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**INTEGRATING VIOLENCE  
AGAINST CHILDREN PREVENTION  
AND RESPONSE INTO HIV SERVICES**

**PARTICIPANTS MANUAL**

# ACKNOWLEDGEMENTS

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## ACRONYMS

<b>HIV</b>	Human Immunodeficiency Virus
<b>VAC</b>	Violence Against Children
<b>UNCRC</b>	United Nation on the Rights of the Child
<b>IPV</b>	Intimate Partner Violence
<b>CPET</b>	Child Protection Enquiry Tool
<b>SOLER</b>	Sitting position, Open posture, Lean forward, Eye contact, Relaxed
<b>LIVES</b>	Listen, Inquire about needs and concerns, Validate, Enhance Safety and Support
<b>IEC</b>	Information, Education and Communication
<b>STS</b>	Secondary Traumatic Stress
<b>PTSD</b>	Post Traumatic Stress Disorder
<b>SV</b>	Sexual Violence
<b>SSA</b>	Sub-Saharan Africa
<b>WHO</b>	World Health Organization
<b>CRC</b>	Convention on the Rights of the Child
<b>HTS</b>	HIV Testing Services
<b>CFS</b>	Child Friendly Service
<b>SOP</b>	Standard Operating Procedure
<b>CBT</b>	Cognitive Behavior Therapy
<b>GBV</b>	Gender-based violence

## KEY DEFINITIONS

**Burnout:** This is as a prolonged response to chronic emotional and interpersonal stressors on the job which consists of three components: exhaustion, depersonalization (defined as: disengagement or detachment from the world around you) and diminished feelings of self-efficacy in the workplace. It reflects a form of “energy depletion”.

**Child Protection Enquiry Tool (CPET):** It is a tool that is designed to help the health care providers to look out for specific symptoms during a consultation where he/ she suspects that the child is at risk of or has experienced violence. It also provides a set of simple questions that the health care providers can ask the child and/ or caregivers to ascertain whether the child requires referral for more specific diagnostic test and services for violence.

**Child:** All human beings below the age of 18 years unless under the law applicable to the child, majority is attained earlier” (United Nations Convention on the Rights of the Child, 1989).

**Disclosure:** This refers to the discovery of child violence as narrated by the very survivor to either a healthcare provider or another individual.

**First line support:** This is defined as the minimum level of primary psychological support and validation of the respondent’s experience that should be received by all who disclose violence to a health-care (or other) provider.

**Informed assent:** This is used when a child is too young to give informed consent, but is old enough to understand and agree to participate in services. Assent in this case may be verbal. In such cases, the health worker should clearly record the verbal assent provided, stating how this was provided, in case notes and ensure that these are kept on file.

**Informed consent:** This is the voluntary agreement of an individual, adult or child, who has the capacity to give consent, and who exercises free and informed choice.

**Perpetrator:** A perpetrator is defined as a person who directly inflicts or supports violence or other abuse inflicted on another against his/her will. (IRC, 2012). These can include caregivers, peers, romantic partners or boyfriend or girlfriend, neighbors, strangers, authority figures such as teachers, police, employers, religious or community leaders, and health care workers. The violence can be perpetrated physically or online.

**Risk of violence:** These are factors that make one more vulnerable to or increases likelihood of experiencing abuse and/or perpetration.

**Secondary Trauma:** This describes the reactions to the emotional demands on health care providers from exposure to trauma survivors’ terrifying, horrifying, and shocking images; strong, chaotic affect; and intrusive traumatic memories.

**Survivor:** Any individual adult or child who has experienced violence. A child who has experienced violence is a child survivor. (Day & Kim, 2013).

**Violence against children:** All forms of physical or mental violence, injury and abuse, neglect or children negligent treatment, maltreatment or exploitation, including sexual abuse. (UNCRC, 1989). Violence can be perpetrated directly or indirectly through digital media, such as through taking of or exposure to images that are sexually or otherwise violent or through sexual harassment or bullying online.

**Violence:** An intentional use of force or power, threatened or actual, against one self, another person, or against a group or community that either results in or has a high likelihood of resulting in injury, death, psychological harm, mal-development, or deprivation (World Health Organization, 2002).



# INTRODUCTION

# INTRODUCTION TO PARTICIPANTS MANUAL

Children are exposed to violence in various settings and circumstances. An estimated one billion children globally are exposed to physical, sexual or emotional violence. There is a direct link between all forms of violence in childhood and increased risks of acquiring HIV in later life.

There is a growing recognition of the critical need to integrate violence prevention and response within all forms of child care, including the HIV continuum of care. However, health workers working within HIV settings report that they often find it challenging to respond to children who report experience of violence due to the following:

- There are few people in health and community settings with sufficient experience and tools in detecting and responding violence against children;
- Many health workers lack sufficient skill, knowledge and confidence to recognize the risk of and treat child survivors of violence – VAC is often not a core part of health worker training;
- Lack of systems for systematically recording VAC services in HIV clinic registers;
- Limited time that a health worker can spend with each individual patient.

This training course seeks to equip health workers who have contact with children in HIV settings with the knowledge and skills to better integrate VAC services into their work. It seeks to transmit information and skills to make them: feel comfortable talking with, providing services and making appropriate referrals to children and their caregivers who are at risk of or experiencing violence. The expected result is that there will be successful integration of VAC services into HIV settings.



This manual is for all participants in the 'Integrating VAC prevention and response into HIV settings' course.

This course is primarily aimed at different cadres of health workers who work in resource-constrained and high HIV prevalence settings, including: nurses and midwives; clinicians; HIV counsellors; medical social workers; pharmacists; community health workers, and others who are involved in children's health care in health settings.

This participant manual is part of the broader training package which also includes a facilitator manual and PowerPoints for the training.

A complementary training package has been adapted for use with non-health facility staff, such as social workers, auxiliary social workers and child protection workers, and others working primarily in the community



The Participant Manual is divided into two parts: the first part contains workshop information including the agenda and background information. The second part is divided into ten modules. Each module contains a brief introduction to the module and a series of handouts that accompany the training sessions. The handouts include useful background information, job aids and tools for future reference, and further reading suggestions.

The manual aims at equipping you with information and basic skills to help you to:

- Understand what is violence against children;
- Understand the guiding principles for supporting children at risk of or experiencing violence;
- Practice how to communicate to children and provide child friendly and sensitive services;
- Apply appropriate techniques to identify children at risk of or experiencing violence;
- Provide immediate first line response within existing health care settings to children identified as at risk or experiencing any form of violence and to provide the appropriate referrals;
- Understand the broader violence prevention and response context and where health workers fit into this
- Undertake effective referrals for children at risk of or experiencing violence including recording
- Understand the importance of looking after ourselves to avoid burn out.

**NOTE:**

This training course is about a topic that can raise strong feelings in people. Some of us may be survivors or know someone who is a survivor of violence.

None of the participants will be expected to share personal experiences.

At any time in the training course, or afterwards, you should feel free to talk in confidence to your facilitator, who will be able to provide or direct you to the appropriate support. Your facilitator will also share a list of support services at the start of the training.

All personal experiences raised during the workshop will be kept confidential.



# ABOUT THE WORKSHOP

The workshop agenda covers the core topics over ten modules and 18 hours (three days).

SESSION	CONTENT	SUGGESTED TIME
Pre-session: Workshop introduction	Introduction to agenda, expectations, pre-test	1 hour
Module 1: Introduction to Violence Against Children	Overview of VAC definitions, scope and scale, consequences	2 hours
Module 2: Guiding principles for health workers working with children at risk of or having experienced violence	Overview of guiding principles for child rights and application to VAC	1 hour 30 minutes
Module 3: Violence against children and HIV	Interlinkages between VAC and HIV, and importance of integration of VAC and HIV	1 hour 30 minutes
Module 4: Communication skills	Practical review of communication skills for children who have experienced VAC	2 hours
Module 5: Identification of VAC in HIV clinical settings	Basic skills for identifying potential VAC risk and immediate referral actions	1 hour 45 minutes
Module 6: First-line support for VAC	Principles of immediate, first-line VAC support in health settings	1 hour 30 minutes
Module 7: Responding to children who are at risk or have experienced VAC	Importance of a comprehensive approach and how to ensure that a child's comprehensive VAC needs are identified	2 hours
Module 8: Referral, linkage and follow-up support	Identification of referral options and practical action to identify and address challenges and develop referral list	2 hours
Module 9: Documentation and reporting	Review of use of documentation and referral tools in health facilities and for referrals	1 hour
Module 10: Support for VAC service providers	Development of options for self-support for health workers engaged with VAC	1 hour
Workshop closing session	Post-test and evaluation	1 hour



**MODULE 1:  
INTRODUCTION  
TO VIOLENCE  
AGAINST  
CHILDREN**

## INTRODUCTION

This module introduces the definition, types, causes, magnitude, and consequences of violence against children (VAC). It outlines the existing international legal frameworks and guidelines that regulate a VAC response.



At the end of this module, you should understand the following:

- The definition of violence against children;
- The different types of violence against children;
- The main causes of violence against children;
- The magnitude of violence against children;
- The main consequences of violence against children;
- The minimum package of a multisectoral response to children and adolescents at risk of or who have experienced violence;
- International legal frameworks and guidelines that regulate the violence against children response.



## HANDOUT 1

### CONCEPTS OF VIOLENCE AGAINST CHILDREN



#### Definitions:

**Violence:** An intentional use of force or power, threatened or actual, against one self, another person, or against a group or community that either results in or has a high likelihood of resulting in injury, death, psychological harm, mal-development, or deprivation (World Health Organization, 2002).

**Child:** All human beings below the age of 18 years unless under the law applicable to the child, majority is attained earlier” (United Nations Convention on the Rights of the Child, 1989).

**Violence against children:** All forms of physical or mental violence, injury and abuse, neglect or children negligent treatment, maltreatment or exploitation, including sexual abuse. (UNCRC, 1989). Violence can be perpetrated directly or indirectly through digital media, such as through taking of or exposure to images that are sexually or otherwise violent or through sexual harassment or bullying online.

**Survivor:** Any individual adult or child who has experienced violence. A child who has experienced violence is a child survivor (Day & Kim, 2013).

**Risk of violence:** These are factors that make one more vulnerable to or increases likelihood of experiencing abuse and/or perpetration.




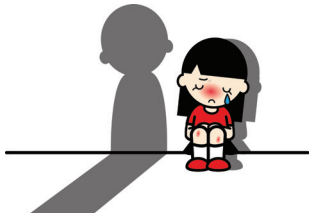

**Perpetrator:** A perpetrator is defined as a person who directly inflicts or supports violence or other abuse inflicted on another against his/her will. (IRC, 2012). These can include caregivers, peers, romantic partners or boyfriend or girlfriend, neighbors, strangers, authority figures such as teachers, police, employers, religious or community leaders, and health care workers. The violence can be perpetrated physically or online.

#### Types of violence against children

The World Health Organization notes defines the six types of child violence that tend to occur at different stages in a child’s development:

- Child maltreatment
- Bullying, including cyberbullying
- Youth violence
- Intimate partner violence (IPV)
- Sexual violence
- Emotional or psychological violence.

Table 1 Common Types of Violence against Children.

