

KINGDOM OF CAMBODIA
NATION RELIGION KING



MINISTRY OF HEALTH

CLINICAL HANDBOOK HEALTH CARE FOR CHILDREN SUBJECTED TO VIOLENCE OR SEXUAL ABUSE



2017

PREFACE

Violence against children is a serious public health concern and a human rights violation with consequences that impact their lives in various ways. Violence and sexual abuse suffered in childhood adversely affects the body as well as the mind, which can lead to a broad range of behavioral, psychological and physical problems that persist into adulthood.

Healthcare practitioners play a significantly important role in prevention and response to violence against children. They are often the first or only point of reference for children who have experienced violence, detecting abuse and providing immediate and longer-term care and support to children and families.

In 2015, the Ministry of Health developed “the National Guidelines for Management of Violence Against Women and Children in the Health Sector”, which provides health care centers and referral hospitals with an overview of prevention and response in the health sector to violence against women and children.

This “Clinical Handbook on Health Care for Children Subjected to Violence or Sexual Abuse” elaborates on knowledge and skills required to implement the National Guidelines. It aims to serve as a guide to ensure a prompt and adequate response to child victims of violence or sexual abuse for all healthcare practitioners. It provides further guidance on first line support, medical treatment, psychosocial support, and referral to key social and legal protection services. It can be also used as a resource manual for capacity development and training.

Phnom Penh, 30th January 2017

Prof. Eng Huot
Secretary of State, Ministry of Health

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I also would like to extend my appreciation to all health care practitioners for their contributions which resulted in the final version of this Clinical Handbook.

ABBREVIATIONS



CCWC	Commune Committee for Women and Children
CVACS	Cambodia Violence Against Children Survey
DoSVY	Department of Social Affairs, Veterans and Youth
EC	Emergency contraceptive
HIV	Human immunodeficiency virus
NGO	Nongovernmental Organization
PEP	Post-exposure prophylaxis
QDS	Once a day
STI	Sexually transmitted infection
TDS	Three Times a Day
TT	Tetanus toxoid
UNICEF	United Nations Children's Fund
VDRL	Venereal Disease Research Laboratory (syphilis test)

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► WHAT IS THIS HANDBOOK?

This handbook will help you care for children who have been subjected to violence. Violence can be physical, sexual or emotional. It can also involve neglect or abandonment. As you meet these children, be mindful of their vulnerability. **Care for them as if they were your own child or family.**

► GUIDING PRINCIPLES FOR PROVIDING CHILD-FOCUSED CARE

PROMOTE THE CHILD'S BEST INTEREST

Always do what is best for the child in terms of his or her safety and emotional and physical development. Listen to input from the parents or caregivers (unless you suspect they are the perpetrator) to help you decide. Use your best judgment to select the least harmful course of action.

Do no harm. Avoid putting the child through multiple examinations and interviews by multiple people because doing so has been shown to cause additional harm to child survivors. When an abused child comes to see you, do not make the child wait. Treat the case as an emergency unless you have another patient who has a truly life-threatening situation. If the child is severely injured, refer him or her for immediate emergency care.

ENSURE SAFETY

Don't do anything that would put the child at increased risk of violence. Be attentive to possible symptoms and signs of abuse and follow up on them.

If you suspect that the perpetrator is with the child, do not allow that person to be in the room. You may have to invent something for the suspected perpetrator to do—for example you could ask them to fill out some paperwork.

Make referral to an appropriate health facility equipped to provide the needed care if the needed care is not available in the health facility. Pre-inform the referral facility about the child and his or her needs.

RESPECT AND DIGNITY FOR THE CHILD

Treat the child with respect, compassion, and dignity. Listen to the child's opinions, thoughts and ideas. If you find yourself thinking that the child must have done something wrong for the violence to happen, you are blaming the victim. This type of thinking is not helpful. Any child who reports any types of violence or abuse should be offered immediate support.

PRIVACY AND APPROPRIATE CONFIDENTIALITY

You and your colleagues must respect the privacy and confidentiality of the child. This means that information about the child's experiences of abuse should be collected, used, shared and stored in a confidential manner. Breaches of confidentiality can have life-threatening consequences for those living in situations of violence.

Treat the child in a quiet, private room. Create a private space. If you really cannot find such a space, lower your voice when you talk to the child and/or caregivers. Make sure others cannot overhear your conversation.

Keep the files regarding the case in a secured lock with restricted access. Share information about the case only with those who **absolutely need to know (on a need-to-know-basis)**, and only after obtaining permission from the child and caregiver. These may be other medical personnel or relevant officials. Do not share the patient's name when consulting with colleagues.

In your facility, keep records confidential from other patients and staff who do not need to know the information. Do not write down "rape" or "abuse" as the reason for the child's visit.

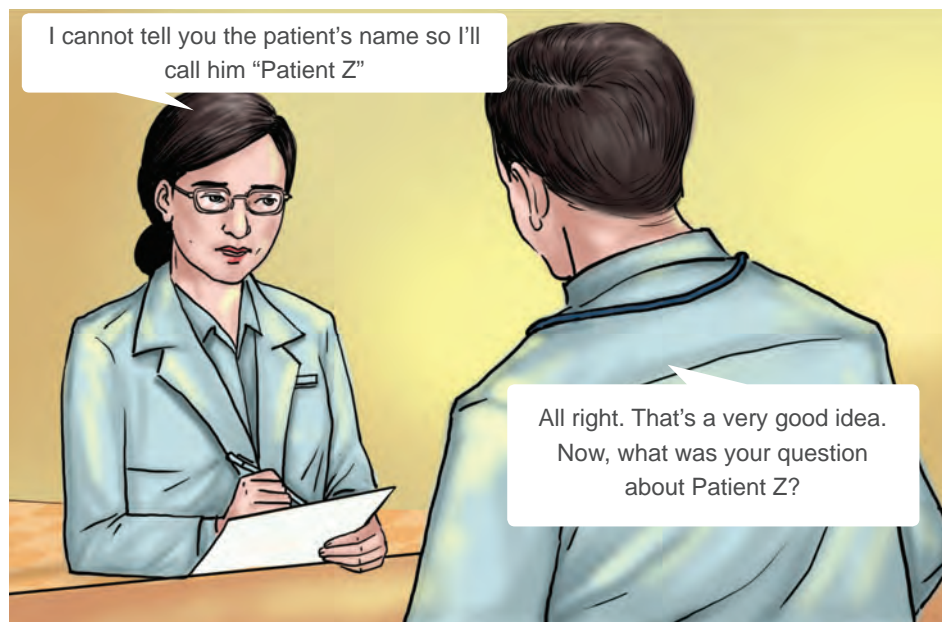
In situations where a child's health or safety is at risk, information about the child may need to be shared with appropriate third parties (based on best interest considerations). It is important that you explain to the child and caregivers these limits of confidentiality.

STIGMA

Children who experienced abuse can be stigmatized by others for having been abused, even though they are not to blame. "Sexually abused", "raped", "neglected", "abandoned" are all negative identities that can follow a child for the rest of their lives. Don't contribute to the child's pain by violating their privacy and confidentiality. Don't talk about patients' cases with your co-workers or other patients in the hospital. And don't talk about it with your friends, neighbors, or family when you go home.

One way to protect a patient's confidentiality is to call them a different name.





AVOID GOSSIP

Nobody likes to be the subject of gossip. It makes a person feel bad. It makes the experience a hundred times worse. Put the child first.

NON-DISCRIMINATION

Treat all children the same. Treat all children as if they were your own. Do not discriminate against any child based on their gender, indigenous group, religion, family situation or the status of their caregivers, financial situation, or unique abilities or disabilities.

CONSENT

Consent is about getting permission to do something before you do it. It involves carefully explaining to the caregivers and the child what will happen. It is important that you use simple words. It also important to ask the caregivers and the child if they have understood the information. The better you explain the procedures and why they are needed, the more likely the caregivers and child will give their permission.

While you may not always be able to follow the child's wishes (based on best interest considerations), you should always empower and support children and work with them in a transparent manner. When you cannot follow the child's wishes, explain the reasons.

PART 1: AWARENESS ABOUT VIOLENCE AGAINST CHILDREN

This chapter will introduce definitions of violence against children. It will also present misbeliefs about violence against children that are commonly held by many people including health care providers. It will also provide information that will help you identify children who may be subjected to violence. The chapter introduces helpful tools for identifying signs of abuse, asking children and caregivers about violence, and documenting violence.

1.1. WHAT IS VIOLENCE AGAINST CHILDREN?

The United Nations defines violence against children in Article 19 of the Convention on the Rights of the Child as: **“all forms of physical or mental violence, injury and abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse”**.

SEXUAL ABUSE

Child sexual abuse often involves physical contact. Abusive physical contact includes:

- **Unwanted sexual touching:** touching a child in a sexual way, such as sexual kissing, touching a child’s genitals or private parts for sexual purposes, or making a child touch someone else’s genitals or play sexual games without their permission.
- **Attempted unwanted intercourse:** attempting to force a child into sexual intercourse of any kind without their permission, but not succeeding.

- **Physically forced intercourse:** physically forcing a child to have sexual intercourse of any kind regardless of whether the child fights back.
- **Pressured intercourse:** using verbal threats or other coercion to pressure a child into having sexual intercourse of any kind when they do not want to. When someone pressures a child into sexual intercourse, it could involve things like threats, harassment, and luring or tricking the child into having sex.

More sexual abuse related definitions:

- **Sexual intercourse for girls:** includes someone penetrating a girl's vagina or anus with their penis, hands, fingers, tongue, or other objects, or penetrating her mouth with their penis.
- **Sexual intercourse for boys:** includes someone penetrating a boy's anus with their penis, hands, fingers, tongue or other objects, or penetrating his mouth with their penis; this can also include someone forcing the boy's penis into their mouth, vagina, or anus.
- According to the Law on Suppression of Human Trafficking and Sexual Exploitation (2008), the age of consent to any form of sexual activity in Cambodia is 15. Any person who has sexual intercourse or other sexual conduct of all kinds with a minor under the age of 15 years shall be punished.
- Grooming is the process whereby child sex offenders target children for the purposes of selecting and recruiting children for the purposes of sexual exploitation. Grooming essentially refers to the means by which a child sex offender gradually gains the confidence and trust of a child with a view to ensuring that the child later acquiesces to sexual contact.

Not all sexual abuse involves body contact or touching. However, it can have an adverse effect on mental health of child survivors, which needs appropriate care and treatment. Non-contact sexual abuse includes:

- Inappropriate sexual language directed to a child (verbal or written)
- Deliberately exposing an adult's genitals to a child for the adult's sexual pleasure or interest
- Forcing a child to watch sex photos or sex videos against their will
- Forcing a child to be in a sex photo or video against their will
- Forcing a child to witness rape and/or other acts of sexual violence

PHYSICAL VIOLENCE

Intentional physical acts of violence such as being slapped, pushed, punched, kicked, whipped, or beaten with an object, choked, smothered, drowned (attempted), burned or scalded intentionally, or injured or threatened with a weapon such as a knife, axe, etc. There may be single or repeated incidents.

EMOTIONAL VIOLENCE

Emotional violence is defined as a pattern of verbal behaviour over time or an isolated incident that is not developmentally appropriate or supportive and that has a high probability of damaging a child's mental health, or his/her physical, mental, spiritual, moral or social development. Emotional acts of violence include such things as being told you are not loved, someone wished you had never been born or being ridiculed or put down.

NEGLECT

Neglect includes the persistent failure to meet a child's basic physical and/or psychological needs, to protect the child from danger, or to obtain medical, birth registration or other services when those responsible for the child's care have the means, knowledge and access to services to do so. Neglect may occur during pregnancy as a result of maternal substance abuse, including the consumption of alcohol.

1.2. MISBELIEFS ABOUT VIOLENCE AGAINST CHILDREN

Research shows that the response of the helping person can positively or negatively affect children¹. Negative attitudes toward the child by service providers are harmful because they can prevent recovery. Positive attitudes, on the other hand, allow you to provide the compassionate care that will support recovery. Because you play such a key role in promoting a child's healing and recovery, you must be aware of the differences between myths and facts about child abuse. **Skills and knowledge will have little impact if they are not delivered in a caring and compassionate manner; your individual attitudes are of the utmost importance in helping a child overcome the harms of abuse².**

1 Perry, B. (2007). *The boy who was raised as a dog: And other stories from a child psychiatrist's notebook: What traumatized children can teach us about loss, love, and healing*. New York: Basic Books.

2 International Rescue Committee. (2012). *Caring for Child Survivors of Sexual Abuse. Guidelines for health and psychosocial service providers in humanitarian settings*. New York: International Rescue Committee.

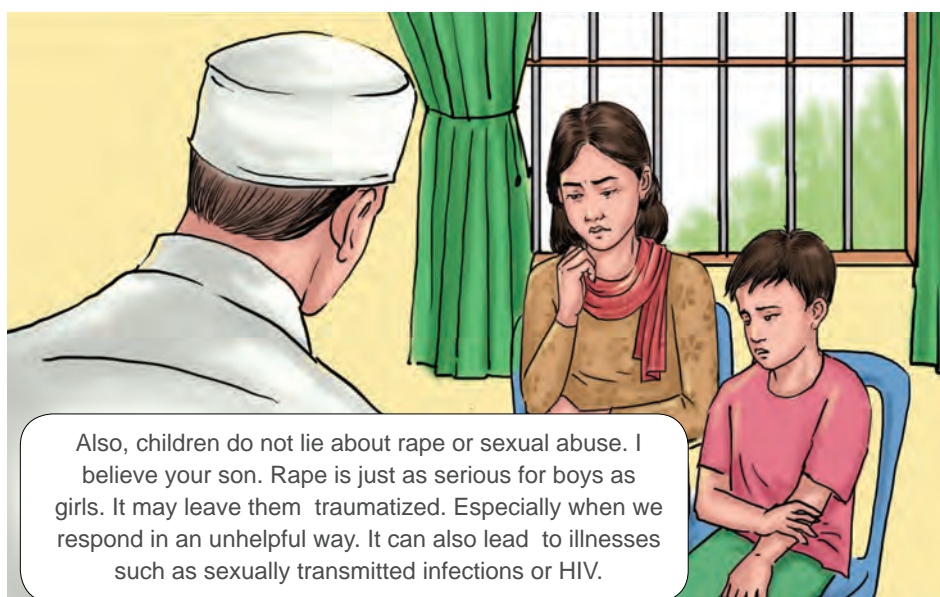
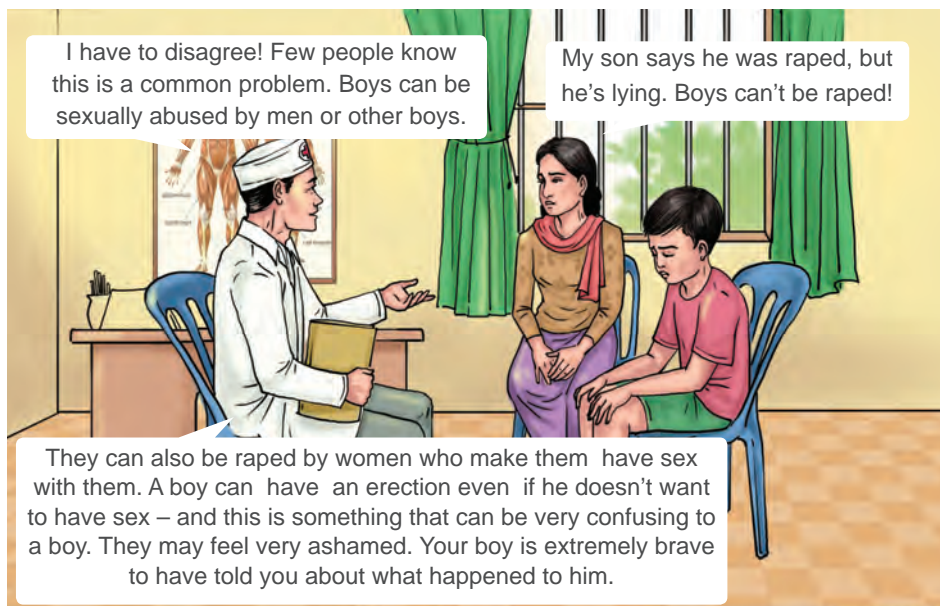
This list of misbeliefs is presented to help you start understanding your personal beliefs and attitudes towards children and child abuse. Perhaps after reading this, you might learn something about your beliefs, or colleagues' beliefs, and begin to think about children in a different way. By questioning your own beliefs, and behaving differently as a result, you can model child-friendly behaviour to caregivers and to your colleagues. The misbeliefs presented here are not a complete list; unfortunately there are many more. You might know of some misbeliefs that are not included in this list.

Misbelief: If a child isn't bleeding, it wasn't really rape.

In many cases, rape doesn't leave any sign at all. Hymens are all different, just as every person's body is a little different. Some bleed and some don't, even if the girl was a virgin she might not bleed. Anuses naturally stretch, so a child's anus will not always bleed if it is penetrated. This is true for both boys and girls.

Misbelief: Boys can't be raped or sexually assaulted.

The lack of knowledge about sexual abuse among boys leaves them more vulnerable.





I THOUGHT IT COULD NEVER HAPPEN TO BOYS

When I was 10 years old, I was abused by a monk. Later I was abused by another man who lived in the pagoda too. When they abused me it was really painful and difficult to go to the toilet. When I was 12, there was a man in the village who took me to his house and abused me. I screamed out but the villagers did not help because they never think a man can have sex with a man. They just think it was for fun. He was a married man as well.

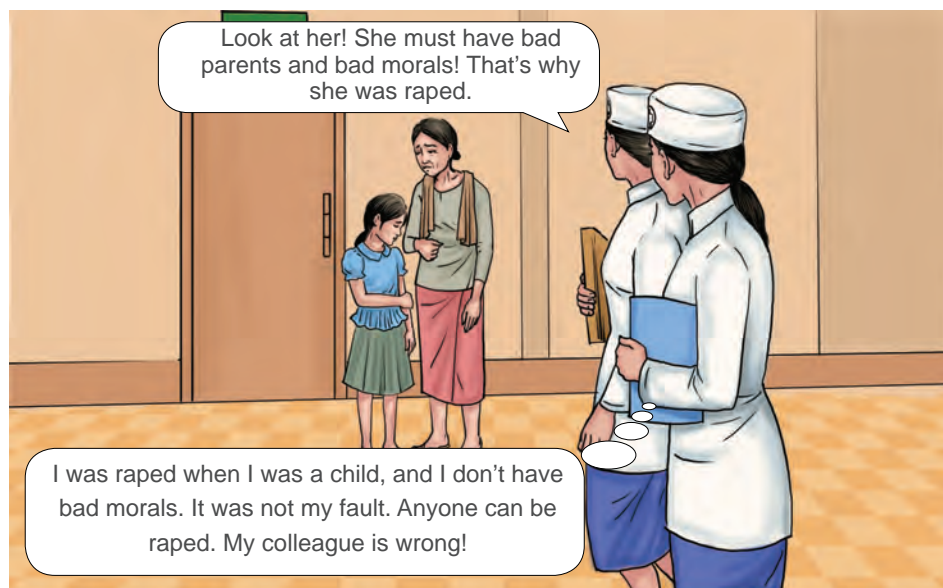
He threatened me not to tell. Until now I never told my family. I am still scared that someone will abuse me. The pain still remains. People think that girls are more embarrassed than boys. If they know about my issue I will never go back to my home village any more. Nowadays when I go back, I still meet the man who abused me and he wants to abuse as before. The villagers are not interested in it because they think it's impossible for a man to have sex with a man.

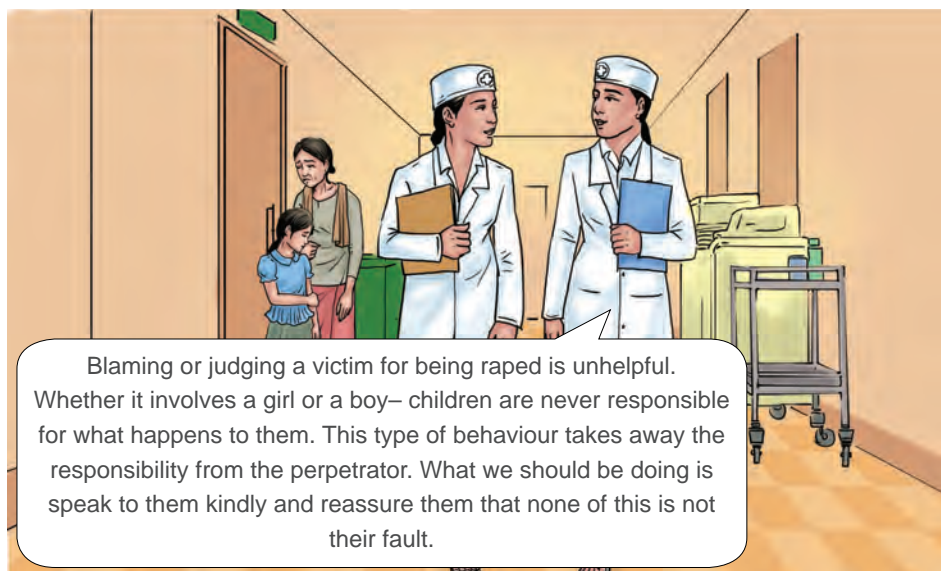
My friend was also abused by a married man when the man got drunk. He is not gay. The people who abuse boys are not only foreigners. Khmers also do it and it has happened since a long time ago. If I tell others, I am afraid they will not believe it, because they do not understand and do not experience it. I have never had sexual desires for boys—but others want to mistreat me. It is difficult to file a complaint with the police because they will not believe us. Therefore, we cannot find justice.

19-YEAR-OLD BOY IN PHNOM PENH

Taken from Hilton. (2008). I thought it could never happen to boys: Sexual abuse and exploitation of boys in Cambodia, an exploratory study. Phnom Penh: Social Services of Cambodia (SSC). Page 112.

Misbelief: A child who is sexually abused probably did something to deserve the abuse





Misbelief: Only foreigners and strangers sexually abuse children.

Of course some people who abuse children are foreigners - we read about these cases in the newspapers and this is a very serious problem. However children are most often abused by those they know and trust. Perpetrators of sexual abuse of children commonly include neighbours, other children, teachers or even family members.

Misbelief: Physical punishment is needed to educate children. Without it children will be spoiled and undisciplined.

It is not true that physical punishment is needed for children to learn, or that stubborn or lazy children need to be hit. Violence is not acceptable or in any way helpful to children. It causes a number of emotional and behavioural problems and can affect a child's development in many harmful ways. Children who grow up experiencing violence often have problems throughout their life and as adults as a result of the violence. They also grow up learning that using violence is an acceptable way of meeting their needs. The 'cycle of abuse' continues into the next generation.

Misbelief: Children lie about being abused.

