolescent (where the parent is in a position to do so) with respect to:

- health;
- education;
- emotional support;
- nutrition;
- shelter and safe living conditions.

The parents of neglected children and adolescents are not necessarily poor; they may be financially well-off.

How many children and adolescents are affected by maltreatment?

Child maltreatment is widespread but often hidden. Nearly a quarter of adults suffered physical abuse as a child [3, 4], 36% experienced emotional abuse [5] and 16% experienced neglect [6]. Overall, 18% of girls and 8% of boys have experienced some form of sexual abuse [7]. While the data cited above have mainly been collected in high-income countries, data from low- and middle-income countries are increasingly available. The Violence against Children and Youth Surveys (VACS), which have been implemented in over 20 countries in Sub-Saharan Africa, Asia and Latin America, report that in the majority of countries in these regions, more than 25% of girls and 10% of boys disclosed childhood sexual violence. Rates of physical violence are commonly twice as high in nearly all countries studied. The prevalence of emotional violence was reported to be between approximately 20–30% for boys and girls in the majority of countries studied [8].

What are the consequences of child maltreatment?

While child maltreatment rarely results in death, globally an estimated 40 150 children under the age of 18 years are murdered each year [9], of which a large proportion are likely to have experienced maltreatment in their short lives. The actual number is likely to be even higher, as a significant number of deaths due to child maltreatment are incorrectly attributed to falls, burns, drowning and other causes.

Child maltreatment can have severe (if nonfatal) short- and long-term physical, sexual and mental health consequences [10]. Physical health consequences include injuries, disabilities and gastro-intestinal disorders, while sexual and reproductive health consequences include sexually transmitted infections (STIs) including HIV. Adolescent girls may face additional health issues, including gynaecological disorders and unwanted pregnancy. Child maltreatment can also overlap with other forms of violence against children and intimate partner violence, for example in the context of child marriage. Mental health consequences include post-traumatic stress,

anxiety, depression, externalizing symptoms, eating disorders, problems with relationships, sleep disorders, self-harm, and suicidal thoughts.

Child maltreatment can affect cognitive and academic performance and is strongly associated with alcohol and drug abuse and smoking – key risk factors for noncommunicable diseases (NCDs) such as cardiovascular disease, cancer, liver disease etc. It can lead to risk-taking behaviours (including behaviours that increase sexual risk) and behavioural and social problems such as violence against peers, delinquency and crime. Caregivers who experienced maltreatment as children have a higher likelihood of maltreating their own children.

Child maltreatment places a heavy strain on health and criminal justice systems and social and welfare services. In the United States of America (USA), for example, the estimated lifetime costs for nonfatal child maltreatment ranged from over US$ 200 000 to over US$ 830 000, while fatal per-child costs ranged from US$ 1.3 million to US$ 16.6 million [11]. In the East Asia and Pacific region, the estimated economic burden of child maltreatment totalled US $194 billion – which accounts for 1.4–2.5% of the region's gross domestic product [12].

Laws relevant to child maltreatment

Child maltreatment is a human rights violation and this is reflected in most national laws. As a health professional it is important to know these laws and how they affect your practice. The following laws can have a direct impact on how health services are provided with regard to child maltreatment:

- Are there criminal law provisions related to child maltreatment (for example in the country's penal code)?
- Are there laws protecting children from maltreatment?
- Are there laws related to sexual violence, including child sexual abuse?
- Are there court orders and regulations that protect children from violent members of the household?
- Does the law allow girls subjected to sexual assault/rape to be provided with abortion services?

    - If yes, are there other regulatory or policy barriers that limit access to abortion (for example, third party authorization, legal age of consent for abortion services)?
    - Are there regulatory or policy barriers that limit access to emergency contraception for girls subjected to sexual assault/rape?
- Do laws specify provision of health care to children and adolescents who experienced maltreatment?
- Do laws or regulations mandate reporting individual cases of child maltreatment to child protection authorities or the police?
- Which providers are authorized to provide testimony in court?
- Legal age of consent for health care decisions (including HIV testing, emergency contraception).
- Legal age of consent for marriage.
- Statutory rape laws.

The role of health care professionals in recognizing and responding to child maltreatment

Child maltreatment is widespread worldwide, but stigma, shame, or fear of repercussions (including risk of further harm) mean that many survivors never talk about it. Most child survivors of maltreatment are never in contact with any official service. Based on data from six countries in Africa, Latin America and Asia, 23–54% of children disclose exposure to violence to a friend or family member, up to 25% seek help, and up to 11% receive some form of formal support [13]. Disclosure is even rarer if caregivers are involved in the abuse or neglect. Infants, toddlers and very young children can also become survivors of child maltreatment and because of their age and developmental stage do not have the capacity to communicate what they have experienced.

Children who are being maltreated often find it difficult to tell someone for the first time because they may:

- have feelings of shame, guilt and being stigmatized;
- not always recognize their own experiences as abusive or neglectful;

- be coerced by (or attached to) the person or persons abusing or neglecting them;
- fear the consequences of telling someone – for example, they may:
    - worry that no one will believe them, the abuse or neglect might get worse, their family will be split up, they will be excluded by their community or they will go into care.
    - have been threatened or warned to not tell about experiences of maltreatment.
    - have had previous negative experiences with health care or social service providers (e.g. not being believed previously) or with the child protection system.

Yet health professionals are in a unique position to identify and support child survivors of maltreatment. The high prevalence of maltreatment means that in your day-to-day practice you will encounter children and adolescents that are being (or have been) maltreated even when maltreatment is not identified as the presenting problem. Children and adolescents who have experienced maltreatment may come to your attention during a routine physical examination, or at the emergency department or general practice for related or unrelated medical events, or other illnesses or complaints. Adolescent girls may also come in for services related to pregnancy care and abortion.

Health professionals thus play a key role in providing first-line support, recognizing maltreatment, mitigating its negative consequences and preventing further harm. This includes:

- creating a safe and supportive space;
- recognizing signs and symptoms associated with child maltreatment;
- inquiring sensitively about signs and symptoms;
- addressing physical, mental, sexual and reproductive health needs;
- liaising with other services (such as child protection, or legal services) as needed.

Basic principles in working with children and adolescents exposed to maltreatment

The following important principles should be considered in all communications and interactions with children or adolescents – especially with children and adolescents who experienced maltreatment, and their caregivers.

The principle of the best interests of the child or adolescent

Focusing on the best interests of the child means that all decisions are made with the goal of ensuring the child's well-being, safety and emotional development. You need to prioritize the well-being of the child, considering all potential benefits and harms of your care decisions, and minimize the negative consequences for the child or adolescent.

Protect and promote safety

The physical and emotional safety of the child or adolescent must be your primary consideration. You must prioritize the child's safety and consider how to keep the child safe.

Provide sensitive care

Listen to the child or adolescent attentively. Do not interpret or judge the history they provide, even when it differs from that of the caregivers or based upon your observations. Offer an empathetic and non-judgemental response. Reassure the child or adolescent that they are not to blame for what occurred to them and that they did the right thing by talking to you. Thank them for telling you and say that you are there to help them.

Protect and promote privacy and confidentiality

Ensure that any conversation occurs in a location that is private and in which the child or adolescent feels comfortable. Only those who need to be present in the room should be allowed. If a child or adolescent discloses abuse, ensure that he/she has immediate access to the person taking the history and providing care, so that that he/she does not have to re-tell what happened to several health professionals. Explain limits to confidentiality, including any obligations to report, at the beginning of care provision. Share information collected from interviews and examinations only on a need-to-know basis and after obtaining informed consent and assent from the child or adolescent (and/or non-offending caregiver, as appropriate). Store collected information securely, for example, protected by key or password.

Respect autonomy

Respect the autonomy and wishes of the child or adolescent. Do not force them to give information or be examined. Sometimes you will have to balance this with the need to protect and promote their safety. In situations where it is not possible to prioritize the child's or adolescent's wishes, the reasons should be explained to the child or adolescent before any further steps are taken. Also respect the wishes of adolescents with regards to not sharing information with their caregivers, unless their life and safety is at risk, in which case explain to them beforehand.

DOs

- Assess whether the child or adolescent is safe in relation to any disclosure by ensuring privacy.
- Express empathy in words and non-verbal cues such as smiling, nodding, looking at the child, using an encouraging tone and gestures.
- Build a rapport with the child or adolescent.
- Use age-appropriate language.
- Ensure that toys or other measures such as appropriate seating, a glass of water etc. are available to help the child or adolescent to feel comfortable.
- Respect the autonomy and wishes of the child or adolescent.

DON'Ts

- Don't judge or blame the child when they disclose maltreatment, or take their trust for granted.
- Don't share information about maltreatment that has occurred without informing the child or caregiver about any obligation to report.
- Don't put the interests of the caregiver above the interests of the child.
- Don't force the child or adolescent to provide information or be examined.

The principle of evolving capacities of the child or adolescent

Children's and adolescents' capacity to make informed choices evolves with their age and developmental stage. Addressing this principle involves:

- providing information according to the child's age and developmental stage and capacity;
- always seeking informed consent or assent, even from young children.

Provide information that is appropriate to age and developmental stage

Tailor the information to the child's or adolescent's age and developmental stage. Choose your words, tools and visual aids, such as drawings and toys, according to the child's capacity. Remember that children often take words very literally, so avoid indirect expressions, slang and idioms. Do not underestimate the capacity of children to understand information if presented appropriately. You should also be honest and open if there is something you do not understand.

Seek informed consent and assent

What is informed consent? Informed consent is the result of communication between patients and health care providers in which the patient has the right to health information and to ask questions prior to any procedure or treatments. This communication process often leads to agreement or permission for care, treatment, or services. Informed consent in a legal context can be provided once the legal age of consent is reached (this age can vary according to country). Familiarize yourself with the laws related to informed consent and parental consent requirements with respect to children and adolescents.

What is informed assent? While children under their country's legal age of consent for medical procedures cannot give informed consent, if they are able to understand what is happening to them (if it is explained to them in an age-appropriate way using, for example, graphics and other visual aids) they can provide "assent" to the investigation and any recommended treatments. Even if children are very young and do not yet have the cognitive ability to understand all the procedures and their implications, they can make some decisions, such as where they will be examined or who should be in the room with them.

If the child has not yet reached the legal age of consent, assent should be obtained from the child and informed consent from the child's caregiver. In some instances, however, 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 some settings and for some procedures, services can be provided to adolescents without the involvement of their parent(s) or caregivers, in line with WHO guidance for adolescent health services and national legislation, and in line with human rights standards. Familiarize yourself with the laws related to informed consent in relation to medical care offered to adolescents.

Also, newborns and infants can become survivors of child maltreatment. In such situations, caregivers must consent to any treatment or further action. Explain to the caregiver what you found, what concerns you have and what you propose to do to promote the child's safety and well-being. In most cases the caregiver will be supportive. If the caregiver is not acting in the best interests of the child – or is resisting or undermining treatment – discuss with your supervisor, a colleague or specialist, if available, about how to proceed.

DOs

- Choose your words according to the child's age, maturity and cognitive abilities.
- Always seek informed consent or assent, even from young children.

DON'Ts

- Don't underestimate the capacity of the child or adolescent to understand information and provide assent.
- Don't share information with others without the child's or the adolescent's permission (except when the life of the child or adolescent may be at risk).

The principle of non-discrimination

All children and adolescents have a right to quality care, regardless of their sex, race, ethnicity, religion, sexual orientation, gender identity, disability or socioeconomic status. Some children – for example adolescent girls from poor communities, children or adolescents with disabilities, children or adolescents that are part of ethnic minorities and indigenous groups, and other groups facing discrimination or exclusion – can be at higher risk of child maltreatment or might face additional barriers to accessing services. It is important to pay attention to the specific needs of groups made vulnerable by structural inequalities, and ensure that services are equally accessible to all children in these parts of the community. This can include alternative ways of communication or working with a translator, if necessary. Use language consistent with children's and adolescents' cultural, religious, gender, ethnic, and ability identities.

DOs

- Provide quality care to all children and adolescents regardless of their sex, race, ethnicity, religion, sexual orientation, gender identity, disability or socioeconomic status.
- Pay attention to the specific needs of children and adolescents in vulnerable situations.

DON'Ts

- Don't discriminate.
- Don't be judgemental.