<b>TYPES OF VIOLENCE AGAINST CHILDREN</b>	
<p style="text-align: center; color: #8e44ad;"><b>CHILD MALTREATMENT</b></p> 	<p>Child Maltreatment (including violent punishment) involves: all forms of physical, sexual and emotional violence; and neglect; and exploitation resulting in harm of the child’s health, survival, development or dignity in the context of a relationship of responsibility, trust or power.</p>
<p style="text-align: center; color: #8e44ad;"><b>BULLYING</b></p> 	<p>Bullying (including cyber-bullying) is propagated online and includes sending, posting or sharing negative, harmful, false content leading to humiliation or embarrassment. It may involve repeated physical, psychological or social harm, and often takes place in schools and other settings where children gather.</p>
<p style="text-align: center; color: #8e44ad;"><b>INTIMATE PARTNER VIOLENCE</b></p> 	<p>Intimate partner violence (IPV): It is also commonly referred to as domestic violence and involves violence by a current or former spouse or partner in an intimate relationship against the other spouse or partner. IPV can take a number of forms, including physical, sexual, emotional and economic abuse.</p>
<p style="text-align: center; color: #8e44ad;"><b>SEXUAL VIOLENCE</b></p> 	<p>Sexual violence (SV): is defined as involvement of a child in sexual activity that he or she does not fully comprehend, is unable to give informed consent to, or for which the child is not developmentally prepared.</p>
<p style="text-align: center; color: #8e44ad;"><b>EMOTIONAL OR PSYCHOLOGICAL VIOLENCE</b></p> 	<p>Emotional or psychological violence and witnessing violence emotional and psychological abuse includes restricting a child’s movements, belittling, ridicule, threats and intimidation, discrimination, rejection and other non-physical forms of hostile treatment. Witnessing violence can involve forcing a child to observe an act of violence, or the incidental witnessing of violence between two or more other persons and this contributes to emotional or psychological abuse to the child.</p>

Source WHO. 2016. *INSPIRE: Seven strategies for ending violence against children.*

Children of all ages experience multiple forms of violence. See figure 1 below for the types of violence by age group

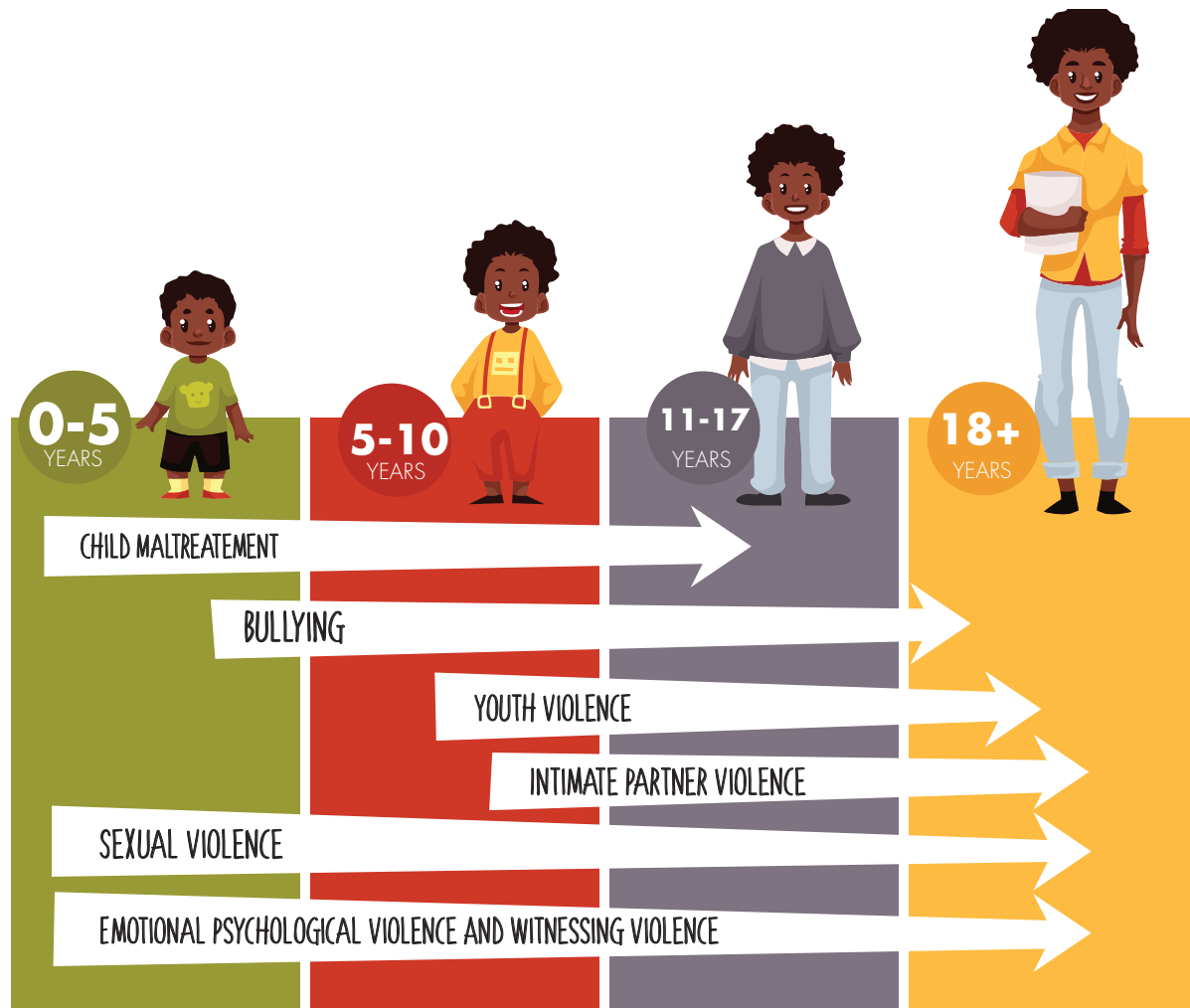


Figure 1: Type of Violence by age group of children affected.

Source; WHO. 2016. INSPIRE. Seven Strategies for Ending Violence against Children.

### Scale of Violence against Children

Violence against children is a major public health issue across the globe, including in Sub-Saharan Africa. An estimated nearly 1.6 billion children globally experience either physical, sexual or emotional violence annually. The World Health Organization has estimated that 150 million girls and 73 million boys under the age of 18 have experienced sexual violence involving physical contact.

The chart below shows the prevalence of VAC in sub-Saharan Africa, as recorded in Violence Against Children Surveys in six Sub-Saharan countries. At least two in five and up to more than three in five boys experience physical violence. Up to one-third of girls in many countries, and one-third of boys in almost as many countries experiencing sexual violence.

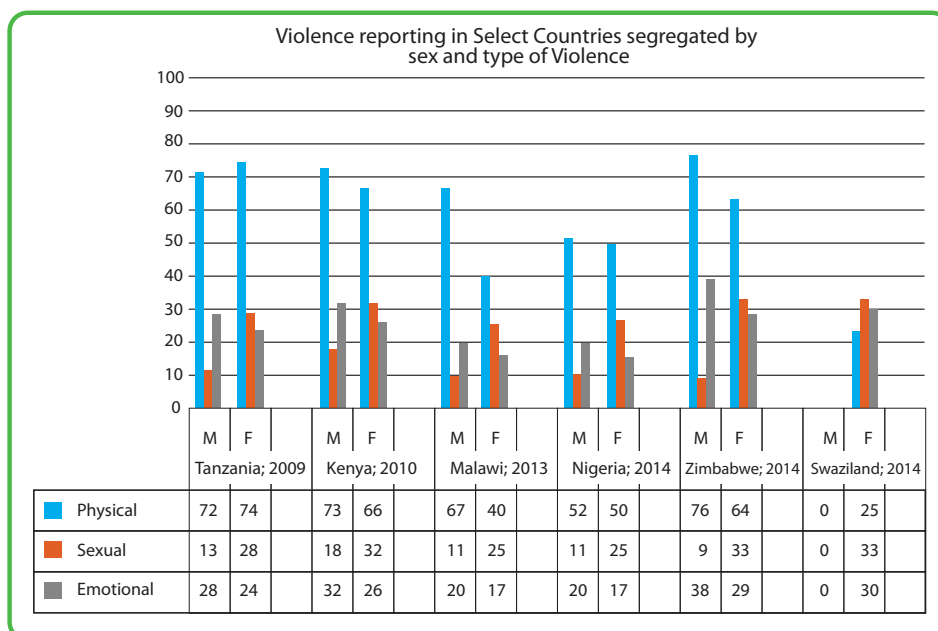


Chart 1: Prevalence of the different forms of Violence against children in different countries in SSA. Source Country specific VAC survey reports

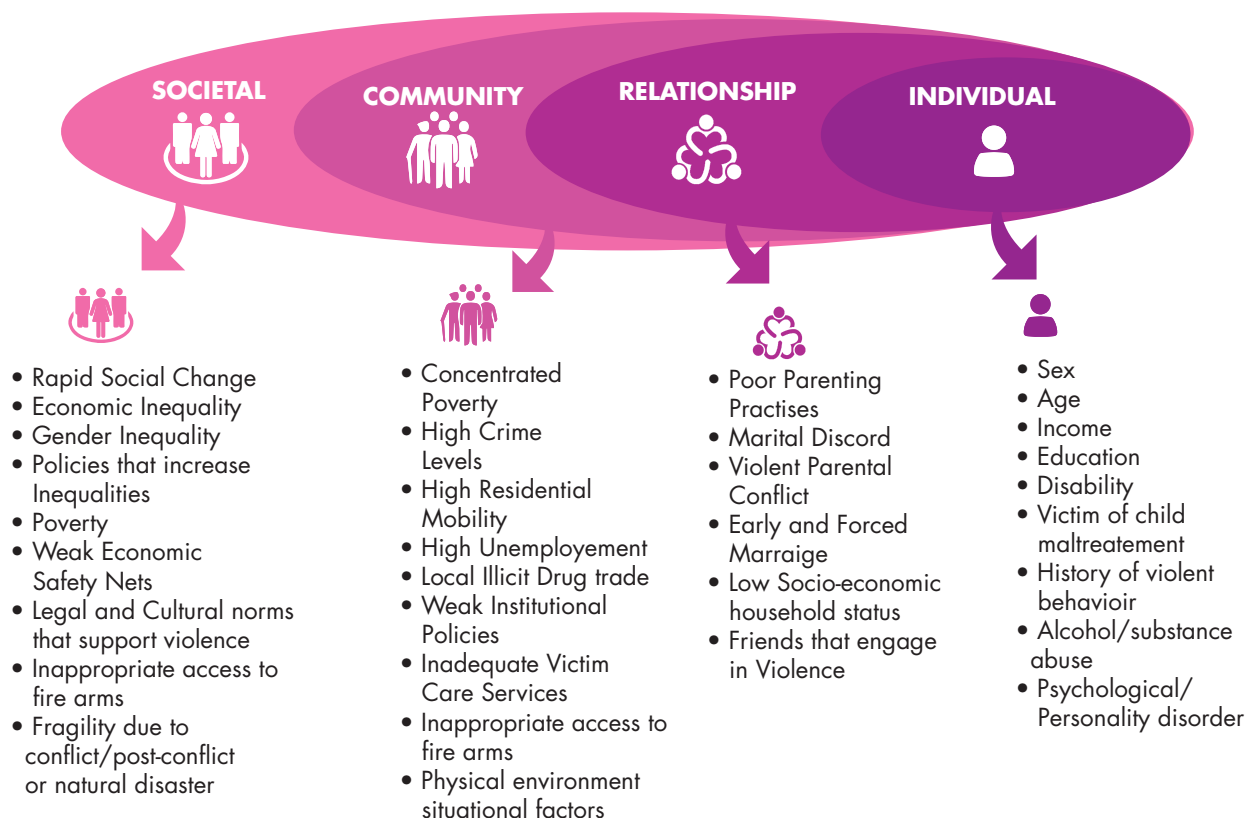


Figure 2: Social Ecological model for understanding and prevention of VAC

Source: WHO INSPIRE Seven Strategies for Ending Violence against Children, 2016.