Children seldom lie about abuse. If a child tells you that he or she has been abused it is extremely important to believe them and to listen. We are all responsible for keeping children safe.



CAN A CHILD SEXUALLY ABUSE ANOTHER CHILD?

YES. Some children who sexually abuse other children fully understand the harmful impact of their actions. Some children, especially younger children, may not understand that their forceful sexual actions toward another child are harmful. Some children who commit sexual abuse have been abused themselves. It is important for children who are perpetrators of sexual abuse to also be offered psychosocial support and rehabilitation services. While most children who have been sexually abused never sexually harm other children, without treatment they may be more vulnerable to and confused about what is considered appropriate behaviour.

International Rescue Committee. (2012). Caring for Child Survivors of Sexual Abuse. Guidelines for health and psychosocial service providers in humanitarian settings. New York: International Rescue Committee.

At a minimum all those working with child survivors of abuse and their families must be able to put into practice the following child-friendly values and beliefs:

CORE CHILD-FRIENDLY ATTITUDE COMPETENCY AREAS³

When working with children it's important that you act on the following fundamental values:

- Children are resilient individuals.
- Children have rights, including the right to healthy development.
- Children have the right to care, love and support.
- Children have the right to be heard and be involved in decisions that affect them.
- Children have the right to live a life free from violence.
- Information should be shared with children in a way they understand.

In addition, when treating children who have been sexually or physically abused, it's important to know that:

- Children tell the truth about abuse.
- Children are not at fault for being abused.
- Children can recover and heal from abuse.
- Children should not be stigmatized, shamed, or ridiculed for being abused.
- Adults, including parents, caregivers and service providers, have the responsibility for helping a child heal by believing them and not blaming them for the abuse.

³ Taken from International Rescue Committee. (2012). *Caring for Child Survivors of Sexual Abuse. Guidelines for health and psychosocial service providers in humanitarian settings*. New York: International Rescue Committee.

1.3. IDENTIFYING A CHILD WHO MAY BE SUBJECTED TO VIOLENCE

RELEVANT JOB AIDS:

- Common signs and symptoms of abuse (p. 22)
- Asking about violence (p. 27)
- Documenting violence (p. 28)

“Disclosure” refers to how the child abuse was revealed or discovered. Disclosure can occur with or without the child’s permission (or consent). It is important for you to understand how the abuse was discovered and disclosed so that you can adapt your approach accordingly. Know that every child’s experience is different.

Some child survivors may have no physical injuries or signs of trauma. Others may have emotional or behavioural symptoms first noticed by a parent, teacher or relative.

You may learn about a child who has been subjected to violence in the following ways:

- The child tells you he or she has been abused.
- A parent, caregiver or other trusted adult informs you that the child has been abused.
- You suspect violence during the routine consultation or based on the physical examination.

1.3.1. DISCLOSURE BY THE CHILD

You should take any disclosure by a child seriously. Treat the child sensitively and with respect. Let the child know you believe him or her. Tell the child he or she is not to blame. Tell the child he or she is brave talking about the abuse.

RESPONDING TO A CHILD WHO DISCLOSES VIOLENCE

When a child tells you about an experience of violence, he or she can be more disturbed by your reaction than his or her physical injuries. Therefore, your first response to the child is very important. Young children may not understand the consequences of sharing the information and may be shocked or confused by the reaction of adults. If your response is not helpful the child may be further traumatized.

Taken from First Step Cambodia. (2013). The Sexual Abuse of Boys Information Pack.

1.3.2. DISCLOSURE BY A PARENT, CAREGIVER OR OTHER TRUSTED ADULT

Abused children rarely seek help on their own. Children subjected to violence most likely come to your attention through a parent, caregiver or other trusted adult.

They may come to see you because the child has told them he or she was abused. They may also come to see you because they have noticed major changes or regression in the child's behaviour and are worried something has happened. Regressive behaviour means that children seem to lose certain skills and behaviours they had previously mastered (for example they may wet the bed).

Authorities or NGO personnel may also seek healthcare for a child who has experienced violence.

DISBELIEF OR DECEPTION BY THE PARENT OR CAREGIVER

If the parent or caregiver didn't expect or doesn't believe abuse has happened, he or she may be shocked by the information. Be patient, and explain with simple words how the physical evidence indicates abuse.

A parent or caregiver may also try to hide the abuse. This could be out of shame or fear of the perpetrator. It may also be because they are the perpetrator. If you believe the parent or caregiver is trying to hide the abuse, interview the child and the parent separately. Notice if their stories do not match, if injuries are inconsistent with the developmental age of the child, or if the description of how the child was injured doesn't match the injury. Be calm as you state your reasons. If the parent becomes angry, manage the situation carefully. If the parent decides to leave, consult with your local DoSVY social worker. You find more information about working with parents and caregivers in Part 4.

1.3.3. NO DISCLOSURE BUT YOU SUSPECT VIOLENCE

The potential for harm to the child increases with increasing frequency and severity of victimization over time. Therefore, it is important to identify violence as early as possible and intervene to stop it. Health professionals have an important role to play in child protection because, except in very remote areas, infants and small children are usually taken to the health centre on a routine basis.

You may suspect a child has been subjected to violence if:

- A parent, caregiver or trusted adults has noticed major changes or regression in the child's behaviour they cannot explain.
- You suspect violence during a routine consultation or following the medical examination.

CHILDREN WHO DENY THE ABUSE

Your role is not to determine whether or not abuse has happened, but to ensure the child feels safe enough to disclose the abuse.

In most abuse cases, particularly with younger children and children with disability, someone other than the child will seek assistance. The information may be disclosed to you without the child's permission or knowledge.

If abuse has been disclosed by a third party, a child may be more likely deny the abuse at first. Children often deny abuse for good reasons—including fear of stigma, shame, or retaliation. Sometimes a parent or caregiver refers an older child or adolescent because they are concerned the child is sexually active before marriage. The child however, may not view the sexual activity as abusive and/or may be embarrassed and unwilling to admit to premarital sexual relations.

In situations where the child denies allegations of abuse you will need to use the following strategies:

- **Stay neutral:** Do not confirm or deny what the child is saying. Rather let the child know you are not there to judge, but to listen, understand and help.
- **Get more facts:** Talk with the child and the person who has referred the child separately to gain a better understanding of the situation.
- **Be patient:** Children may not be willing or able to talk about abuse because of the associated shame or stigma. Do not force the child to talk.

International Rescue Committee. (2012). Caring for Child Survivors of Sexual Abuse. Guidelines for health and psychosocial service providers in humanitarian settings. New York: International Rescue Committee.

Most children know abuse is wrong. However a small number of children may not understand the full implications of the abuse and may therefore appear less distressed. These children might be very young or have intellectual challenges. There are lots of reasons why many children do not tell anyone when they have been abused. In general, younger children are less likely to deliberately disclose abuse than older children. Even if abuse is disclosed, children are significantly more likely to deny or minimize their experiences. Whereas adult survivors of violence often present as a medical emergency, children are often brought to the attention of health professionals through different routes and circumstances, and after time has passed.

1.3.4. JOB AID: COMMON SIGNS AND SYMPTOMS OF ABUSE

Any one sign or symptom does not necessarily mean the child has been abused, but the presence of several signs and symptoms may suggest that a child is at risk. **Remember that it is important to believe reports of abuse no matter what you observe about the child.** Some child survivors may present no physical injuries or signs of trauma.

Boys and girls react differently to abuse based on factors such as their age, developmental stage and cultural context. The majority of signs and symptoms are behavioural and emotional in nature, but physical signs can indicate abuse as well.

Physical signs of sexual abuse⁴

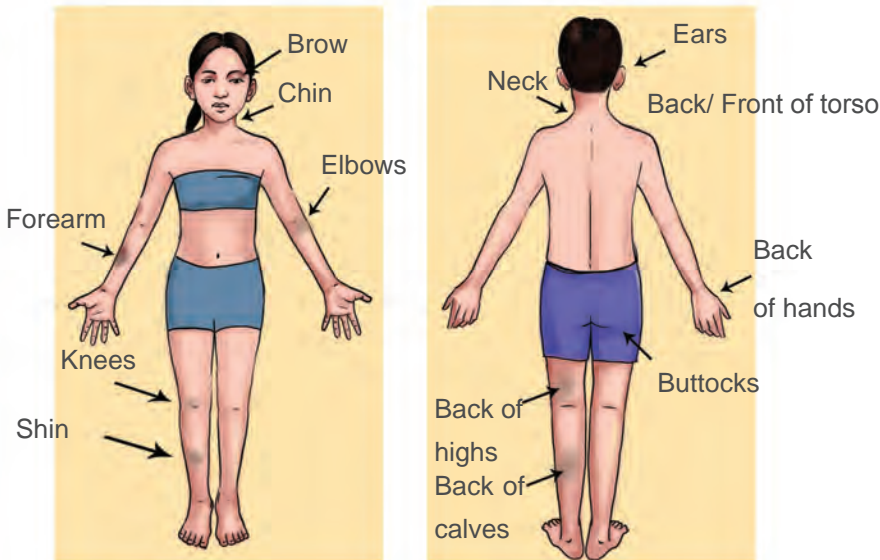
- Pain, discoloration, sores, cuts, bleeding or discharges in genitals, anus or mouth;
- Recurrent vulvo-vaginitis;
- Persistent or recurring pain during urination and/or bowel movements;
- Wetting and soiling accidents unrelated to bathroom training;
- Urinary tract infection;
- Weight loss or weight gain;
- Lack of personal care;
- Sexually transmitted infections;
- Pregnancy/presence of sperm.

⁴ See International Rescue Committee. (2012). *Caring for Child Survivors of Sexual Abuse. Guidelines for health and psychosocial service providers in humanitarian settings*. New York: International Rescue Committee

Signs of physical abuse⁵

Bruises – Most child abuse is visible in bruises. Normal bruising is common on leading bony parts of the child's body, such as the chin, the bone at the eyebrow (brow), elbows, forearms, knees and shins. Bruises on the buttocks, neck, breast, ears, the fleshy part of the face, back of hands, or genitals can indicate abuse. The bruise may reflect the object used such as a hand or knuckles, stick, belt or electric cord. If you see bruises that are both fresh and nearly healed, this may indicate that the bruises are not from a single, isolated incident.

Normal Bruising Areas Suspicious Bruising Areas



⁵ Adapted from National Collaborating Centre for Women's and Children's Health (UK). *When To Suspect Child Maltreatment*. London: RCOG Press; 2009 Jul. (NICE Clinical Guidelines, No. 89.) 4, Physical features. <http://www.ncbi.nlm.nih.gov/books/NBK57169/>

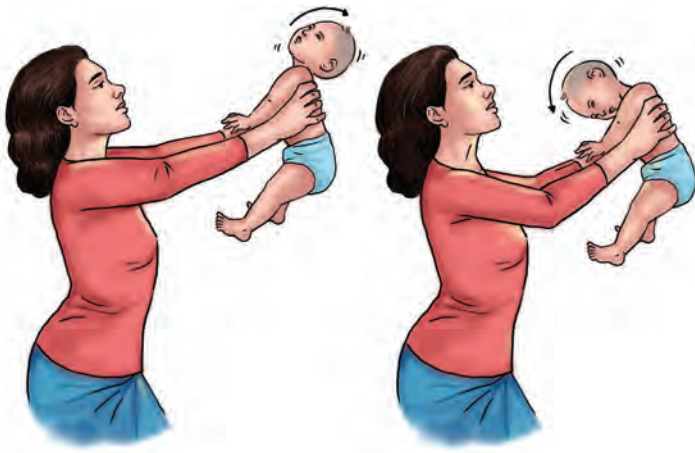
Fractures – Fractures are the second most common manifestation of child abuse after bruises. Any fracture in a young child should leave you concerned about the possibility of abuse, especially if the child is not yet crawling or walking. You should be especially concerned when you find multiple fractures at various stages of healing. Types of fractures that may indicate abuse:

- “Bucket handle” fracture from picking up a child by the arm
- Spiral fracture in the bone shaft
- Femur fracture or bilateral long-bone fractures in children too young to walk
- Anterior or posterior rib fractures in infants or young children
- Fractures of the breast bone, the shoulder blade or spine
- Skull fractures (especially linear fractures)

Burns – The pattern and location of a burn can indicate whether or not it is the result of abuse. Very young children explore things with their hands. So light burns on their hands would not necessarily be very suspicious. Deeper burns indicate that the child was not able to withdraw his or her body from the heat. The burn shape can be similar to the shape of the object that was used to burn the child. Some people may abuse a child by immersing them in hot liquid.

Signs of abusive head trauma in infants

Abusive head trauma is caused by shaking a baby, striking its head, or some other head injury. If you have a baby with symptoms of abusive head trauma, refer the child immediately to a (paediatric) doctor.



The signs of abuse can be easy to miss. Knowing the difference between injuries left by accidents and those left by non-accidents you can help save a child's life.

TRADITIONAL PRACTICES AND HOSPITAL CARE

It is important to remember that not all parents and caregivers understand the hospital environment and its procedures. Sometimes they will be scared of the treatment or procedures recommended for their child, such as taking blood samples. It is also possible that families prefer traditional medicine over hospital medical treatment. These are just some examples that may cause a family to take their child home from the hospital before they receive the necessary medical treatment. Such situations can be life-threatening as the child might be seriously ill and in need of further treatment at the hospital.

To protect the child and support the family to make the right decision it is very important to explain all medical procedures in a clear, simple, and friendly matter. Be persistent enough to ensure that child receives the medical treatment it needs. If the family still leaves with the child it is appropriate to contact DoSVY to inform them that a child is at risk and help is needed to follow up with the family.

WHAT TO DO IF A CHILD IS ABANDONED

Basic instructions on how to respond to cases of child abandonment are outlined below. All hospitals and health centres should have protocols in place and provide training to all staff on how to respond.

A child can be abandoned at the hospital, brought in by someone who found the child, or parents or caregivers might leave the child with you. When a child is abandoned a staff member should be immediately designated to make sure the child is safe and his or her basic needs are met. In all cases, the best outcome for the child is to return to the family setting, with the parents, caregivers or extended family. Experts have learned that the worst outcome for a child is to go to an orphanage, especially below three years. Referring a child to an orphanage is not recommended.

If you are caring for an abandoned child, take the following actions to help:

- Document the name, address, phone number, relation to the child and any other information you can gather about the person who is leaving the child and about the family of the child. This will help DoSVY reunite the child with his or her family at a later stage.
- Give the child needed medical care, food, water and a bath. Let them play with any toys you might have.
- Comfort the child, and reassure him or her that you will help keep them safe.
- Report the case to DoSVY.

1.3.5. JOB AID: ASKING ABOUT VIOLENCE

Asking the right questions will help you find out whether or not the child has been abused when you, a parent or caregiver suspects violence.

Here are some questions you may ask of a **parent, caregiver or legal guardian** when you suspect child abuse:

- “Have you noticed your child behaving differently lately?” Listen for the parent to comment on major changes or regression in behaviour like thumb-sucking or wetting the bed, or fearful, depressed, or anxious behaviour, or changes in bathing routines.
- “Can you tell me how your child got these bruises (burns, fractures, cuts, injuries)?”
- “When did the injury happen?”

Here are some questions you may ask of **boys and girls of all ages**:

- “Sometimes an injury like yours is caused by hitting (punching, kicking, whipping, beating with an object, burning, etc.). Did any such thing happen to you?”
- “Sometimes when I see an injury like yours, it is because someone touched your vagina, penis or anus, or private body part, when you didn’t want this to happen. Did any such thing happen to you?” (Make sure to use the child’s word for their vagina, penis or anus.)

Here are some questions you make ask of **pubertal boys and girls**:

- “I often meet a boy (girl) your age to be hit, or yelled at, or be touched on your private parts. Has this ever happened to you?”
- “**Has anyone forced or pressured you to do sex things that you did not want to happen?**”

Be mindful if injuries are not well explained. Or if the explanation

changes over the course of the interview. You may also note inconsistencies between the explanation provided by the parent or caregiver and the explanation provided by the child. When asking about violence the following situations may also raise suspicion:

- If the explanation does not match the injury type
- If the explanation does not match the severity of the injury
- If there were delays in seeking medical care that were not due to the parents' or caregivers' lack of access to care.
- If the injury doesn't match the child's development age (for example a one-month-old baby cannot roll out of bed)


1.3.6. JOB AID: DOCUMENTING VIOLENCE

Documenting helps you to provide ongoing sensitive care and to remember details of the case, or to alert another provider at later visits. Documentation of injuries could be important if the child and his or her caregivers decide to go to the police.

- Tell the child and caregiver what you would like to write down and why.
- Enter in the medical record any health complaints, symptoms, and signs as you would for any other patient, including a description of the child's injuries. It may be helpful to note the cause or suspected cause of the injuries or other conditions, including who injured the child.
- When you note the child's injuries, it might also be helpful to describe the size and location of injury, and what type of injury it is ("Burn shaped like a glove on the left hand" or "shallow cut on the left arm" for example.).

- Be aware of situations where confidentiality may be broken. Be cautious about what you write where, and where you leave the records.
- Do not write anything where it can be seen by those who do not need to know, for example on an X-ray slip, reception book or bed chart.
- For greater confidentiality, some facilities use a code or special mark to indicate cases of abuse or suspected abuse.
- Patient's records/documents should be kept in a safe place.

PART 2: FIRST-LINE SUPPORT FOR CHILD SURVIVORS OF VIOLENCE



In this chapter you will learn how to establish a child-friendly environment, and how to approach children and their caregivers under different circumstances of disclosure when offering first-line support. You'll learn strategies and techniques for talking to young children and older children, to boys and girls, as well as to families. You'll also learn about the different communication milestones achieved by children at different ages, and techniques for talking with very young children. In the LIVES sections you'll learn how to put these simple tasks of first-line support into action.

2.1. WHAT IS FIRST-LINE SUPPORT?

First-line support provides practical care and responds to a child's emotional, physical, safety and support needs, while protecting the child's privacy and confidentiality.

First-line support is often the most important care you can provide.

Even if it is all you can do, you will have greatly helped the child. While you are not responsible for solving the child's problems, your support can help them overcome the difficulties they have faced. Remember that children can be positively (and negatively) affected based on your response to the disclosure.

FIRST-LINE SUPPORT RESPONDS TO BOTH EMOTIONAL AND PRACTICAL NEEDS. ITS GOALS INCLUDE:

- Treating the child with respect and dignity, and reassuring them that the violence was not their fault.
- Greeting the child by his or her preferred name.
- Introducing yourself (if you are a new person) and identifying yourself as a helping person.
- Having a calm demeanor.
- Reassuring the child that he or she is in a safe place now.
- Taking the child to a private place away from other patients.
- Offering children the choice to have a trusted adult present, or not while you talk to them.
- Telling the child the truth—even when this is emotionally difficult.
- Offering brief, simple explanations of the steps of any actions you are about to undertake.
- Speaking in age-appropriate ways.
- Avoiding the appearance of being rushed or distracted.

First-line support involves 5 simple tasks. The letters in the word “LIVES” can remind you of these 5 tasks that protect children’s lives:

LISTEN

Listen to the child closely, with empathy, and without judging.

INQUIRE ABOUT NEEDS AND CONCERNS

Address and respond to various needs and concerns—emotional, physical, social and practical needs.

VALIDATE

Reassure the child that you believe him or her and take their situation seriously. Assure the child that he or she is not to blame. Tell the child he or she is brave and doing the right thing by talking about the abuse.

ENHANCE SAFETY

If there is an immediate risk of safety, ask the child what he or she needs to feel safe. Ensure confidentiality. Respect the child's wishes but only make promises you can keep (do not agree, for instance, to keep what the child said a secret as you might need to share some of the information they provide for you to keep them safe).

SUPPORT

Encourage the child to access support from safe people who might be helpful. Support the child by helping connect them to services and social support.

Please go to the following sections to learn more about each of the 5 tasks of first-line support. A reminder card for the steps of First Line Support appears on the page 150.

2.2. LISTEN

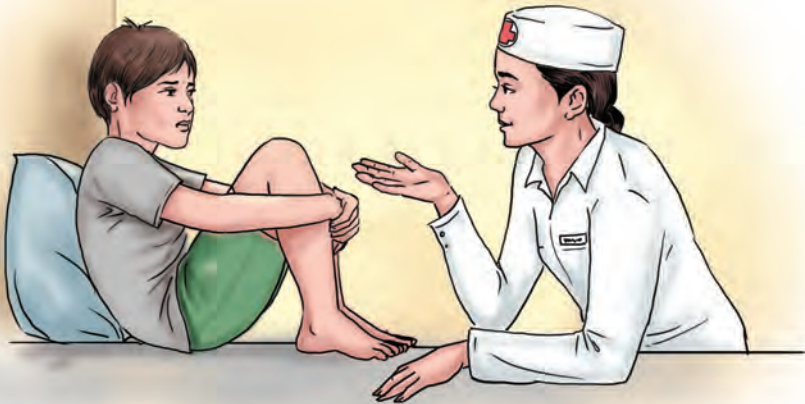
Give a child a chance to say what he or she wants to say in a safe and private space to a caring person who wants to help. Listening is an important step in emotional recovery. Listening is the basis of first-line support.

RELEVANT JOB AID:

- Listening to parents' and caregivers' concerns (p. 39)

Listening involves more than hearing words. It also means:

- Being aware of the feelings behind the child's words.
- Hearing what the child says and noticing what he or she doesn't say.
- Being attentive to body language – both the child's and your own – this includes facial expression, eye contact, and gestures. For example, children may show that they are distressed by crying, shaking, hiding their face, or changing their posture. If this happens, you should pause or stop the interview altogether. Similarly, if your body becomes tense, or if you appear uninterested in the child's story, he or she may interpret your non-verbal behaviour in negative ways. This will affect the child's trust and willingness to talk.
- Sitting or standing at the same level and close enough to the child to show concern and attention but not so close as to intrude.
- Empathizing with the child's feelings; for example say "I am sorry this happened to you".



Get on eye-level with the child. Sit so you are not higher than the child. Get down and play on floor with very young children. Try not to bend over or look down at the child, or squat to look up into the child's face.