The principle of participation

Children and adolescents have a right to participate in decisions that have implications for their lives, in accordance with their developing capacities. In practice this means they should be asked what they think, have their opinions respected and taken into account when decisions are being made in relation to their clinical care. This can, for example, be done by asking them about where they prefer examinations to take place, and who should be present in the room. Because the act of abuse is a disempowering situation, you can contribute to restoring that power in every interaction, no matter how small. For example you can ask: *Would you like to sit in this chair or that chair? What colour pen do you prefer?*

DOs

- Ask the child or adolescent if they prefer to communicate verbally, in writing, with pictures, or with dolls/models.
- Ask the child or adolescent about preferences or wishes in relation to the treatment.

DON'Ts

- Don't assume you know what is best for the child, adolescent or caregiver.

Basic principles in working with children and adolescents who are suspected to have experienced abuse or neglect

Act in the **BEST INTERESTS** of children or adolescents:

- Promote and protect safety
- Provide sensitive care
- Protect and promote privacy and confidentiality
- Respect children's and adolescents' autonomy and wishes and offer choices in relation to any medical care

Address children's or adolescents' **EVOLVING CAPACITIES**:

- Provide information that is age appropriate
- Seek informed consent or assent

Practice **NON-DISCRIMINATION**, so that each child receives quality care regardless of their sex, race, ethnicity, religion, sexual orientation, gender identity, disability or socioeconomic status.

Ensure the **PARTICIPATION** of children or adolescents in decisions that have implications for their lives:

- Ask for their opinion and take it into account
- Involve them in the design and delivery of care

Interacting with caregivers in situations of suspected child maltreatment

In most instances, children and adolescents will be accompanied by their caregivers when seeking health services. In situations where child maltreatment is a concern, caregivers may have played one of many roles. They may have also been exposed to abuse themselves, they may have allowed the child maltreatment to occur, or they may have been the perpetrator. The following principles should be observed in interactions with caregivers:

- Establish a rapport with caregivers and encourage their active engagement and participation in the provision of care, whenever safe and appropriate.
- Treat caregivers with respect and without being confrontational.
- Avoid blaming or stigmatizing caregivers and identify what they are doing well.
- Empower non-offending caregivers with the information they need to make informed choices and decisions together with their child about the examination, treatment, care and referral options.
- Reassure them that the child is not to blame.
- Speak to caregivers separately from the child, but without inferring judgement when accounts between the child and caregiver are different.
- Do not involve the caregiver if an adolescent with the capacity to make decisions, or able to give informed consent, has expressly wished for them not to be involved.
- Be aware of potential safety concerns for the child. Consider that the caregiver might be the perpetrator or, in the case of a non-offending caregiver, may be subjected to abuse themselves, or may have knowingly allowed the maltreatment to continue or felt powerless to stop it.
- Consider that the caregiver might also be affected by violence in the home and recognize and address any urgent health and safety needs of caregivers.
- Consider that caregivers may feel significant stress, and that past and current trauma may be affecting their emotional state and behaviour.

Part II:
Identifying child maltreatment

Child maltreatment is often hidden and rarely disclosed. The following section will help you identify child maltreatment and provide strategies to inquire further about signs and symptoms associated with it without putting the child or adolescent at increased risk.

Be alert to the signs and symptoms of child maltreatment

Children and adolescents exposed to maltreatment often do not disclose abuse due to fear, stigma or the assumption that nobody can help them. Identifying maltreatment therefore often requires that you recognize the signs, symptoms, and child and adolescent behaviours that are more frequently present among children and adolescents exposed to maltreatment. This can also involve interactions between the child or adolescent and their caregivers. It is important to note that while particular signs and symptoms should make you consider child maltreatment as a possibility, they cannot be seen as proof that child maltreatment occurred. It is also common that several different types of maltreatment occur at the same time, for example emotional abuse and physical abuse.

Based on systematic reviews, the United Kingdom's National Institute for Health and Care Excellence (NICE) has summarized over 70 "alerting features" of physical abuse, sexual abuse, emotional abuse or neglect that should lead you to suspect maltreatment (Tables 1–4 outline some of these signs, symptoms and considerations). A more comprehensive list can be found in the NICE guideline, "Child maltreatment: when to suspect maltreatment in under 18s" [14].

Important:

The absence of signs and symptoms does not mean that child maltreatment did not take place. In some instances, there will be no visible or observable signs or symptoms. At the same time, the presence of particular signs and symptoms is not a proof that child maltreatment occurred.

Table 1: **Physical signs of possible maltreatment**

- Any serious or unusual injury with an absent or unsuitable explanation.
- Reports or appearance of a human bite mark that is thought unlikely to have been caused by a young child.
- Poor weight gain, malnutrition.
- Lacerations, abrasions or scars, and the explanation is unsuitable.
- One or more fractures in the absence of a medical condition that predisposes a child to fragile bones (for example, osteogenesis imperfecta, osteopenia of prematurity) or if the explanation is absent or unsuitable.
- Signs of a spinal injury (injury to vertebrae or within the spinal canal) in the absence of major confirmed accidental trauma.
- Bruising or petechiae (tiny red or purple spots) that are not caused by a medical condition (for example, a coagulation disorder) and if the explanation for the bruising is unsuitable. Examples include:
    - bruising in a child who is not independently mobile;
    - multiple bruises or bruises in clusters;
    - bruises of a similar shape and size;
    - bruises in the shape of a hand, ligature, stick, teeth mark or an object;
    - bruises on any non-bony part of the body or face, including the eyes, ears and buttocks;
    - bruises on the neck that look like attempted strangulation;
    - bruises on the ankles and wrists that look like ligature marks.
- Burn or scald injuries if the explanation is absent or unsuitable, particularly if the child is not independently mobile, on a soft tissue area not likely to come into contact with a hot object in an accident, or in the shape of an implement (for example, a cigarette tip or iron).
- Repeated, apparent life-threatening events in a child, if the onset is witnessed only by one caregiver and a medical explanation has not been identified.

Source: Adapted from Child maltreatment: when to suspect maltreatment in under 18s [14]

Table 2: **Signs and symptoms related to sexual abuse**

- Persistent and/or recurrent anal/genital symptoms that are without a medical explanation.
- Evidence of one or more foreign bodies in the vagina or anus. Foreign bodies in the vagina may be indicated by offensive vaginal discharge.
- In pre-pubertal children, presence of infection that can be transmitted sexually without clear indication of non-sexual transmission.
- In post-pubertal children or youth, presence of infection without clear indication of consensual sexual activity with a peer or without clear indication of non-sexual transmission.
- Pregnancy in a child or young adolescent. (In some settings teen pregnancies from consensual sex are frequent, which would not be a sign for maltreatment).

Source: Adapted from Child maltreatment: when to suspect maltreatment in under 18s [14]

Table 3: **Behavioural cues for possible maltreatment**

Child or adolescent behaviour:

- Excessive crying or developmental delay.
- Fear and anxiety.
- Sleeping problems.
- Bed wetting.
- Social withdrawal.
- Poor self-regulation.
- Regressive behaviour compared to what would be expected for the age of the child or adolescent.
- Repeated or coercive sexualized behaviours or preoccupation (for example, sexual talk by a pre-pubertal child associated with knowledge or emulating sexual activity with another child).
- Sexual behaviour that is indiscriminate, precocious or coercive.
- Reports or displays of sexualized behaviour in a pre-pubertal child, such as oral-genital contact with another child or a doll; requesting to be touched in the genital area; or inserting or attempting to insert an object, finger or penis into another child's vagina or anus.

Caregiver behaviour and potentially harmful caregiver-child interactions:

- Emotional unavailability and unresponsiveness from the caregiver towards a child and in particular towards an infant.
- If caregivers fail to seek medical advice for their child to the extent that the child's health and well-being is compromised, including if the child is in ongoing pain.
- Negativity or hostility toward, or rejection or scapegoating of, a child.
- Developmentally inappropriate expectations of, or interactions with a child, including inappropriate threats or methods of disciplining.
- Using the child for the fulfilment of the adult's needs (for example, in disputes between caregivers).
- Failure to promote the child's appropriate socialization (for example, involving children in unlawful activities, isolating them, not providing stimulation or education).

Source: Adapted from Child maltreatment: when to suspect maltreatment in under 18s. [14]

Table 4: **Signs related to appearance of the child or adolescent and environmental factors**

- Child has consistently poor hygiene that is becoming a health concern (e.g. baby being left in soiled diapers for long periods of time despite access to diapers and adequate resources).
- If caregivers fail to seek medical advice for their child or adolescent to the extent that their health and well-being is compromised, including if they are in ongoing pain.
- Child or adolescent is inappropriately dressed for the weather.
- Decreased academic performance or increased absenteeism from school.
- Lack of care of medical needs, wound care, medication.
- If you repeatedly observe or hear reports of any of the following in the home that is in the caregiver's control:
    - inadequate provision of food;
    - a living environment that is unsafe for the child's or adolescent's developmental stage.

Note: Some of these signs may be common in situations of high levels of poverty and limited access to health care. It is important to consider the local context.

Source: Adapted from Child maltreatment: when to suspect maltreatment in under 18s [14]

Asking about child maltreatment, if suspected

If you have noticed signs, symptoms or information in the clinical history that lead you to consider that child maltreatment may have occurred, it is usually necessary to obtain further information.

The recommended approach to inquire about child maltreatment is called ***clinical inquiry***: When a child or adolescent exhibits signs and symptoms of maltreatment or conditions that may be caused or complicated by abuse, the trained health care professional safely inquires about potential exposure to child maltreatment.

The following minimum requirements must be in place: a private setting; ensured confidentiality; a protocol or standard operating procedure; providers trained to ask and provide a minimum response, such as first-line support through the LIVES CC (Listen, Inquire, Validate, Enhance Safety, Support, Child and adolescent friendly, Caregiver support - see page 43) approach for children, adolescents and their caregivers; and a system for referrals.

The World Health Organization does not recommend universal screening for violence of children attending health care. WHO does encourage health care providers to raise the topic, if children have injuries or conditions that they suspect may be related to violence.

Not recommended: Universal screening

Health professionals ask all children seeking any type of service about their experiences of violence. This approach can cause serious harm and is NOT recommended by WHO.

Although rare, children may disclose their exposure to maltreatment in an unsolicited way. Health professionals should be prepared for such situations and follow the steps of the LIVES CC approach.

When inquiring about child maltreatment the following steps should be followed:

Ask the caregiver if he/she agrees that you can see the child or adolescent alone

Caregivers can be sources of support for children affected by maltreatment or when maltreatment is suspected. However, interacting with caregivers may be complicated if the caregiver is the perpetrator; may have allowed the maltreatment to occur; or may also be facing violence at home. Each of these scenarios may lead the non-offending caregiver to deny the abuse, feel guilty, or not be supportive of the child or adolescent.

Therefore, it is helpful to speak to the child or adolescent on his/her own. You might say: *"I'm going to spend a few minutes alone with your child; I'll come and get you when we are finished"* [15].

CLINICAL TIP

Children and adolescents should always be offered the opportunity to be seen on their own, without caregivers

Clarify the confidential nature of the discussion

Indicate in what circumstances parents or other adults will be given information

In some instances, the caregiver may not agree to the child being seen alone. If this is the case, you should emphasize that this is common practice to get the views of the child or adolescent. Most caregivers will agree. If the caregiver continues to disagree, you will need to take a decision based on the best interest of the child. If you insist on seeing the child or adolescent alone you might alienate the caregiver; if you allow the caregiver to be present, there is a risk that the child or adolescent cannot speak openly. Your main focus should be to determine the risk for the child or adolescent if he/she leaves the health institution with the caregiver.

Explain limits of confidentiality

Before you start to explore with the child or adolescent the possibility that maltreatment has occurred, it is important to explain clearly what information will be kept confidential, and if any information will need to be shared with others. This is because the child or adolescent might feel betrayed if information disclosed confidentially is later shared with, for example, child protection agencies. What you can promise depends on the policies and legislation in the setting in which you work.

TIPS AND HINTS – How to explain confidentiality to a child or adolescent

Below are some examples on how you can explain confidentiality to children and adolescents in the absence of their caregivers (adapted from [15]). In different cultures, languages and settings, different words may be used. In some settings it might be appropriate to use drawings, pictures or toys to explain what you are describing or asking.

Explain what your job is and that you are concerned about their well-being:

- *"Part of my job is to help children with problems they face. I care about your well-being. It is important for me that you are safe."*

Explain confidentiality and its limits:

- *"What you tell me is between you and me. I will not tell anybody what you tell me."*
- *"There is however one exception: When something you tell me makes me worry about your safety or the safety about somebody else, or if you need help that I cannot give you, I might need to involve someone else who can help you."*
- *"How do you understand safety?" [Let child respond.] "An example for not being safe is when an adult is hurting you or not taking care of you. In these situations, I would be worried about safety and would need to talk to someone to help keep you safe."*

Explain how you will involve others if necessary:

- *"What we discuss now remains between us and I will not tell anyone about it. However, if I am very worried about your safety or the safety of somebody else, I might need to speak with other colleagues about it. We will however discuss together how we best speak to them, if needed."*
- *"Before talking to anybody else I will always let you know first who I need to talk with and which of the things you told me I will tell the other person."*

Ensure that the child or adolescent understands this. Wait for the answer first, before asking a new question. Avoid compound questions that include several questions and that include "and" or "or".