### Consequences of Violence Against Children

Violence against children has been associated with immediate and long-term negative health outcomes. The consequences are costly to the child, his or her family and to the society for many years. They have a huge economic impact on child and society, as well as the direct psychosocial and physical impact on the child.

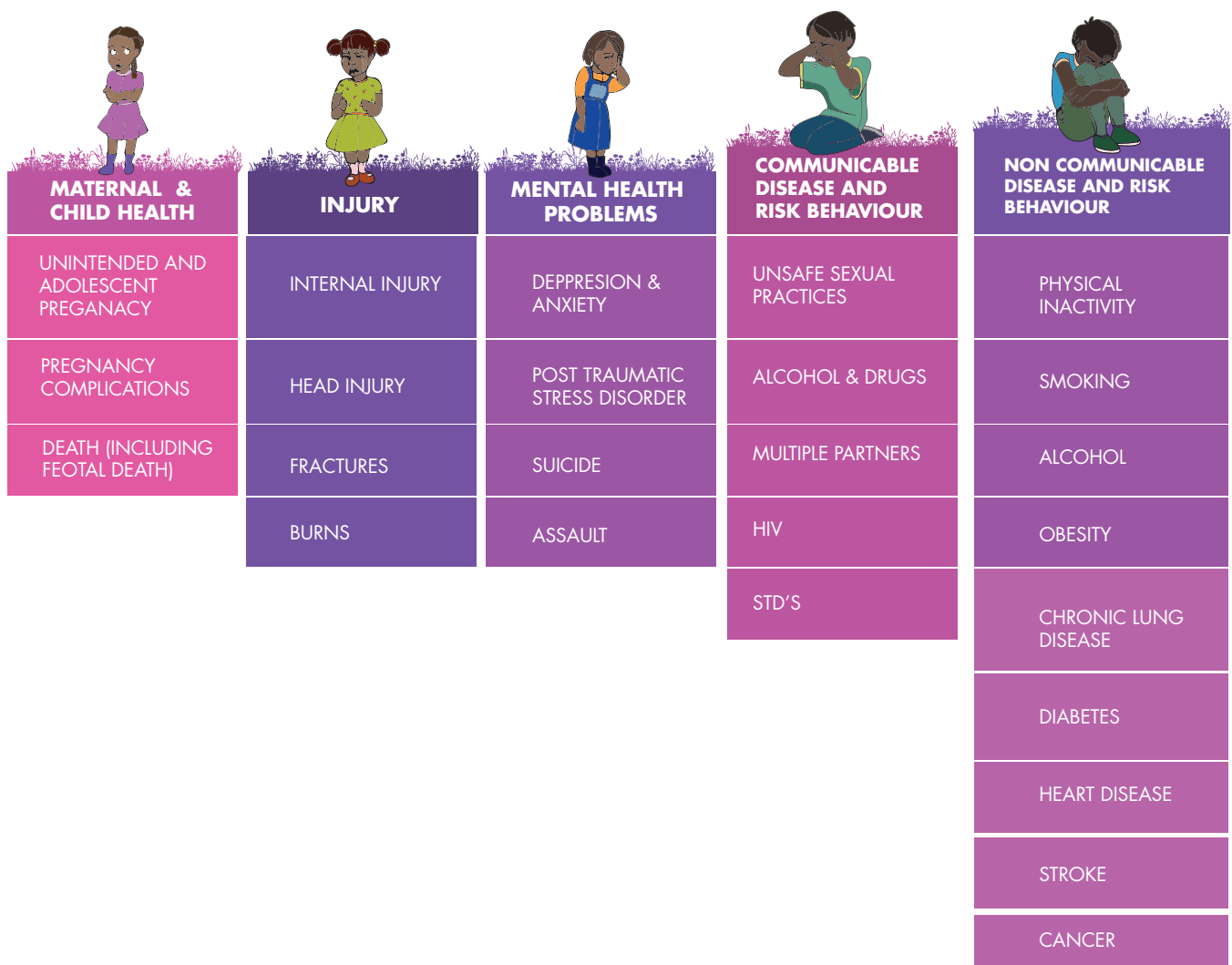


Figure 3: Potential Health Consequences of VAC.

Source: WHO INSPIRE. Seven Strategies for Ending Violence against Children, 2016

### Legal and Policy Frameworks that Regulate the VAC Response

International and national laws, standards and guidelines outlaw all forms of VAC against children, whether in the care of parents, legal guardians, or any other person who has authority over the child. Table 2 outlines some of international and regional legal frameworks and guidelines that address VAC.

For these laws, standards, guidelines and supportive policies to be effective, they must be implemented and enforced. It is as important that laws focus on the prevention of VAC as on effective responses. Responses need to look at the immediate and longer-term health and social support, as well as justice. Improving the prosecution of perpetrators of VAC through specialized prosecutors, police and courts can have a preventative effect, when the child wishes for justice processes to be followed. Health workers should familiarize themselves with their country specific legal frameworks, protocols and guidelines that look at the prevention of and response to VAC.



Table 2: Prevalence of the different forms of violence against children in different countries in SSA.

## LEGAL FRAMEWORKS

UN Convention on the Rights of the Child (CRC)

The UN Convention against Torture and other Cruel, Inhuman or Degrading treatment or punishment, 1984.

African Charter on the Rights and Welfare of the Child (ACRWC) - 1999

## GUIDELINES AND STANDARDS

Clinical Guidelines for responding to children and adolescents who have been sexually abused (WHO 2017)

INSPIRE; Seven Strategies for Ending Violence Against Children (WHO, 2016).

The clinical management of children and adolescents who have experienced sexual violence technical considerations for PEPFAR programs (2013)

Caring for Child Survivors of Sexual Abuse Guidelines for health and psychosocial service providers in humanitarian settings, 1st Edition; (ICRC, 2012)

Guidelines for medico-legal care for victims of sexual violence (WHO, 2003)



Source Country specific VAC survey reports

### Remember!

- The rate of violence against children is extremely high.
- VAC in all its forms is caused by a range of factors from individual up to society factors.
- All forms of VAC have adverse consequences on children and their lifetime development.
- There are international legal frameworks, and national specific laws that confer protection and safeguarding of children.



## HANDOUT 2

### A Minimum Package for the Comprehensive VAC prevention and Response services

The diagram below shows the five main categories of intervention that are needed to promote the wellbeing of a child who is at risk of or experiencing violence. The detailed interventions are shown later in the workshop, in Module 7 Handout 3: Minimum Package for the Comprehensive Response to Violence Against Children – core interventions.





## REFERENCES & FURTHER READING

### Further Reading

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**GUIDING  
PRINCIPLES FOR  
RESPONDING  
TO VIOLENCE  
AGAINST  
CHILDREN**

## INTRODUCTION

This module discusses the guiding principles that must be observed by health workers when providing care to children and adolescents who are at risk of, or may have experienced VAC. The principles are derived from the United Nations Convention on the Rights of Children (CRC) and other important human rights standards.



At the end of this module, you should be able to:

- Apply guiding principles for promoting children’s rights when providing care to children who are at risk of or have experienced violence.



# HANDOUT 1

## Guiding Principles for Health Workers Working with Children who are at Risk of or have Experienced Violence

The United Nations Convention on the Rights of the Child (CRC) states that:

‘children are full human beings in their own right, who deserve the best that life can provide at every single stage of their development.’ All health workers must use their professional skills in an ethical manner and therefore should be aware of these principles, where possible as applied in national laws, and must apply these principles in all their work. This is especially important for children at risk of or who have experienced violence.

Table 3: Guiding Principles for Providing VAC services



PRINCIPLE	ACTION FROM HEALTH
THE PRINCIPLE OF BEST INTERESTS OF THE CHILD	<ul style="list-style-type: none"> <li>• Protect and promote safety of the child (do no harm): health-care providers need to consider all potential harms and take or choose actions that will minimize the negative consequences on the child.</li> <li>• Provide sensitive care to the child by listening attentively, empathetically and without being judgmental so as to reassure them that they are not to blame for the abuse and that they have acted appropriately in disclosing it.</li> <li>• Protect and promote privacy and confidentiality of the child: For safety reasons, children should be interviewed on their own. Health-care providers need to ensure that only those who need to be present in the room (WHO 2017)</li> </ul>
THE PRINCIPLE OF EVOLVING CAPACITIES OF THE CHILD	<ul style="list-style-type: none"> <li>• Provide information that is appropriate to age: Health care providers should tailor the information that is offered and how it is delivered to the child’s age and developmental stage, including their cognitive, behavioral and emotional maturity to understand the information.</li> <li>• Seek informed consent as appropriate to the child’s age, evolving capacity and the legal age of consent for obtaining clinical care for all decisions and actions to be taken. In situations where it is assessed to be in the best interests of the child (especially adolescents) who are in need of care, and based on their preferences, health-care providers may consider whether to involve the parents or legal guardians.</li> <li>• Respect the autonomy and wishes of children by not forcing them to give information or be examined while balancing this with the need to protect their best interests. In cases where a child’s wishes cannot be prioritized, the reasons should be explained to the child before further steps are taken.</li> <li>• Offer choices in the course of the medical care: different options of care should be discussed with the child and all efforts should be made to provide the services as per their wishes where appropriate. Where it is not possible to offer the child’s choice reasons should be given.</li> </ul>
THE PRINCIPLE OF NON-DISCRIMINATION	<ul style="list-style-type: none"> <li>• Health care providers should observe non-discrimination while providing services to children irrespective of their sex, race, ethnicity, health status, religion, sexual orientation, gender identity, disability or socioeconomic status.</li> </ul>
THE PRINCIPLE OF PARTICIPATION	<ul style="list-style-type: none"> <li>• Health care providers should ensure children have a right to participate in decisions that an implications in their lives, in accordance with their evolving capacities. This means they should be asked what they think and have their opinions respected and taken into account when decisions are being made in relation to clinical care being offered to them.</li> </ul>

Source: WHO Clinical Guidelines for Responding to Children and Adolescents who have been Sexually Abused, 2017



**APPLICATION OF PRINCIPLE OF BEST INTEREST OF THE CHILD AND EVOLVING CAPACITIES**

Elena, a 14-year-old student was raped by John, her 17 year old boyfriend on their way back from school. Upon visiting the health facility, she tried to narrate what happened, however the health worker was too busy to listen to her ordeal and directed her to an adjacent room to await further assessment. When it was her turn to be called, the health worker shouted “where is the girl who has been raped?” Elena, who by this time looked embarrassed and ashamed, reluctantly followed the health worker to a room where post violence services were offered. The health worker then gave Elena a prescription form to take a HIV test, but she said that she was not ready to take the test. The provider advices her that she must take it as it mandatory to test all survivors of violence as per the national guidelines and it will do her good.

**DISCUSS:**

1. What concerns do you have with Elena’s management at the health facility?
2. Do you think the principle of best interest of a child was observed?
3. Do you think the principle of evolving capacities was observed?
4. What could have been done differently to improve the quality of services that were offered to Elena?

If you have time, can you think of similar experiences from your area of work where these two principles have been bypassed and how you might react differently moving forward.



**APPLICATION OF PRINCIPLE OF BEST INTEREST OF THE CHILD AND EVOLVING CAPACITIES**

Peter, a 10-year-old street boy living with HIV reports to the health facility unaccompanied, badly beaten and bruised on the face and left arm. When Peter arrives at the health facility, the health worker takes one look at his unkempt appearance and straight away starts to dress the wound. The health worker has not asked Peter what has happened to him or explained the treatment. The health worker then sends Peter away with anti-bullying handouts but without a referral card or follow up appointment.

**Discuss:**

1. Discuss some of the good practices you notice from Peter’s consultation visit
2. Do you think the principle of participation was observed?
3. Do you think the principle of non-discrimination was observed?
4. What could have been done differently to improve the quality of services that were offered to Peter?