DOs

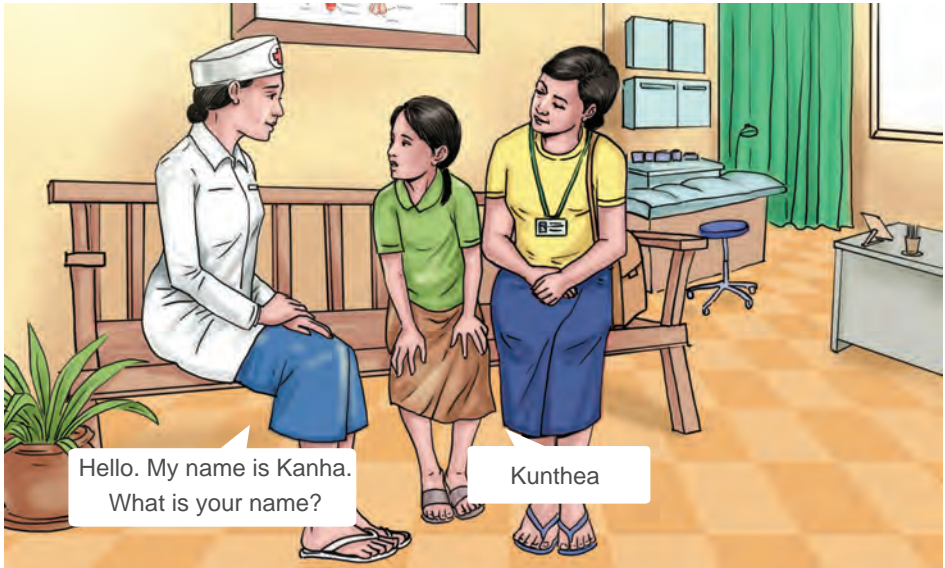
- Identify yourself as a helping person; for example “My job is to make sure children get the care they need”.
- Take time to get to know the child; for example “Do you have any brothers or sisters?” If the child is very young, establish rapport by playing a game.
- Show you are listening; for example nod your head or say “hmm...”
- Be calm and patient.
- Allow the child to express himself/herself at their own pace.

- Be emphatic and non-judgmental.
- Allow for silence. Give the child time to think.
- Tell the child you believe them and that the abuse is not their fault.
- Remind parents and caregivers that children rarely lie about such things as violence.

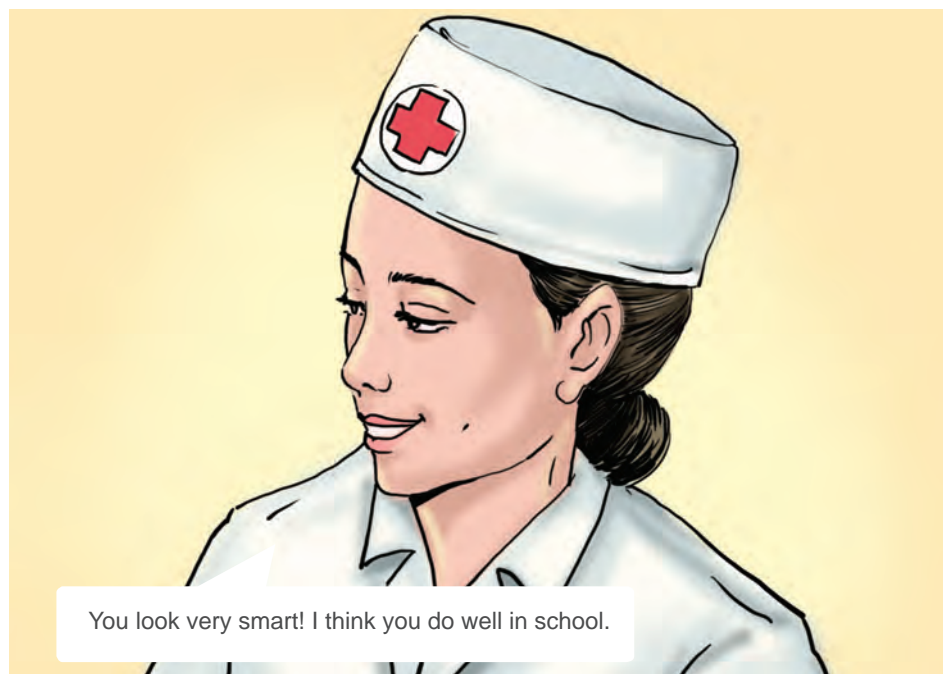
DON'Ts

- Don't express reactions such as shock or disbelief; for example "Boys don't get raped".
- Don't answer the phone, look at your watch or computer during the conversation.
- Don't pressure a child to tell their story; for example "I need to know what happened. Tell me".
- Don't interpret the child's answers or finish their thoughts; for example "So when you said that a man did this, you meant your neighbour, right?"
- Don't interrupt. Wait until the child finishes talking.
- Don't express disapproval of the alleged perpetrator as the individual may be loved or cared for by the child.
- Don't make assumptions about how the child feels (or should feel).
- Don't tell the child they will forget the experience in time.
- Don't laugh at the child. Remember to treat the child with respect and to take seriously what he or she says.

Take time to get to know the child







2.2.1. JOB AID: LISTENING TO PARENT’S AND CAREGIVER’S CONCERNS

Caregivers are likely to go through several phases when they first find out about their child being abused. They may go back and forth from one to the next. They may feel guilty, blamed, shame, fear, and other emotions. Many of these emotions may be conflicting, especially if the accused perpetrator is a trusted or close friend or family member. Caregivers may want the problem to “go away”. They may not even realize that abuse can cause harm and that their child needs care. The different phases which parents and caregivers may experience include:

Shock and helplessness	“I can’t believe this is happening.”
Denial	“I would have noticed if this were truly happening.”
Anger	“Why did he/she (a perpetrator) do it? I’ll hurt whoever did this!”
Grief	“Will our child be able to marry? What will happen to him/her (a child)?”
Resolution	“We will call the police”. Or “We will go to the hospital”. Or “We will do nothing and go home”. Or “We will get revenge.”

Caregivers also need support in coping after a disclosure of child abuse. It is important for you to:

- Be patient. If the caregivers get upset or emotional, it might close any further conversation with the child.
- Ask about their worries and fears in private (and away from the child). See if they have any questions.
- Discuss the treatment the child will need. Explain why this treatment is needed.
- Explain that you will discuss options for follow-up care and support.

If the caregivers get upset or emotional, it might close any further conversation with the child. If the family expresses disbelief, judgment or criticism, it is best to speak with the child and the family separately.

2.3. INQUIRE ABOUT NEEDS AND CONCERNS

Invite the child to talk about what he or she has disclosed. Ask open-ended questions. Learn from the child what particular needs he or she might have.

RELEVANT JOB AIDS:

- Communicating with children of different ages (p. 45)
- Talking with children with disabilities (p. 47)
- Communicating with boys about sexual abuse (p. 48)

2.3.1. TECHNIQUES FOR INTERACTING

Children, ages six years and older, who are able to communicate verbally can benefit from the following communication techniques:

Principles	Examples
Phrase your questions as invitations to speak.	"What would you like to talk about?"
If the child is shy or cautious, ask some close-ended and yes/no questions to help build the child's confidence.	"How old are you?" "Did someone hurt you?" "Does it hurt when I touch you here?"
Review the child's knowledge of body parts.	"What do you call this?" Point to the child's ear. Continue in this fashion until the children has named most body parts, including their genitalia. Use the child's language when talking to them about their body parts.
Move to open-ended questions that encourage the child to talk.	"Can you tell me what happened to you that day?"
Ask one question at a time	"What was he wearing? Wait for answer. "What did he look like?" Not: "What was he wearing and what did he look like?"
Explore as needed.	"Could you tell me more about that?" "Give me an example of..." or "Describe for me..." "And then what happened?"
Ask the child to clarify if you don't understand something.	"I'm not sure I understood what you meant when you said X. Can you explain it to me?" "What do you mean by..."

Principles	Examples
Adapt your strategy to the developmental age of the child.	Play with younger children, play or draw with children in middle childhood, and talk with older children and adolescents.
Choose the right words.	Children, especially children under the age of six, take words literally. You should therefore use concrete language yourself. For example, if you ask a young child, "Did he drive you away in his car?" the child may answer negatively if the actual vehicle was a motorcycle.
Empower children.	After the child described events or incidents they must be reassured that what you are telling others is the right thing.

Some things to avoid:

- Don't ask leading questions, such as "Did he put his hands on your breasts?"
- Don't ask "why" questions, such as:
 - "Why did this happen to you?"
 - "Why did you not tell me this before?"
 - "Why did you let him do those things to you?"
- Don't correct the child or challenge what the child is saying; for example "Are you sure it was your uncle?"
- Don't ask younger children any "when" or "quantity" questions, such as "When did this happen to you?" or "How many times did this happen?"
- Don't give the child the impression that there are right or wrong answers.
- Avoid words that may frighten the child such as "rape", "incest", or "assault".
- Avoid the use of prepositions with young children. They may not developmentally understand concepts such as inside, outside, on or under.

Question types

Yes or No

Yes or no questions are questions whose answer is either ‘yes’ or ‘no.’ They are helpful to learn basic information. For example, “Does it hurt when I do this?” They are helpful to start an interview with a child who is cautious or shy.

Close-ended

Close-ended questions can be answered with one word. Examples are: “Where does it hurt?” “How old are you?” In general, close-ended questions should be avoided unless you are trying to learn a particular detail.

Leading questions

Leading questions are questions where the provider suggests the answers. They should be avoided. For example “Was it your mother or your father who did this?” Instead, ask “Can you tell me who did this to you?”

Open-ended questions

Open-ended questions require the child to give more thorough answers, or to explain something. They are the best type of questions to learn what happened to the child. However, they might be the most difficult to answer, especially if the child is feeling shy, ashamed, or unsure. Consider warming up with yes-no questions before moving to open-ended questions.

2.3.2. JOB AID: COMMUNICATING WITH CHILDREN OF DIFFERENT AGES⁶

As a general rule, history-taking should not take more than:

- 30 minutes for children under the age of 9;
- 45 minutes for children between 10-14 years;
- One hour for children 15-18 years old.

A child's communication ability changes dramatically from one developmental stage to another. Your knowledge and comfort with those stages plays an important role in care.

For very young children, much of the information needs to be obtained from the parent, or caregiver; however, when possible, information should be obtained directly from the child.

Developmental Stage	Considerations
Infants and toddlers (0-5 years old)	<ul style="list-style-type: none">● Children in this age group have limited to no verbal skills and should not be asked to provide any history.● Non-offending caregivers or adults presenting with the child for care are the primary sources of information.
Younger children (6-9 years old)	<ul style="list-style-type: none">● Children in this age range should provide their own history whenever possible.● Parents, caregivers, or trusted sources in the child's life may provide additional information● Non-offending parents or caregivers can be involved in the history-taking as long as the child requests that the adult be present.

6 Adapted from Day, Kim and Jennifer Pierce-Weeks. 2013. *The Clinical Management of Children and Adolescents Who Have Experienced Sexual Violence: Technical Considerations for PEPFAR Programs*. Arlington, VA: USAID's AIDS Support and Technical Assistance Resources, AIDSTAR-One, Task Order 1.

Developmental Stage	Considerations
Early and later adolescents (10-18 years old)	<ul style="list-style-type: none"> • Children in this age range should provide their own history. • Parents or caregivers should not be involved in the history-taking to allow the child to express their own viewpoint, unless the child cannot recall pertinent medical information, like allergies, etc. • Parents or caregivers can inhibit this age group from sharing information.

If a child refuses to talk:

- Continue to talk with the child and explain the examination process, but have no expectation that the child will give you a history.
- It is not unusual for a child who initially will not speak to begin speaking as the examination progresses, and they begin to feel more comfortable with you.
- Some children may not be willing to talk about the abuse or violence –and you should not force them to because it can further traumatize them.

Consider the following factors as possible reasons as to why the child refuses to speak:

- Is there someone in the room who seems to make the child reluctant to speak?
- Does the child stop talking when their parent or caregiver leaves the room, indicating he or she is afraid to talk alone?
- Is the child not speaking because the environment in which they find themselves is not safe or private?

It may also be that the child is not comfortable talking to you because of your age, sex or another factor. If a child does not want to talk to you, it's not your fault. Try to find another colleague to work with the child (if possible).

CASE STUDY: USING A DOLL DURING AN INTERVIEW WITH A SIX-YEAR-OLD BOY

A social worker interviewed a six-year-old-boy child about his experiences with sexual abuse. The child had been sexually abused by an older boy, and the child told the social worker that he was hurt in his “bum”. The social worker wanted to make sure that she, and the child, had the same understanding of the word “bum”. So she brought out her boy doll and she asked the child to show her where the bum was located on the doll. The boy took the doll and pointed to the doll's rear end. This confirmed for the social worker that she accurately understood what the child was saying.

Taken from International Rescue Committee. (2012). Caring for Child Survivors of Sexual Abuse. Guidelines for health and psychosocial service providers in humanitarian settings. New York: International Rescue Committee.

2.3.3. JOB AID: TALKING WITH CHILDREN WITH DISABILITIES

Children with disabilities should be treated with the same respect and dignity as children without disabilities. If a child has a physical disability or intellectual disability (for example, is deaf and mute, autistic, or has brain damage from an accident) find a way to communicate.

Don't let your beliefs, attitudes and assumptions become barriers to communicating with children with disabilities. It's normal to feel self-conscious when communicating with a child whose communication method is new to you; remember, communication needs two people.

Do not use the child's impairment or disability when you talk to or about the child (e.g. the blind girl)—it promotes a negative stereotype. Call the child by his or her preferred name.

Never assume the child is not capable of communication. Never assume that because the child has a disability they will not understand. Do not talk as if the child cannot understand or as if they are “not in the room”.

Some tips when communicating with children with disabilities:

- Use short and clear sentences.
- Use non-verbal forms of communication such as facial expression and body language (for example, smiling or hand gestures).
- Use communication aids such as pictures, art materials or toys to allow the child to communicate freely.

In some cases, it may be appropriate to ask a family member to help you communicate with the child. Children with disabilities may not have a lot of experience speaking with strangers—they will need to be put at ease or assisted by a family member.

Some children wish to have a physical exam and may not understand its purpose. They may not want to expose their body to a stranger. Don't go against the child's wishes unless it is needed to ensure the safety and well-being of the child, determined, in large part, by the urgency of the child's needs (based on best interest considerations).

2.3.4. JOB AID: COMMUNICATING WITH BOYS ABOUT SEXUAL ABUSE

In Cambodia many people think that boys are not shy and can easily talk about problems, including sexual abuse. This is not true. All children find abuse extremely difficult to talk about—including boys. It is extremely

important that you take time to explain things carefully and calmly. Treat him with respect. Avoid treating the abuse as just a ‘normal thing’ that is easy for him to talk about. This will help you to develop trust.

Explain your role to him and what will happen. To help build rapport you can ask a few simple questions (appropriate for the age), such as “What is your favourite food/hobby/music/school subject?”

Many people in Cambodia also believe that the sexual abuse of boys is not serious and that boys do not feel shame or pain in the same way that girls do. This is not true at all. Boys feel great shame and loss of honour as a result of sexual abuse. Much of this shame is rooted in ideas about gender and sexuality. They may be afraid people will believe they are gay when they tell that they were abused. Boys may worry no one will want to marry them. They may be afraid of what their parents and friends may think of them. Boys often worry that they may be blamed for the abuse—because boys and men are expected to be able to fight and protect themselves. These beliefs are common but not true and very harmful.

Some key facts to keep in mind:

- Boys can be sexually abused.
- Sexual abuse does not cause homosexuality.
- Boys do not always prefer to speak with male service providers.
- Boys require care, support and treatment to recover and heal.

Never pressure him to talk. Let him know that you believe him and he is not alone; sexual abuse happens to other boys too. Assure him that he is not to blame for what happened. If he talks, listen carefully and tell him he is extremely brave to do so.

For further helpful information related to the sexual abuse of boys, please visit the web site of an organisation that works with male survivors: <http://www.first-step-cambodia.org/kh/home/>

2.4. VALIDATE

Let the child know that their feelings are normal and that it is okay to express them.

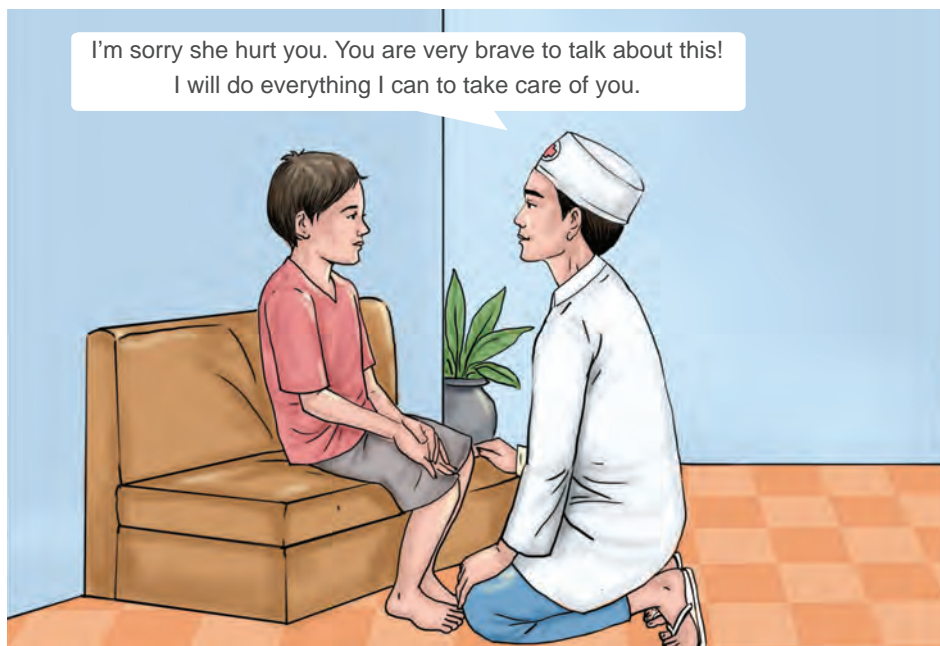
2.4.1. IMPORTANT THINGS YOU CAN SAY

Continue to reassure the child Children subjected to violence may have been threatened with further violence if they tell anyone. The perpetrator may have told the child they will hurt someone the child loves if he or she tells. Children may also feel a great deal of shame.

Let the child know that you believe them, that they are not to blame, and that you will help keep them safe and protect their privacy.

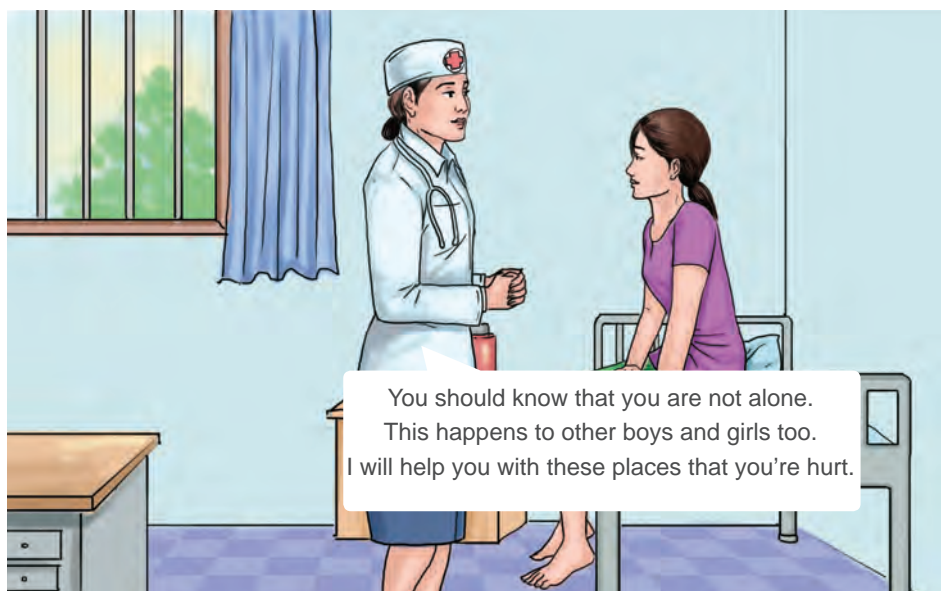
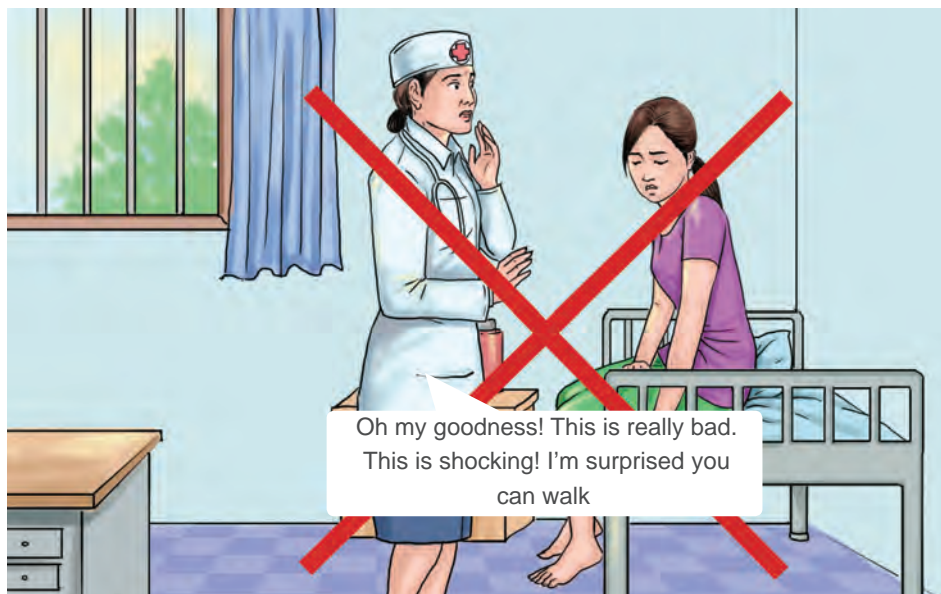
Some things you can say to children are:

- “You are very brave to tell me about this”.
- “I’m very sorry someone hurt you this way”.
- “I believe you”.
- “You are not to blame; this was not your fault”.
- “You are not alone; this happens to other boys and girls too”.
- “It’s okay to talk”.
- “I will try to help you”.
- “I am glad you are telling me about this”.
- “You are doing the right thing to talk about this”.
- “It’s all right to cry”.



Some things you should not do or say:

- Don't express shock. "I have never seen anything like this!"
- Don't blame the child. "You must have been really bad to get a beating like this!"
- Don't ask 'why' questions. "Why did you allow this to happen?"
- Don't tell the child they will forget. "Don't worry, you are still young, you will forget about this before you know it".



2.5. ENHANCE SAFETY AND PRIVACY

Ensure the child is received in a child-friendly environment and privacy is protected. Assess immediate risks and handle them appropriately. Make a plan for the future safety of the child.

RELEVANT JOB AID:

- Immediate risk assessment (p. 56)

2.5.1. ENSURE A CHILD-FRIENDLY ENVIRONMENT

A child-friendly environment will greet the child before the interview, and will surround him or her during and after the interview and examination. A child-friendly environment will be respectful of a child's needs.