- *"Did you understand that?"*
- *"Should I explain once more?"*
- *"Do you have any questions?"*

Get assent

- *"Is this OK with you?"*

Listen, observe and establish a rapport

It is important to listen carefully, observe nonverbal cues and establish a rapport with the child or adolescent. Establishing a rapport means developing mutual trust with the child or adolescent, and creating some affinity. The child or adolescent should trust you and not be scared to talk to you. Identifying or excluding child maltreatment involves considering information from many sources:

- Presenting history.
- Previous report/s of maltreatment, or disclosure of maltreatment.
- Symptoms or physical signs.
- Interaction between child and caregiver.
- Physical examination.

Be alert to further signs and symptoms of child maltreatment. Note that some of these features may also be seen in a wide range of children and adolescents for other reasons.

Seek an explanation

If during the history taking any signs or symptoms are noted that could be the result of child maltreatment, seek an explanation. Gather further information about the sign or symptom in an open-ended manner. For example, if you notice a bruise, you could ask in a neutral and interested manner: *"I have just noticed this bruise on your thigh. Do you want to tell me about how it happened?" [15].*

This can be more challenging for symptoms of abuse that are not physical, such as behavioural cues like aggression, tearfulness, or withrdrawal. Here you might ask a few questions about the situation at home and how people get along with each other, or if the child or adolescent is concerned about anything. Remember that you can encourage younger children to draw, use pictures, or show their answer using dolls, for example:

"Tell me about who you live with at the moment."

"Are you afraid of anything or anyone at home?"

"What happens if you get in trouble or don't listen to your caregivers?"

"What is the worst thing that happens?"[15]

Don't ask any suggestive questions such as: *"I noticed [symptom]. Was it your father who was hurting you?"*

Suitable explanations are those that indicate a certain physical sign is due to an injury that was clearly described, and where the symptom matches the time and type of injury. There could be other explanations for a child's or adolescent's behaviour, for example the loss of a family member, living through a divorce, moving houses or changing schools, which (among others) can all be events causing stress.

Unsuitable explanations are those that are:

- implausible, inadequate or inconsistent with factors such as how the child or adolescent is presenting; the child's or adolescent's normal activities; the child's or adolescent's medical condition (if one exists); their age; the account of how the signs or symptoms appeared, as the given a) by caregivers, b) between caregivers, or c) between accounts over time;
- based on a cultural practice, or the caregiver's own experiences of being beaten as a child, which may be wrongly used to justify hurting a child.

Keep a record

Record exactly:

- what is observed;
- who said what, and when;
- why this is of concern.

Exclude or suspect maltreatment

All the information gathered can be used to exclude the possibility of maltreatment; actively suspect the possibility of maltreatment; or to continue investigating through further clinical inquiries with the child or adolescent. To determine next steps, distinguishing between these three options is useful (see Figure 1 for an overview of this process).

Excluding child maltreatment

You may exclude child maltreatment when a consistent and suitable explanation has been found for the symptoms that triggered alerts of child maltreatment in the first place, and no other signs and symptoms have been noted. This may be the decision following discussion of the case with a more experienced colleague.

Suspecting child maltreatment

You may suspect child maltreatment if, during the process of the clinical inquiry, any of the following occurred (in some countries, a suspicion of child maltreatment requires that the case is reported to a designated authority):

- You did not hear a suitable explanation for the signs and symptoms you observed.
- You observed further signs or symptoms that could also be associated with child maltreatment.
- The child, adolescent or caregiver disclosed child maltreatment.
- Your level of concern about child maltreatment got stronger during the interaction.
- You observed signs and symptoms for which any other explanation than child maltreatment is unlikely (e.g. physical injuries in children that are not mobile, sexually transmitted infection in pre-pubertal children).

When you suspect child maltreatment, explain to the child, adolescent and/or caregiver that you are concerned about the child's or adolescent's health or well-being and do a comprehensive assessment. This might involve suggesting a complete physical exam. Also, provide first-line support by applying the LIVES CC approach, described in Part III: Responding to child maltreatment.

Considering child maltreatment

If no other signs and symptoms are present but you are still unsure about ruling out child maltreatment, arrange a follow-up visit with the child or adolescent at an appropriate date. You should also consider:

- discussing your concerns with an experienced colleague, paediatric nurse, paediatrician or mental health specialist, if available at your workplace;
- collecting additional information, if available, either from other agencies (education, child protection) or other health disciplines;
- looking for repeated presentations of the alerting signs or symptoms or for any other features of concern during the follow-up visit.

Figure 1: **Steps to determine if child or adolescent maltreatment has occurred**

Listen and observe

Take into account all available sources of information including:

- any history given;
- reports of maltreatment, or disclosure from a child or adolescent or somebody else;
- appearance of the child or adolescent;
- behaviour of the child or adolescent;
- symptoms;
- physical signs;
- results of any investigation;
- interaction between the caregiver and child or adolescent.

Seek an explanation

Seek an explanation for any injury, sign or symptom from the child or adolescent, or caregiver, in an open and non-judgemental manner. An unsuitable explanation is one that is:

- implausible for the child's or adolescent's presentation of signs, symptoms or behaviours;
- implausible for the child's or adolescent's developmental stage or age;
- inconsistent with accounts given by caregivers, or between caregivers, and the child or adolescent;
- inconsistent if the symptom is explained differently at different points in time.

Record

Record in the child's or adolescent's clinical record exactly what is being heard and observed from whom and when, and why this is of concern.

If a sign or symptom leads you to consider child maltreatment

- Look for other alerting features of maltreatment.
- Ask for more information.
- Discuss with experienced colleague or peer.
- Ensure to see the child or adolescent within appropriate time.

If a sign or symptom leads you to suspect child maltreatment

- Arrange a comprehensive assessment.
- Provide first-line support (LIVES CC).
- Consider referral to other services (depending on rules, regulations and existing services in your setting).

Exclude child maltreatment

- If a suitable explanation for the alerting sign or symptom was found.
- This might happen after discussion with a more experienced colleague.

Record

- All actions taken.
- All outcomes that follow.

Source: Adapted from [14].

Take a medical history and determine the need and timing for a physical examination

Taking a medical history and conducting a comprehensive physical examination should not be limited to looking for evidence of a certain type of suspected maltreatment because – even when an initial report indicates suspected sexual abuse and no other type of maltreatment – an examination may reveal signs of physical abuse or neglect; or physical and mental health consequences caused by stress related to the abuse; or a previously undiagnosed medical problem.

That said, in cases that appear to be of sexual abuse, a detailed examination that includes genito-anal examination may be required. The main reason for the physical examination is to determine what medical care is needed. It may also be used to complete any legal documentation.

Important aspects of history taking include:

- basic demographic data;
- basic information about the environment in which the child or adolescent lives;
- medical history, including (for girls) onset of menstruation (or not) and mental health;
- if abuse is disclosed then sensitively inquiring about specific details (e.g. where they were hurt or touched) so that you know where to examine them in detail for additional symptoms.

Finding out if child maltreatment has occurred is not a linear process. Sometimes a clinical inquiry might follow the discovery of a sign or symptom of child maltreatment during a routine medical examination. Alternatively, a comprehensive exam might follow a conversation in which the child or adolescent disclosed that violence or abuse had occurred. Where maltreatment is suspected, children should have access to a comprehensive health assessment to determine any further health needs (see Table 5).

Important issues to consider when conducting a comprehensive exam

Remember:

Experiencing maltreatment is a traumatic event. Children and adolescents who have been maltreated may be very sensitive to being examined or touched. Health professionals should seek to minimize additional trauma and distress for children and adolescents by minimizing the number of assessments the child or adolescent undergoes, including asking them the same questions more than once. Asking a child repeatedly to tell their history can be re-traumatizing.

The following issues should be considered during the examination:

- Explain the exam in child-friendly language that uses developmentally appropriate words. Remember that children often interpret statements very literally. You can use dolls or drawings to explain the procedures to younger children.
- Show verbally and non-verbally that you are interested in what the child is saying and that you believe him or her. Do not stand above the child when communicating, but rather sit down to be at the child's physical level.
- Allow the child or adolescent to ask questions at any time.
- Give careful consideration as to who can best support the child or adolescent during a physical examination. If the accompanying caregiver might be involved in suspected maltreatment, another health care provider such as a nurse or social worker could support the child or adolescent during the examination.
- Obtain informed consent and assent from the child or adolescent and caregivers, as appropriate.
- Enable the child or adolescent to make choices in all interactions and to be engaged in decision-making.
- Pay attention to the appearance and emotional state of the child or adolescent. At each step of the exam, tell the child or adolescent what you are going to do, and ask permission first.

- Respect personal boundaries and only touch the child or adolescent if needed for the examination.
- Minimize delays, but do not rush the child.
- Do not use medical restraints or force of any kind during the examination.
- In every case, the medical and emotional needs of the child or adolescent should come before aspects of the examination that pertain to legal considerations, for example, the gathering of evidence.
- Clearly explain what to expect after the exam and provide instructions for follow-up in developmentally appropriate language. Follow through on anything told to the child, adolescent or caregiver.

Table 5: **Physical exam checklist**

Appearance	Document the general appearance and emotional state of the child or adolescent.
Growth	Measure and record (on a standardized growth chart) the child's or adolescent's height and weight, and in children under the age of 2 years, their head circumference.
Skin	Check for bruises, bite marks, abrasions, lacerations, burns or other dermatologic lesions. Describe the size, shape, colour, and location of any of these. Note degree of healing of an abrasion.
Mouth	Check for injury or sexually transmitted infections. Note bruising of lips, buccal mucosa, gums, palate, mucosal tears, or dental trauma.
Head, eyes and ears	Check the anterior fontanelle in infants, palpate the head for hematomas or fractures; evaluate the eye for globe injury or orbital fracture. Check the ears for bruising on the pinnae, hemotympanum, tympanic membrane perforation, and cerebrospinal fluid otorrhea. Look for patches of alopecia as might be seen in a neglected infant or abused child. Conduct a fundoscopic examination of the eyes looking for retinal haemorrhages.
Neck	Check for ligature or other choke marks.
Chest	Check for costo-chondral tenderness or chest deformity. In females, record the Tanner stage (see Figure 5) of the breast development.
Abdomen	Examine for bruises; palpate the abdomen for bowel sounds, tenderness, masses.
Back	Examine for bruises; palpate for tenderness.
Extremities	Examine for tenderness, swelling, or deformity.
Neurological status	Examine the mental status and other neurological symptoms.
Development	Determine developmental stage.

Source: Adapted from [16]

Genito-anal examination in cases of suspected sexual abuse

In cases of suspected sexual abuse, a genito-anal examination might be indicated to ensure children or adolescents are offered appropriate health care and support. Only those who have had specialized training and experience in working with children should conduct genito-anal examinations in children. A child or adolescent should never be examined against his or her will unless the examination is essential for the provision of health care. Examinations that are medically unnecessary or are likely to increase harms or distress should not be undertaken.

All practitioners working with children should be aware of the relevant laws and policies in place in the setting (including those related to consent, mandatory reporting, definitions of sexual violence against children), and who can collect and provide medico-legal evidence in court.

The genital examination of the prepubertal child is principally an external visualization. For girls, note the location of any fresh or healed tears in the vulva, introitus and vagina by holding the labia at the posterior edge between index finger and thumb and gently pulling outwards and downwards. Instrumentation is rarely necessary. Speculums or anoscopes and bimanual examinations of the vagina or rectum of a prepubertal child are not routinely required. Do not carry out a digital examination to assess vaginal orifice size or anal sphincter tone. A speculum may be used only when you suspect a penetrating vaginal injury and internal bleeding. Depending on the setting, the child may need to be referred to a higher level of health care. If the use of a speculum is required, use the smallest size possible. Occasionally, examinations may need to be done under general anesthesia but this should only occur for health indications. For boys, check for injuries to the frenulum of the prepuce, and for anal or urethral discharge (adapted from [16]).

Positioning

The supine position is most commonly used in genital exams in pre-adolescent children. Younger children can be placed on the lap of the non-offending caregiver, if this is comfortable for them. Older girls can be examined in the supine lithotomy position with stirrups if they agree. The prone knee chest position is most commonly used for the perineal and anal examinations (adapted from [16]).