If you have time, can you think of similar experiences from your area of work where these two principles have been bypassed and how you might react differently moving forward.



**REFERENCES & FURTHER READING**

1. Convention on the Rights of the Child. New York: United Nations; 1989 (<http://www.ohchr.org/Documents/ProfessionalInterest/crc.pdf>)
2. Responding to children and adolescents who have been sexually abused: WHO clinical guidelines. Geneva: World Health Organization; 2017. <http://apps.who.int/iris/bitstream/handle/10665/259270/9789241550147-eng.pdf?sequence=1>



**VIOLENCE  
AGAINST  
CHILDREN  
AND HIV**



## INTRODUCTION

Violence against children plays an important and devastating role in the HIV epidemic. It is both a cause and a consequence of HIV infection and is a driving force behind the epidemic.

This module examines the relationship between VAC and HIV and highlights the importance of integrating VAC into HIV clinical settings.



At the end of this module you should understand the following:

- Interlinkages between VAC and HIV
- The importance of integrating VAC into HIV services.



## HANDOUT 1

### The interlinkages between VAC and HIV

The two-way linkage between HIV and VAC

VAC has been shown to increase risks of acquiring HIV in later life. For example, physical, sexual and emotional violence have been shown to lead to earlier initiation of HIV risk behaviors and reduced ability to access HIV treatment services. Examples of the HIV risk behaviors include:

- Increased likelihood of engaging in transactional sex
- Early sexual initiation
- Having multiple sexual partners
- Having unprotected sex
- Increased likelihood of harmful substance abuse (drugs or alcohol)
- Increased likelihood of perpetration or experience of violence as an adult

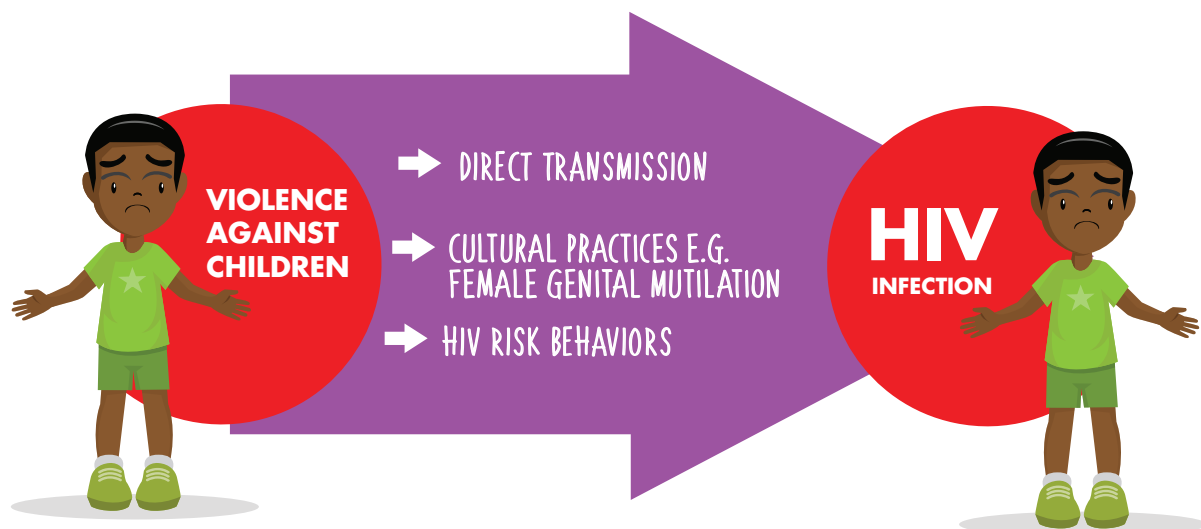


Figure 4: Ways through which VAC may increase risk of HIV infection

Similarly, children living with HIV or in households where a member may be HIV positive are also more likely to experience violence. This is perpetuated in the following ways:

- At an individual level, the child tends to experience emotional abuse and maltreatment including lack of family support;
- At a family level, HIV is associated with a range of factors that predict child violence, including occurrence of domestic violence which children witness;
- Having household members or the child diagnosed with HIV exposes the children in the household to HIV-related stigma and social isolation.

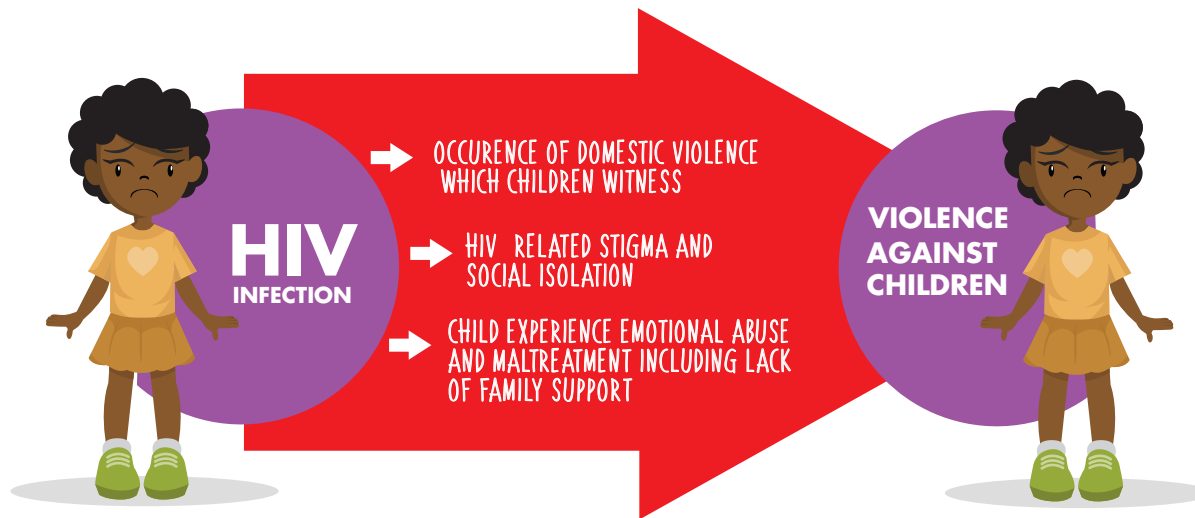


Figure 5: Ways through which HIV may lead to VAC

**VAC and HIV should be addressed together because:**

1. VAC is a known risk factor for HIV infection or worsened HIV outcomes.
2. HIV is a known risk factor for increased risk of violence.
3. Global guidance on HIV testing and treatment for children and adolescents recognize the need to address violence.
4. Children who are at risk of or have experienced violence present to health facilities routinely but rarely disclose their exposure. It is therefore important for health care providers to have the skills to suspect and identify these children.
5. Health care providers regularly encounter child survivors of violence, in their routine practice but do not have the knowledge and skill on how to appropriately respond.
6. Available evidence shows that addressing integrating VAC can improve HIV and other health related outcomes, health seeking behavior and partner communication (for adolescents).

**Addressing VAC is an important way to achieve 90:90:90 targets.**

**90% of people living with HIV have tested and know their HIV status**

- Fear of violence from intimate partners or families may be a barrier to people accessing HIV testing;
- HIV tests that are not disclosed in a safe and open way may increase violence within the home or community;
- An HIV test may be a good entry point for enabling children, adolescents and their caregivers to have more open communication, which can be a way to identify and prevent or to disclose and access support for violence.
- For women experiencing violence, HIV tests that screen for intimate partner violence (IPV) during PMTCT programs may be a way to access GBV prevention results, and reduce the impact of violence on their children also.

**90% of people living with HIV are accessing HIV treatment**

- Fear of violence may reduce disclosure, especially to and by children and adolescents, which in turn may reduce treatment adherence;
- Children who are neglected, for example those living with extended family and experiencing stigma, may not have access to consistent HIV treatment;
- HIV treatment can be a way to access support for addressing violence;
- Positive living interventions and linking HIV treatment to other services, such as sexual and reproductive health services for adolescents, can be a way to build up skills to avoid potentially violent or coercive relationships

**90% of people on treatment are virally suppressed**

- A person experiencing violence may find it harder to adhere to treatment, thus reducing the likelihood of achieving viral suppression;
- Being virally suppressed may promote a sense of empowerment and well-being which, in turn, could assist a caregiver or child to reduce the risk of violence.



## REFERENCES & FURTHER READING

### Further Reading

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2. Country specific legal frameworks and policies addressing violence against children e.g. sexual offences act, child protection policies etc.

### References

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**4** **COMMUNICATION  
SKILLS**

## INTRODUCTION

Our communication style and attitude can influence the decisions of a child or caregiver to seek support and to remain in care. It is important that we, as providers, are able to build trust with the child, actively listen to the child and involve them in decisions made about their care.



At the end of this module, you should:

- Be familiar with the different aspects of good listening to make the survivor feel more comfortable and believed;
- Understand the key approaches for appropriate communication with children who are at risk or have experienced violence;
- Practice techniques for communicating with children of different ages about sensitive issues.



## HANDOUT 1

### Communicating with children

It is important to talk to children about their health even though it can be difficult. Health care providers may find it hard to communicate effectively with children for a number of reasons:

- 1. Using the wrong words:** When adult language is used to explain things to children, they may not understand either complicated words or the meaning. It is important to use language that is at the appropriate level for the child and does not make the child feel that they are responsible for the situation or that it is their fault.
- 2. Assuming that children can't understand:** When health care providers assume that children are too young to understand complicated things, they may communicate with caregivers only. The truth is, children can understand a lot more than we give them credit for if it is communicated at their level.
- 3. We want to protect children:** It is natural for adults to want to protect children from all worries, but this can sometimes make the situation worse. Children can often sense if something is not right, and may start to imagine realities that are worse than the truth. Children are resilient if they have loving, attentive caregivers to support them.



#### NOTE:

To best communicate with a child, you should build a trusting relationship from the beginning of a visit. Starting a visit with a warm greeting and a discussion about an easy, non-threatening topic can help to get the conversation going.

Children have different communication needs along their development age and health care providers need to be equipped with this knowledge in order to communicate differently and use different tools to help them to open up. However, there are some basic principles that should be used when communicating with children of all ages:

- 1. Honesty:** You should be careful not to lie to a child. Lying can not only add to a child's anxiety if they find out, but also destroy the child's trust in you. Keep your communication short and simple, but always truthful.
- 2. Respect:** Always listen to the child and never make the child feel that what has happened is his or her fault. Do not ignore, dismiss or judge a child's viewpoints or feelings. You should give children the space to express their feelings, even if you don't agree with these feelings or they are uncomfortable to discuss their feelings.
- 3. Participation:** Children should be involved in their own care, be encouraged to learn about their illness, and be supported to make decisions where appropriate. You should always speak with the child, and not to the child.

#### Building Trust through Effective Communication with Children

Children who have experienced any form of violence rarely disclose their exposure to violence to health care providers. They may be afraid, embarrassed or ashamed to talk to anyone about it. Health care providers should therefore aim to build trust from the child and make them comfortable enough to disclose their experiences

## The following communication skills are recommended while talking to a child:

- 1. Keep things confidential:** Reassure the child that everything they say in the consultation room will not be shared with anyone else, even their caregivers. If you think it is important to tell other family members some of the things you have heard, then you should let the child know of this first, and help him or her understand why this is necessary. Listen to how the child feels about this and try to accommodate any concerns the child might have. When a child knows they can rely on you to keep the things they tell you are confidential, then they will trust you and speak more freely with you.
- 2. Show empathy:** One of the most important things that health care providers can do to encourage trust is to try to put themselves in the shoes of their patients and imagine how they may be feeling. This is called empathy the ability to recognize and acknowledge the feelings of others. Empathy can help to encourage people to talk more about what is bothering them because they feel understood and supported. It is important to make sure that the child knows that what has happened is not his or her fault.