Some things you can do:

- Introduce yourself and explain what will happen.
- Sit so you are not higher than the child when you talk to them. Make sure you can make easy eye contact with the child. Avoid sitting at a desk across from a child because that might seem like an interrogation.
- Take off your white coat and remove any medical instruments so that you are not intimidating to the child.
- Put up some decorations like drawings, toys, pictures of animal etc. made by children, for example by your own children or your nieces and nephews.
- Have some paper and colour pencils or pens, dolls or toys for younger children to play with.

2.5.2. ENSURE PRIVACY⁷

- Close the door. Or if this is not possible draw a curtain and lower your voice.
- Prepare a “Please do not disturb” sign and hang it on the door or curtain.



2.5.3. ASSESS IMMEDIATE RISK

Child survivors may continue to be at risk when they return to their home, school or neighbourhood. Safety risks for children may be hidden. In cases of child abuse, especially if the abuse happened at home or within the family, you should ask the child (if aged six or above) about their safety concerns in private.

⁷ Text and interventions draw heavily from International Rescue Committee. (2012). *Caring for Child Survivors of Sexual Abuse. Guidelines for health and psychosocial service providers in humanitarian settings*. New York: International Rescue Committee

Assessment areas to evaluate are:

- **The child's sense of personal safety in the home environment:**

Some children recognize the dangers they face, so take it seriously if a child is afraid to go home, or is afraid of his or her parents or caregivers.

Sample questions to ask include:

"Does anyone at your home scare you?"

"Do you worry that you will be hurt?"

"Does the person who hurt you live in the house with you?", or

"Does the person who hurt you visit your home?"

- **The child's sense of personal safety in the community: environment.**

Sample questions include:

"Do you ever feel scared outside of your home... if yes, where?"

"Do you feel safe at school?"

"Will you continue to see the person who hurt you?", or "Did the person who hurt you threaten you in any way?"

- **The child's identified safety/support systems:**

Sample questions include:

"Who do you feel safe with?"

"When you have a problem, who do you talk to?", or

"Who do you trust at home?"

The pattern of abuse of children is generally different from that of adults. For example, there is often repeated abuse. Gathering information about the accused perpetrator helps assess immediate risk. Consider:

- What is the relationship of the perpetrator to the child and his or her family?

- Where is the perpetrator? Can the perpetrator access the child easily?
- What is the occupation of the perpetrator (his/her position—and level of power—could raise safety concerns)?
- What is the caregiver's capacity to protect the child from this perpetrator?
- How many perpetrators are involved?

In cases of child abuse involving a close male relative, you should be alert to other kinds of violence, including domestic violence. Specific risk factors you must assess include:

- Indications of violence or abuse occurring within the family.
- The caregiver's or family's willingness to protect the child from further violence and abuse.
- The child's and caregiver's perceived sense of safety.

2.5.4. JOB AID: IMMEDIATE RISK ASSESSMENT

The most important question for you to answer is whether or not the child is safe from further abuse.

Child safety assessment	
<input type="checkbox"/> Yes, the child is safe.	<input type="checkbox"/> No, the child is not safe.
	<p>The following safety risks have been identified:</p> <ul style="list-style-type: none"> <input type="checkbox"/> The child's caregivers cannot or will not protect the child from further abuse. <input type="checkbox"/> The perpetrator lives with the child or can easily access the child at home. <input type="checkbox"/> The child is fearful of family members and does not want to return home. <input type="checkbox"/> Other reason (please identify):

2.5.5. MAKE A SAFETY PLAN⁸

If the immediate risk assessment indicates the child is **NOT SAFE** you should contact **DoSVY** or the **police** for their immediate assistance.

Children who do not face immediate risk still need a safety plan. A safety plan will help the child better respond to situations in which violence occurs. Talk to the child about:

Safety planning	
Safe people	Who are some people you feel safe with (such as family members, teachers, friends and neighbours)?
Safe places	Where do you feel safe? Where could you go if you do not feel safe at home?
Transport	Where do the people you feel safe with live? How can you go to there? How can you go to the places you feel safe?
Support of someone close by	When you have a problem, who do you talk to? Who could call the police or come to help you if violence is happening?
Contacting the police	Explain the child how to contact the police. Who could come with you?

2.5.6. AVOID PUTTING THE CHILD AT RISK

If you suspect that the person accompanying the child is the perpetrator, do not interview the child or discuss the abuse while the person is present in the room.

⁸ International Rescue Committee. (2012). *Caring for Child Survivors of Sexual Abuse. Guidelines for health and psychosocial service providers in humanitarian settings*. New York: International Rescue Committee

If the accompanying person is not the perpetrator, but is also afraid of the perpetrator, or maybe has been abused by the same perpetrator, discuss with the person how to keep the child safe. For example, how will he/she explain where he/she has been and what was discussed at the hospital? Can he/she and the child go to live with family or neighbours until the police have intervened?

Remember to maintain confidentiality over the child's records. Keep documents in a safe place, not out on a desk or anywhere else that anyone can see them.

2.6. SUPPORT

Connect the child with other resources for his or her health, safety and social support

RELEVANT JOB AID:

- Pathway of care for children subjected to violence (p. 62)

The needs of a child subjected to violence are complex and generally beyond what you can provide in the clinic or hospital. You can help by connecting the child to the right sources of support to ensure the child's safety

HOW TO HELP

In most cases, admission is recommended to allow sufficient time to perform a thorough medical assessment and for investigations to start while the child is in a safe place.

- Ask if the child has already been to the police, or has received services from another agency. If not, explain referral options fully and accurately. Offer referrals to police services, psychosocial support or legal services.
- Before referring a child to other services, obtain permission from the child and the caregiver. Agree with the child and caregiver which information will be shared with the different referral agencies.
- Provide information in a neutral and non-judgmental manner. Never demand a child or caregiver to take a particular action.
- Ensure children are never sent to referral agencies alone, unless they are adolescents and there is a good reason to do so. Generally children should be accompanied by their caregivers.

2.6.1. TIPS ON REPORTING⁹

If reporting could further jeopardize a child's safety at home, school or within the community, you should follow a decision-making process that first considers the child's safety (based on best interest considerations) and then the implications of not reporting.

You may use the following questions to guide decision-making:

- Will reporting increase risk of harm for the child?
- What are the positive and negative impacts of reporting?
- What are the legal implications of not reporting?

⁹ *International Rescue Committee. (2012). Caring for Child Survivors of Sexual Abuse. Guidelines for health and psychosocial service providers in humanitarian settings. New York: International Rescue Committee.*

2.6.2. OPTIONS FOR REPORTING

A child subjected to violence should be reported to the relevant authorities (respecting confidentiality and on a need-to-know-basis), including the:

- DoSVY Social Worker
- Provincial Anti-Human Trafficking and Juvenile Protection Police

At the commune level cases may be reported to the:

- Commune Committee for Women and Children (CCWC) Women and Children Focal Point
- Commune Police
- Village Chief or Commune Chief

In serious cases when the family or caregivers of the child have been confirmed to be or are the suspected perpetrators, the child may not be able to return to the family. In those cases, family-based solutions should be sought as a first option. Residential care such as orphanages should be avoided and only used as a last option and for short periods of time.

2.6.3. TIPS ON GIVING REFERRALS

- Be sure that the referral meets the child's needs and concerns and complies with the decision of the commune/Sangkat council.
- If the family of the child expresses problems with going to a referral for any reason, help them think about ways to solve the problem. Or alternatively, see if the service can come to them.
- Make the referral as easy as possible for the family of the child. Tell them where to go, give the address, explain how to get there and who they will see. If needed, provide the information in writing.
- Offer to telephone to make an appointment.
- Always check to see if the child or family has questions or concerns.

2.6.4. OPTIONS FOR CRISIS SERVICES, PSYCHOSOCIAL SUPPORT AND COUNSELLING, AFTERCARE AND REHABILITATION, AND RE/INTEGRATION

Child survivors require many different kinds of resources and supports based on their individual situation and the type of violence experienced. These services can include crisis services, psychosocial support and counselling, aftercare and rehabilitation, and re/integration. Some services are provided by the Government and some services by NGOs.

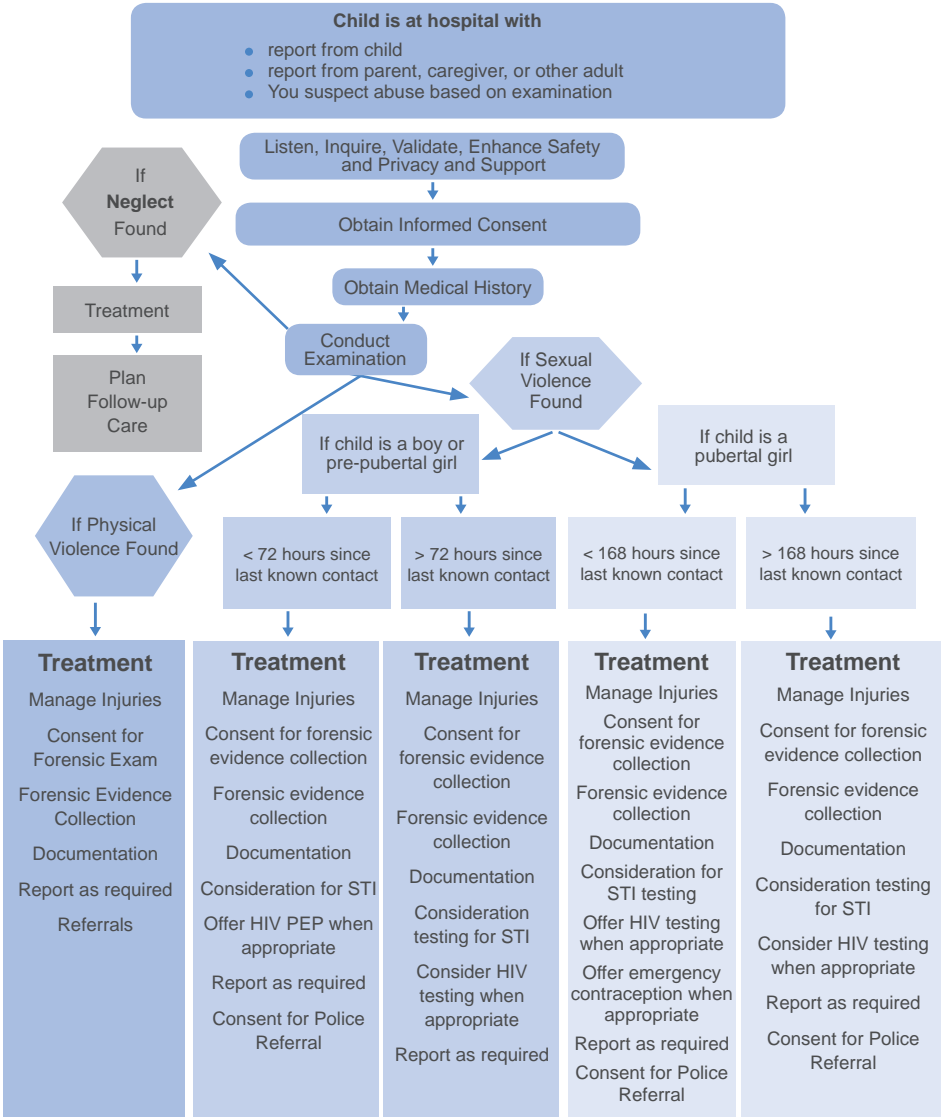
Find out what support and places are available for children in your area (see Job Aid “Pathway of care for children subjected to violence” on page 62). It is best to have formal referral agreements with the services providers and organizations you refer children to. These agreements should specify how you will find out the child reaches the referral resource—will you contact them or will they contact you?

Possible places:

- Child Helpline
- Safe shelter
- DoSVY Social Worker
- Judicial Police Officer of Ministry of Women’s Affairs
- Psychologist
- Mental health counsellor
- Person in charge of CCWC Women and Children
- Specialized NGOs

To ensure the functionality of the referral system, the health facility should, where possible, assign one individual responsible for ongoing communication and coordination with other service providers.

2.6.5. JOB AID: PATHWAYS TO CARE



All Patients: Immediate counseling if suicidal

Referral to relevant resources

Follow-up for medical care and treatment

PART 3: ADDITIONAL CARE FOR PHYSICAL HEALTH

In this part you will learn how to combine the First Line Support steps (LIVES) with your clinical responsibilities. The following topics are covered:

- How to sensitively interview child survivors of violence about their medical history and a description of the assault.
- How and when to include the family in the medical history, interview and examination.
- The importance of gaining informed consent and informed assent, and how the process differs for children of different ages.
- What information to cover during the physical examination.
- What treatments to give, depending on the type of abuse the child has suffered, and if the child is a boy or a girl.

3.1. THE STEPS OF CARE

First, Listen, Inquire, Validate and Enhance safety and privacy (first-line support). Then:

1. Take the child's medical history and obtain informed consent (p. 64)
2. Conduct the examination (p. 79)
3. Treat any physical injuries (p. 88)
4. Prevent sexually transmitted infections (STIs) (p. 90)
5. Prevent HIV (p. 93)
6. Provide emergency contraception (for pubertal girls) (p. 95)
7. Plan for follow-up care (p. 97)

Then, arrange Support (first-line response).

The following pages explain the seven steps. The Job Aid “pathways to CARE” on the page 62 shows the order of steps.

3.2. STEP 1. TAKE HISTORY, OBTAIN INFORMED CONSENT AND CONDUCT THE EXAMINATION

This step involves:

- Take the child’s history—overall medical history, information about the assault, and gynaecological and mental health assessment.
- Obtain informed consent.
- Conduct a head-to-toe physical examination.

3.2.1. TAKE A HISTORY

RELEVANT JOBS AIDS:

- Listening to parent’s and caregiver’s concerns (p. 39)
- Communicating with children of different ages (p. 45)
- Talking with children with disabilities (p. 47)
- Communicating with boys about sexual abuse (p. 48)

The history-taking includes: (1) general medical information, (2) questions about the assault (only ask what is needed for medical care), (3) a gynaecological history, and (4) an assessment of mental state (see Part 4).

History-taking is not the same as interviewing the child about abuse. When you take the child’s medical history, you are gathering general information

about their health. This information will be used to make sure the child receives the care needed. Take special care in determining who is present during the interview and examination (remember that it is possible that a family member is the perpetrator of the abuse). It is preferable to have a parent or caregiver wait outside during the interview and have an independent trusted person present. For the examination, either a parent or caregiver or a trusted person should be present. Always ask the child who he or she would like to be present, and respect his or her wishes (see Job Aid on History Taking and the Family on the page 70).

As a general rule, history-taking should not take more than:

- 30 minutes for children under the age of 9;
- 45 minutes for children between 10-14 years;
- One hour for children 15-18 years old.

General tips

- Continue to identify yourself as a helping person.
- Make sure you are in an area that allows for privacy. Place a “do not disturb” sign on the door or curtain.
- Limit the number of people in the room.
- Get down to the level of the child.
- Assure the child that he or she is not in trouble.
- Avoid words that may frighten the child such as “rape”, “incest”, or “assault.”
- If the child becomes anxious during any part of the interview pause for a moment and allow the child time to recover.

Ways to begin a history-taking session

- “My name is Sopheap, I am a doctor. My job is to make sure you are all right”.
- “Can you tell me your name?”
- “How old are you?”
- “What do you call this?” Point to the child’s ear.
 - Continue in this fashion until the children has named most body parts, including their genitalia.
 - Make sure to use the exact same words the child used to describe his or her body parts including their genitalia during the rest of the interview and examination.
- “Do you know why you are here today?”
- “Do you hurt anywhere?”

Ground rules to establish with a child before an interview¹⁰

- Tell the child it is okay if he or she doesn’t know the answer to a question. “If I ask you a question, and you don’t know the answer, just say ‘I don’t know’. Okay?”
- Reassure the child that there are no right and wrong answers. Explain that it is very important for the child to tell you everything in his or her own words.
- “If I ask you a question and you don’t remember, it’s okay to say you don’t remember”.

¹⁰ Adapted from American Professional Society on the Abuse of Children. 2012. Practice Guidelines: Forensic interviewing in cases of suspected child abuse. www.apsac.org.

- “If I ask you the same question more than once, it doesn’t mean your first answer was wrong, maybe I forgot or got confused. If your first answer was right, just tell me again”.
- “If I ask you a question you don’t want to answer, just tell me ‘I don’t want to talk about it right now’”.

Offer reassurance. “Telling the truth might seem scary sometimes, but I will know you are very brave”.

(1) Ask about general medical information

General medical information should cover any current or past health problems, allergies, and any medications that the child is taking. See the sample history and examination form (p. 128) for questions to ask.

(2) Talk about the physical or sexual assault

In principle, only female providers should speak with girls about sexual abuse. Boys subjected to sexual abuse should be offered the choice (if possible) to speak with a female or male provider.

To get a clear picture of what happened, try to obtain information on:

- The home situations (does the child have a safe place to go?)
- How the abuse was discovered
- Who did it, and whether he or she is still a threat
- If this has happened before, how many times and the date of the last incident
- Whether there have been any physical complaints (for example bleeding, dysuria, discharge, difficulty walking, etc.)
- Whether any other siblings are at risk

The reason to obtain this information is to:

- Guide the exam so that all injuries can be found and treated
- Assess the risk of STIs and HIV
- Assess the risk of pregnancy for pubertal girls
- Guide specimen collection and documentation

TALK ABOUT THE ASSAULT

- Carefully review the Listen DOs and DON'Ts on and the Inquire techniques on as well as the Job Aid on “Communicating with children of different ages”.
- With a calm voice ask the child to describe the event(s). Do not force the child to talk. It is not necessary to elicit every single specific detail about the physical or sexual assault. Limit questions to what is required for medical care. Do not interrupt or cut the child short while talking.
- Explain that telling you about what happened will help you to take better care of the child. It is important to reassure the child that he or she can trust you, but also to inform the child that you might need to share some of the information with other people so they can help keep you safe.
- Phrase your questions gently. Start with some close-ended and yes/no questions (Part 2 First Line Support – Inquire about needs and concerns for more information on different question types) to help build the child's confidence. Move to open-ended questions that encourage the child to talk. Avoid questions that might suggest blame, such as “Why did you allow this to happen?” Do not correct or challenge what the child is saying, for example “Are you sure it was your uncle?”
- The child may avoid talking about painful or frightening details. Do not force the child to describe them as it is traumatizing. If you absolutely must know the information in order to treat the child properly, explain why you need to know in a gentle manner.
- If the child has already been to the police, the child protection authorities or another service provider, be cautious when asking the child questions about the abuse. Ideally the option of gathering information from the service provider(s) already involved in the child's case should be explored, if it is safe and approved by the child and family. You can also gather information from the non-offending parent or adult accompanying the child before talking to the child about the abuse. This prevents children from unnecessarily having to repeat their stories.

(3) Take a gynaecological history

The sample history and examination form (p. 128) suggests the questions to ask.

With adequate preparation, most children will be able to relax and participate in the examination. Ensure the following:

- There should be a support person for the child or trained health worker whom the child trusts in the examination room with you.
- Encourage the child to ask questions about anything he or she is concerned about or does not understand at any time during the examination.
- Explain what will happen during the examination, using terms the child can understand.
- It is possible that the child cannot relax because he or she has pain. If this is a possibility, give paracetamol or other simple painkillers, and wait for them to take effect.
- Never restrain or force a frightened, resistant child to complete an examination.

The purpose of taking a gynaecological history is to:

- Check the risk of STIs and HIV
- Check the risk of pregnancy for pubertal girls
- Check whether any exam findings could have resulted from previous traumatic events, pregnancy or delivery

(4) Assess mental health

Ask general questions about how the child feels and what his or her emotions are while taking the history. If you see signs of emotional distress, ask more specific questions (see Part 4).

Obtain immediate assistance regarding crisis intervention if the child expresses suicidal or homicidal thoughts (see page 124).

“What can I do if the child is brought in late after the sexual assault?”

Post-exposure prophylaxis (PEP) for HIV must be started as soon as possible and no later than 72 hours after exposure. For pubertal girls, emergency contraception (EC) pills should also be started as soon as possible and can be commenced up to 3 days after unprotected intercourse.

If a child comes too late for some of these steps, you can still always:

- Provide first-line support (Part 2)
- Provide STI prevention and treatment
- Provide hepatitis B immunization
- Test for pregnancy and HIV
- Assess mental health and provide care as needed (Part 4)

3.2.2. JOB AID: HISTORY-TAKING AND THE FAMILY

It is preferable to have a parent or caregiver wait outside during the interview and have an independent trusted person present. Always ask the child who he or she would like to be present, and respect his or her wishes.

- Some children will feel more comfortable with their parent or caregiver being present in the room, at least until the child develops trust in you.
- Building rapport with the caregiver, in addition to building rapport with the child, is extremely important. A child who sees that their caregiver trusts you will feel more comfortable and be more ready to talk.
- Once rapport is established ask the caregiver to leave the room. If the child refuses to speak with you and/or appears upset or agitated, then consider and determine whether to proceed jointly.

If you suspect the person that has brought the child to the health facility is the perpetrator do not permit the person to be in the interview and examination.

For children under the age of six years the history is generally obtained from the non-offending parent, caregiver or trusted adult accompanying the child. No information is specifically asked of the child. However, the child may spontaneously disclose information during the exam. These spontaneous statements should be recorded exactly as the child has spoken them.

While caregivers may be a source of support for the child, they can also be an obstacle. Children may feel more self-conscious with their caregivers present. They may not talk as freely with their caregivers present. This is especially true for older children.

Adolescents should be asked if they want to be alone, or with a trusted adult. They may have also a trusted friend present if they wish.

If you suspect abuse during a routine consultation, use your best judgment to decide whether to have the caregiver present when asking the child questions about violence (Job Aid “Asking about violence” on page 27. If you feel the child will not speak freely, ask the caregiver to wait outside.

3.2.3. OBTAIN INFORMED CONSENT¹¹

Relevant Jobs Aids in this section:

- Obtaining informed assent from children (p. 75)
- Explaining risks and benefits of each phase of intervention (p. 76)
- Sample consent form (p. 126)
- Sample assent form (p. 127)

¹¹ This section draws heavily from the International Rescue Committee. (2012). *Caring for Child Survivors of Sexual Abuse. Guidelines for health and psychosocial service providers in humanitarian settings*. New York: International Rescue Committee

Before you provide any medical services it is important to receive permission to do so from the caregiver or legal guardian and (when appropriate) the child. This is called “consent”. In seeking consent, you must ensure that children and caregivers know what to expect during each phase of their visit to your medical facility – including the interview, the forensic examination, the medical management of any injuries, and possible police and court referral. You should fully explain the risks and benefits of each phase of their visit before you begin, as well as the purpose and methods of any procedure. You should always offer children and caregivers the opportunity to ask questions and share concerns during this discussion. There are three levels of intervention that the caregivers are asked to consent to:

Level 1 – Consent for medical management only

Level 2 – Consent for medical management and forensic management

Level 3 – Consent for medical management, forensic management and police and court referral

When to obtain permission from children and caregivers:

- Consent forms should be signed by the child’s caregiver or legal guardian unless they are the suspected perpetrator or the child does not want him or her to know about the abuse (and the child is old enough/mentally sound to make such a complex decision). In such situations, the consent form may be signed by a representative from the police, the court, DoSVY or the health facility. Adolescent minors may be able to give consent themselves.