Be aware that these positions may cause embarrassment for some survivors or bring back memories of prior abuse. Always ensure that the child is in control of the positioning and provide constant reassurance. See Tables 6–9 for what to look out for and assess, and Figure 2 and Figure 3 for definitions of key terms.

Table 6: **What to assess in a genito-anal examination, males and females**

Pubic hair development	Note Tanner stage.
Inguinal adenopathy	Estimate diameter of nodes if enlarged.
Thigh	Note dried or moist secretions, grab marks, bite marks, or evidence of other injuries. Note any healed scars, sexually transmitted infection (STI) lesions, or other abnormal findings.
Perineum	Note fresh or healed lacerations, STI lesions, pubic lice, rashes, or other unusual findings.
Vaginal or urethral discharge	Note presence of discharge in terms of amount, colour, and presence of odour. Identify source, i.e. vagina or urethra.
Sexually transmitted infections	Note condyloma acuminata, condyloma lata, herpes, or primary syphilis lesions.

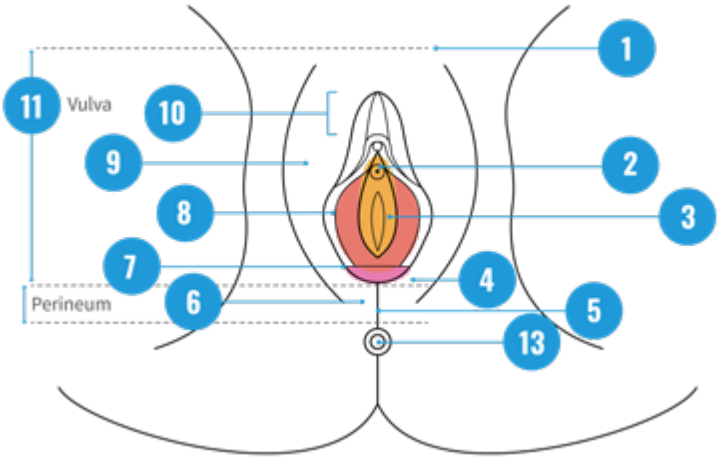
Table 7: **What to assess in a genito-anal examination, females**

Female genital examination	
Labia majora and minora	Note skin lesions, unusual pigmentations, or other skin changes.
Clitoris	Note unusual size or changes of the clitoris or hood.
Urethral meatus	Note signs of inflammation, oedema, or other lesions of the periurethral tissue.
Perihymenal tissue	Note fresh or healed lacerations, STI lesions, pubic lice, rashes, or other unusual findings.
Hymen[1]	Note any signs of trauma or STI lesions. Evaluate for significant distortion of the hymenal shape, fresh tears, transections, fresh haemorrhages, abrasions, and bruises.
Posterior fourchette and fossa navicularis	Note lacerations or scars, bruises, healing abraded areas, STI lesions, or neovascularization.
Vagina	Note bleeding, discharge, STI lesions, foreign bodies, abnormal vascular pattern, petechiae, or other lesions on the walls of the vagina.
Cervix	Note bleeding, discharge, STI lesions, cervicitis, tears, or other signs of trauma.

Source: Adapted from [16].

[1] Remember that examining for past sexual history or virginity testing should not be done, as these tests have no scientific validity and are harmful to the child or adolescent.

Figure 2: **Definitions for female genitalia**



Definitions

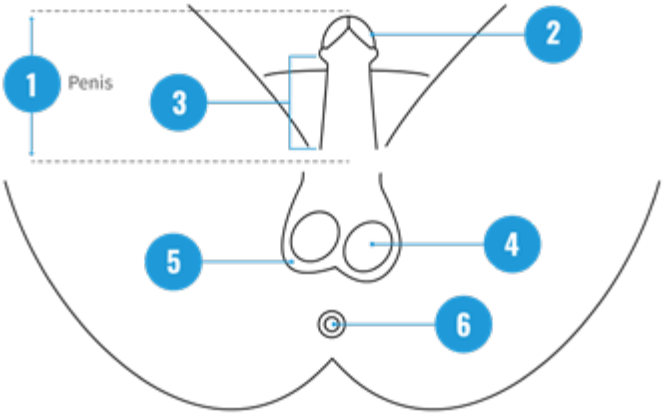
1. Mons pubis: where the labia majora meet in front and covered with hair after puberty
2. Urethral opening: opening of the urethra to external environment to allow urine to be expelled
3. Hymen: membrane at the vaginal opening almost always with a visible opening
4. Posterior fourchette: where the labia minora meet at the back in the midline
5. Perineal raphe: the visible line running from the genitalia to the anus
6. Perineum: region between the thighs that is bounded by the vulva in the front and the anus at the back
7. Fossa navicularis: the concave area between the back of the vaginal wall and the posterior fourchette
8. Labia minora: skin folds that cover or partially cover the hymen and vagina
9. Labia majora: broad skin fold that surrounds the labia minora (covered with hair after puberty)
10. Clitoris: erectile tissue that expands when stimulated
11. Vulva: all of the components of the external genitalia, including the mons
12. Vagina (not displayed): a tubular canal between the cervix and the hymen
13. Anus: outlet for faeces

Table 8: **What to assess in a genito-anal examination, males**

Male genital examination	
Penis	STI lesions, bite marks, oedema, haematomas, lacerations, abrasions, or dried secretions. Check Tanner stage.
Urethral meatus	Scars, STI lesions, discharge, or bleeding.
Scrotum	Erythema, ecchymoses, STI lesions, abrasions, or bite marks. Check Tanner stage.
Testes	Presence of descended testes, any signs of atrophy or differences in firmness of the tissue. Check Tanner stage.
Sexually transmitted infections	Note condyloma acuminata, condyloma lata, herpes, or primary syphilis lesions.

Source: Adapted from [16].

Figure 3: **Definitions for male genitalia**



Definitions

1. Penis: male organ of copulation and of urinary excretion
2. Glans (head): the expanded head of the penis
3. Shaft: the cylinder of tissue between the body and the head of the penis
4. Testicle: the egg-shaped glands housed within the scrotum
5. Scrotum: the pouch of skin containing the male reproductive glands (testes)
6. Anus: outlet for faeces

Table 9: **What to look for in an anal/rectal examination**

Buttocks	Fresh or healed lesions, dried secretions, ecchymoses, rashes, STI lesions, handprints or fingerprints.
Perianal skin	Inflammation, dried secretions, bruising, fissures, tears, or lacerations.
Anal verge/folds/rugae	Prominent, normal, or flattened.
Tone	Note whether within normal limits.
Anal laxity	Estimate diameter of any anal dilatation, record presence or absence of stool in rectal ampulla.

Source: Adapted from [16].

DOs

- Maximize all efforts to have the child or adolescent undergo the minimum number of examinations to reduce the risk of retraumatizing them.
- Explain what will be done prior to each step.
- Offer choice in the sex of the examiner, wherever possible.
- Make sure that there is another adult present during the examination. Ideally this is an adult the child or adolescent chooses for emotional support. It can be the non-offending caregiver or another staff member.

DON'Ts

- Health practitioners (and others) should not conduct virginity examinations or hymenal reconstruction; these activities cannot be supported scientifically or ethically.
- Do not use a speculum to examine pre-pubertal girls. It is painful and may cause injury.
- Do not carry out a digital examination on a child to assess anal sphincter tone – such assessments have no validity.
- Do not collect forensic evidence unless it can be stored securely and there are systems accessible for their analysis.

Carefully document any signs or symptoms of child maltreatment

Document the findings of the medical history and physical examination accurately and completely. This is because health care providers may sometimes need to answer questions from police, lawyers or the courts about injuries or other medical conditions in children they have treated. Careful documentation of findings will make it easier for you to answer accurately. Include in the medical record any explanation given by the child or adolescent for the injury or other medical condition, using the child's or adolescent's exact words when possible.

In many countries, medico-legal or forensic laws mandate a format for documenting medical history and physical examination findings. You may be mandated to use these forms for medico-legal or forensic evidence purposes. If such a form is not available or mandated, you can use and adapt the following list to document the medical history and physical examination findings in a systematic way.

Remember – documenting the abuse and its health consequences is not only important for good quality care (including follow up for the child or adolescent survivor) but may be critical in enabling them to get access to justice.

Remember:

The absence of physical evidence does NOT mean that abuse did not occur.

Also note that no particular emotional state is indicative of abuse.

Document all observations exactly.

For the documentation of your findings:

- Use a structured format.
- Document both the presence and absence of physical findings.
- Write down or record verbatim statements of the child or adolescent and the caregiver.
- If there are any discrepancies between the child's or adolescent's account of what happened and the caregiver's account, note them carefully but do not include your own interpretation.
- Record a detailed and accurate description of all symptoms, injuries and other medical conditions.

- Document the child's position during the examination.
- Avoid using the phrase "within normal limits". It leaves too much room for interpretation.
- Describe the child's or adolescent's behaviour factually, such as "patient crying" rather than "patient upset".
- Avoid using terms that can be misinterpreted.
- Remember your role as a provider is to factually and simply document verbatim all findings, observations and history. It is not your role to investigate whether or not abuse took place. That should be left to the child protection and legal authorities.
- Seek informed consent or assent for taking any anonymized photographs and/or videos, after explaining how they will be used.
- Handle all information confidentially, for example, sharing information only after obtaining permission from the child or adolescent and caregiver and only on a need-to-know basis (i.e. those dealing directly with the case, for example a mental health worker) in order to provide care.
- Store the information securely and, if the information is in digital form, preferably in a password-protected file or in a locked cupboard in a cool dry place with access to the key restricted and recorded.
- Anonymize identifying information.
- Do not disclose any identifying information about a specific case to anyone who does not need to know, and especially not to the media.
- Be aware of national laws and guidelines on reporting and document the information that might be reported.

Handling information confidentially

- Do not disclose the identity of a child, adolescent or caregiver to other colleagues.
- Do keep all personal information in a locked cabinet or encrypted files.
- Do not add any information about exposure to violence in patient files that the child or adolescent takes home.

Part III:
Responding to child maltreatment

The following sections cover the LIVES CC approach (Listen, Inquire, Validate, Enhance Safety, Support, Child and adolescent friendly, Caregiver support). The LIVES CC approach sets out the minimum support that all children who disclose child maltreatment should receive from any health care provider. This section identifies specific health issues that can be a consequence of child maltreatment. It looks at how to respond to physical injuries and sexual abuse, and how to address mental health issues.

Provide first-line support – The LIVES CC approach for children, adolescents, and their caregivers

What is first-line support?

First-line support is a practical, child-centred, empathetic approach to responding to (potential) survivors of violence, and in some cases may be the only care possible in the absence of other health services. First-line support is one of the most important elements of care to survivors of maltreatment and is based on psychological first aid. It responds to a child's emotional, safety, and support needs, while respecting their privacy. In cases of child maltreatment, first-line support may need to be provided to both the child or adolescent, and the non-offending caregiver, and should be offered immediately after violence is disclosed or suspected.

First-line support, which is also provided to adult survivors of violence, consists of five different components. Two additional components have been proposed to account for specific needs of children and adolescents who experience maltreatment. These components do not follow a particular order. They should be woven into the conversation you have with the child or adolescent. The acronym "LIVES CC" (LIVES for **C**hildren, adolescents and their **C**aregivers) can remind you of these key components in responding to children and adolescents where maltreatment has been disclosed. The LIVES CC approach can be applied regardless of whether the child or adolescent or the caregiver disclosed violence.

Listen	Listen to the child or adolescent closely with empathy and without judging in a private space.
Inquire	Assess and respond to needs, wishes and concerns – emotional, physical, social and practical.
Validate	Show the child or adolescent that you understand and believe them, and that they are not to blame for what happened.
Enhance safety	Protect the child or adolescent from further harm. Enhance the safety of the child or adolescent.
Support	Facilitate support by connecting children and adolescents to formal and informal support services.
Child and adolescent friendly environment	Create a child and adolescent friendly environment by training providers and improving service readiness to provide survivor-centred care.
Caregiver support	Provide support to non-offending caregivers to support the child or adolescent.

LISTEN

The purpose is to actively listen and learn what is most important for the child or adolescent. As you listen, pay attention to what the child or adolescent says about his/her needs and concerns. Take note of the interaction between the caregiver and the child or adolescent. Also pay attention to the body language of the child or adolescent and the caregiver. Try to learn about physical, emotional, or economic needs, safety concerns, or social support the child or adolescent might need.