Health care providers should be aware of possibilities of revictimization where children survivors' violence are more than 3 times more likely to experience victimization again as adults. Children who have been victimized by a relative will need much more support and ongoing services than those victimized by strangers because there is an ongoing and very real risk of further victimization and cover up by the family.
- 3. Don't judge:** Health care providers must be respectful of the child's point of view. You should be aware of your own attitudes and beliefs, and not let them interfere with providing the care. Avoid judging words like 'right,' 'wrong,' 'bad,' 'good,' and 'enough.'
- 4. Communicate without words:** What you 'say' when you are not talking is also important in building trust and making people feel comfortable with you. Children especially respond strongly to our tone of voice, body language and other forms of non-verbal communication. You should take care to send the right message by:
  - o Making eye contact.
  - o Facing the child while talking to him/her
  - o Being relaxed and open with your posture.
  - o Nodding your head
  - o Leaning forward
  - o Smiling, when appropriate.
  - o Focusing on the person you are talking to, rather than looking at your watch, the clock, or anything else.
  - o Turning your mobile phone off.
- 5. Reflect:** To show the child that you have been listening keenly and check if you really understand them, you can repeat back or summarize what they have said, or say it back in a slightly different way.
- 6. Listen actively:** Devote your full attention to the child and what they have to say. Use SOLER principles: Sitting position, Open posture, Lean forward, Eye contact, Relaxed for effective listening; show the child, with your body and your gestures, that you are listening carefully and that it is important to you. Active listeners do the following:
  - o Show the child you are listening by saying things like "ok" or "mmm hmmm."
  - o Listen to the content of what the child is saying — are there themes or patterns that are being repeated?
  - o Listen to how it is been said— do they seem worried, angry or shy for example?
  - o Allow the child to express their emotions — for example if they are crying, allow them time to cry.
  - o Keep distractions to a minimum and find a private place to talk.
  - o Don't do other tasks while listening
  - o Don't interrupt.
  - o Ask questions or gently probe if you would like more information.



**7. Ask open-ended questions:** Open-ended questions are questions such as “Tell me about...” or “What is it like when...” that start discussions, while closed questions are questions such as “Did you do...” or “Did you want...” that can only get a one word or short answer. Asking open-ended questions gives you the chance to hear more about children’s fears, concerns and motivations, and better understand what lies behind them.

**8. Reassure the child by using some of the following healing statements:**

- o “I believe you.” Builds trust
- o “I am glad that you told me.” Builds a relationship with the child
- o “I am sorry this happened to you.” Expresses empathy
- o “This is not your fault.” Non-blaming
- o “You are very brave to talk with me and we will try to help you.” Reassuring and empowering



# HANDOUT 2

There are tools that can be used to communicate with children depending on their age. Children who are too young to express themselves clearly verbally should be communicated to using alternative approaches that may include: feeling cards and pictures; role plays and drama; drawing and storytelling as shown in Figure 6 below.

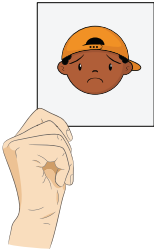



TOOLS FOR COMMUNICATION WITH CHILDREN	
<p><b>FEELING CARDS OR PICTURES</b></p> 	<ul style="list-style-type: none"> <li>Use card pictures by showing the child a variety of such pictures in order to help him/her to learn new words to describe and in the process understand their feelings. Draw faces on a piece of paper (or ask the child to draw faces) that show anger, fear, sadness, happiness and other feelings. Talk with the child about the faces, asking them about the sorts of situations that could make children experience the feelings.</li> </ul>
<p><b>ROLE-PLAY AND DRAMA</b></p> 	<ul style="list-style-type: none"> <li>Let children pretend to be someone else and act out situations that they might otherwise not be comfortable talking about. You can ask them questions about the characters they are playing, and take note of feelings and ideas that come up.</li> </ul>
<p><b>DRAWING</b></p> 	<ul style="list-style-type: none"> <li>Drawing helps children to express themselves without having to use words. You should encourage the child to use crayons, pens, pencils or whatever materials you have available to draw something related to what you want to talk to them about, e.g. what makes them angry. Use open-ended questions to ask them about the drawing, checking your understanding with them as you go. The drawing can form the basis for your conversation. Things that should be done and the ones not to be done during communication with children</li> </ul>
<p><b>STORYTELLING</b></p> 	<ul style="list-style-type: none"> <li>Storytelling helps children to talk about themselves in a non-threatening way. This may help the health care worker to support them to solve a problem. You can use a short story with made-up characters or animals to convey a message to the child. Afterwards, ask the child to talk about what happened in the story and probe to link it to the child's experience where appropriate. This will encourage children to tell their own stories by asking a question like "Tell me a story about a boy who was feeling very angry"</li> </ul>

Figure 6: Tools for Communication with children

# DO'S & DON'TS

- **GET DOWN TO THE CHILD'S EYE LEVEL:** let the child see your eyes and read your intentions.
- **SPEAK SOFTLY AND DIRECTLY TO THE CHILD:** children respond better when they are addressed rather than just the caregiver.
- **SMILE AND PLAY:** a smiling face makes a big difference and will help to improve interaction with the child.
- **BE HONEST:** telling the children the truth will build their confidence for future clinic visits and develop a trusting relationship.
- **ALLOW AND RESPECT NORMAL EMOTIONS:** sadness and crying are okay and so is anger – be patient with the child.
- **START WITH THE LEAST INVASIVE ACTIVITY:** keep the child on the caregiver's lap as much as possible and don't start with painful or invasive activities such as blood draws.
- **BE MINDFUL WHEN YOU TOUCH THE CHILD:** children should never be made to feel uncomfortable and if touching the child is inevitable then it should always be made in respectful manner to the child
- **OFFER THE CHILD CHOICES:** choices provide a sense of control. For instance, let the child choose whether to start by measuring this/her height or weight.
- **ENGAGE WITH THE CHILD:** talk about things of interest to the child, such as school, friends or hobbies.
- **SUPPORT THE CAREGIVER/CHILD RELATIONSHIP:** caregivers are experts on the children in their care, so involve and engage them as you look to understand the child.

- **DON'T COMPARE THE CHILD TO OTHERS:** each child is an individual with unique characteristics - strengths and weaknesses. Comparing a child with others will do more to damage self-esteem than motivate.
- **DON'T FORGET THE CHILD IS IN THE ROOM:** if you want to have a private conversation with the caregiver, make a separate time or create a separate space. Children always understand more than we think.
- **DON'T PITY:** children need love, support and care, but not pity.
- **DON'T TREAT OLDER CHILDREN LIKE INFANTS:** treat the child appropriately for their age and respect their level of understanding and maturity.
- **RESPECT CHILDREN'S DIFFERENT UPBRINGINGS:** approaches to child rearing and discipline differ by family. There are many ways to raise children that will lead to good results. Don't judge caregiver styles that differ from your own background.
- **DON'T USE YOUR POSITION TO BUILD FEAR IN THE CHILD:** children often feel fearful and anxiety when attending clinic visits and interacting with health care workers. Help the child to feel comfortable at the clinic and encourage them to interact health care workers freely to build their trust and confidence in clinic visits.

Figure 7: Do's and Don'ts for communicating with children



### CHILD:

You are a 9-year-old girl called Maria and live with your father and step mother and 3 younger step children. Your step mother gives you a lot of housework, does not give you enough food and beats you when you fail to work in the house. Your other step siblings go to school, but you do not. Sometimes you sleep outside in the cold. Today you have been taken to the hospital by your step mother as you have been complaining of frequent headaches. This is your 3rd visit to the facility in the last 2 months.



### HEALTH WORKER:

Maria is a 9-year-old girl who has come to the facility with complaints of recurring headaches. You have previously run tests with no evidence of disease that would cause the persistent headache. You notice that she is withdrawn and seems scared when you take her history.

Take the following communication tips into consideration while acting out the role play:

- SOLER – SOLER, Sitting position, Open posture, Lean forward, Eye contact, Relaxed
- Ask open-ended questions such as
  - o “Tell me about...”
  - o “What is it like when...” that start discussions,
- Avoid judging words like ‘right,’ ‘wrong,’ ‘bad,’ ‘good,’ and ‘enough.
- Show the child you are listening by saying things like “ok” or “mmm hmmm.”
- Allow the child to express their emotions — for example if they are crying, allow them time to cry.
- Don’t do other tasks while listening e.g. do not look at your phone or computer
- Don’t interrupt.
- Ask questions or gently probe if you would like more information.



## REFERENCES & FURTHER READING

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**IDENTIFICATION  
OF VAC IN HIV  
CLINICAL  
SETTINGS**

## INTRODUCTION

Children who are at risk of or have experienced violence rarely directly seek help for the violence. Sometimes a child is taken to a health facility with a result of the violence. More commonly, the child will attend for another, unrelated health issue or will present with a violence-related issue such as headache or stomach pain, without saying that this is caused by violence.

Children may be afraid what could happen if they disclose abuse, especially if the abuser is a parent, caregiver, or other family member. Most children will feel embarrassed or ashamed to talk to anyone about it or may not be aware of the availability and importance of health services for violence. It is therefore important that health workers who routinely offer clinical care to children have the appropriate skills to observe and knowledge to ask the appropriate questions where they suspect possibility of child violence.



At the end of this module, you should:

- Attain or increase skills to enable you to identify children who are at risk or are experiencing any form of violence.



### IMPORTANT NOTE:

This module acknowledges WHO's guidelines on 'universal screening' or 'routine enquiry' for violence. The guidelines describe procedures to be followed when handling various aspects of VAC in different settings, including settings with limited resources to handle VAC response services. The module does NOT provide information on how to routinely screen all children for violence exposure. Rather, it seeks to equip health workers with the knowledge and skills to have a high index of suspicion when they encounter a child who they believe may have experienced violence, and to create an enabling environment that encourages the child or their non-offending caregivers to disclose.



## HANDOUT 1

### **Disclosure of VAC**

Many children who are at risk of or have experienced violence commonly present to health facilities to seek care for other ailments and rarely disclose their exposure to violence to the health care providers. They may be afraid what could happen if they disclose abuse, especially if the abuser is a parent, caregiver, or other family member. The majority of children feel embarrassed or ashamed to talk to anyone about it or may not be aware of the availability and importance of health services for violence. It is therefore important that healthcare providers who routinely offer clinical care to children have the appropriate skills to observe and knowledge to ask the appropriate questions where they suspect possibility of child violence.

### **Nature of disclosure by children**

- Disclosure refers to the discovery of child violence as narrated by the very survivor to either a healthcare provider or another individual.
- VAC is usually difficult and distressing. The majority of children who experience violence do not disclose the experience to anyone.
- The decision on whether to disclose the experience of violence may depend on the reaction of the recipients.
- Health care providers should take reasonable time to develop rapport with the child and make the child feel safe in order to build trust and encourage disclosure.



### Common reasons why children do not disclose violence

Some of the reasons for reluctance to disclose are shown in Figure 8.