- While legally children cannot give consent to examination and treatment, they shall not be compelled or forced to undergo examination or treatment unless it is necessary to secure their immediate safety and/or mobilize life-saving medical interventions (following best interest considerations). As a general principle, permission is sought from the child as well as the parent or caregiver, unless it is deemed inappropriate to involve the child's caregiver (for example, if they are the abuser).

Informed consent and informed assent are similar, but not exactly the same	
Informed consent	Involves the voluntary agreement of an individual who has the legal capacity to give consent for medical services after having been informed of the purpose, methods, procedures, benefits and risks of any action taken by the medical provider. Parents or caregivers are typically responsible for giving consent for their child to receive services until the child reaches 18 years of age. In some settings, older adolescents are also legally able to provide consent in lieu of, or in addition to, their parents or caregivers.
Informed assent	Involves the expressed willingness to receive medical services after having been informed of the purpose, methods, procedures, benefits and risks of any action taken by the medical provider. For younger children who are too young to give informed consent, but old enough to understand and agree to participate in services, the child's "informed assent" is sought.

Snapshot of informed consent/assent guidelines				
Age group	Child	Caregiver	If no caregiver or not in the best interest of the child	Means
Infants and toddlers (0-5)	No informed assent will be sought	Informed consent	Other trusted adult's consent or consent from a representative of the health facility	Written consent
Younger children (6-11)	Informed assent	Informed consent	Other trusted adult's consent or consent from a representative of the health facility	Oral assent, written consent
Younger adolescents (12-14)	Informed assent	Informed consent	Other trusted adult's or the child's informed assent. Sufficient level of maturity (of the child) can take due weight.	Written assent, written consent
Older adolescents (15-17)	Informed consent	Informed consent with child's permission	Child's informed consent and sufficient level of maturity takes due weight.	Written consent

3.2.4. JOB AID: OBTAINING INFORMED ASSENT FROM CHILDREN

It is important for you to understand the age and developmental stages of children and how they affect children’s rights to participate in decision-making. The child’s age, level of maturity, and developmental stage should be considered before determining a child’s ability to participate in decision-making processes. For example:

16 years and older	Children 16 years and older are generally sufficiently mature to fully participate in decisions.
14 to 16 years old	Children aged 14 to 16 years old are mature enough to make a major contribution and to share their view when it comes to decision-making.
9 to 14 years old	Children aged 9 to 14 years old can meaningfully participate in the decision-making processes, but their maturity must be assessed on an individual basis.
9 years and younger	Children 9 years and younger have the right to give their opinion and to be heard. They may be able to participate in decision-making processes, but should not be burdened with decisions beyond their ability to understand.

Ultimately, children of all ages should be provided the opportunity to express their views and opinions. That said, children may not always have their wishes and desires met; in such cases, children have the right to be informed as to why their wishes cannot be accommodated. The best interest of the child shall prevail in all decisions.

If the child refuses the medical examination, explore with the child what their reasons are. It could be something simple, like fear of needles, or

not feeling comfortable with the health care provider or the room in which they are treated. Or perhaps it is a case of parents forcing an examination on a child whom they fear is sexually active.

In situations where the child is hesitant to proceed, take steps to address the worries the child has. Some things to consider include:

- Have a young child sit on their parent's or caregiver's lap during the interview and examination. Have the caregiver sit on the bed next to the child for children too big for a lap.
- Remember that caregivers may be a source of support to some children, but an obstacle to others. Children may feel self-conscious with their caregivers present. Especially with older children, you may wish to ask the parent or caregiver to leave the room.
- Have the child go outside and play for a while to relieve anxiety.

Remember that the child should never be examined against his or her will, whatever the age, unless the examination is necessary for medical care.

3.2.5. JOB AID: EXPLAINING RISKS AND BENEFITS OF EACH PHASE OF INTERVENTION

In order to provide informed consent and informed assent, the child and caregivers must be aware of the potential risks and benefits of any intervention or treatment. In this way, they will be informed of the activities or interventions that they are consenting to. In addition, informed consent and informed assent must be obtained before any act including history taking. Provided here is a list of the risks and benefits that the child and caregivers should be aware of. Be aware that each individual case is different, and some risks/benefits may not be applicable, and there may be other risks or benefits not listed here.

Activity	Risks	Benefits
Level 1 Medical Management	<ul style="list-style-type: none"> • All medications have side effects; explain the side effects of any medication you administer or prescribe, including HIV/PEP, STI treatment or prophylaxis, emergency contraception, etc. 	<ul style="list-style-type: none"> • Medical treatment of injury or infection can prevent ongoing problems that may have serious consequences in the short- and long-term.
9 to 14 years old	<ul style="list-style-type: none"> • The child will be bodily exposed and their injuries will be examined, and this may be physically or emotionally uncomfortable. • Procedures used to gather forensic samples may be physically or emotionally uncomfortable. • There is a potential that the samples could be damaged or lost. 	<ul style="list-style-type: none"> • Fully knowing the scope of injuries will allow the doctor to provide comprehensive treatment. • Obtaining a full picture of the violence will allow the doctor to gather evidence that can be used in a court of law.

Activity	Risks	Benefits
Level 3 Police and Court Referral	<ul style="list-style-type: none"> Police and court personnel may see the patient's records, including interviews and photographs. There is potential that members of the public could gain access to the records. 	<ul style="list-style-type: none"> Involving police and the court is necessary if the child and caretakers wish to prosecute the perpetrator.

Special situation: if caregivers do not provide their consent

The best interest of the child is usually most effectively secured by involving the parents or caregivers in the child's care and treatment.

In situations where the caregiver, the child, and/or you have differing opinions of what is needed to promote the child's best interest, you should discuss the matter with the caregiver and ideally come to an agreement that best supports the child's well-being. If you and the caregiver are unable to come to an agreement and it is your opinion that the caregiver is not acting in support of the child's best interest, you may need to medically intervene (for example, if a parent refuses to grant permission for life-saving measures or post-sexual abuse medical care.)

Remember that it is very important to explain all medical procedures in a clear, simple, and friendly manner. Generally, once concerned parents and caregivers are informed as to why a certain intervention is needed to secure their child's health and well-being, they will most often provide their permission to proceed and take part in the healing process. Be persistent enough to ensure that the child receives the medical treatment he or she needs.

The decision to go against caregiver's wishes should be taken on a case-by-case basis. It involves a serious decision which should be determined, in large part, by the urgency of the child's medical and emotional needs (following best interest considerations).

If, however, the caregivers refuse involvement by the police and courts, this is within their rights (unless they are the suspected perpetrator).

3.2.6. PERFORM A HEAD-TO-TOE EXAMINATION

The main reason for the physical examination is to determine what medical care is needed. It is also used to complete any legal documentation. Before you conduct the physical examination, you need to inform the child, and his or her parent or caregiver of the process of care and treatment, including what will happen in the interview and medical examination.

RELEVANT JOBS AIDS:

- Physical examination checklist (p. 87)

Ground rules

- Treat the child with extreme sensitivity and recognize their vulnerability during the examination. Remain calm at all times.
- Children should not be examined more than once.
- Absolute privacy and confidentiality is required. Limit the number of people in the room. Place a "do not disturb" sign on the door or curtain.
- Cover the child's body with a piece of cloth when that part is not being examined so that the child doesn't feel exposed.
- Don't comment or react with body language on the child's injuries and the child's physical appearance.

- Before you begin, show the child each instrument that you will use. Describe how it is used and on what part of the body. This will decrease the child's anxiety.
- Keep the child informed about any steps you take.
- Ask the child if he or she would like a parent, caregiver or trusted adult to be present during the examination. Position that person in the room so that they are close to the child, but are not in eye-line of the genito-anal exam.
- Have young children sit on their parent's or caregiver's lap. Older children should be offered the choice of sitting on a chair or on their mother's lap, or lying on the bed.

If the child becomes anxious at any stage of the examination pause for a bit. Cover the child's body and let them sit up. Gently ask what the problem is. If it is something you can alter, do so. Allow the child time to recover and continue to identify yourself as a helping person.

Remember to

- Ask the child whether he or she would like to have someone present
- Ensure a private and safe location
- Offer the a choice of a female or male provider (if possible)

Examine

- Make sure equipment and supplies are prepared before you begin.
- Carefully review the Job Aid on "Common Signs of Abuse" on page 22.
- Take the child's vital signs—pulse, blood pressure, respiratory rate and temperature.

- Record the child's height and weight.
- Record the pubertal stage.
- Work systematically, using the chart provided in the Job Aid, "Physical Examination Checklist" on page 87
- Don't rush. Give your full time and attention to the examination.
- Record your findings and observations clearly and fully (see sample history and examination form on page 128).
- Document carefully and fully any injury or other marks as this can be important evidence.

Note:

It is not the responsibility of the Forensic Examination Committee to determine if there has been a rape or sexual assault.

Common mistakes among forensic medical examiners

It is not uncommon for forensic medical examiners to feel like they must decide whether or not a rape has occurred; however, this is not the responsibility of the physician. Rather, they are responsible for documenting injuries, collecting available evidence, offering first-line support, treating injuries and offering referral. The court will make a judgment as to whether a crime was committed.

Below are some of the common mistakes made by examiners:

- Thinking that if the exam is normal, abuse has not occurred.
- Thinking that if the girl's hymen is intact, then sexual abuse has not occurred. In the majority of cases the medical examination neither confirms nor refutes allegations of sexual abuse.

- Believing that it's possible to determine whether a pubertal child has had sex or not.
- Trying to measure the size of the hymenal opening.
- Forcing exams on children.
- When uncertain about findings, feeling pressured to guess.

Finn, Robert. 2010. Tips for Conducting a Sexual Abuse Exam. American College of Emergency Physicians News. <http://www.acep.org/Clinical---Practice-Management/Tips-for-Conducting-a-Child-Sexual-Abuse-Exam/>

Genito-anal examination for girls (in case of sexual assault)

In cases of sexual assault, a genito-anal examination is needed. **This is an extremely sensitive examination.**

- **Do not carry out a digital examination. In most cases a speculum exam is not advised.** A speculum may be used only when you suspect vaginal injury and internal bleeding as a result of penetration.
- Whenever possible avoid a speculum exam on girls who have not reached puberty. It is extremely painful and may cause additional trauma and serious injury. A speculum examination of a pre-pubertal child is usually done under general anaesthesia or sedation.

During the genito-anal examination:

- Help the girl feel as comfortable as possible.
- Explain the procedure providing details of each step – let her know when and where you will touch her.
- Have young children sit on the lap of their parent or caregiver. Older children should be offered the choice of sitting on a chair or on their mother's lap, or lying on the bed.

- Help the girl lie on her back with her legs in a frog-leg position (laying on back and legs spread open). Check the hymen by holding the labia at the posterior edge between your index finger and thumb and gently pulling outwards and downwards. Note the location of any fresh or healed tears in the hymen and the vaginal mucosa. The amount of hymenal tissues and the size of the vaginal orifice are not sensitive signs of penetration.
- Look for vaginal discharge. In pre-pubertal girls, vaginal specimens can be collected with a dry sterile cotton swab.
- Examine the anus. Look for bruises, tears or discharge. Help the child lie on her back or on her side. Avoid the knee-chest position, as perpetrators often use it. For small girls, a paediatric speculum is **ONLY** recommended if medically necessary.
- Place a sheet over her body that can be drawn up at the time of the examination.
- Record all your findings and observations clearly and fully in the body pictograms (see sample history and examination form on the page 128).

Genito-anal examination for boys (in case of sexual assault)

- Help the boy feel as comfortable as possible.
- Explain the procedure providing details of each step – let him know when and where you will touch him.
- Have young children sit on the lap of their parent or caregiver. Older children should be offered the choice of sitting on a chair or on their mother's lap, or lying on the bed.
- Help the boy to lie on his back or on his side. Examine the anus. Look

for bruises, tears or discharge. Do not place a boy on his knees as this may be the position in which he was violated.

- For older boys, the foreskin should be gently pulled back to examine the penis. Do not force it since doing so can cause trauma, especially in young boys.
- Place a sheet over his body that can be drawn up at the time of the examination.
- Record all your findings and observations clearly and fully in the body pictograms (see sample history and examination form (on page 128).

Do not carry out a digital examination to assess anal sphincter tone.

Additional procedures (if evidence is collected for forensic examination)

- **For girls**, take swabs, in the following order: external vaginal swab, internal vaginal swab, high vaginal swab, and rectal swab. Also take oral swabs for secretor factors in cases where oral sex is implicated and skin swabs when a suspicious seminal stain is present on the skin. All specimens collected for forensic examination should be put in a paper bag, not a plastic bag because paper helps preserve the evidence.
- **For boys**, take rectal swabs. Also take oral swabs for secretor factors in cases where oral sex is implicated and skin swabs when a suspicious seminal stain is present on the skin. All specimens collected for forensic examination should be put in a paper bag, not a plastic bag because paper helps preserve the evidence.
- **For boys and girls**, obtain pubic hair and any other pieces of physical evidence that may have been left by the perpetrator on the genitalia of the child. If DNA testing is available collect the scrapings from under the child's fingernails if he or she scratched the assailant.

The examination is best done under natural light. However, there are special lamps that can be used to see injuries better, such as woods lamps or UV light.

GUIDELINES FOR PHOTOGRAPHS

If photographs are required, frame the photograph so that a child's face is not shown. When injuries are on the child's face, take steps to avoid revealing his or her identity. For example, cover their eyes with a piece of paper. Take three photographs of each injury:

- A close-up of the injury
- A close-up of the injury with an object included to show the scale (e.g. a ruler)
- A photograph taken from farther away to give the viewer a sense of the size of the injury and its relation to other potential injuries

Make sure to store the camera and/or the images where no one will see the pictures.

LABORATORY INVESTIGATIONS

Laboratory investigations are done to help address medical problems as a result of the violence and to collect forensic evidence. The forensic evidence may be used for medical and legal purposes.

Legally if specimens are collected they should be sealed appropriately, signed and delivered to the laboratory by a certified provider to preserve the chain of evidence. This ensures that the evidence has not been disturbed, and therefore will be useful in a trial.

The common laboratory tests for child survivors, particularly in case of sexual assault, must include: HIV testing and counselling, pregnancy tests, urinalysis and screening for STIs, swabs from vaginal and other strained areas for presence of semen, blood/urine for intoxication and additional tests can be done according to the clinician's opinion and as recommended by protocol according to the availability of services at the health facility.

RECORD FINDINGS AND TREATMENT

Healthcare providers are often asked questions from the police, lawyers or the courts about the injuries of children they have treated. Careful documentation of findings and treatment provided will make it easier for you to answer and recall the information accurately later (see the sample history and examination form on the page 128).

Details authorities would want to know about:

- Type of injury (cut, bruise, abrasion, burn, fracture, other)
- Appearance of the injuries (recent, healing, scar)
- Description of the injuries (length, depth, other characteristics)
- Location of the injuries on the body
- Possible cause of the injuries (e.g. bite, electric cord, other)
- The immediate and potential long-term consequences of the injuries
- Treatment provided
- Lab results

3.2.7. JOB AID: PHYSICAL EXAMINATION CHECKLIST

Inspect all the following	Look for and record
<ul style="list-style-type: none"> • General appearance of the child • Hands and wrists, forearms, inner surfaces of upper arms, armpits • Face, including the inside of the mouth • Teeth • Ears, including inside and behind the ears • Eyes • Head, including the scalp • Neck and throat • Chest, including breasts • Abdomen • Buttocks, thighs, including inner thighs, legs and feet • Back 	<ul style="list-style-type: none"> • Active bleeding • Bruising • Burns • Fractures • Redness or swelling • Cuts or abrasions • Evidence that clumps of hair have been pulled out, and recent evidence of missing teeth • Injuries such as bit marks or gunshot wounds • Evidence of internal injuries in the abdomen • Ruptured ear drum • Tears to the frenulum
Genito-anal examination for girls	
<ul style="list-style-type: none"> • Genitals (external) • Genitals (internal, only if medically indicated) • Anal region (external) 	<ul style="list-style-type: none"> • Active bleeding • Bruising or tearing • Redness or swelling • Cuts or abrasions • Abnormal discharge • Foreign object presence

Genito-anal examination for boys

- | | |
|--|---|
| <ul style="list-style-type: none">• Penis• Anus (external)• Digital rectal examination (only if medically indicated) | <ul style="list-style-type: none">• Active bleeding• Bruising or tearing• Redness or swelling• Cuts or abrasions• Discharge (at the tip of the penis and/or the anus)• Foreign object presence |
|--|---|

3.3. STEP 2. PROVIDE TREATMENT

Treat the case as an emergency unless you have another patient who has a truly life-threatening situation. If the child is severely injured, refer him or her for immediate emergency treatment. In case another patient is suffering from more serious condition which is life-threatening, priority should be granted to that patient to receive treatment first.

3.3.1. TREAT PHYSICAL INJURIES OR REFER

Immediately refer children who have been subjected to physical or sexual violence with life-threatening or severe conditions for emergency treatment.

Complications that may require urgent hospitalization:

- Extensive injury (to genital region, head, chest or abdomen)
- Neurological deficits (for example when the child is unable to speak or has problems walking)
- Respiratory distress
- Swelling of joints on one side of the body (septic arthritis)

- Persistent vomiting
- Inability to drink or breastfeed

In children younger than 3 months, also look for:

- Fever
- Low body temperature
- Bulging fontanelle
- Grunting, chest in drawing, and a breathing rate of more than 60 breaths/minute

Patients with less severe injuries—for example, superficial wounds—can usually be treated on site. Clean and treat any wounds as necessary.

The following medications may be indicated:

- Antibiotics to prevent wound infection
- A tetanus booster or vaccination or serum
- Paracetamol or other simple painkillers

Special protocols for children should be followed for all vaccinations and drug regimes.

3.3.2. BOYS AND GIRLS OF ALL AGES SUBJECTED TO SEXUAL ABUSE

RELEVANT JOBS AIDS IN THIS SECTION:

- STI treatments (p. 91)

Regarding STIs, HIV, Hepatitis B, and tetanus, children have the same prevention and treatment needs as adults, but may require different doses.

Prevent sexually transmitted infections

- Children of any age who have been sexually assaulted should be given antibiotics to treat the following sexually transmitted infections (STIs):
 - Chlamydia
 - Gonorrhea
 - Trichomonas
 - Syphilis
- Offer the treatment on your first meeting with the child.
- There is no need to test the child for STIs before treating.
- Give the shortest courses available in the national protocol.

3.3.3. JOB AID: STI TREATMENTS (FILL IN)

STI	Medication	Dosage and schedule
Chlamydia		
Gonorrhoea		
Trichomonas		
Syphilis		
Other locally common STIs (fill in)		

Hepatitis B

The hepatitis B virus can be sexually transmitted. Therefore, children subjected to sexual violence should be offered immunization for hepatitis B. Offer treatment according to national immunization protocols.

- Ask the parent or caregiver if the child has received a vaccine against hepatitis B (if possible check the child's immunization card).
- If the child or the family is uncertain, test first if possible. If already immune no further vaccination is needed. If testing is not possible, then vaccinate.
- Use the type of vaccine, dosage and immunization schedule that is used in your area.
- Give the injection in the muscle of the outside of the upper arm (the deltoid muscle).

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PREVENT HIV

Post-exposure prophylaxis (PEP) to prevent HIV should be started as soon as possible up to 72 hours after possible exposure to HIV. If more than 72 hours have passed since the sexual assault, the medicine will no longer be effective.

Talk to the parents and/or the child to find out whether PEP is appropriate in their situation.

You should consider PEP if:

- The perpetrator is HIV-infected or of unknown HIV status
- The child's HIV status is unknown
- The child has been exposed to blood or semen
- The child has experienced oral, vaginal and/or anal penetration
- The child was unconscious and cannot remember what happened

If the child is known to be HIV-positive you do not need to give PEP.

The procedures for provision of PEP should be based on the national guidelines for HIV and AIDs. For small children the same medicine can be used but must be given according to weight.

If the child takes HIV PEP:

- **Start the regimen as soon as possible and no later than 72 hours after the assault.**
- Offer HIV testing at the initial consultation.
- If the test is negative, give PEP for 28 days
- Retest at 3 or 6 months.
- In case of a positive test result, refer the child for HIV treatment and care.

PEP adherence counselling

Adherence is a crucial element of delivering PEP. Discuss the following points with the child and his or her parents or caregivers before administering the drugs:

- It is important to take each dose. Taking it at the same time every day, such as at breakfast or dinner, helps as a reminder to take the pills.
- An alarm on a mobile phone can be a reminder to take the pills.
- If the child forgets to take the medicine on time, he or she should still take it, if it is less than 12 hours late.
- If it is more than 12 hours late, the child should wait and take the next dose at the regular time.
- The child should never take two doses at the same time.
- The child should come back to see you if side-effects do not go away in a few days, if the child is unable to take the medicine, or in case of any other problems.

Some things to know about PEP

- PEP can lower the child's chances of getting HIV, but it is not 100% effective.
- The child 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 or headaches (for most people these effects decrease after a few days).
- Nevirapine (NVP) should not be offered for PEP due to high toxicity risks in HIV-negative individuals.

3.3.4. PUBERTAL GIRLS SUBJECTED TO SEXUAL ABUSE

A girl who has started menstruating and who has been sexually assaulted may be worried that she could get pregnant. She should be offered emergency contraception (EC) in addition to the treatment above.

Considering her privacy, gently ask her if she has been using an effective contraceptive method such as pills, injectables, implants, or an IUD. If so, it is not likely she will get pregnant.

You should give EC to girls who have not been using effective birth control. In any case, she can take EC if she wishes.

- A baseline pregnancy test should be done first, although this should not delay the dose of EC.
- She should take the EC pills as soon as possible. EC is most effective when given within 72 hours (or 3 days) of assault, the earlier the better.
- EC pills may cause nausea and vomiting. If she vomits within 2 hours after taking EC pills, she should return for another dose as soon as possible.
- If she had other acts of unprotected sex since her last menstrual period, she may already be pregnant. In this case, EC pills will not work, but they will not harm the pregnancy.
- Another pregnancy test should be done 6 weeks after the incident at the follow-up visit, whether or not she took EC after the assault.
- Safe abortion should be offered where it is within the law. Pregnancy resulting from sexual assault may be safely terminated up to 22 weeks.