Consider that the non-offending caregiver may also be part of the LIVES CC process. The caregiver may be shocked by the disclosure, may also be exposed to violence from the perpetrator, or may feel guilty because he/she was not able to protect the child or adolescent.

DOs

- Be patient and calm. Don't pressure the child or adolescent to talk.
- Let the child or adolescent know that you are listening. You can for example nod your head or say something affirmative such as *"hmm…."* (depending what is typically used in your language).
- Be at the same physical level as the child or adolescent and be aware of your body posture. Be close enough to the child or adolescent to show concern and attention, but not so close as to make him/her uncomfortable.

DON'Ts

- Don't look at your watch, answer the telephone, look at your computer, or write.
- Don't speak too fast.
- Don't judge what the child or adolescent has done or had not done.
- Don't say things like, *"You shouldn't feel that way,"* or *"You should feel lucky you survived"*, or *"Poor you".*

- Acknowledge how the child or adolescent is feeling, for example, by saying *"It sounds like you are feeling some anger about what happened."*
- Let the child or adolescent talk at her/his pace.
- Let the child or adolescent choose how to express him/herself, for example, by drawing, writing, showing.
- Ask open-ended questions to encourage the child or adolescent to talk instead of saying yes or no, for example, by asking *"How do you feel about that?"*
- Reflect the feelings of the child, for example, by saying *"It sounds as if you are feeling angry about that."* or *"You seem upset."* Pay attention to non-verbal cues and body language.
- Address the child or adolescent directly.
- Allow for silence. Give the child or adolescent the time he/she needs to think.

- Don't assume that you already know what is best for him/her.
- Don't talk with the caregiver about the child or adolescent in the third person.
- Don't interrupt or ask questions before the child or adolescent has finished speaking.
- Don't try to finish the thoughts for the child or adolescent or caregiver.
- Don't tell the child or adolescent someone else's story or talk about how you interact with your own children.

Source: Adapted from [18].

INQUIRE

As you listen, inquire about the child's or adolescent's physical, emotional and social support needs and any safety concerns. They can be raised by the child or adolescent, and/or the non-offending caregiver. Inquiring will have to be nuanced on the situation and the age/developmental stage of the child or adolescent. Pay attention to words or body language. You can use the techniques below to help the child or adolescent express what they need and to be sure that you understand.

TIPS AND HINTS

- Phrase your questions as invitations to speak, for example by asking *"How can I help today?"*
- Help the child or adolescent to identify and express needs and concerns, for example, *"Is there anything that you need or that you worry about?"*
- Explore as needed, for example, by asking *"Can you tell me a bit more about what you mean when you say…?"*
- Ask for clarification if you don't understand, for example, *"Can you explain that, please?"*
- Summarize and repeat what you understood, using the same words as the child or adolescent.

VALIDATE

Validating the experience of the child or adolescent means letting the child or adolescent know that you are listening attentively, that you understand what he/she is saying, and that you believe what he/she says without any judgement. The purpose is to let the child or adolescent know that his/her feelings are normal, that it is safe to express them and that he/she has a right to live without violence and fear.

Words you can use to show your understanding

"I believe you."

"This is not your fault. You are not to blame."

"I am very glad you told me."

"It's OK to talk."

"I am sorry this happened to you."

"You are very brave for telling me."

Helping children and adolescents cope with negative feelings	
Feeling	**Things you can say**
Hopelessness	*"Many children/adolescents feel what you're feeling after such experience. I'm here to help you and there are ways we can support you to help you feel better."*
Powerlessness and loss of control	*"I will explain to you how we proceed today. You can also make some choices by yourself."*
Guilt and shame	*"You are not to blame for what happened to you. You are not responsible for his/her/their behaviour."*
Fear	*"Right now, you are in a safe place."*
Anger	*"It's OK to be angry."* Acknowledge that this is a valid feeling.

ENHANCE SAFETY

Although as a health professional you may not be able to ensure a child's or adolescent's safety (especially if a coordinated response is not possible), you can do something to empower them, explore any immediate safety risks and their assets for keeping them safe. The purpose of this activity is not to develop a comprehensive safety plan for the child or adolescent as this is usually the responsibility of child protection services. But you can take important first steps to contribute to the safety of the child or adolescent by:

- assessing whether the child or adolescent and also the non-offending caregiver are safe at home or in his/her immediate environment;
- developing a strategy (together with the child or adolescent and non-offending caregiver) to protect the child or adolescent from further harm.

Immediate safety risks for children and adolescents can include but are not limited to the following:

- Child maltreatment by family members with access to the child.
- A caregiver who is unwilling or unable to protect the child from physical, sexual or emotional abuse.
- A caregiver who has threatened to harm or retaliate against the child or adolescent, or fears he/she will injure the child.
- A caregiver who refuses or is unable to meet the child's immediate needs (for example, food, clothing, shelter, medical care, supervision, emotional support, any special needs).
- A caregiver who has a substance abuse problem that seriously impairs his/her ability to supervise, protect, or care for the child.
- A caregiver with mental illness or disability that impairs his/her current ability to supervise, protect, or care for the child.
- Previous episodes of abuse or neglect.
- Domestic violence exists in the household and poses an imminent danger of serious physical and/or emotional harm to the child.

You can explore jointly with the child or adolescent and the non-offending caregiver strategies to enhance safety. These should take account of the age of the child or adolescent, and the specific circumstances in which they live.

Not all strategies (or combinations thereof) will be appropriate for each child or adolescent, but they include:

- strategies and assets that are within the control of the adolescent or the non-offending caregiver – for example, older children or adolescents may have a limited and specific safety strategy of their own, such as leaving the room when a caregiver starts to yell at or hit another caregiver;
- addressing emotional safety needs – this includes strategies to access relationships, activities, and opportunities that foster resilience;
- making a plan for follow-up contact with the child and/or caregivers, including what will happen if the child cannot be reached for follow-up care;
- helping the child or adolescent and non-offending caregiver to identify a safe person or safe place to go if they need to leave home in a hurry;
- connecting a child or adolescent who is at risk of, or is experiencing, violence with other resources for their health, safety, and social support, if he/she wishes so. It is important to ALWAYS follow-up on all referrals.
- In some instances it might be appropriate to consider short periods of hospitalization. In this case it is important to ensure that the child or adolescent can be kept safe at this time and can be provided with emotional support by an adult or non-offending caregiver.

SUPPORT

The child's or adolescent's needs are often beyond what can be provided for in your clinic or practice. The purpose of this strategy is to connect the child or adolescent and the caregiver with other resources for their health, safety, and social support. These might include referral to:

- specialized health services in a different institution;
- mental health care;
- social welfare services, shelter or housing support;
- a specialized support agency for survivors of violence or child helplines;
- an advocate or legal services.

Know the roles and responsibilities of the relevant service providers in your area

Official service provider agreements or referral systems exist in some settings, where all relevant agencies and services agree on who provides which service and how referral between different services is organized. In other settings, services are offered using the one-stop-centre approach, where all services to address child maltreatment are provided in one place by a multisectoral team. In yet other places, there may be no official coordination between different services, or informal coordination structures.

To be able to make a referral, complete and up-to-date service mapping needs to be available in the form of a table. This table should include:

- which institutions offer relevant services, and when and how they can be reached;
- the contact person in each institution;
- whether they offer services to children and adolescents of all age groups;
- what support they offer;
- an agreed referral structure (ideally).

If there is no full service mapping yet, as a minimum you should at least have a contact person in other support services. You also should consider whether the services that are provided are of appropriate quality and whether services are provided to the age group of the child or adolescent concerned.

If you do not have enough information about a particular service, be honest with the child or adolescent and their caregiver by saying *"I don't know"*. It is important that the service is appropriate, of high quality, and accessible – otherwise the referral risks more harm than good.

Be aware of information-sharing protocols and policies

It can be traumatic for a child or adolescent to unnecessarily repeat his/her account of maltreatment experiences, or to find out that more people know about their experience than should be the case. To avoid such situations, many settings have established information-sharing protocols that regulate how, when and by whom interviews of child and adolescent survivors of maltreatment are conducted. The protocols should also outline when and how this information can be shared in a confidential and respectful way and how to obtain consent or assent from the child, adolescent or caregiver.

If such protocols are not in place, be sure to obtain consent and assent each time you share personal information with another service or person, and share information only if your counterpart applies the same principles.

Know your counterparts

Referral processes are more likely to succeed and be faster if you personally know your counterparts. This will also help you to get a better understanding of the services that can be provided and will help you to better inform your clients. It also can help you follow-up with the person to see how the referral is progressing.

Warm referral

You should always aim to do a "warm referral". This includes, for example, making the call on behalf of the caregiver of the child and introducing him/her and the child or adolescent. You can also offer to make a call using the speaker feature of the phone, so that they feel fully involved in the process and can ask any questions while you are present. If desired you can also schedule an initial joint appointment with the new provider to help ease the transition. You can also discuss with the caregiver how they will get to the appointment. To facilitate the referral process you should:

- offer to call to make an appointment;
- describe the location, how to get there, and exactly who the child or adolescent will see;
- offer to provide written information such as time, location, how to get

there, name of the contact person, and make sure that the perpetrator does not have access to this information;

- always check for any concerns, and whether all information was understood.

Children and adolescents should not be left to contact referral agencies on their own. Younger children in particular should be accompanied by a person of trust, such as a non-offending caregiver or a hospital social worker, if available. Adolescents should have the opportunity to go on their own if they prefer to do so. Referral should be done discretely with confidentiality ensured. In some settings, social workers concerned with addressing violence against children or domestic violence might be known in the community and their involvement may raise curiosity among community members. It is therefore important to choose the right person to accompany the child or adolescent.

Possible barriers

If the child or non-offending caregiver expresses concerns about going to a referral for any reason, think creatively with them about solutions. Typical problems might be:

- the person committing the violence might find out and try to prevent contacting a service. Solution: offer to contact the service from the health facility or arrange the first meeting in a room of the health facility.
- unavailability of transport. Solution: explore whether it is possible to contact the service remotely by phone from a safe location and if there are opportunities to provide transport grants.
- non-offending caregiver or accompanying person is unable to take off time from work or duties. Solution: explore whether childcare opportunities exist. Offer to speak with the caregiver's employer. Explore whether the service can be provided closer to the home of the child or the workplace and whether there are opportunities or grants to replace lost income.

Making a follow-up plan

Ensuring that there is a follow up plan in place is important. Always follow up on referrals made to relevant agencies (see Figure 4 for a sample referral directory form). In situations where there is no legal mechanism to place children in a protected environment, especially when the situation has been deemed unsafe, follow up by health care workers can be vital to ensuring a child's or adolescent's safety or well-being.

Figure 4: **Sample referral directory form**

Need	Name of agency and contact person	Contact	Responsible for follow-up
Family protection unit/ social worker		Phone: E-mail:	
Counselling/crisis centre		Phone: E-mail:	
Support groups		Phone: E-mail:	
Mental health care		Phone: E-mail:	
Reproductive health care		Phone: E-mail:	
Laboratory services		Phone: E-mail:	
Child protection		Phone: E-mail:	
Education/school		Phone: E-mail:	
Police		Phone: E-mail:	
Forensics		Phone: E-mail:	
Shelter/housing/foster care		Phone: E-mail:	
Financial aid		Phone: E-mail:	
Legal aid		Phone: E-mail:	
Other		Phone: E-mail:	

Source: Adapted from [19].

CHILD AND ADOLESCENT FRIENDLY ENVIRONMENT

There are various barriers that make it difficult for children and adolescents who have experienced maltreatment to access services. These include stigma, administrative barriers, lack of awareness about the existence of services, and lack of transport options. It is important to make efforts to overcome these barriers and to make it easier for children and adolescents to obtain the health services they need. Health care providers can help to make services more child and adolescent-friendly, by:

- making their workspace appealing and "friendly" to children and adolescents;
- being non-judgemental and considerate in their dealings with children and adolescents;
- having the competencies needed to deliver the right health services in the right way to children and adolescents;
- making children and adolescents aware of where they can obtain the health services they need.

DOs

- Use simple, jargon-free, easy-to-understand language for children.
- Use pictures, dolls, or models to illustrate.
- Give the child a choice to respond in the way they wish.
- Have toys and other materials to help children relax and engage and build a rapport.
- Take time to build rapport and ask light and friendly questions to engage the child.

DON'Ts

- Don't rush to examination.
- Don't force them to respond to anything they do not wish to.
- Don't probe details that they clearly find uncomfortable.
- Don't ask them leading questions.
- Don't ask them to repeat information they have already provided.