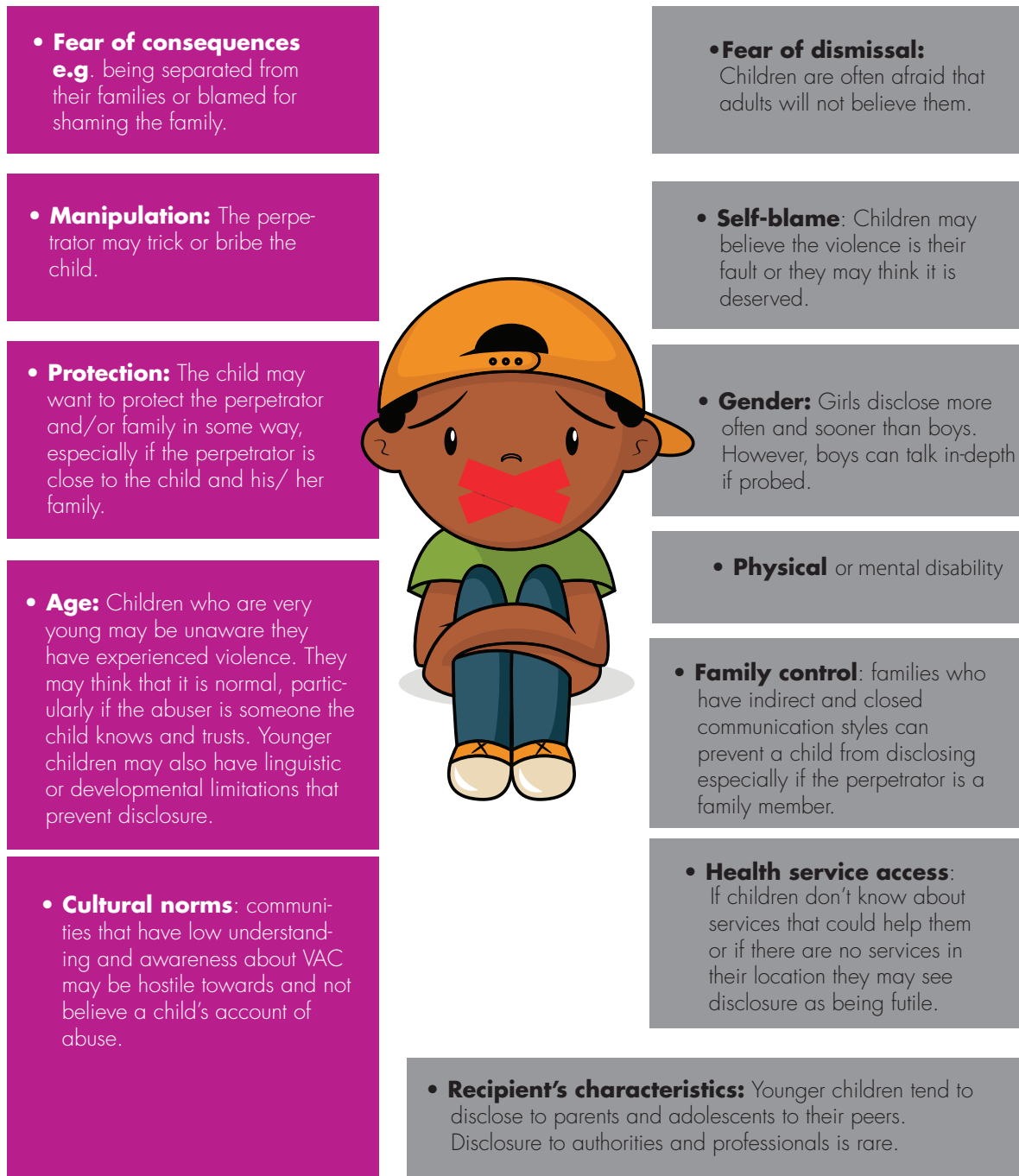


Figure 8: Common reasons why children do not disclose violence



## HANDOUT 2

### Introduction to Child Protection Enquiry Tool

#### What is the Child Protection Enquiry Tool (CPET)?

It is a tool that is designed to help the health care providers to look out for specific symptoms during a consultation where he/she suspects that the child is at risk of or has experienced violence. It also provides a set of simple questions that the health care providers can ask the child and/ or caregivers to ascertain whether the child requires referral for more specific diagnostic test and services for violence.

The CPET comprises four sections, which include:

- i. Age:** The tool has two versions that differ slightly to accommodate symptoms and questions that are relevant for the age groups 0 to 5 years or 6 to 18 years. This section informs the health care provider about the age group that each version of the tool was designed to assess.
- ii. Modes of administration:** This section indicates who the tool should be administered to by the health care provider. The version that targets the age group 0 to 5 years should be administered to the caregivers who accompany the child to the health facility while the one that targets the age group 6 to 18 years should be administered directly to the child.
- iii. Observation:** This section outlines the typical symptoms that the health care provider observes from the child during the consultation session. These signs can either be physical and/ or behavioral.
- iv. Questions to ask:** These are structured open-ended questions that enquire about a child's general well-being.



#### NOTE:

**Note 1:** The questions in the CPET are deliberately designed to be general and non-invasive and do not therefore directly ask about any type of violence, focusing more on getting more detailed history on the symptoms that the health care provider observes.

**Note 2:** The questions in the CPET are not formulated to aid the health care providers in making a definitive diagnosis of violence experience but rather to help them get more details in cases where they suspect risk of or experience of violence. Therefore any child who gives a positive response to any of the questions in the tool should be offered appropriate referral for more specific diagnostic test and services.

There are two versions of the Child Protection Enquiry Tool, one for the age group 0 to 5 years (Figure 9) and one for the age group 6 to 18 years (Figure 10).

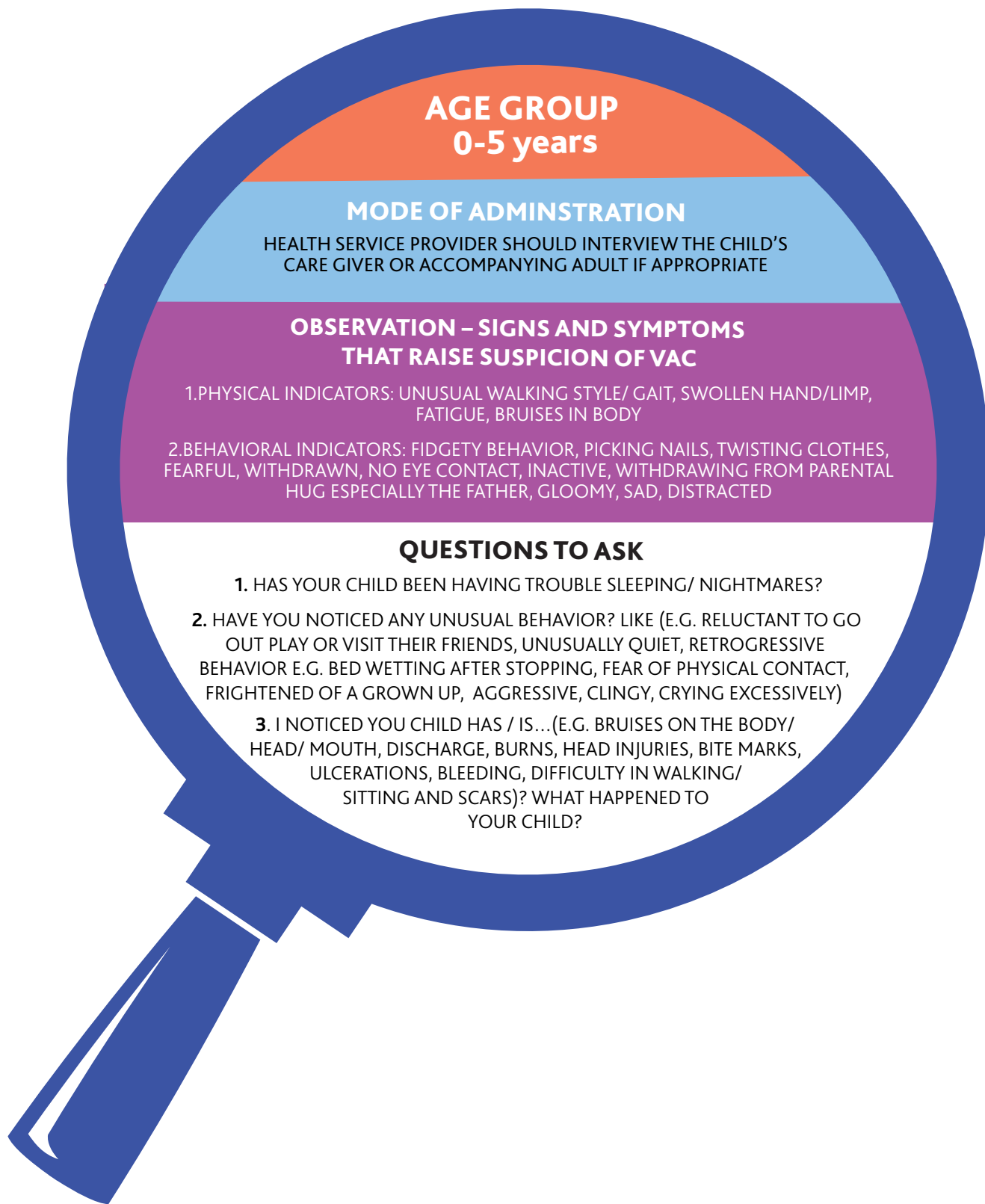


Figure 9 Children Protection Enquiry Tool for Children aged 0 to 5 Years



Figure 10 Child Protection Enquiry Tool for Children aged 6 to 18 Years

## Use and Interpretation of the Child Protection Enquiry Tool findings

The CPET should be used routinely to help the health care provider in HIV clinics and other clinical settings where children who attend the routine services may be at a higher risk of exposure to violence.

### Steps For Administering The CPET

Health care providers should use the following guidance while using the CPET tool.

**1. For children 6-18, Be sure that you interview the child alone, or perhaps with one co-worker,** but do not have the caregiver in the room with you.

There are many ways to explain to a parent why you need to talk to their child alone. Part of it depends on whether the parent already has a concern that their child was abused. Here are 2 ways to explain it to a parent, but feel free to shape this explanation in a way that fits the cultural context and the specific facts of your case. Tell the caregiver:

- a. “When children are being treated for HIV, it is our practice to talk with all children alone to learn more about their fears and questions. Children want to show their parents they are brave, and they want to make you proud, so sometimes they won’t tell everything, but these are things we need to know so we can provide them the best treatment. I would like to go with your child to this other room to talk for a few minutes, and if they tell me anything important I will let you know. Is that fine?”
- b. Or if the parent already has a concern of abuse and wants to hear it straight from the child, explain “Children even as young as age 4 know that talking about abuse makes their mum sad or mad, and children don’t want their parents to be sad or mad, so children often won’t tell us everything because they don’t want you to be sad. I would like to go with your child to this other room to talk for a few minutes, and if they tell me anything important I will let you know. Is that fine?”



#### NOTE:

**Note to clinicians: if the child tells you that the caregiver who brought them to the clinic today is the abuser, then you are not obligated to tell the caregiver what the child told you – this could put the child at risk for further abuse once they walk out your door. See more, in Module 7 in section “What to do if the abuser brought them to the clinic today.”**

**2. Use all the techniques from Module 5 on SOLER, Sitting position, Open posture, Lean forward, Eye contact, Relaxed.**

**3. Introduce yourself:** Say your name, your role, and why you are talking with them: “Hi, my name is Mrs. Kante, I’m a nurse, and part of my job is to talk with kids to see how I can help them.”

- a. If the child is much shorter than you, crouch down to their level when you introduce yourself, make eye contact and smile.

**4. Build rapport:** Talking to a child for a few minutes about school or who they live with, can help make children feel more comfortable with you. This will also help you understand if this is a child can explain things to you when discussing easy, comfortable topics.