Some things to know about emergency contraception

- Use of emergency contraception is a personal choice that only the girl herself can make.
- Emergency contraception can help avoid pregnancy, but it is not 100% effective.
- Any woman or girl can take EC pills. There is no need to screen for health conditions or test for pregnancy. If she is already pregnant, EC pills will not harm the pregnancy.
- EC pills will not prevent pregnancy the next time she has sex.
- EC pills are not meant for regular use in place of a more effective, continuing contraceptive method.
- A girl can take EC pills, antibiotics for STIs and PEP for HIV prevention at the same time without harm. However, to reduce nausea, she should take EC and antibiotics at different times from each other. She should take the pills with food, also to avoid nausea.

Emergency copper IUD

- Should be inserted within 5 days after unprotected intercourse
- More effective than EC pills
- Should not be inserted in girls at risk for STIs

3.4. STEP 3. FOLLOW-UP AFTER INITIAL INCIDENT OF VIOLENCE

Follow-up visits should take place at 2 weeks, 1 month, 3 months and 6 months after the initial incident of violence.

3.4.1. JOB AID: FOLLOW UP VISIT CHECKLISTS

2-week follow-up visit		
Injury	<ul style="list-style-type: none"> • Check that any injuries are healing properly. Check if no new injuries occurred. • In cases of abuse by a family member, refer to DoSVY if new suspicious injuries are present. 	<input type="checkbox"/> <input type="checkbox"/>
STIs	<ul style="list-style-type: none"> • Check that the child has completed the course of any medications given for STIs. • Check adherence to PEP, if the child is taking it. • Discuss any test results. 	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Pregnancy	<ul style="list-style-type: none"> • For pubertal girls, test for pregnancy if she was at risk. If she is pregnant, tell her about the available options. If abortion is permitted and desired, refer her for safe abortion. 	<input type="checkbox"/>
Psychosocial support and mental health	<ul style="list-style-type: none"> • Continue first-line support and care. 	<input type="checkbox"/>

2-week follow-up visit

	<ul style="list-style-type: none"> • Assess the child's emotional state and mental status. If any problems, plan for psychosocial support and stress management. For more details, see Part 4, pages 104-124. 	<input type="checkbox"/>
Planning	<ul style="list-style-type: none"> • Remind the child and their caregiver to return in two weeks for the next tetanus toxoid and hepatitis B vaccinations (if applicable). • Remind the child and their caregiver, to return for HIV testing at 3 and 6 months, or else to follow up with the child's usual health-care provider (if applicable). • Ask the child to return for follow-up if emotional and physical symptoms of stress have emerged or become more severe, or if there is no improvement at all by one month after the event. • Make the next routine follow-up appointment for 2 weeks after your current appointment. 	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

1-month follow-up visit		
Injury	<ul style="list-style-type: none"> • Check that any injuries are healing properly. Check to see if new injuries occurred. • In cases of abuse by a family member, refer to DoSVY if new suspicious injuries are present. 	<input type="checkbox"/> <input type="checkbox"/>
Vaccinations	<ul style="list-style-type: none"> • Give 2nd tetanus toxoid vaccination (if needed). Explain that the next vaccination should be received in 6 months. • Give 2nd hepatitis B vaccination (if needed). Explain that the next vaccination should be received in 5 months. 	<input type="checkbox"/> <input type="checkbox"/>
STIs, HIV/ AIDS	<ul style="list-style-type: none"> • Confirm completion of 28-day adherence to PEP, if the child was taking it. Remind about next testing (3 months or 6 months) 	<input type="checkbox"/>
Psychosocial support and mental health	<ul style="list-style-type: none"> • Continue first-line support and care. • Assess the child's emotional state and mental status. Ask if the child is feeling better now. If there are new or continuing problems, plan for psychosocial support and stress management. For more details, see Part 4, pages 104-124. • For depression, or alcohol or substance use, or post-traumatic stress disorder, refer the child for specialized care to a specifically trained provider or agency in child and adolescent mental health. 	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Planning	<ul style="list-style-type: none"> • Make the next follow-up appointment in 2 months after your current appointment. 	<input type="checkbox"/>

3-month follow-up visit

Injury	<ul style="list-style-type: none"> • Check to see if new injuries occurred. In cases of abuse by a family member, refer to DoSVY if new suspicious injuries are present. 	<input type="checkbox"/>
STIs	<ul style="list-style-type: none"> • Offer HIV testing and counselling (if applicable). Make sure that pre- and post-test counselling are available and refer for HIV prevention, treatment and care. 	<input type="checkbox"/>
Psychosocial support and mental health	<ul style="list-style-type: none"> • Continue first-line support and care. • Assess the child's emotional state and mental status. Ask if the child is feeling better now. If there are new or continuing problems, plan for psychosocial support and stress management. For more details, see Part 4, pages 104-124. • For depression, or alcohol or substance use, or post-traumatic stress disorder, refer the child for specialized care to a specifically trained provider or agency in child and adolescent mental health. 	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Planning	<ul style="list-style-type: none"> • Remind child and caregiver of the 6-month hepatitis B vaccine and the 7-month tetanus and vaccine (if needed). • Make the next follow-up appointment for 3 months after your current appointment. 	<input type="checkbox"/> <input type="checkbox"/>

6-month follow-up visit

Injury	<ul style="list-style-type: none"> • Check to see if new injuries occurred. In cases of abuse by a family member, refer to DoSVY if new suspicious injuries are present. 	<input type="checkbox"/>
Vaccinations	<ul style="list-style-type: none"> • Give the final dose of hepatitis B vaccine (if applicable). 	<input type="checkbox"/>
STIs	<ul style="list-style-type: none"> • Offer HIV testing and counselling (if applicable). Make sure that pre- and post-test counselling are available and refer for HIV prevention, treatment and care. 	<input type="checkbox"/>
Psychosocial support and mental health	<ul style="list-style-type: none"> • Continue first-line support and care. 	<input type="checkbox"/>
	<ul style="list-style-type: none"> • Assess the child's emotional state and mental status. Ask if the child is feeling better now. If there are new or continuing problems, plan for psychosocial support and stress management. For more details, see Part 4, pages 104-124. 	<input type="checkbox"/>
	<ul style="list-style-type: none"> • For depression, or alcohol or substance use, or post-traumatic stress disorder, refer the child for specialized care to a specifically trained provider or agency in child and adolescent mental health. 	<input type="checkbox"/>
Planning	<ul style="list-style-type: none"> • If applicable, make an appointment for the 3rd dose of tetanus toxoid (6 months after 2nd dose). Remind the caregiver that the 4th dose should be given in one year after the 3rd dose. 	<input type="checkbox"/>

7-month follow-up visit

Injury	<ul style="list-style-type: none"> • Check to see if new injuries occurred. In cases of abuse by a family member, refer to DoSVY if new suspicious injuries are present. 	<input type="checkbox"/>
Vaccinations	<ul style="list-style-type: none"> • Give the 3rd dose of tetanus toxoid vaccine, if needed. 	<input type="checkbox"/>
Psychosocial support and mental health	<ul style="list-style-type: none"> • Continue first-line support and care. 	<input type="checkbox"/>
	<ul style="list-style-type: none"> • Assess the child's emotional state and mental status. Ask if the child is feeling better now. If there are new or continuing problems, plan for psychosocial support and stress management. For more details, see Part 4, pages 104-124. • For depression, or alcohol or substance use, or post-traumatic stress disorder, refer the child for specialized care to a specifically trained provider or agency in child and adolescent mental health. 	<input type="checkbox"/>
Planning	<ul style="list-style-type: none"> • Remind the caregiver that the child should return for the 4th dose in one year after the 3rd dose. Remind the caregiver also that there is a 5th and final dose that should be given one year after the 4th dose. 	<input type="checkbox"/>

3.4.2. JOB AID: TESTING SCHEDULE

Test for	Initial test	Retest
Pregnancy	Within 4 weeks from the last menstruation period	None
Syphilis	Within 4 weeks	Within 3 months
HIV	At first visit	Within 3 and 6 months
Hepatitis B (recommended)	At first visit	None
Chlamydia, gonorrhoea, trichomonas (recommended)	Within 2 weeks	None

PART 4: ADDITIONAL CARE FOR PSYCHOSOCIAL SUPPORT¹²

In this chapter you will learn how to provide basic psychosocial support to children who have experienced abuse and violence.

The following topics are covered:

- How to provide a basic psychosocial assessment, including:
 - How to determine the child's level of functioning in his or her daily routine How well the child's caregiver is able to respond to the child's psychosocial needs
 - How to learn from the caregiver what the child's progress has been.
 - The child's and the caregiver's strengths which will help them recover.
- How to provide basic psychosocial support including
 - Emotional support
 - Basic education about sexual abuse
 - Helping the child develop coping skills
 - Stress reduction exercises for both child and caregiver
 - Intervention for children with suicidal thoughts

¹² Much of the text and interventions in this chapter are taken directly from International Rescue Committee. (2012). *Caring for Child Survivors of Sexual Abuse. Guidelines for health and psychosocial service providers in humanitarian settings*. New York: International Rescue Committee

Violence against children – sexual, physical or emotional – can have a great impact on children’s emotional health, their ability to keep up with day-to-day tasks, and their overall sense of safety in the world. Children most often communicate their distress through changed behaviour. Children may behave in nervous or upset ways. Children may have bad dreams. Children may be anxious or worried. Children, especially boys, might exhibit behaviour problems, for example, fighting more often. Other children respond by becoming depressed. They may withdraw from friends and family. Older children or teens might try to hurt or even kill themselves.

Most children recover after experiencing abuse, but for some, the problems still continue throughout their life. This part provides some basic tools to help you support children overcome these difficulties and aid them in their recovery.

Some children experience more severe mental health problems as a result of the abuse. This part does not provide instruction for how to deliver mental health services for survivors of child abuse. However, the psychosocial support tools described can be used as a starting point to help children recover and contribute to their own healing in low-resources settings¹³.

In cases of children who suffer from severe mental health problems you can refer the child to a specialized agency. Refer to the Support Section from the LIVES (page 30-62) and the job aid “Pathway of care for children subjected to violence” on page 62 for more information.

¹³ *The psychosocial interventions presented in this chapter do not constitute a complete mental health intervention for children suffering from posttraumatic stress disorder, depression or other serious mental health diagnoses.*

4.1. BASIC PSYCHOSOCIAL ASSESSMENT

RELEVANT JOBS AIDS:

- Review the First Line Support (LIVES) (p. 30)
- Child functioning assessment (p. 107)

Below, a basic psychosocial assessment is introduced, along with instructions for providers who can use it in support of a more comprehensive and complete psychosocial assessment of child survivors.

The basic psychosocial assessment will help you better understand the child's situation in regard to:

1. The child's day-to-day well-being and functioning
2. Caregivers' feelings and beliefs toward the child and the abuse
3. Building on child and caregiver strengths to support the healing process

As a general rule psychosocial assessments can be conducted with children ages eight and above. Information should be gathered from the non-offending parents or caregivers and/or other trusted sources close to the child. In order to talk with other people in the child's life, you must first discuss with—and gain permission from—the child.

Parents or caregivers should be involved from the very start unless:

- The parent or caregiver is the suspected or actual perpetrator.
- The child does not want the parent or caregiver to be included in the assessment.
- You feel that the child cannot or will not speak freely.

4.1.1. CHILD FUNCTIONING

The main goal of this part of the assessment is to determine the child's current level of functioning.

Before you start, explain to the child and caregiver the purpose of asking the questions. For example, "The experience of _____ can be very scary for children. This can cause children to act differently and feel differently from before the _____ happened. I would like to ask you some questions about your (or your child's) day-to-day activities so I can help you recover from the event. Is that okay?"

Go through the following key areas:

- Have you stopped attending school?
- Have you stopped leaving the house?
- Have you stopped playing with friends?
- Do you feel sad most of the time?
- Have you exhibited changes in sleeping or eating habits?

Assessing these areas will help you understand to what extent the abuse is currently affecting the child. If the answer to any of these questions is yes, the child might be suffering from psychosocial after effects of the violence.

4.1.2. CHILD FUNCTIONING ASSESSMENT

DIRECTIONS: Ask the child the following questions in a private and confidential room. Say: I am going to read some sentences. Please tell me how TRUE these sentences are about you. Think about how true these things are since _____ [describe the abusive event e.g., you were raped].

There can only be the ✓ mark in one column	YES	NO	COMMENTS
1. I don't see my friends as much as I used to.			
2. I have stopped my daily activity (e.g. school).			
3. I am having fights with people more than I used to.			
4. I am having a hard time going to sleep or staying asleep.			
5. I am having body aches, stomach ache, headache or other aches.			
6. I worry that something bad is going to happen.			
7. I am feeling sad and hopeless.			

4.1.3. CAREGIVERS' FEELINGS AND BELIEFS

- Understanding the perspectives of parents and caregivers helps you get insight into the support (or lack of support) they provide to their child.
- It is possible that parents and caregives blame or say negative things during this part of the assessment. You should therefore assess them in a private and safe space (and not in front of the child or in a place where the child may overhear your conversation).
- Allow parents and caregivers to share their views, opinions and/or questions freely.

The key questions are:

What is your understanding of the abuse/what happened?	<p>Helps you understand how much the parent or caregiver knows and understands about what happened.</p> <p>Watch out for statements of blame directed to the child.</p>
What are your feelings about the abuse/situation?	<p>Helps you to assess the parents' or caregivers' own level of emotional distress and their feelings toward their child.</p> <p>Ask whether their feelings have changed toward their child since the abuse.</p>
What changes have you noticed in your child since the abuse?	<p>Provides you with more information about the child's current level of functioning as well as the parents' or caregivers' perspectives on their child.</p>
What do you think will help your child right now?	<p>Helps you identify what parents and caregivers feel is useful and important to help their children heal and recover.</p> <p>Supportive caregivers know their children well and their ideas about how to support their child's healing should be taken seriously.</p>
What are your main worries and needs right now?	<p>Provides an opportunity for parents and caregivers to share their personal worries and fears.</p> <p>It may alert you to additional needs and worries that could impact the child.</p>

4.1.4.CHILD AND CAREGIVER STRENGTHS

Children and families are resilient. Resilience results from individual characteristics, coping mechanisms and the protective factors in a child’s environment (such as positive attitudes and involvement on the part of parents or caregivers).

The majority of children subjected to violence will cope and recover with good care and support. Their own strengths support their natural capacity to heal from difficult experiences. These strengths include their courage in facing their fears, their positive personality characteristics that they identify (such as politeness, intelligence, kindness, etc.), and their experiences of feeling pride or accomplishment in themselves (help with siblings, go to school, etc.).

It is important that you help the child identify these strengths. To do so, you might introduce the conversation in this way: “I’m going to ask you some questions that are going to help you identify your own strengths that will help you continue to heal. When you feel anxious or upset, you can remember some of what we talked about here today to help you feel better.” Some questions to guide this part of the assessment:

Before the _____ (incident), what did you do when you were scared?	Helps children think about people, places or actions they can call upon in times of danger.
Who are some people you feel safe with?	Helps children identify supportive people, such as family members, teachers, friends and neighbours. People who can be part of their recovery and healing.
What do you do to make yourself feel safe?	Helps children identify ways they themselves contribute to their own safety.

What are your interests?

Helps children identify activities they enjoy and feel good engaging in.

Building on children's interests helps to reengage them in activities that bring happiness and joy to their daily lives, thus facilitating the healing process.

Caregiver strengths include, but are not limited to, the following:

- Supporting their child
- Advocating for their child's care
- Protecting their child and reaching out to support services
- Handling family problems
- Encouraging their child's hopes and dreams
- Strong social ties and community support

4.2. BASIC PSYCHOSOCIAL SUPPORT

RELEVANT JOBS AIDS IN THIS SECTION:

- About child sexual abuse (p. 113)
- Body safety and safety planning (p. 117)
- Body relaxation for young children (p. 119)
- Belly breathing (p. 120)
- Body relaxation (p. 121)

In many settings, more advanced psychosocial and mental health services will not be available to address the specific emotional and psychological distress that may children and families experience following the disclosure of abuse. Despite this, there are common and effective interventions that can help children with the difficulties discovered during the assessment process.

Psychosocial support for the child and his or her non-offending parents or caregivers may be sufficient for the first 1-3 months. Continue to monitor the child for more severe mental health problems.

- Continue to offer first-line support at each follow-up meeting (p. 30-62)
- Provide emotional support (p. 112)
- Provide basic education about sexual abuse (if applicable) (p.113).
- Help the child with coping skills (p. 116)
- Teach stress reduction exercises to the child and caregiver (p. 118)
- Crisis intervention for children with suicidal thoughts (p. 124)
- Make regular follow-up appointments for further support.

4.2.1. PROVIDE EMOTIONAL SUPPORT

- Provide non-judgemental and child-friendly counselling
- Means talking to the child at his or her own pace and level

Requires your continued reinforcement that:

- The abuse is not the child's fault;
- That the child is strong and can heal;
- That the child did the right thing by speaking up;
- That there are people to support and believe them.

4.2.2. PROVIDE BASIC EDUCATION ABOUT SEXUAL ABUSE

This helps children and their caregivers understand and manage their emotions, and provides them with specific information about the impact of abuse.

How much time you will have to work with a child and caregiver will depend upon your relationship with the child and caregiver, their willingness and ability to engage and the context of the situation. If you can plan only one session, then try to cover as much information as possible. Sessions should take place in a private space and last no longer than one hour.

Key facts and information to cover, using age-appropriate language:

- a. An explanation of what sexual abuse is
- b. Why it happens and who perpetrates it
- c. How children may feel after sexual abuse (common reactions)
- d. Children’s tendency not to speak about abuse (especially relevant for discussions with parents and caregivers)

4.2.3. JOB AID: ABOUT CHILD SEXUAL ABUSE

What is sexual abuse?	<ul style="list-style-type: none">• Child sexual abuse is when an adult or someone touches, kisses or rubs a child’s private parts or makes the child engage in a sexual activity or watch something sexual in front of the child. Sometimes the older person asks the child to touch or look at his or her private parts. Sexual abuse is also when someone talks to a child or writes about a child in a sexual way or makes a child watch or be in sex photos or videos.
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	<ul style="list-style-type: none"> • Sexual abuse is always wrong, and it is always the fault of the perpetrator. • Note: information should be adapted to the specific local context.
Why it happens and who perpetrates it	<ul style="list-style-type: none"> • Sexual abuse happens to many children. It happens to boys and girls of all ages. It doesn't matter if you are rich or poor—sexual abuse happens to many children around the world. • The important thing to remember is that being sexually abused is not the victim's fault; it is not about what you look like or something that you did or did not do. • The perpetrator can be a female or male you know, like a relative or close family friend. Or, the perpetrator could be a complete stranger. • Most of the time, children are sexually abused by someone they know and trust.
How children may feel	<ul style="list-style-type: none"> • Children have many different feelings when they are sexually abused. These feelings can be difficult to understand. It's okay for children to have many different feelings about the abuse. • Some children feel really mad at the perpetrator or afraid of him or her. Some children feel sad and do not want to talk to anyone, even their friends and family. Some children feel guilty or responsible about what happened.

	<ul style="list-style-type: none"> • Children who feel scared might not like to be alone or sleep alone. Children who feel angry might get into fights. Children who feel sad or hopeless might just want to cry all the time or may lose interest in things that had previously made them happy. • All these feelings are normal and common. • What really helps is to talk about all of these feelings.
Reasons children don't talk about the abuse	<ul style="list-style-type: none"> • There are different reasons why some children do not tell anyone when they have been abused. • The perpetrator may have told the child that the abuse is 'a secret', and that they shouldn't tell anyone. • The perpetrator may have threatened the child and said things like 'if you tell anyone, I will hurt you, or I will hurt your family'. • The perpetrator may have told the child that there is no use telling anyone because no-one would believe them if they told. • Children might not tell because they feel ashamed, guilty, responsible, embarrassed or afraid of getting into trouble. • It is important to understand that what happened to the child is not the child's fault. The child needs support and acceptance from his or her parents or caregivers. • Caregivers may have many feelings about the child being sexually abused. They should be encouraged to talk about their feelings and how they can be supported as well.

4.2.4. HELP THE CHILD WITH COPING SKILLS

Coping skills help children learn how to help themselves. Strengthening the child's coping skills involves helping the child recognize both positive and negative feelings, and supporting the child in his or her capacity to cope with difficult emotions.

Children may have negative feelings after the abuse. As a result they may find it difficult to return to their normal routines. Yet, one of the best ways for children to heal from abuse is to resume their daily activities, such as attending school or playing with their friends.

Encourage the child to take small, simple steps. Talk to the child about his or her life, interests and activities. Develop a plan together. **Let the child know that they are strong, and that it's possible for them to heal, recover and live happy and healthy lives.**

Build on the child's strengths identified as part of the psychosocial assessment:

- Be sure children know how to locate the people they feel safe with and supported by, and help them develop a safety plan (p. 117).
- Help the child identify positive feelings (happy, relaxed, etc.) associated with the interests and activities they described. Remember that building on children's interests helps to reengage them in activities that bring happiness and joy to their daily lives, thus facilitating the healing process.
- Develop a plan with the child to engage the others, activities, interests and other strengths they have identified, to help them when they need support. You can follow up with the child and caregivers at their next meeting to find out if they have tried the plan and whether or not it is helping the child to feel better.

- Practice relaxation techniques if the child is experiencing anxiety (see page 118-123).

4.2.5. JOB AID: BODY SAFETY AND SAFETY PLANNING

Children need the communication skills and confidence to respond to potentially abusive traumatic experiences.

BE ATTENTIVE AND KNOWLEDGEABLE

- Teach the child about possible dangers in their environment. Help the child pay attention to their intuition.
- Help the child recognize danger signs that indicate increased risk. Practice with the child how they might respond to dangers.

BE CAUTIOUS AND PREPARED

Talk with the child about what to do if/when he or she feels unsafe.

Discuss:

- Safe people – Help the child identify people he or she could tell when the child feels worried or unsafe.
- Safe places – Help the child identify places that make them feel safe.

Practice with the child proper responses to danger or potential violence. What would the child do? What would the child say? It is important to have children practice saying “No!” to an adult who is doing anything to make them feel uncomfortable.

BE ASSERTIVE

Start with a review of what is okay and NOT okay touching. Practice with the child what they would do if they experience “NOT okay” touching. It is helpful to explain to the child the following points:

- Nobody should touch your private parts in a sexual way; even if it is someone you know and love.
- If you feel strange or uncomfortable about the way someone is touching you, you should tell that person, “NO!”
- Introduce ways the child can use in response to inappropriate touching or behaviours (run, hide, ask for help, call out, or scream). Make sure to help the child identify a trusted adult whom he/she can turn to if anyone threatens them again.