CAREGIVER SUPPORT

Non-offending caregivers can play an important role in helping the recovery of children who have experienced child maltreatment. A child's disclosure of maltreatment can have strong emotional effects on the non-offending caregiver and may also have a big impact on the way the entire family functions. Therefore it is important to support both the caregiver's ability to support the child and to support the caregiver themselves.

- Talk to the non-offending caregiver separately from the child or adolescent, if appropriate.
- Ask the non-offending caregiver how they can be supported.
- Provide them with emotional support to help them cope with the situation.
- Non-offending caregivers may have been victimized in the past and may also show symptoms of extreme stress. If possible, provide them with the assistance they need through psychosocial support or mental health services.
- Ask them about perceived safety at home for the child or adolescent, and themselves.
- Provide them with information about the examination and care, long-term consequences of child maltreatment, how to be more supportive of the child or adolescent, and the implications of disclosure on the wider family.
- Some children may display problems sleeping, increased anger, or regressive behaviours. Provide parenting guidance to deal with these behaviours.
- When sending the child or adolescent home, explain to them the follow up steps that will be required and what they should look for in terms of signs and symptoms and medication.

Provide support and care in cases of sexual abuse

If you see the child or adolescent within 5 days of the sexual abuse, several steps are needed in addition to the LIVES CC steps in first-line response.

1. Listen, inquire, validate (see first three steps of the LIVES CC approach).
2. Take a history and conduct the examination.
3. Treat any physical injuries.
4. Provide emergency contraception (where relevant, within 120 hours).
5. Prevent STIs.
6. Prevent HIV through PEP (where relevant, within 72 hours).
7. Plan for self-care.
8. Enhance safety and arrange Support (the fourth and fifth steps of the LIVES CC approach).

Offer HIV post-exposure prophylaxis (PEP) treatment and adherence counselling (within 72 hours)

Rape of a child or adolescent (i.e. penetrative sexual assault) involving oral, vaginal or anal intercourse carries with it the risk of HIV transmission. Children and adolescents are known to be biologically at higher risk of HIV transmission than adults. Factors that further increase the likelihood of HIV transmission are the presence of lesions and genital injuries from forced sexual intercourse and the involvement of multiple perpetrators. If you see the survivor of sexual assault within **72 hours**, HIV post-exposure prophylaxis (PEP) should be considered.

When should PEP be offered?[1]

Both the following conditions must be met:

- When the child or adolescent has been raped involving oral, vaginal, or anal penetration with a penis or when the child or adolescent has been exposed to blood or semen through wounds or other mucous membranes.

[1] See also WHO Guidelines on post-exposure prophylaxis for HIV and the use of co-trimoxazole prophylaxis for HIV-related Infections among adults, adolescents and children: recommendations for a public health approach[20] https://apps.who.int/iris/handle/10665/145719.

- When the child or adolescent presents up to 72 hours after the incident (if multiple incidents took place, consider the most recent incident).

Exposures that do not require PEP include:

- When the exposed child or adolescent is already HIV positive. If this is unknown, offer a HIV test and counselling.
- When the perpetrator is established to be HIV negative.
- When the exposure to bodily fluids does not pose a significant risk, such as tears, blood-free saliva, urine and sweat.

Prescribing and dispensing PEP

- The choice of PEP drugs should be based on national protocols and guidelines, with a preference for a three-drug regimen.
- A 28-day prescription of antiretroviral drugs (ARVs) should be provided for HIV PEP following initial risk assessment, considering the exposures above and local prevalence rates.
- To improve uptake and completion of PEP, provide the full 28-day course at the first visit, and do not require the patient to return multiple times for prescriptions.

For children and adolescents aged 11 years and older (over 30 kgs) WHO recommends the following:

- A triple-therapy (i.e. three drug) ARV regimen, but a two-drug regimen is also effective.
- Tenofovir disoproxil fumarate (TDF) + Lamivudine (3TC) (or FTC/ emtricitabine) is recommended as the preferred backbone regimen for HIV PEP.
- Lopinavir/ritonavir (LPV/r) or Atazanavir/ritonavir (ATV/r) is recommended as the preferred third drug for HIV PEP.

For children aged 10 years or younger, WHO recommends:

- Zidovudine (AZT) + Lamivudine (3TC) as the preferred regimen for HIV PEP.

- Abacavir (ABC) + Lamivudine (3TC) or Tenofovir disoproxil fumarate (TDF) + Lamivudine (3TC) (or FTC/emtricitabine) can be considered alternative regimens.
- Lopinavir/ritonavir (LPV/r) is recommended as the preferred third drug for HIV PEP.
- An age-appropriate alternative regimen can be identified among Atazanavir/ritonavir (ATV/r), Raltegravir (RAL), Daruvanir (DRV), Evavirenz (EFV) and Nevirapine (NVP).

Explain the following points to the child or adolescent and/or the non-offending caregiver:

- PEP can lower the chances of getting HIV, but it is not 100% effective.
- The child or adolescent will need to take the medicine for 28 days, either once or twice daily depending on the regimen used.
- About half of people who take PEP have side-effects such as nausea, tiredness and headaches. For most people, side-effects subside in a few days.

Support adherence
It is very difficult to attain adherence. Given the stigma associated with sexual abuse, the first visit to the health care provider may be the only visit and, therefore, the only opportunity to provide adherence counselling to the child or adolescent and/or accompanying caregiver.

- Communicate side effects clearly, but without inducing fear.
- Consider the impact of the traumatic event.
- For young children, adherence counselling needs to involve caregivers. For adolescents, engage them in developing an adherence plan, with age-tailored messages and respecting their autonomy (e.g. ascertaining whether they wish to engage caregivers).

Discuss the following points:

- It is important to remember to take each dose, so it is helpful to take it at the same time every day, such as at breakfast and dinner. Taking the pills at regular intervals ensures that the level in the blood stays about the same.

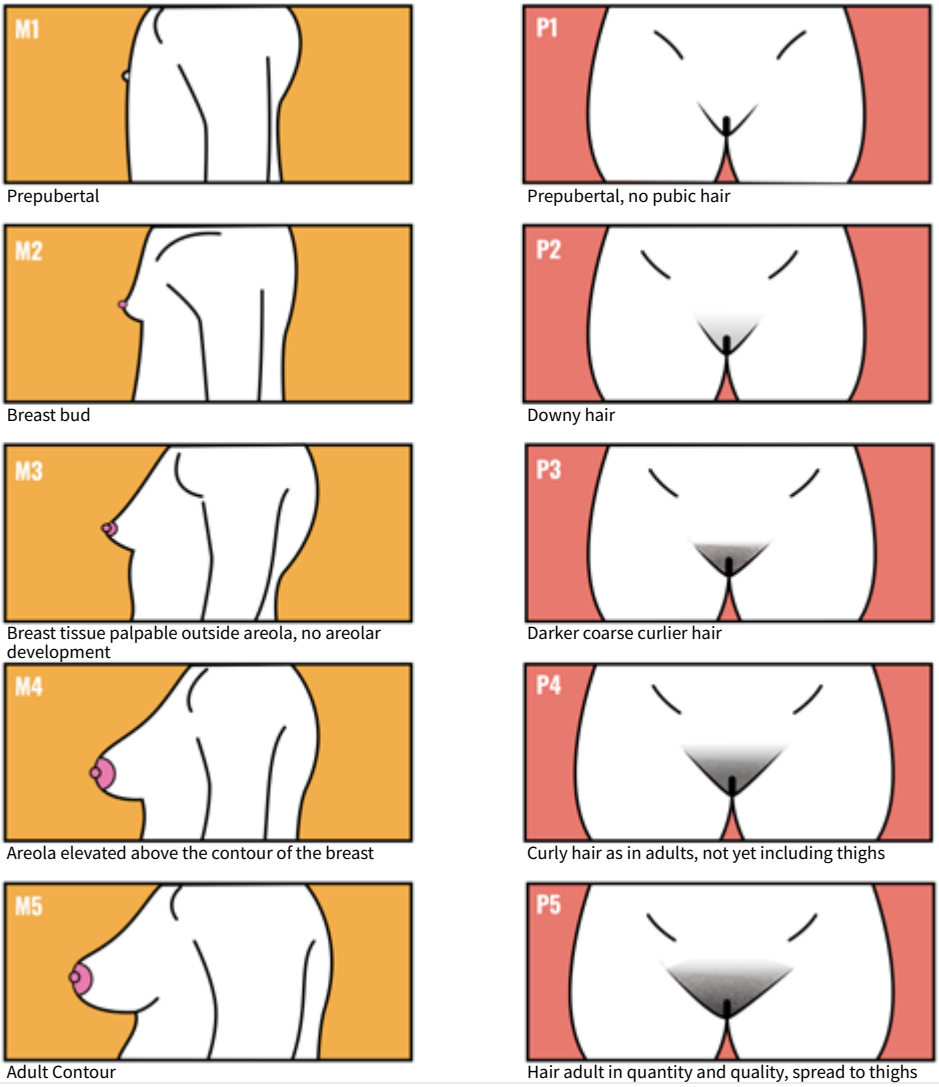
- An alarm on a mobile phone or some other device can be a reminder to take the pills, or a family member or friend can help remember.
- If they forget to take the medicine on time, they should still take it, if it is less than 12 hours late.
- If it is more than 12 hours late, they should wait and take the next dose at the regular time.
- They should not take two doses at the same time.
- They should return to the clinic if side-effects do not go away in a few days, if they are unable to take the drugs as prescribed, or have any other problems.

Offer emergency contraception to girls who have been raped (within 120 hours)

Emergency contraception is a method of contraception that can be used to prevent pregnancy after sexual intercourse or sexual assault involving penetrative sex. These are **recommended for use within 5 days (120 hours)** but are more effective the sooner they are used after the sexual act has occurred.

Girls who have had their first period may worry about pregnancy. You may ask adolescents if they have been using any contraceptive method such as pills, injectables, implants or an intrauterine device (IUD). If so, it is not likely she will get pregnant. Also, if her last menstrual period began within 7 days before the attack, she is not likely to get pregnant. Girls who are post-menarche, or those in the beginning stages of puberty (i.e. Tanner stage 2 or 3 - see Figure 5) should be informed and counselled regarding the risk of pregnancy and offered the choice of emergency contraception soon after sexual abuse to avoid pregnancy.

Figure 5: **Tanner stages**



Note: At the beginning of puberty, girls who reach Tanner stage 2 (or "thelarche", i.e. onset of secondary breast development) or Tanner stage 3 (i.e. breast development becomes more elevated) may face the risk of an unwanted pregnancy as a result of sexual assault or rape because they are likely to be ovulating even prior to the onset of menstruation.

Emergency contraception counselling points

Explain emergency contraception:

- Emergency contraception can help the girl to avoid pregnancy, but it is not 100% effective.
- Emergency contraceptive pills prevent pregnancy by preventing or delaying ovulation and they do not induce an abortion. The copper-bearing IUD prevents fertilization by causing a chemical change in sperm and egg before they meet. If necessary, explain how conception functions.
- Emergency contraceptive pills will not cause abortion.
- Emergency contraceptive pills will not prevent pregnancy the next time she has sex. Combined oral contraceptives, condoms or a copper-bearing IUD will.
- Emergency contraceptive pills are not meant for regular use in place of a more effective, continuing contraceptive method.
- She does not need to have a pregnancy test before taking emergency contraceptive pills. If she is already pregnant, emergency contraceptive pills will not harm the pregnancy. However, a pregnancy test may identify if she is pregnant already, and she can have one if she wishes.

Give emergency contraceptive pills:

- Ulipristal acetate (UPA): 30 mg tablet (single dose)

OR

- Levonorgestrel-only (LNG): 1.5 mg tablet (single dose is preferred; but can also be split: one dose of 0.75 mg, followed by a second dose of 0.75 mg 12 hours later)

If UPA or LNG are not available, give combined oral estrogen–progestogen contraceptives (COCs):

- 100 µg ethinyl estradiol/0.50 mg LNG, followed by a second dose 100 µg ethinyl estradiol/0.50 mg LNG after 12 hours;
- and anti-emetics if available.

Any girl can take emergency contraceptive pills. There is no need to screen for health conditions or test for pregnancy. If a pregnancy test is done and the result confirms pregnancy, do not provide emergency contraception.