**5. Explain the rules of the interview: “Like I said, one of my jobs is to talk with kids to see how I can help. And whenever I talk with kids I have 3 rules:**

- a. The first rule is, since I’m a <insert title, i.e. Nurse or doctor>, you can tell me anything, and I won’t get mad at you and you won’t be in trouble with me.
- b. My second rule is, if I ask you something and you don’t know the answer, that’s ok, just say ‘I don’t know.’ Don’t guess or making anything up, if you don’t know, just say I don’t know.
- c. The third rule is ‘We only tell the truth.’ Sometimes it can be scary to tell the truth – like if someone did something bad to you, it can be scary to tell the truth about it, but I need you to tell me the truth about everything so that I can help you. OK?”
- d. Note, when speaking with adolescents age 11 and up, it’s helpful to add a 4th rule: “Don’t worry that if you tell me something that I might judge you negatively. I know that life is difficult, and bad things happen, but I don’t judge. I’m just here to help.”

## **6. Transition to the open-ended questions about abuse.**

- a. "I noticed you have (physical indicator)... how did this happen?"
- b. "Has anyone ever touched you in a way that made you uncomfortable or confused?"
- c. For adolescents, ask "Has anyone offered you any gifts, food, or a place to stay in exchange for sex or touching?"  
If they answer yes, to any of the above, respond with "Tell me what happened from the very beginning."

**7. Stay silent if they don't answer immediately.** When we ask a patient a sensitive question, and they remain silent, it is our natural inclination to say something to help encourage them. Just stay silent. Even if it's for 1-2 minutes – sometimes they just need the time to build the courage to tell you what happened. 1-2 minutes of silence can feel like a long time, but you will get used to it. When the child sees that you are comfortable with the silence, it puts them at ease, they feel they can breathe, and build their strength to tell you. After 2 minutes of silence, ask them gently again "Tell me what happened."

## **8. Only ask enough questions to know what medical treatment they need and whether they are safe to return home today:**

- a. If the child was raped, and it occurred less than 72 hours ago, the child can be given HIV PEP for 28 days to help prevent HIV.
- b. Regardless of when it happened, the child can be given medication to treat gonorrhea, chlamydia and bacterial vaginosis.
- d. All survivors of sexual abuse need to be referred for medical care, even if it was "only" fondling and no rape.

## **9. What to say when a child become quiet and they look afraid: Don't just say "Trust me, I'm here to help." They don't know you, and if they were abused then all they know that adults lie and betray, so saying "Trust me" is not very helpful. When you sense the child is afraid, acknowledge their fear, explore their fear and then educate them:**

- a. Acknowledge their fear: Simply ask "Are you afraid to tell me what really happened?" Children will often nod their head yes. Even if they do not respond, then proceed to
- b. Explore their fear: "What are you afraid will happen if you tell me?" Children can often be honest about this because they have a very real fear that is preventing them from talking. If they don't answer:
  - i. Remind them "Remember, like I said, because I'm a <doctor> you can tell me anything, and I won't get mad and you won't be in trouble with me."
  - ii. "I know it's scary to talk about these things, but I only need you to tell me a little bit so that I can know how to help you. Tell me what happened."
- c. Educate: If the child tells you what they are afraid of, and their fear shows they misunderstand the situation, then you can talk with them about that and explain there is benefit to telling. For example, if the child says "Mommy told me not to break up the family" you could respond with "Well, if your dad did something bad to you, it doesn't always mean you have to get taken from your mother, maybe just your dad can get in trouble and leave the home." Note: you can only make this statement if it's possibly true – i.e. if you have police who could respond to a disclosure of abuse and who might arrest him.
- d. After you have finished asking questions about abuse, make affirming statements (see Module 7, Slide 4) and begin inquiring about current needs and developing a safety plan (Module 7)

## **Referral should be made based on the following criteria after administering the CPET:**

1. Unexplained physical and / or behavioral symptoms as per the CPET.
2. If responses to questions provided by caregiver for physical symptoms observed are not plausible.
3. Request for referral by child or caregiver even in absence of symptom or suggestive history.



## NOTE:

The questions in the CPET are deliberately designed to be general and non-invasive and do not therefore directly ask about any type of violence, focusing more on getting more detailed history on the symptoms that the healthcare provider observes. The questions in the CPET are not formulated to aid the healthcare providers in making a definitive diagnosis of violence experience but rather to help them get more details in cases where they suspect risk of or have experienced violence. Therefore, any child who gives a positive response to any questions in the tool should be appropriately referred for more specific diagnostic tests and services.



## NOTE:

During the consultation session while the health care provider is taking history and asking the questions as per the CPET, the following may occur as the caregiver or the older child narrate the reasons behind the symptoms:

- The child or caregiver may become visibly upset, distressed
- The child or caregiver may state that their environment at home is unsafe and require immediate help
- The caregiver or older child may declare who the perpetrator is and that they live in the same household

In this instance, the health care provider is expected to offer 'First Line Support' to the child or caregiver experiencing distress and make the appropriate referrals while ensuring the child's safety is at the forefront of all decisions made. First line support is discussed in detail in the next module.

### Key considerations for the introduction of the CPET at health facilities

The CPET can be used at various service delivery points and by different cadres of health care providers. However, certain conditions must be put in place to ensure that the child's safety, privacy, confidentiality are of uttermost priority and that systems are in place to enable appropriate referrals. These considerations include:

1. Health facilities should introduce the use of the CPET only when they can ensure child survivors safety, privacy and confidentiality. To ensure safety, privacy and confidentiality of child survivors of violence a health facility must have the following:
  - Consultation rooms where child survivors' history cannot be overheard by others;
  - Policies about who can access the survivors clinic records and when providers are allowed to disclose survivor information;
  - Well trained staff who understand how to provide good reception, clinical assessment, immediate response and appropriate referrals to the survivor and be able to alert the receiving point, so as to prevent further abuse.
2. Facilities should introduce the use of the CPET only after ensuring that healthcare providers have the appropriate attitudes and skills.
  - The spontaneous reactions of healthcare providers as various issues of violence are being narrated can have a tremendous impact – positive or negative – on a survivor.
  - A sensitive and supportive reaction by health care provider can help initiate the process of getting the child survivor out of the violent situation and begin the recovery process. In contrast, a blaming or judgmental reaction, shaming and questioning credibility can be emotionally devastating
  - Health service providers must be taken through appropriate training to equip them with the necessary skills to communicate sensitively to children and the health programs can use various strategies to assess the providers' attitude and beliefs.

3. Facilities should introduce the use of the CPET only after ensuring that the healthcare providers are able to offer the immediate violence response services and appropriate referrals.

- Healthcare providers have a responsibility to ensure that the child survivor is safe and any emergency condition is treated.
- Health facilities need to have structures of referral systems including referral directories and link the child to the nearest and affordable services where possible.

In summary, the health facilities must ensure that they have adequate resources to protect children who disclose violence risk or experience violence and to offer them some kind of benefit.

#### **Who can use the CPET tool?**

The end users of this tool include, but are not limited to, clinical staff of various cadres who work closely with children through their routine clinical work. These include: medical officers, clinical officers, nurses and midwives, medical social workers, pharmacist and counselors. However, the tool is simple enough to be used by non-clinical staff including social workers, community health volunteers etc. outside health facilities.

#### **Where can the CPET be used?**

The intended settings for use of this tool are the HIV services delivery points including Comprehensive Care Clinics (CCCs), standalone HIV testing sites, and any other service delivery points within health facilities where HIV services are provided. However, it can also be used in other non-HIV clinical settings that offer services to children. These include Outpatient and Inpatient departments (OIPD), Maternal, New-born and Child Health (MNCH) clinics, adolescent health services and community outreach services.

#### **When can the CPET be used?**

This tool can be used at any point of contact with the child within the health facility.





## Role play script (0-5 years)



### CHILD SCRIPT:

You are a 5 year old girl called Maria and live with your father and step mother and three older step children. Your step mother gives you a lot of housework, does not give you enough food and beats you when you fail to work in the house. Your other step siblings go to school but you do not. Sometimes you sleep outside in the cold. Today you have been taken to the hospital by your step mother for medical review.

- Act withdrawn , picking fingernails, fidgety
- Altered gait / difficulty in walking
- Bruise on the forehead, holding your arm



### CLINICIAN'S SCRIPT:

You are attending to Maria in the consultation room. She has come for a medical review with her guardian. Engage with Maria and the guardian. Gather history and presenting issues then manage appropriately.



### GUARDIAN'S SCRIPT (OFFENDING GUARDIAN) :

You are Maria's step mother accompanying her for medical review.

Act as follows while in the consultation room:

- Appear more concerned with what the clinician is doing with Maria
- Interject before Maria answers the clinician
- Appear intimidating – tone of voice
- Unsettled / nervous

Act like you are providing satisfactory responses for all questions asked by the clinician about Maria's health status

## Role play script (6-18 years)



### CHILD SCRIPT:

You are a 14 year old boy called Adam in an abusive family where both parents are in constant fights. Your classmates in boarding school have isolated you for being a bully and abusing drugs, a habit which was not there before. Lately, you were noted to be missing classes and the school matron observed bruises on your swollen face. You visit the clinic today for your HIV treatment refill. Act as follows:

- You are adherent to treatment
- Revengeful, angry, irrational and irritable, unkempt
- Hesitate to share family indifferences
- Report being beaten



### HEALTH WORKER'S SCRIPT:

You are attending to Adam in the consultation room. He has come for a medical review. Engage with Adam and gather history and presenting issues then manage appropriately.



## REFERENCES & FURTHER READING

1. McElvaney, Greene, & Hogan. (2014) To tell or not to tell? Factors influencing young people's informal disclosures of child sexual abuse. *Journal of Interpersonal Violence*, 29, 928–947. Doi: 10.1177/0886260513506281. <http://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.888.2685&rep=rep1&type=pdf>
2. Meinck F, Cluver L, Loening-Voysey H, et al. Disclosure of physical, emotional and sexual child abuse, help-seeking and access to abuse response services in two South African Provinces. *3. Psychology, Health & Medicine* 2017; 22(sup1): 94-106 <https://www.tandfonline.com/doi/pdf/10.1080/13548506.2016.1271950?needAccess>
3. Responding to children & adolescents who have been sexually abused; WHO guidelines (2017)



**FIRST-LINE  
SUPPORT  
FOR VAC**

## INTRODUCTION

First-line support provides practical care and responds to the child's emotional, physical, safety and support needs, without re-traumatizing them or intruding on their privacy. Often, first-line support is the most important care that health workers can provide. Even if this is all the health worker can do, it will have greatly helped the client. First-line support has helped people who have been through various upsetting or stressful events, including children subjected to violence.



At the end of this module, the participant should gain or improve:

- Knowledge and skills to be able to provide immediate, first-line support to children who are at risk of or have undergone violence.



## HANDOUT 1

### The Five Key Steps in First-Line Support

**Remember!** This may be your only opportunity to help this child.

**First-line support involves five simple tasks.** It responds to both emotional and practical needs at the same time. The letters in the word “LIVES” can remind you of these five tasks that protect the children’s lives.

<b>L</b> LISTEN	Listen to the child closely, with empathy, and without judging
<b>I</b> INQUIRE ABOUT NEEDS AND CONCERNS	Assess and respond to the child’s various needs and concern - emotional, physical, social and practical
<b>V</b> VALIDATE	Show the child that you understand and believe her/him. Assure the child that she/he is not to blame.
<b>E</b> ENHANCE SAFETY	Discuss a plan to protect the child from further harm if violence occurs again.
<b>S</b> SUPPORT	Support by helping connect the child and their offending caregiver to information, services and social support.

#### 1. LISTEN

##### Purpose

To give the child a chance to say what she wants to say in a safe and private place to a caring person who wants to help. Listening is the most important part of good communication and the basis of first-line support. It involves more than just hearing the child’s words. It means:

- being aware of the feelings behind the child’s words
- hearing both what the child says and what s/he does not say
- paying attention to body language – both the child’s and yours –including facial expressions, eye contact, gestures
- 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
- showing understanding and empathy of how the child feels.