Be wary of using language and gesture if abuse happens again it is not the child's fault. Children who have been taught how to better protect their bodies may still experience abuse. This is NOT BECAUSE of something the child did or did not do. Sexual abuse is always the fault of the perpetrator

4.2.6. TEACH STRESS REDUCTION EXERCISES

Research suggests that children tend to express stress in physical ways. By learning relaxation techniques, children gain tools to help reduce their physical symptoms. Some examples of stress reduction activities are provided in the Job Aids.

Because all children are different, these techniques may not work for everyone. In case these techniques do not work well, think about other local activities to help children relax. For example, saying a prayer; watching a candle flicker; dancing and singing; and/or any other techniques that may help the child relax his/her body and mind.

The examples of relaxation techniques are:

- **Body relaxation for young children** – the goal is to help young children find a simple and engaging way to relax their bodies through tensing and relaxing their muscles.
- **Belly breathing** – the goal is to have children focus on their breathing so that they breathe deeply and slowly. Breathing in this way helps to relax their physical body.
- **Body relaxation** – to help children relax their bodies and decrease muscle tensions. The exercise is helpful for children who have trouble falling asleep or who have physical symptoms of anxiety.

4.2.7. JOB AID: BODY RELAXATION FOR YOUNG CHILDREN

This exercise is useful for young children who may not be able to focus on the relaxation techniques that are more helpful for older children.

In this exercise, ask the child “Have you ever seen rice before it is cooked? What does it look like? It is very stiff. How about rice after it’s cooked, what is it like? It is soft and mushier.

Let’s pretend we are cooked and uncooked rice! First, we will pretend to be uncooked rice and be very tense and strong and stand up very straight. And then we will be cooked rice, loose and relaxed and soft.

Let’s try again (repeat here, having the child follow you): Let’s be uncooked rice... okay, now cooked rice... then uncooked rice... then, pause a few seconds and say cooked rice...”(you can repeat this several times).

Children can do this exercise at home either alone or with their parents who will also benefit from the exercise.

4.2.8. JOB AID: BELLY BREATHING

You can use the following sample script with children and their caregivers (if they are present). It should take about 10 minutes.

- *“Today we’re going to learn one way to help ourselves calm down and control our nervousness and upset feelings. I’m going to show you a breathing activity that can help you calm your mind and your body. When we get upset, we tend to breathe faster and not as deeply. This does not allow enough air into our lungs, which can make our body feel out of control. Doing this breathing exercise when you are upset will help you get more air into your lungs. Controlling your breathing will help your body and mind relax. It’s also something you can do anytime and anywhere.”*
- *“Get comfortable (either laying down or sitting comfortably in a chair), and close your eyes.”*
- *“Concentrate on breathing, inhaling and exhaling through the nose. Put one hand on your stomach and one hand on your chest. When inhaling, the hand on your stomach should move up, and when exhaling it should move down. The hand on your chest should stay still and not move the whole time. You can even put a small toy or object on your stomach. With each breath, the object should move up and down.”*
- Be sure to praise the child as he or she practices. Once the child has tried a few breaths, instruct the child to breathe more slowly on the exhalations than on the inhalations. It can help to count during breaths, by saying the following: *“First take slow deep breaths in through your nose. Count in 1...2...3 and watch your stomach, not your chest, rise. Then breathe out 1...2...3...4...5 and watch your stomach fall.”*

- Once the child is able to get into a breathing rhythm, have him/her choose a word to say silently while they exhale. Good examples are “calm” or “relax.” Instruct the child to try to think only about their breathing and this word. As other thoughts come into his/her head, the child should try to picture them floating away.
- Ask the child to practice controlled breathing every day, for 10 minutes. Doing this at night before bed is helpful. Parents and caregivers can also benefit from this exercise.

4.2.9. JOB AID: BODY RELAXATION

- Explain the child that sometimes we all feel a little scared or nervous. When we have these feelings, our bodies can get tense or tight. This is an uncomfortable feeling; sometimes it even hurts. The exercise is to help you get rid of these tense feelings. It helps you relax your body and makes you feel calmer.
- Ask the child to get in a comfortable position (sitting or lying down). Have the child close their eyes if they would like.
- Tell the child, “What we will do is tightening and then relaxing specific muscles in your body. After tightening, your muscle will feel more relaxed”.
- Start with the legs. Tell the child, “Tighten all the muscles of your legs. This may hurt a little. Feel how tight and tense the muscles of your legs are right now. Hold it for a few moments...now relax. Let all the tension go. Notice how relaxed your muscles feel right now.”
- Do the same for each of the following body parts. Each time, ask the child to breathe in deeply as they tighten the muscles, to count 1-2-3, and then to relax and breathe out slowly.

- Hold your belly tight...
- Make fists with your hands...
- Bend your arms at the elbows and hold your arms tight...
- Squeeze your shoulder blades together...
- Shrug your shoulders as high as you can...
- Tighten all the muscles in your face...
- Tell the child, "Try to think about all the muscles in your body...notice how relaxed they feel. Allow any last bits of tension to leave your body. Notice how calm you breathe, how relaxed your muscles are. Enjoy this relaxation for a few moments."

Ask children to practice this at home before they go to sleep. Parents or caregivers can be taught the body relaxation techniques to help their children at home. The same techniques will benefit parents and caregivers dealing with high levels of stress themselves.

The role of parents and caregivers in children's healing

Resilience, or the ability to maintain or recover one's well-being despite experiencing traumatic events, is developed when a child feels confident, safe, has a sense of control, and an understanding of his or her strengths and limitations. Parents and caregivers are in the position to help children develop these qualities. They play an essential role in the child's healing. In fact, healing is facilitated when a child is supported by friends and family in their home, school and community environment.

As a health provider you are in the position to support parents to help their children recover from abuse. Some tips to offer parents:

- You play an essential role in your child's healing. Most children

recover more easily when they have support from their parents, caregivers and families.

- Encourage your family to support your child. Ensure your family treats your child with compassion and makes him/her feel loved.
- If you notice that your child is behaving differently (for example, refusing to go to school or see friends), talk to your child, and if needed, reach out for help.
- Never blame your child for the abuse. Tell your child that abuse is always wrong, and always the fault of the perpetrator.
- Ensure your child feels happy and safe at home. Allow your child to come to terms with the experience in their own time and space.
- Make sure your child will not be harmed by the perpetrator or anyone else.
- Encourage your child to go back to school and resume daily activities.
- Do not gossip about the abuse with people such as your neighbours or friends. Do not discuss the abuse in front of your child.

When you meet with the child for follow-up appointments, ask the child how he or she is feeling, and ask the parent or caregiver how the child has responded to these steps.

If parents or caregivers appear to blame the child for the abuse, or if they take judgmental attitudes toward the child your role is to challenge such attitudes and practices. You are in the position to educate parents and caregivers and help them understand that dismissing a child's disclosure of abuse or blaming a child for such abuse, is very harmful.

Encourage the parent or caregiver to return if they need further support.

4.2.10. CRISIS INTERVENTION FOR CHILDREN WITH SUICIDAL THOUGHTS

Young people, especially adolescents, may experience very serious reactions to experiences of abuse. It is your responsibility to watch for warning signs that a child is at risk of self-harm or suicide. Asking children about suicidal thoughts and/or plans can be hard, but is crucial for addressing a potential crisis situation. Crisis situations, such as a child feeling intense and urgent suicidal thoughts, are largely time-limited and context-specific. With the passage of time and the mobilization of the right resources and safety precautions, you can help the child return to pre-crisis levels of functioning.

Basic instructions for crisis response are outlined below. However, all hospitals and health centres should have specific suicide protocols and training for all staff working with children.

If the child is in imminent danger of suicide or self-harm refer him or her for immediate care.

Imminent risk of suicide and self-harm

If you are concerned that a child is feeling so badly they are thinking of ending their life, it is important to begin to assess the potential seriousness of such feelings and thoughts immediately. Your main task is to determine whether or not this is feeling only, or if the child has the real intention to take their life. Children need to feel that you understand them and their feelings, and that you are not there to judge.

Some health care workers fear that asking about suicide may provoke the patient to commit it. On the contrary, talking about suicide often reduces a person's anxiety around suicidal thoughts and helps him or her feel understood.

Explain to the child: “I’m going to ask you some questions that may be hard for you to answer, but I am worried about you, so I know that you are going to be ok with all these questions.” Some sample questions include:

- Do you think about dying? Or do you wish you were dead?
- Have you thought about hurting or killing yourself recently?
- Do you ever wish you could go to sleep and just not wake up? How often? Since when?
- In the past have you ever harmed yourself or tried to take your own life?

If the child has:

- current thoughts or plans to commit suicide or to harm him/herself,

OR

- a history of thoughts or plans for self-harm in the past month or acts of self-harm in the past year, and he or she is currently extremely agitated, violent, distressed or uncommunicative,

Then there is immediate risk of self-harm or suicide, and the child should not be left alone.

It is important to stay calm. Do not try to talk the child out of harming themselves, nor offer advice about what they should do. This feeling to die serves a purpose for the child—it’s a last attempt to feel that they are in control of something.

Tell the child: “I understand that you are feeling this way and I am sorry. I know that it was hard for you to share that information. You are very brave for telling me. It is important for me that you do not hurt yourself. I would like to get you further help from a specialist who knows exactly how to help you, so I am going to call someone to help you stay safe.”

Refer the child immediately to a specialist or emergency health facility.

SAMPLE CONSENT FORM

CONFIDENTIAL	CODE:
Name of Facility:	

I (name) _____, (relationship to the child) _____ authorize the above named health facility to perform the following levels of care for (child's name) _____:

	Yes	No
Conduct a medical examination, including a pelvic examination		
Collect evidence, such as body fluid samples, collection of clothing, hair combings, scrapings or cutting of fingernails, blood samples and photographs.		
Provide evidence and medical information to the police and the court concerning my child's case; this information will be limited to the results of this examination.		

Authorized Signature:

Date:

Witness Name:

Witness Signature:

Date:

SAMPLE ASSENT FORM

CONFIDENTIAL	CODE:
Name of Facility:	

I (name) _____, assent the above named health facility to perform the following levels of care for myself (child over 16) _____:

	Yes	No
Conduct a medical examination, including a pelvic examination		
Collect evidence, such as body fluid samples, collection of clothing, hair combings, scrapings or cutting of fingernails, blood samples and photographs.		
Provide evidence and medical information to the police and the court concerning my child's case; this information will be limited to the results of this examination.		

Authorized Signature:

Date:

Witness Name:

Witness Signature:

Date:

SAMPLE HISTORY AND EXAMINATION FORM

CONFIDENTIAL	CODE:
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Medical History and Examination Form

May I ask you some questions that we can decide how to help you? I know that some things may be difficult to talk about. Please try to answer. But you do not have to answer if it is too difficult.

1. GENERAL INFORMATION

Name of health facility:	
Date and time of examination: ____ / ____ / ____ ; ____ DD MM YY Time	Name of medical staff:
Child's family name:	Given name:
Date of birth: ____ / ____ / ____ ; ____ DD MM YY Time	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
Parent or legal guardian name:	Parent's or legal guardian's civil status: <input type="checkbox"/> Dependent child <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed

Address:	Phone number(s):
Other contact information:	
Also present for examination (if any):	
Names of witnesses to violence (if any):	Witness contact information (if known):

2. MEDICAL HISTORY

Existing health problems
Do you (the child) have any ongoing health problems? <input type="checkbox"/> Yes <input type="checkbox"/> No
If “yes”, What health problems? How long have you (the child) had the health problem?
Do you (the child) have any allergies? <input type="checkbox"/> Yes <input type="checkbox"/> No
If so, to what?
Are you (the child) taking any medicines, herbs or potions? <input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, what are you (the child) taking? When did you (the child) last take it?

Vaccination status

Have you (the child) ever been vaccinated for...

...tetanus? ☐ Yes When? ____ / ____ / ____

DD MM YY

☐ No

☐ Does not know

...hepatitis? ☐ Yes When? ____ / ____ / ____

DD MM YY

☐ No

☐ Does not know

HIV/AIDS status

Have you (the child) had an HIV test

☐ Yes When? ____ / ____ / ____

DD MM YY

☐ No

If "yes", may I ask the results

☐ Negative

☐ Positive

☐ Not disclosed

3. DESCRIPTION OF THE INCIDENT

Date (or dates) of incident(s):			___/___/___ DD MM YY	Time of incident(s):
<p>Could you tell me what happened, please? Record the child's (or the parent's or caregiver's) description of the incident, using quotes and as much detail as possible. Remember not to force the child to talk or pressure for details.</p>				
<p>Has something like this happened before? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>				
<p>If "yes": When was this? ___/___/___ DD MM YY</p>				
<p>Was the same person responsible? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>				
Physical violence	Yes	No	Not sure	Describe type and location on the body
Type (beating, biting, pulling hair, burning, broken bones, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Use of restraints	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Use of weapon(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Drugs/alcohol involved	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Neglect	Yes	No	Not sure	Describe
Type (withholding food, untreated medical problems, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Emotional violence	Yes	No	Not sure	Describe

Single instance of verbal abuse (or other)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Ongoing verbal abuse (or other)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Sexual assault (girls)				
Penetration Perpetrator assaulted the child with:	Yes	No	Not sure	Describe (vagina, anus, mouth) The child was assaulted on this part of her body
Penis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Hands	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Fingers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Tongue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other object (describe)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Ejaculation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Condom used	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Sexual assault (boys)				
Penetration Perpetrator assaulted the child with:	Yes	No	Not sure	Describe (anus, mouth) The child was assaulted on this part of his body
Penis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Hands	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Fingers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Tongue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other object (describe)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Ejaculation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Condom used	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Penetration	Yes	No	Not sure	Describe (vagina, anus, mouth, other)
The child was assaulted using this part of his body				Perpetrator forced the child's penis into this part of his/her body or object
Penis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Ejaculation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Condom used	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Actions taken (by the child) after the assault				
After this happened, did you (the child)...				
Vomit?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Urinate?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Defecate?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Brush your teeth?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Rinse your mouth?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Change your clothes?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Wash or bathe?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Use a tampon or pad (for girls)?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No

4. GYNAECOLOGICAL HISTORY

Contraception use

Only ask these questions to a pubertal girl who has been sexually abused

Are you using a contraceptive method?

- ☐ No
- ☐ IUD
- ☐ Pill
- ☐ Injectable
- ☐ Sterilization
- ☐ Condom
- ☐ Other (describe):

Were you using this method when the incident happened?

☐ Yes ☐ No

Menstruation and pregnancy Only ask these questions to a pubertal girl who has been sexually abused

When did your most recent menstrual bleeding start? ____ / ____ / ____
DD MM YY

Were you menstruating at time of event? ☐ Yes ☐ No

Do you think you could be pregnant? ☐ Yes ☐ No

If "yes", number of weeks pregnant: _____ weeks

Have you ever been pregnant? ☐ Yes ☐ No

If "yes", how many times: _____time

What was the outcome of your last pregnancy?

- ☐ Child birth
- ☐ Still birth
- ☐ Miscarriage
- ☐ Abortion
- ☐ Other (describe):

History of consenting intercourse (Only ask these questions if samples are taken for DNA analysis in sexual assault or abuse cases, and if consent for police and court referral was granted. The answers to these questions, along with the DNA sample found on the child's body will be used in court. THESE QUESTIONS ARE FOR BOYS AND GIRLS.)

When was the last time you had sex willingly?

____ / ____ / ____
DD MM YY

Who was it?

- ☐ Husband/Wife
- ☐ Boyfriend/Girlfriend
- ☐ Stranger
- ☐ Other: _____

5. HEAD-TO-TOE PHYSICAL EXAMINATION

Weight:	Height:	Pubertal stage <input type="checkbox"/> Pre-pubertal <input type="checkbox"/> Pubertal <input type="checkbox"/> Mature
Pulse rate:	Blood pressure:	Respiratory rate: Temperature:

Physical findings

Systematically describe the exact location of all wounds, bruises, petechiae (signs of bleeding under the skin), marks, etc. Document the type, size, colour, form and other details. Be objective. Do not interpret the findings. Record the description of your findings in the appropriate box below. If there is no injury to a particular part of the body, make note of that—do not leave a box blank. Lastly, draw on the attached body pictograms the location of any injury you find.

Head and face	Mouth and nose
Eyes and ears	Neck and throat
Chest	Back
Abdomen	Buttocks
Arms and hands	Legs and feet

6. GENITAL AND ANAL EXAMINATION

Physical findings

Systematically describe the exact location of all wounds, bruises, petechiae (signs of bleeding under the skin), marks, etc. Document the type, size, colour, form and other details. Be objective. Do not interpret the findings. Record the description of your findings in the appropriate box below. If there is no injury to a particular part of the genitals, make note of that—do not leave a box blank.

Vulva / Scrotum	Introitus and hymen	Anus
Vagina/Penis	Cervix	Bimanual/ Rectovaginal/ Speculum examination?

Evidence of female genital mutilation? ☐ Yes ☐ No

Position of patient (supine, prone, knee-chest, lying on their side, sitting on their caregiver's lap)

For genital examination	For anal examination	
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7. TREATMENT PRESCRIBED

Treatment	Yes	No	Type and comment
STI prevention/treatment	<input type="checkbox"/>	<input type="checkbox"/>	
Emergency contraception	<input type="checkbox"/>	<input type="checkbox"/>	
Wound treatment	<input type="checkbox"/>	<input type="checkbox"/>	
Tetanus prophylaxis	<input type="checkbox"/>	<input type="checkbox"/>	
Hepatitis B vaccination	<input type="checkbox"/>	<input type="checkbox"/>	
Post-exposure prophylaxis for HIV	<input type="checkbox"/>	<input type="checkbox"/>	
Other	<input type="checkbox"/>	<input type="checkbox"/>	

8. INVESTIGATIONS DONE

Can include: urine pregnancy test, microscopy, vaginal swab or anal swab for semen, blood, or other.

Type of test and location on the body (if relevant)	Examined / Sent to laboratory	Name of the laboratory (if relevant)	Result <i>Attached lab results if relevant</i>
	<input type="checkbox"/> Examined <input type="checkbox"/> Sent to lab		
	<input type="checkbox"/> Examined <input type="checkbox"/> Sent to lab		
	<input type="checkbox"/> Examined <input type="checkbox"/> Sent to lab		

9. EVIDENCE TAKEN

Package each sample in its own container. Never store samples in plastic, because plastic bags will degrade the samples. Only store samples in clean, unused paper bags.

Type and location (on body)	Date collected	Stored on site (yes/no and where)	Sent to (yes/no and to where)
	___ / ___ / ___ DD MM YY		
	___ / ___ / ___ DD MM YY		
	___ / ___ / ___ DD MM YY		

10. REFERRALS AND FOLLOW-UP

Has the child or child's caregiver reported the incident to the police?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If no, does the child or child's caregiver have plans to report the incident to the police?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Is the child safe from further abuse?

☐ Yes

☐ No

The following safety risks have been identified:

☐ The child's caregivers cannot or will not protect the child from further abuse.

☐ The perpetrator lives with the child or can easily access the child at home.

☐ The child is fearful of family members and does not want to return home.

☐ Other reason (please identify):

Does the child have a safe place to go?

☐ Yes ☐ No

Is the child accompanied by someone?

☐ Yes ☐ No

What counselling was provided:

Were further referrals made (for example, for further health care, protective services, psychosocial support, etc.)?

☐ Yes ☐ No

If "yes", what referrals were made?

Name of the agency or organization	Purpose of the referral (for example, crisis services, psychosocial support and counselling, aftercare and rehabilitation, and reintegration)
Follow-up agreed with child and caregiver?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Date of next visit:	<div>___ / ___ / ___</div> <div>DD MM YY</div>

Name and signature of health care provider conducting the examination and interview:

Name: _____

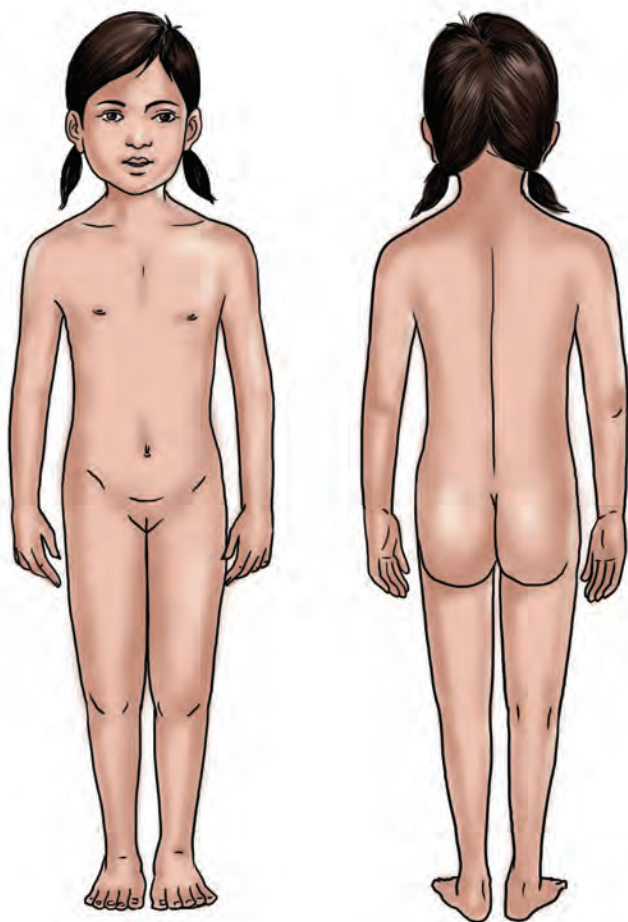
Title: _____

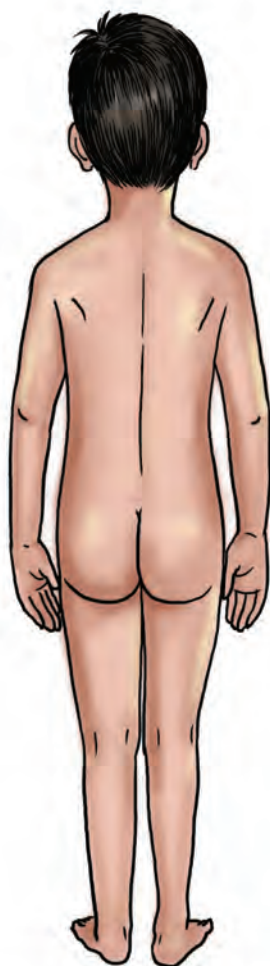
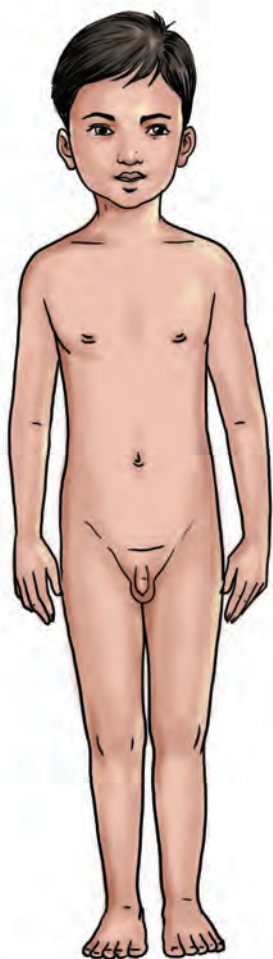
Signature: _____