Provide instructions:

- She should take the emergency contraceptive pills as soon as possible. She can take them up to 5 days after the sexual assault, but they become less effective with each day that passes.
- Emergency contraceptive pills may cause nausea and vomiting. If she vomits within 2 hours after taking emergency contraceptive pills, she should return for another dose as soon as possible. If she is taking combined pills for emergency contraception, she can take medicine (Meclazine hydrochloride) 30 minutes to 1 hour before the emergency contraceptive pills to reduce nausea.
- She may have spotting or bleeding a few days after taking emergency contraceptive pills, which does not indicate that an abortion or miscarriage has taken place, or changes to her next period.
- If she had other acts of unprotected sex since her last menstrual period, she may already be pregnant. Emergency contraceptive pills will not work, but they will not harm the pregnancy.
- She should return if her next menstrual period is more than 1 week late to determine if she is pregnant and, if so, access safe abortion if desired and permitted by the law.

Emergency copper IUD (Cu-IUD)

- Can also be used for emergency contraception up to 5 days (120 hours) after the (latest) incident occurred for survivors who have attained menarche (i.e. post-menarche).
- The higher risk of STIs following rape should be considered if using a Cu-IUD. If the risk is considered high, the Cu-IUD should only be considered if no other methods are available or acceptable.
- Good choice for very effective long-acting contraception if an adolescent girl is interested in the IUD and could have it immediately inserted.

Pregnancy management and access to safe abortion

If a girl is pregnant as a result of rape, she should be offered the choice of safe abortion to the fullest extent of the law. Familiarize yourself with all the grounds on which abortion can be offered to girls under the age of 18. Details can be obtained from WHO at https://abortion-policies.srhr.org/.

Any administrative requirements (e.g. forensic evidence, police reports, third party signatures) that are necessary for obtaining a safe abortion should be kept to a minimum. Every effort should be made to ensure she has timely access to safe abortion services, within the gestational time limits.

In settings where abortion is not permitted, or the pregnancy is too advanced for abortion when the child or adolescent seeks services, the pregnant child or adolescent should be supported throughout her pregnancy and for safe delivery. Other options, such as adoption, should be explored with her, if she wishes.

Prevent sexually transmitted infections

Children and adolescents who experience sexual abuse may become infected with an STI. In many settings it is not feasible to test children and adolescents who have been sexually assaulted for STIs, either because tests are not available or it is very unlikely that children or adolescents return to the health facility for a second time to get treatment, due to barriers accessing health services. Therefore, in many instances, particularly where laboratory testing is not feasible, presumptive or prophylactic treatments are recommended. Ideally, however, and where possible for children and adolescents, efforts should be made to conduct molecular assay (e.g. Nucleic Acid Amplification Test (NAAT) for chlamydial infection and gonorrhoea), and STIs treated according to the results.

Offer presumptive treatment for chlamydia, gonorrhoea and syphilis

Undetected and untreated gonorrhoea, chlamydial infection and syphilis can result in adverse reproductive and sexual complications. If children and adolescents have been sexually abused involving oral, genital or anal contact, give treatment, based on national guidelines, to prevent and treat chlamydia, gonorrhoea, and, if common in the area, syphilis.

In settings where rapid, point-of-care tests for syphilis, gonorrhoea and chlamydial infection are available, test for syphilis, gonorrhoea and chlamydial infection prior to offering treatment.

- Offer STI treatment on your first meeting.
- If tests are not available or it does not seem likely that the child or adolescent will return, then there is no need to test for STIs before treating. However, taking a specimen for diagnosis or forensic use can be done.
- Give preventive treatment for STIs common in the area (for example, chlamydial infection, gonorrhoea and syphilis).
- Give the shortest courses available in the local or national protocol, as these are easiest to take.
- The drug regimens and dosages for syndromic case management and presumptive STI treatment should be based on national guidelines.

For more information, see also WHO guidelines on gonorrhoea, chlamydia, syphilis and herpes simplex virus.

Syndromic case management for children and adolescents who present with clinical symptoms of STIs

If children and adolescents present clinical symptoms indicative of STIs, for example genital ulcer syndrome, vaginal , urethral and ano-rectal discharge syndrome, or ano-genital warts, treat the underlying condition for these symptoms. This is particularly recommended in settings where laboratory testing is not feasible.

For more information, see also WHO guidelines for the management of symptomatic STIs. (https://www.who.int/publications/i/item/9789240024168)

Hepatitis B

Hepatitis B can be sexually transmitted. Therefore, children and adolescents subjected to sexual violence should be offered immunization for hepatitis B.

- Ask if he/she has received a vaccine against hepatitis B.
- Respond according to the chart below.
- Testing first is not routinely recommended. If tests are available and cost-effective, test for immunity if it is unknown whether the child or adolescent has been vaccinated. If already immune, no further vaccination is needed. If testing is not possible, vaccinate.

Has the child or adolescent been vaccinated for hepatitis B?

Immunization status	Treatment guidelines
No, never vaccinated for hepatitis B	1st dose of vaccine: at first visit 2nd dose: 1–2 months after the first dose (or at the 3-month visit if not done earlier) 3rd dose 4–6 months after the first dose
Started but has not yet completed a series of hepatitis B vaccinations	Complete the series as scheduled
Yes, completed a series of hepatitis B vaccinations	No need to re-vaccinate

HPV vaccination for girls aged 9–14 years

Girls aged of 9–14 years should be offered HPV vaccination as per national guidance. It is not necessary to screen prior to vaccinating. While the HPV vaccination is intended for girls before the onset of sexual activity involving vaginal penetration, girls who have been raped may still benefit from the vaccine as they may be infected by a strain not covered in the vaccine or by one of the four strains in the quadrivalent vaccine.

Provide mental health care

There is a strong association between experiencing violence and mental health issues. Exposure to child maltreatment increases the risk for many mental disorders, including depression, anxiety, substance abuse, disruptive and antisocial behaviour, and suicidal behaviour. Remember also, that some children with pre-existing mental health problems have a higher likelihood of experiencing abuse and neglect.

Even if you are not a mental health specialist you can play a very important role in improving the mental well-being of children and adolescents exposed to violence. While it is generally not expected of health workers to provide multi-session therapeutic interventions, they can undertake the following brief interventions, which can on their own improve mental well-being:

- Providing first-line support as outlined in the LIVES CC approach.
- Providing psychoeducation or basic psychosocial support.
- Assessing for moderate to severe mental health problems.
- Treating and/or referring to mental health specialists, where necessary.

However, some children will not experience mental health problems after exposure to violence, while others may experience symptoms that resolve on their own after some time or with minimal support to get back to their normal routines. Some will experience more severe mental health problems and require additional support.

Helpful resources:

If you suspect mental health conditions in a child or adolescent you are seeing, please use the mhGAP intervention guide, available at https://www.who.int/publications/i/item/9789241549790, or download the mhGAP application on your mobile phone.

Among the children who experience more severe mental health issues, not all will experience the same symptoms. It is important to understand that child maltreatment is an exposure, not a diagnosis. Children should receive support based on their mental health symptoms, not on the basis of their exposure to violence.

Provide psychoeducation and guidance, and basic psychosocial support

Psychoeducation can empower children and adolescents who have been exposed to maltreatment to better understand the symptoms they may encounter and to improve their ability to lead their lives. The goal is to give them a stronger knowledge base with which to cope and thrive. Non-offending caregivers can play an important role in this process.

The following brief interventions can be conducted, even in settings where limited time is available for psychosocial interventions.

Provide guidance on child or adolescent well-being

The following basic suggestions are important to re-establish daily routines and can improve well-being for all children and adolescents, whether they have a mental health problem or not.

Encourage and help the child or adolescent to do the following:

- Get enough sleep. Promote regular bed routines and remove electronic devices with screens from the sleeping area/bedroom.
- Eat regularly. All children and adolescents need three meals (breakfast, midday, and evening) and some snacks each day.
- Be physically active. If they are able, children and adolescents aged 5–17 years should do 60 minutes or more of physical activity each day through daily activities, play or sports.
- Participate in school, community, and other social activities as much as possible.
- Spend time with trusted friends and family.
- Avoid the use of drugs, alcohol, and nicotine.

Source: Adapted from [21].

Provide guidance on improving behaviour

If the child displays behavioural problems, including aggressive behaviour, truancy etc., advise the non-offending caregiver to:

- give affection, including playing with the child every day;
- encourage age-appropriate play (e.g. sports, drawing or other hobbies)

for adolescents and offer age-appropriate support in practical ways (e.g. with homework or other life skills);

- provide opportunities for the child or adolescent to talk;
- be consistent about what your child or adolescent is allowed and not allowed to do;
- give clear, simple, and short instructions on what the child should and should not do, e.g., *"Please stop yelling at me, I want you to try and talk to me using a calm voice";*
- give the child or adolescent simple daily household tasks to do that matches their ability level and praise them immediately after they do the task;
- give praise whenever you observe appropriate or desired behaviour;
- model appropriate behaviour that they want to see in their child (e.g. speaking nicely to others, tidying up);
- find ways to avoid severe confrontations or foreseeable difficult situations;
- respond only to the most important problem behaviours and make correction mild (e.g. withholding rewards and fun activities) and infrequent compared to the amount of praise;
- put off discussions with the child or adolescent until you are calm;
- in all instances, avoid labelling children negatively or calling them names;
- not shame or blame the child or adolescent;
- not use threats or physical punishment.

Source: Adapted from [22].

Explore the availability of social support

Social support is one of the most important protections for those with stress-related problems. When children experience abuse they may lack energy or feel ashamed.

You can ask:

- *"When you are not feeling well, who do you like to be with?"*
- *"Who do you feel most comfortable sharing your problems with?"*

Strengthen positive coping mechanisms for children and adolescents with emotional problems

The following psychoeducational guidance can be used to encourage caregivers of children and adolescents with emotional disorders and depression. When engaging with children and adolescents and their caregivers, you can:

- explain that emotional disorders are common and can happen to anybody (the occurrence of emotional disorders does not mean that the person is weak or lazy. Emotional disorders can cause unjustified thoughts of hopelessness and worthlessness. Explain that these views are likely to improve once the emotional disorders subside);
- make the person aware that if they notice thoughts of self-harm or suicide, they should tell a trusted person and come back for help immediately;
- address any stressful situation in the family environment such as parental discord or a parent's mental disorder;
- consider training the child or adolescent and caregiver in breathing exercises or relaxation exercises.

Provide caregivers with the following advice:

- Provide opportunities for quality time within the family.
- Help the child or adolescent to continue (or restart) enjoyable and social activities. Encourage the child or adolescent to practice regular physical activity, gradually increasing the duration of sessions.
- Make predictable routines in the morning and at bedtime.
- Promote regular sleep habits.
- Schedule the day with regular times for eating, playing, learning and sleeping.
- For excessive and unrealistic fears: praise the child or adolescent or give small rewards when they try new things or act bravely.
- Help the child practice facing the difficult situation one small step at a time (e.g. if the child is afraid of separating from the caregiver, help the child gradually increase the amount of time he/she plays alone while the caregiver is nearby).

- Acknowledge the child's feelings and worries and encourage him/her to confront his/her fears.
- Help the child or adolescent create a plan to help them cope in case a feared situation occurs.

Source: Adapted from [21].

Identifying and helping with more severe mental health problems

Mental health conditions associated with child maltreatment often include emotional disorders such as depression, anxiety, post-traumatic stress disorder (PTSD) and behavioural problems such as conduct-dissocial disorder.

Typical symptoms for **emotional disorders** include the following:

- Often feeling irritable, easily annoyed, down or sad.
- Presenting as numb, or unable to feel any pleasure.
- Lack of interest in or enjoyment of activities, including withdrawal from activities (e.g. school, social activities).
- Often feeling worried and being easily scared.
- Having many fears, in particular contextualized fear of a person or places associated with abuse.
- Frequent headaches, stomach-aches or sickness.
- Avoiding or strongly disliking certain situations (e.g. separation from trusted adult, meeting new people, or closed spaces).

If these symptoms are present in adolescents, it is important to assess for depression. Depression is an important risk factor for suicidal behaviour.

Typical symptoms for **behavioural problems** include the following:

- Arguing with adults.
- Defying or refusing to comply with their requests or rules.
- Extreme irritability/anger.
- Frequent and severe temper tantrums.
- Difficulty getting along with others.
- Provocative behaviour.
- Excessive levels of fighting or bullying.
- Cruelty to animals or people.
- Severe destructiveness to property, fire-setting.
- Stealing, repeated lying, truancy from school, running away from home.
- Sexualized behaviour not appropriate to developmental stage.

Typical symptoms of **PTSD** include the following:

- Re-experiencing the traumatic experience as if it is occurring in the here and now (e.g. through frightening dreams without clear content, night terrors, flashbacks or intrusive memories accompanied by intense fear or horror, trauma-specific re-enactments in repetitive play or drawings).
- Deliberate avoidance of thoughts, memories, activities or situations that remind the person of the event.
- Symptoms related to a sense of heightened current threat. These involve hypervigilance (excessively watchful for potential threats) or exaggerated startle responses (e.g. easily startled or jumpy with fear).
- Regressive behaviours, such as bedwetting, clinging and or inconsolable when angry/upset.
- Risk-taking behaviours (sexual risk behaviours, substance use).

Source: Adapted from [21].

If you identify problems that indicate emotional disorders, behavioural disorders or PTSD that make it difficult or impossible for the child or adolescent to function in their daily life, they may have more severe mental health problems. In addition to providing first-line support and basic psychoeducation, consider referral to a health care provider trained in mental health, or a mental health specialist.

Further support through counselling and therapeutic interventions

This handbook does not provide specific protocols to implement psychological interventions, such as parenting skills training, interpersonal therapy and behavioural therapy. If services exist that enable referral for a behavioural intervention, the following therapeutic interventions are recommended:

- Cognitive-behavioural therapy with a trauma focus might be provided to children or adolescents with symptoms of PTSD.
- Cognitive-behavioural therapy can be provided to children or adolescents with behavioural or emotional disorders.
- When safe and appropriate to involve at least one non-offending caregiver, cognitive-behavioural therapy with a trauma focus should be considered for both: (i) children and adolescents who have been sexually abused and are experiencing symptoms of PTSD; and (ii) their non-offending caregiver(s).

Reporting if child maltreatment is suspected

The scope, nature and status of mechanisms available to professionals to report violence against children differ significantly across the world. In some countries, health professionals who suspect child maltreatment are legally required to make a report to child protection services or child welfare services, while in other countries reporting mechanisms exist but are not mandatory.

Take time to learn about reporting duties in your setting

It is important to have an accurate understanding of the reporting laws and policies in your context. This might also depend on your specific professional status. You should identify the legal obligations of health care providers in relation to addressing child maltreatment. These include, but are not limited to the following:

- Do laws specify the provision of health care to children experiencing physical abuse, emotional abuse, sexual abuse and/or neglect?
- Do laws or regulations mandate reporting individual cases of child maltreatment to child protection services or the police?
- Do laws mandate reporting data/statistics on child maltreatment to health or other authorities?
- Which providers are authorized to provide testimony in court, if requested?

Inform children, adolescents and caregivers about any duty to report

Where mandatory reporting laws exist, you should explain any obligation to share information at the very beginning of care and treatment. This can be done in conjunction with the initial informed consent or assent procedure for the services being offered.

If a mandatory report is required, share the following information with the child or adolescent and the non-offending caregiver:

- The agency/person to which/whom you will report.
- The specific information being reported.
- How the information must be reported (written, verbal, etc.).

- The likely outcome of the report.
- The child's, adolescent's and family's rights in the process.

When you do not have a legal duty to report

In settings where you are not obliged by law to make a report about suspected cases of child maltreatment to child protection authorities, you have a moral duty to do your best to ensure the safety of the child or adolescent and non-offending caregiver, and take account of the best interests of that child or adolescent and their evolving capacity to make autonomous decisions.

However, the safety of the child or adolescent should be your utmost priority. Carefully consider the following:

- Assess the implications of reporting for the health and safety of the child or adolescent and take steps to promote their safety; there may be situations in which it may not be in the best interests of the child or adolescent to report.
- Define who will be told about disclosure of child maltreatment, and who will not be told.
- There should be clear rules in the facility regarding who will have access to specific information. Only those directly involved in the case should have access to information.
- Consider if the caregiver will know about the disclosure and how likely it is that he/she will share any information with the perpetrator which can put the child or adolescent at increased risk.
- Recognize psychological barriers to following-up on the case, such as assumptions made about caregivers based on their demeanour or appearance, or relationships you may have with the caregivers in your community.
- Inform the child, adolescent and non-offending caregiver about available child protection services and legal services and discuss with them options of referral or reporting, considering the following questions with them:

- What are the positive and negative impacts of reporting?
- Will reporting increase risk of harm for the child?

Document the reasons for reporting; otherwise, document the safety and protection issues that rule out making a report.

How to report suspected cases of child maltreatment

When reporting cases of child maltreatment, either through a mandate to report or based on a discussion and consultation with the child/adolescent and caregiver (as appropriate), you must:

- Inform caregivers that a report will be made and about who you need to inform (e.g. child protective services, police). You should explain your duty to report, and the reasons why you are concerned about the child's or adolescent's safety and health. Explain that you will be there to help them through the process and that you care about the entire family's safety and well-being.

  Exception: If you are concerned that doing so will put the child and/or another family member at risk (e.g. if there is a concern that the caregiver may flee with the child).

- Explain the roles of other agencies and help them to communicate with agency professionals by providing phone numbers and assistance.
- Maintain the utmost discretion and confidentiality.
- Document the reporting procedure and maintain confidentiality of the documented information with extra precautions where the perpetrator is a caregiver who could access the child's or adolescent's file.
- Make verbal and/or written reports (as indicated by law) within a specified timeframe (usually 24 to 48 hours).
- Avoid promising the child or adolescent or family that you will be able to protect them, or "make things better". Don't say things like "everything will be fine". You cannot predict the outcome of a possible investigation. It is often a long and emotionally charged process. Children may be most afraid and concerned that the perpetrator will go to jail.

- It is important to inform child protection services of your intention to provide any ongoing treatment or referrals for the child/family, as this can facilitate collaboration and continuity of care.

Example on how to talk to caregivers about your obligation or suggestion to report [15]:

"I gather that there are times when you are having a hard time with your child's behaviour. Parenting can be really tough. In meeting with you and your child, I am concerned about your child's safety and think that your family could use some help. It's my responsibility to call child protection services when I am worried about a child's safety."

"I am concerned about your child's well-being and the challenges you are experiencing. When I have these concerns, I need to talk to child protection services about how to best support you."

Mandatory reporting requirements can raise ethical and safety concerns when governance structures break down and laws exist in theory but not in practice. In emergency settings, where safe mechanisms to report child maltreatment might not exist and where security can be unstable and dangerous, mandatory reporting can set off a chain of events that potentially exposes the child to further harm. For example, investigators may show up to a child's home, therefore potentially breaching a child's confidentiality at the family or community level (and potentially prompting retaliation). In addition, services for children may be non-existent, thus creating additional risk (e.g. separation from family, placement in institutions).

If you are concerned that child protection services may negatively impact the well-being of the child or family, there are strategies you can use to mitigate potential harms:

- identify points of contact in your local child protection agency and meet regularly. You can also allow the caregiver to make a report (when safe and appropriate to do so);
- sensitize your local child protection agency to the child's or adolescent's and non-offending caregiver's needs during the reporting process.

Your decisions should always be guided by what is in the best interest of the child. This is particularly important where:

- authorities lack clear procedures and guidelines for mandatory reporting;

- the setting lacks effective protection and legal services to deal properly with a report;
- reporting could further jeopardize a child's safety at home or within their community.

TIPS AND HINTS: What to report to the designated child protection agency?

(adapted from [15])

When you make a report to child protection services, they may ask you for the following details. Only information that is directly relevant to the concern about possible maltreatment should be shared when reporting to child protection services.

Information about the child or adolescent	
Full name	
Birth date	
Address	
Contact number	
Conditions that require medical attention (physical, psychological)	
Information about the environment of the child or adolescent	
Siblings at risk of abuse or neglect	
Physical conditions (home, day-care, school) that present danger to child	
Available social support	
Information about the caregiver	
Factors that impact ability to care for or protect the child/adolescent (e.g. significant substance abuse concerns)	
Worrying caregiver-child interactions	

Part IV:
Taking care of your own health

Working with children in cases of suspected child maltreatment can also be personally challenging and requires that health care providers take care of their own health and well-being.

Manage safety issues, stress and care for yourself

Your personal safety and well-being is a priority. Only if you are feeling safe and well at your workplace will you be able to help the children and adolescents for whom you are caring. You may have strong reactions or emotions when listening to or talking about maltreatment. This is especially true if you have experienced abuse or violence yourself – or are experiencing it now. Be aware of your emotions and take the opportunity to understand yourself better. Be sure to get the help and support you need for yourself.

Protect yourself from aggressive behaviour and violence
Situations where child maltreatment is suspected can be stressful and emotional for caregivers and for children and adolescents exposed to child maltreatment. Although most of your encounters will go well, on rare occasions you might meet children and/or caregivers who are agitated or behave aggressively.

Here are some tips on how to prevent and deal with these situations:

- Communication plays an important role in de-escalating heated situations. Be sure to always keep the child or adolescent and caregiver informed about next steps, remain calm and show them you are caring for them and understand their emotions.
- Try to minimize waiting times in overcrowded waiting rooms – this can be very stressful.
- Alcohol and substances often inhibit normal behaviours and can work as a trigger for aggressive behaviours. Get support from a colleague if you have to deal with a person who is intoxicated. Treat the person with respect.
- If you have any concerns for your safety in a particular situation, do not work on your own and immediately ask a colleague for support.
- Make sure you always carry your phone with you to seek help if a situation unexpectedly becomes dangerous. Make sure the number where you can receive support (security service etc.) is saved in a way that is quick to find.

- Do not hesitate to discuss difficult situations with colleagues and get advice from each other. Sometimes it can be helpful to get the perspective from a colleague who has not been directly involved in the situation.
- Try to not take any accusations or aggressive behaviours personally. Your clients are in an extremely challenging and emotional situation.
- Discuss with the facility supervisor or manager what measures are available for provider safety in situations of risk. These can include calling for security or additional security measures that can be added to facilities.
- Discuss with colleagues a plan on how safety can be supported for all colleagues in clinics responding to child maltreatment. This could include having a colleague nearby, or an SMS or messenger app to communicate with a colleague in case help is needed.

Protect yourself from stress
Continued stress at the workplace may lead to exhaustion, lack of motivation, dysfunctional work behaviours, burnout, alcohol or drug misuse, and psychosomatic diseases if the stress is not proactively managed. Often these problems are structural and not your responsibility. Ways to help you to manage stress in positive ways include the following:

- **Try to take regular breaks** to recharge.
- **Try to take care of your body.**
  - Take deep breaths, stretch, or meditate when you feel stressed.
  - Try to eat regular, healthy, well-balanced meals.
  - Exercise regularly.
  - Get enough sleep.
  - Avoid excessive alcohol, tobacco, and substance use.
- **Make time for things you enjoy after work.** Try to do some other activities you enjoy regularly.
- **Connect with others.** Make time to connect with your friends and family. Talk with people you trust about your concerns and how you are feeling.

- **Connect with community- or faith-based organizations.**
- **Recognize when you need more help.** If you continue to feel high levels of distress over a long period of time, if you are increasingly resorting to unhealthy coping strategies such as alcohol, if you feel depressed or you are thinking about suicide, do not hesitate to seek help from a psychologist, social worker, or professional counsellor.

Vicarious trauma

In addition to stress, health professionals who encounter children and adolescent survivors of maltreatment might hear detailed and heartbreaking stories about the traumatic experiences that their clients have endured. As a result, they are at risk for vicarious trauma, which is also sometimes called secondary traumatization. It occurs if somebody who was not an immediate witness of the traumatic experience develops a trauma reaction as well. Vicarious trauma can have serious and lasting impacts on health care workers' personal and professional lives.

In addition to the tips for managing stress, which also help to prevent vicarious trauma, the following tips can help:

- **Monitor yourself.** Keep track of any trauma symptoms you might experience in yourself such as intrusions (flashbacks, nightmares), avoidance or suddenly being highly alert (hyperarousal).
- **Separate yourself.** It might be difficult to keep a balance between empathy and professional distance.
- **Limit yourself.** Make sure you are maintaining proper boundaries with your clients and your workplace.
- **Help yourself.** Be aware of when you need to seek professional help. This is completely normal and nothing to feel embarrassed about. You are dealing with very difficult situations. Remember that this will ultimately make you a better professional.
- **Empower yourself.** Attend professional trainings regularly in order to keep your skills and knowledge as up-to-date as possible.
- **Get support** from a supervisor, colleagues or professional help.

Conclusion

No matter where you work, as a health care provider you are likely to encounter children in the course of your normal working activities. You are in a unique position to observe signs of abuse or neglect, or changes in behaviour that may indicate a child is being abused or neglected. In some instances, for example when very young children are concerned, you will most likely be representing the only official institution with which these children will ever be in contact.

Currently, very few children exposed to severe maltreatment are identified by any official services. If all health professionals make a joint effort to recognize child survivors of maltreatment and provide immediate support, applying the first-line support, LIVES CC approach, together we can make an immense difference in the lives of millions of children.

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