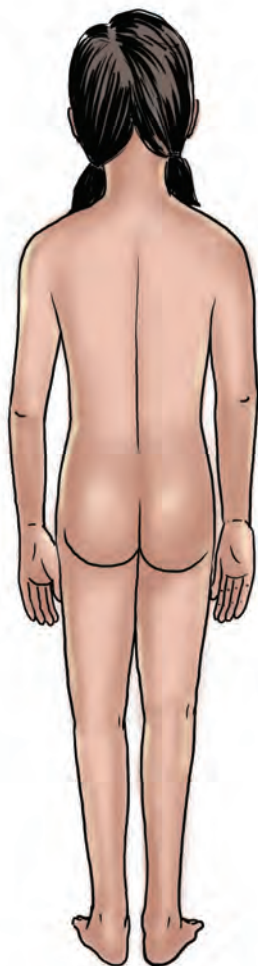
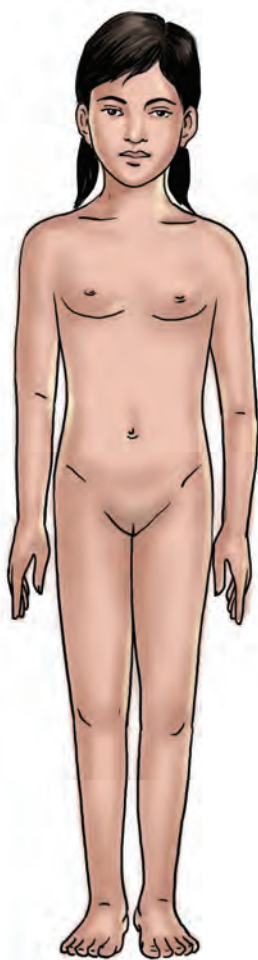
Date: ___ / ___ / ___

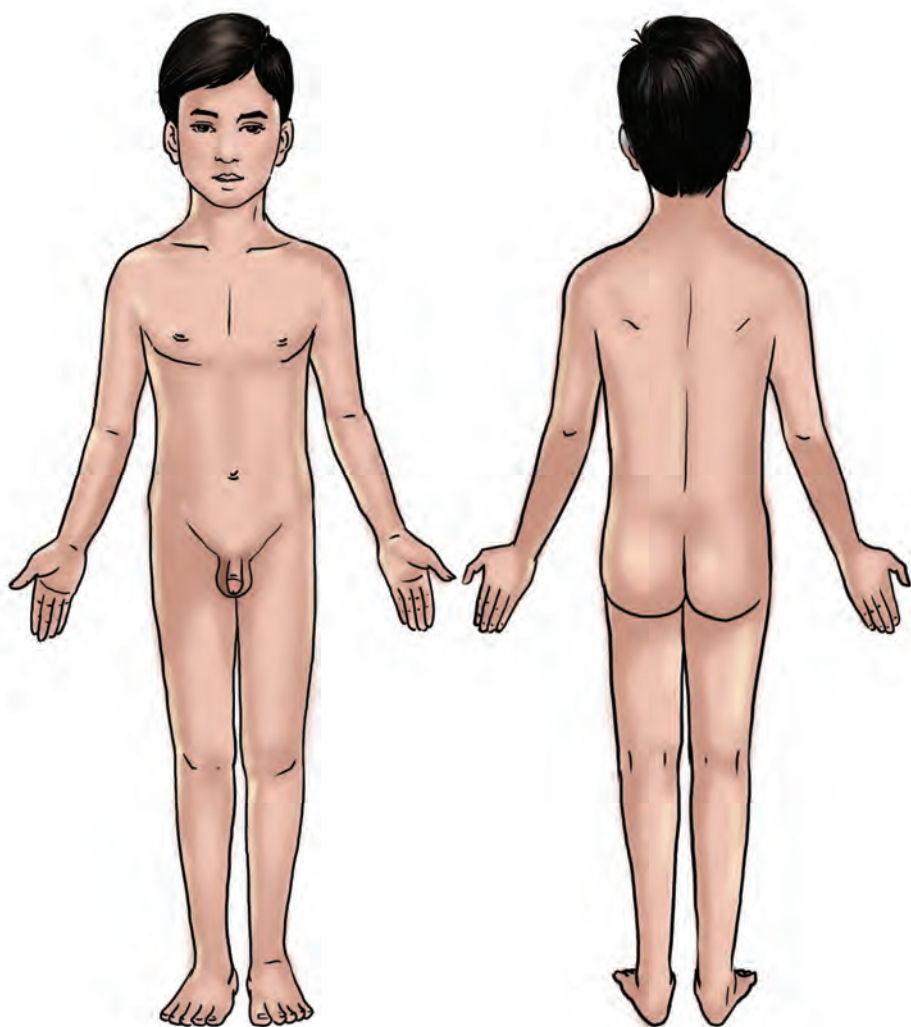
DD MM YY

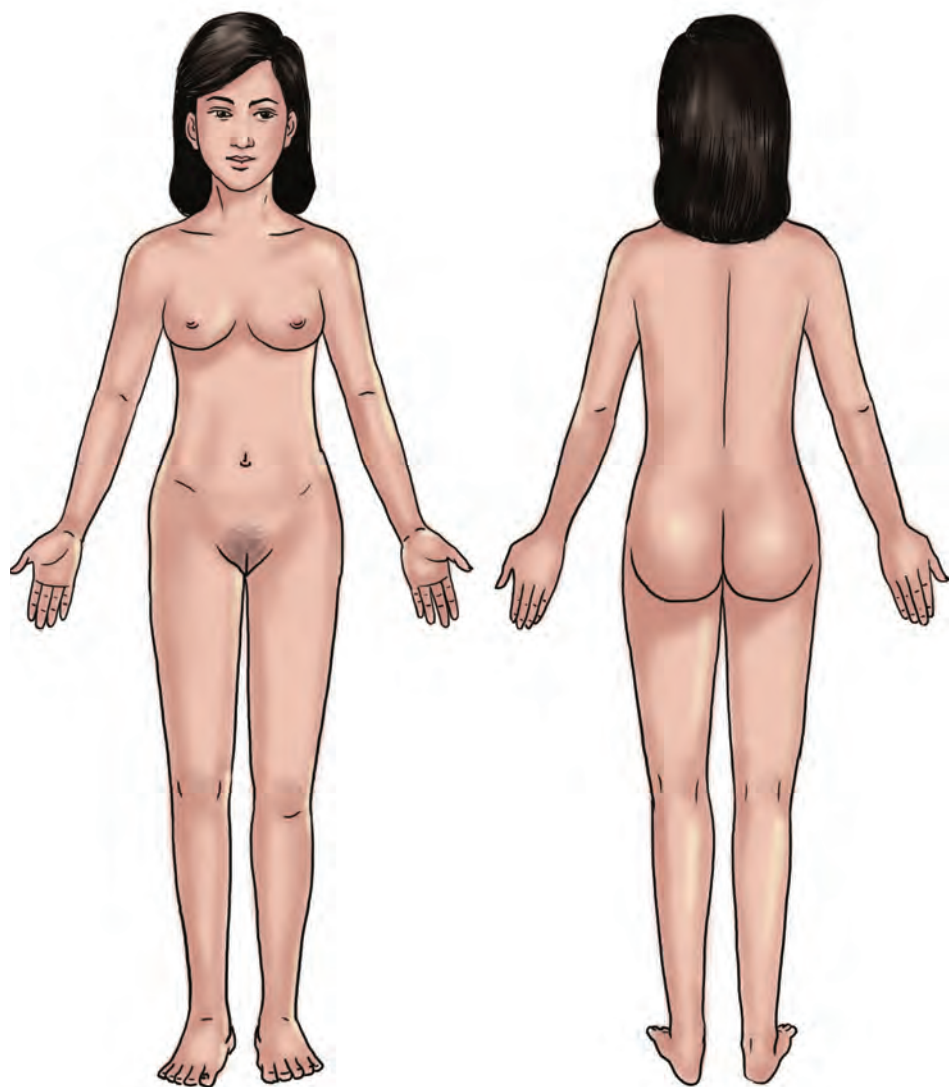
BODY PICTOGRAMS

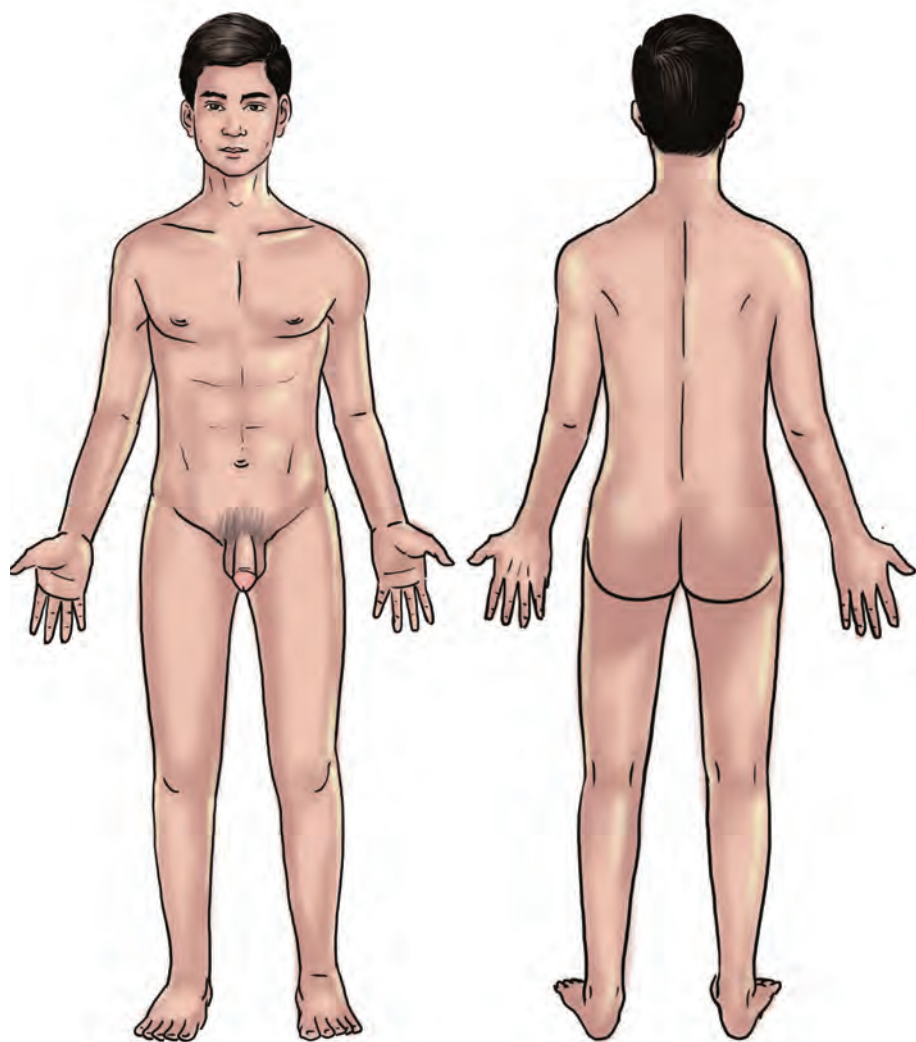


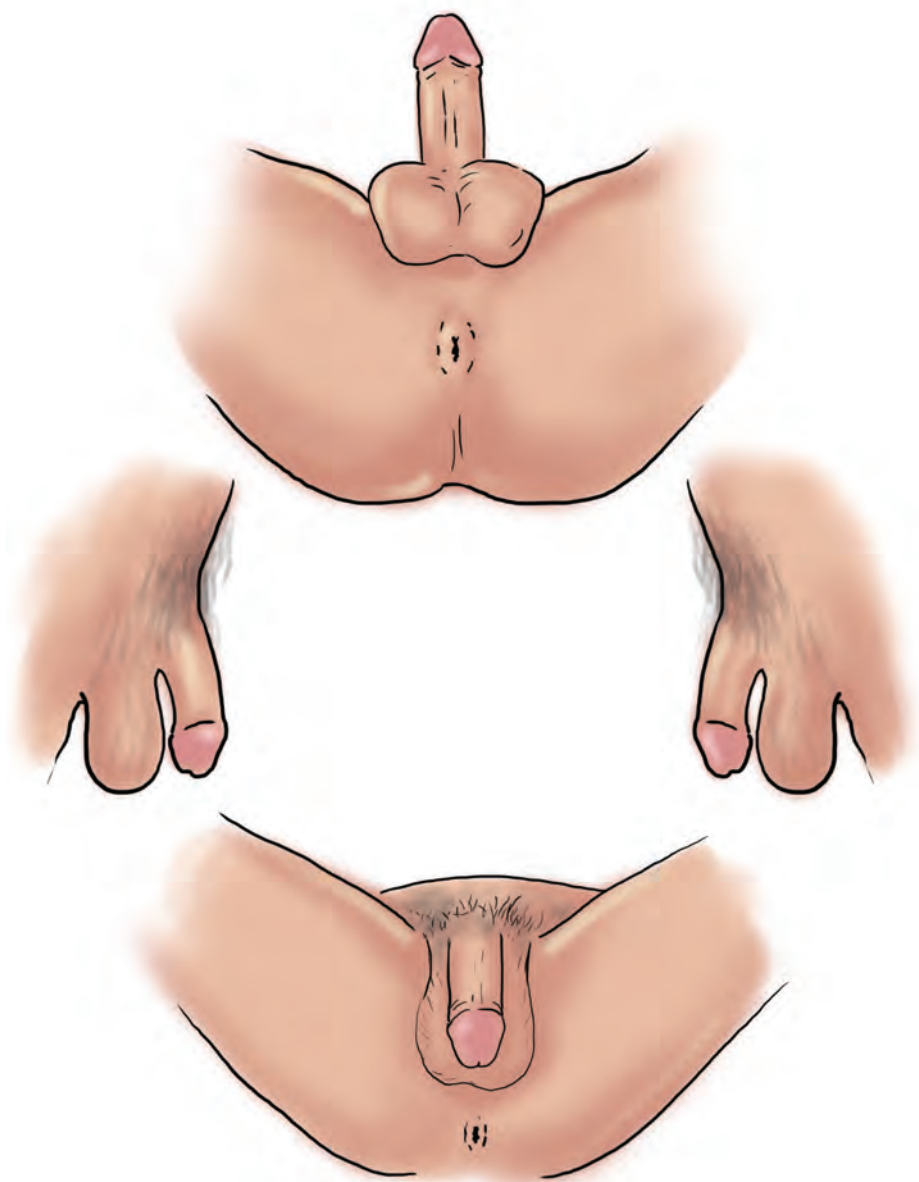


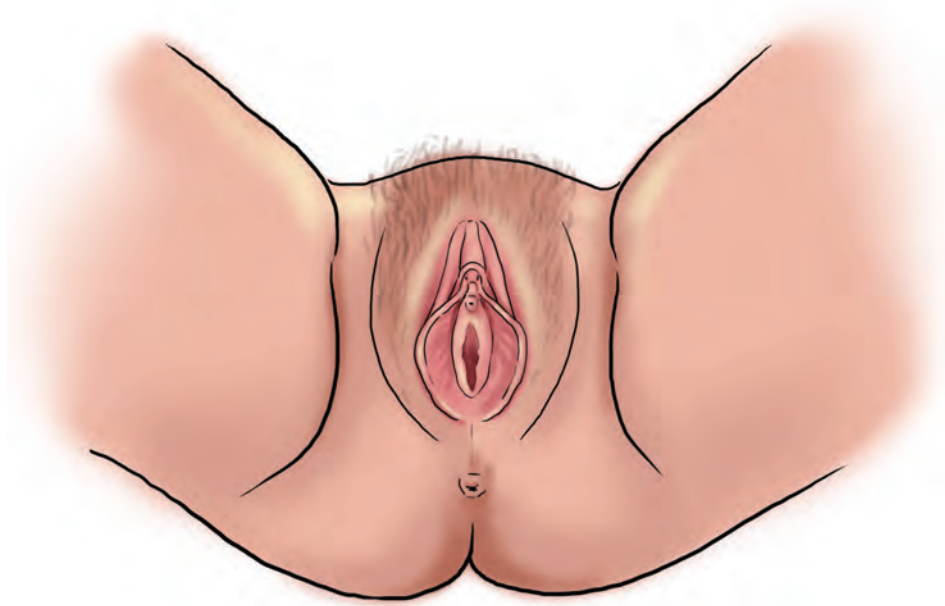












Listen	Listen to the child closely, with empathy, and without judging.
Inquire about needs and concerns	Address and respond to various needs and concerns—emotional, physical, social and practical needs.
Validate and believe	Reassure the child that you believe him or her and take their situation seriously. Assure the child that he or she is not to blame. Tell the child he or she is brave and doing the right thing by talking about the abuse.
Enhance safety and privacy	If there is an immediate risk of safety, ask the child what he or she needs to feel safe. Ensure confidentiality. Respect the child's wishes but only make promises you can keep (do not agree, for instance, to keep what the child said a secret as you might need to share some of the information they provide for you to keep them safe).
Support	Encourage the child to access support from safe people who might be helpful. Support the child by helping connect them to services and social support.

Asking about violence	Questions to assess immediate danger
<p>You might say:</p> <ul style="list-style-type: none"> • “You are very brave to tell me about this”. • “I believe you.” • “I’m sorry this happened to you”. • “You are not to blame; this was not your fault”. • “You’re not alone; this happens to other boys/girls too”. • “You are doing the right thing to talk about this”. 	<p>You might ask:</p> <ul style="list-style-type: none"> • “Does anyone at your home scare you?” • “Does the person who hurt you live in the house with you?” • “Do you ever feel scared outside of your home... if yes, where?” • “Will you continue to see the person who hurt you?” • “Did the person who hurt you threaten you in any way?”
<p>You might ask:</p> <ul style="list-style-type: none"> • “Sometimes an injury like yours is caused by beating with an object (or hitting, kicking, etc.). Did that happen to you?” • “Has anyone forced or pressured you to do things of a sexual nature that you didn’t want to do?” • “Can you tell me if you hurt anywhere?” 	<p>You need to assess:</p> <ul style="list-style-type: none"> • Indications of violence occurring within the family. • Access of the perpetrator to the child (perpetrator lives with the child or can easily access the child at home). • The caregiver’s or family’s capacity and/or willingness to protect the child from further violence and abuse. • The child’s and caregiver’s perceived sense of safety.

KEY RESOURCES

- Best Start/Meilleur Départ (nd). Building Resilience in Young Children: Booklet for parents of children aged birth to six years. Toronto: Health Nexus Santé.http://www.beststart.org/resources/hlthy_chld_dev/pdf/BSRC_Resilience_English_fnl.pdf
- Child Welfare Information Gateway (2012). Trauma-focused cognitive behavioral therapy for children affected by sexual abuse or trauma. <http://www.childwelfare.gov/pubs/trauma>
- Day, Kim and Jennifer Pierce-Weeks (2013). The Clinical Management of Children and Adolescents Who Have Experienced Sexual Violence: Technical Considerations for PEPFAR Programs. Arlington, VA: USAID's AIDS Support and Technical Assistance Resources, AIDSTAR-One, Task Order 1.
- Endom EE, Medez DR (2009). Abusive head injury. In: A Practical Guide to the Evaluation of Child Physical Abuse and Neglect. New York, NY: Springer Publishing.
- Finn, Robert (2010). Tips for Conducting a Sexual Abuse Exam. American College of Emergency Physicians News. <http://www.acep.org/Clinical---Practice-Management/Tips-for-Conducting-a-Child-Sexual-Abuse-Exam/>
- Grotberg, E (1997). A guide to promoting resilience in children: strengthening the human spirit. Bernard van Leer Foundation. The Hague, p.7. http://www.bernardvanleer.org/A_guide_to_promoting_resilience_in_children_Strengthening_the_human_spirit

- Hilton, Alistair (2008). "I thought it could never happen to boys" Sexual abuse & exploitation of boys in Cambodia: an exploratory study. Phnom Penh: Hagar.
- The Institute for Human Services for The Ohio Child Welfare Training Program (2007). Developmental Milestones Chart Developed http://www.rsd.k12.pa.us/Downloads/Development_Chart_for_Booklet.pdf
- International Rescue Committee. (2012). Caring for Child Survivors of Sexual Abuse. Guidelines for health and psychosocial service providers in humanitarian settings. New York: International Rescue Committee.
- Kennah, Erin and Jekyll, AM (nd). "Approaches to Non-Accidental Injuries." Department of Pediatrics, University of British Columbia. <http://learnpediatrics.com/body-systems/musculoskeletal-system/approach-to-non-accidental-injuries/>
- Loder RT, Bookout C. (1991). Fracture patterns in battered children. *Journal of Orthopedic Trauma*. 5:428.
- Mayo Clinic (nd). Child Abuse Symptoms. <http://www.mayoclinic.org/diseases-conditions/child-abuse/basics/symptoms/con-20033789>
- Ministry of Health (2014). National Guidelines for Managing Violence Against Women and Children in the Health System. Royal Kingdom of Cambodia.
- Ministry of Veterans, Social Affairs and Youth (2009). Operational guide and tools for implementing the Prakas on procedures to implement the policy on alternative care for children. Royal Kingdom of Cambodia.

- Ministry of Women's Affairs (2014). Findings from Cambodia's Violence Against Children Survey 2013. Royal Kingdom of Cambodia.
- National Collaborating Centre for Women's and Children's Health (UK). When To Suspect Child Maltreatment. London: RCOG Press; 2009 Jul. (NICE Clinical Guidelines, No. 89.) 4, Physical features. Available from: <http://www.ncbi.nlm.nih.gov/books/NBK57169/>
- National Institute of Child Health and Development. NICHD Protocol: International Evidence-Based Investigative Interviewing of Children. <http://nichdprotocol.com/the-nichd-protocol/>
- Rape, Abuse & Incest National Network (nd) "If you suspect a child is being harmed". <https://rainn.org/get-information/types-of-sexual-assault/child-sexual-abuse/if-you-suspect>
- Reimer, J.K. (2014). A system just for children: Voices of child victims and witnesses about their experiences in the Cambodian Criminal Justice System. Hagar: Phnom Penh, Cambodia
- Saade, DN, Simon, HK, Greenwald, M (2002) Abused children. Missed opportunities for recognition in the ED. Academy of Emergency Medicine. 9:524.
- World Health Organization (2003). Guidelines for medico-legal care for victims of sexual violence. Geneva: WHO.
- World Health Organization (2013). Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines. Geneva: WHO.



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