## Learn to listen with your



Eyes – giving the child your undivided attention



Ears – truly hearing the child's concerns



Heart – with caring and respect



<b>HOW TO ACT</b>	<b>HOW TO ACT</b>
Be patient and calm	Do not pressure the child to tell their story
Let the child know that you are listening; for example nod your head and say "hmm...."	Do not look at your watch or speak too rapidly
	Do not answer the telephone, look at the computer or write
<b>YOUR ATTITUDE</b>	<b>YOUR ATTITUDE</b>
Acknowledge how the child is feeling	Do not judge what she/ he has or has not done, or is feeling. Do not say "you shouldn't feel that way", or "you should feel lucky you survived", or "Poor you".
Let the child tell their story at his/her own pace	Do not rush the child. Do not look at your watch or speak too rapidly.
<b>WHAT YOU SAY</b>	<b>WHAT YOU SAY</b>
Give the child the opportunity to say what she/he wants. "Ask how can I help you?"	Do not assume you know what is best for the child
Encourage the child to keep talking if she/he wishes to. Ask "would you like to tell me more?"	Do not interrupt. Wait until the child has finished before asking questions
Allow for silence. Give the child time to think	Don't try and finish the child's thoughts. Do not ask for more details than the child is ready to give.
Stay focused on the child's experience and offering support	Do not tell the child's someone else's story or talk about your own trouble
Acknowledge what the child wants and respect his/her wishes	Don't think and act as if you must solve the child's problem for him/her

## 2. INQUIRE ABOUT NEEDS AND CONCERNS

### Purpose

To learn what is most important for the child. Respect the child's wishes and respond to their needs. As you listen to the child's story, pay particular attention to what the child says about their needs and concerns – and what s/he doesn't say but implies with words or body language. You can use the techniques below to help the child express her/ his needs and to be sure that you understand.

## TECHNIQUES FOR INTERACTING



PRINCIPLE	EXAMPLES
PHRASE YOUR QUESTIONS AS INVITATIONS TO SPEAK	"What would you like to talk about?"
ASK OPEN ENDED QUESTIONS TO ENCOURAGE THE CHILD TO SPEAK INSTEAD OF SAYING YES OR NO	"How do you feel about that?"
REPEAT OR RESTATE WHAT THE CHILD SAYS TO CHECK YOUR UNDERSTANDING	"You mentioned that you feel very frustrated."
REFLECT THE CHILD'S FEELINGS	"It sounds as if you are feeling angry about that..." "You seem upset...."
EXPLORE AS NEEDED	"Could you tell me more about that?"
ASK FOR CLARIFICATION IF YOU DO NOT UNDERSTAND	"Could you explain that again, please?"
HELP THE CHILD IDENTIFY AND EXPRESS THEIR NEEDS AND CONCERNS	"Is there anything that you need or are concerned about?"
SUM UP WHAT THE CHILD HAS EXPRESSED	"You seem to be saying that....."
SOME THINGS TO AVOID	Do not ask leading questions, such as "I would imagine that made you feel upset, didn't it?" Don't ask "why" questions. Such as "why did you do that...?" they may sound accusing

### 3. VALIDATE

#### Purpose

To let the child know that their feelings are normal, that it is safe to express them and that s/he has a right to live without violence and fear. Validating another's experience means letting the person know that you are listening attentively, that you understand what they are saying, and that you believe what they say without judgment or conditions.

Important things that you can say

- "It's not your fault. You are not to blame."
- "It's okay to talk."
- "Help is available." [Say this only if it is true.]
- "What happened has no justification or excuse."
- You are not alone. Unfortunately, many other children have faced this problem too."
- "Your life, your health, you are of value."
- "Everybody deserves to feel safe at home."
- "I am worried that this may be affecting your health."

### 4. ENHANCE SAFETY

It IS NOT the responsibility of a health worker who is not a qualified VAC counsellor to assess whether a child is at risk of or experiencing harm. It is their responsibility to refer all situations where the health worker suspects harm. The referral must be to someone who has the training, skills and the mandate (where possible) to undertake further assessment and action.

See Module 6 Handout 2 for a flowchart that helps you make decisions about when to refer and when a child is at risk of harm.

It IS the responsibility of every health worker to ensure that the child, and caregiver where relevant, is immediately safe.



NOTE:

#### Definitions of child protection and safeguarding

Child protection is the act of preventing or responding to specific concerns about individual children or groups of children who are at risk of harm. It is the interventions taken to protect that child. A child protection system is the full set of components needed at national or program level to address the risks that all children face from abuse, violence, exploitation and neglect. Child protection is increasingly an explicit part of a government's laws and policies that set out the roles and responsibilities of all adults to ensure that children are free from harm.

Child safeguarding "is the responsibility that organisations have to make sure their staff, operations, and programmes do no harm to children, that is that they do not expose children to the risk of harm and abuse, and that any concerns the organization has about children's safety within the communities in which they work, are reported to the appropriate authorities." Keeping Children Safe definition. Keeping Children Safe has set the international norms and standards for ensuring that children are protected in all aspects of work. <https://www.keepingchildrensafe.org.uk/>

**Remember, when there is any doubt or suspicion, refer!**

**During consultations the following actions are essential to confirming a child's safety:**

- Making sure that you have the child's contact details; if appropriate, find a way that the child can be contacted e.g. via school;
- Ensuring that there is some way to follow up with the child after the consultation before referring. If you make a follow-up appointment, follow-up directly in case of a no-show;
- In case of possible harm during or immediately after leaving the clinic, help the child and caregiver to a safe space while waiting for a referral; do not leave the child until the focal point, social worker or police have received the referral.



Helping to make a safety plan (only if there is no urgent need for the child to see the VAC focal point):

- Give the Child Helpline number where available (116 in most countries)
- Support the child to find a safe adult that they can talk to in case of feeling scared
- Ask the child if they have somewhere safe they can go if they feel scared; if they have no safety contingency plan, this can happen over time, it is not necessary to do one if the child is not ready

### **Remember!**

The flowchart is not a screening tool. It assists health worker to decide when to make an immediate referral to a VAC focal point or, if that focal point is not available, to a social worker.

It is important to note that in some countries it is mandatory to report any case of child violence to the child welfare department. In this case, the child and their non-offending caregiver should be supported to understand why the disclosure must be made.

### **SUPPORT**

Services for violence prevention and response require a multidisciplinary team and generally require that the child visits more than one service delivery point. This services may be within the health facility or to other external service providers. Health care providers can help by discussing the child's needs with them and/or their non-offending caregiver telling them about other sources of help, and assisting them to get help if the child wants it.

The next module will look into the importance of making effective referrals and will provide guidance on how to develop and sustain good referral networks for VAC services.

### **Remember!**

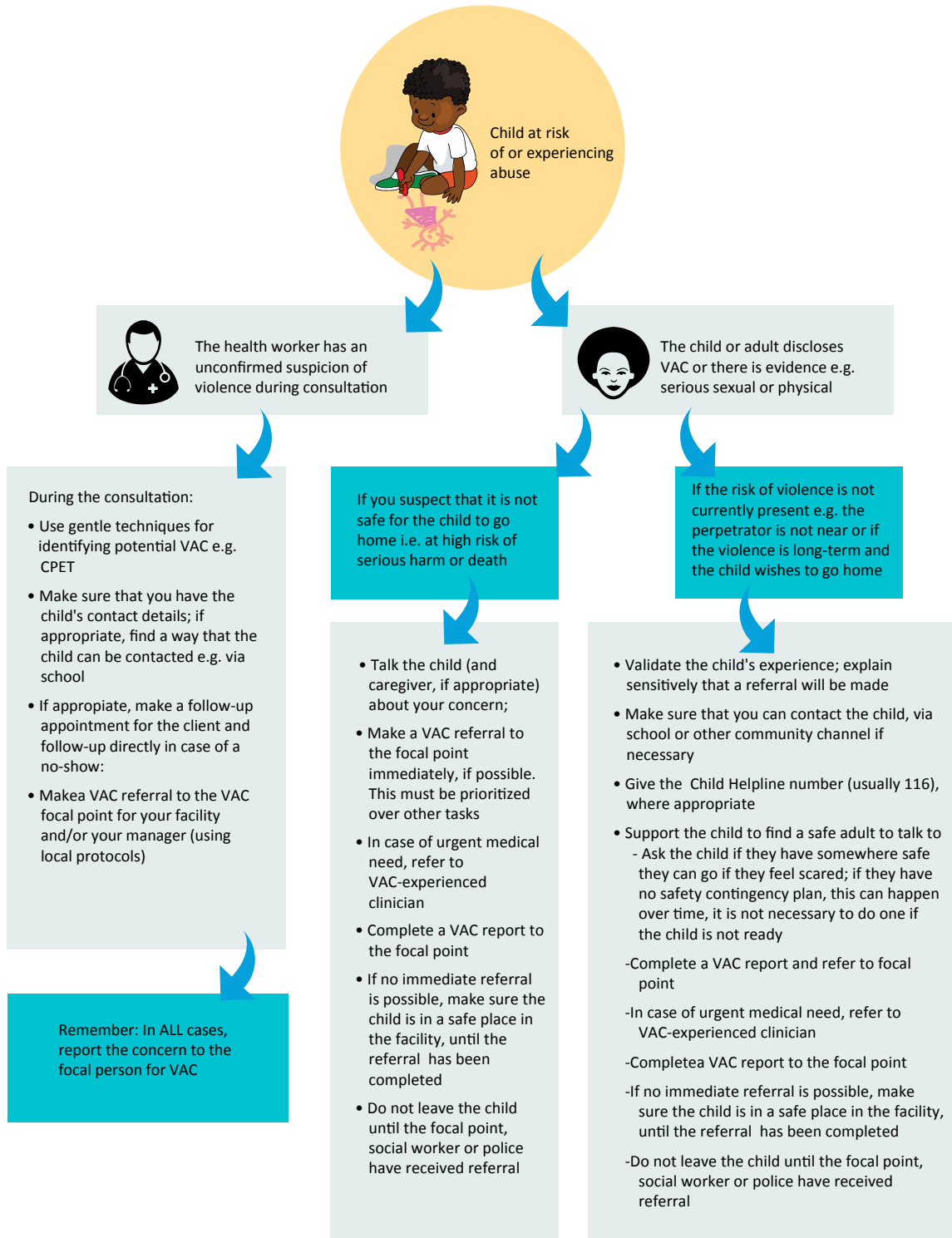
- Whenever you have a concern about a child's safety, remember LIVES.
- Have a focal person for contacting in case of any concern.
- If you have a concern that a child is facing risk to life or serious harm, keep the child safe and bring in support immediately.
- If in doubt, assume that a child is at serious risk and contact the focal point.
- Have a set of simple 'keeping safe' instructions for a child who may be at risk but does not appear to be in immediate harm.
- Ongoing referrals and support are essential. These will be looked at in the next session.



## HANDOUT 2

### Flowchart for action when a child who is at risk of or is experiencing violence is unsafe or in danger

This flowchart is a suggested course of action for health workers who come across violence against children where no existing child protection case management protocol is in place. It is designed to guide health workers who are not trained to provide post-violence care on what to do when they suspect that a child may be in danger.





### APPLICATION OF PRINCIPLE OF BEST INTEREST OF THE CHILD AND EVOLVING CAPACITIES

Elena, a 14-year-old student was raped by John, her 17 year old boyfriend on their way back from school. Upon visiting the health facility, she tried to narrate what happened, however the health worker was too busy to listen to her ordeal and directed her to an adjacent room to await further assessment. When it was her turn to be called, the health worker shouted “where is the girl who has been raped?” Elena, who by this time looked embarrassed and ashamed, reluctantly followed the health worker to a room where post violence services were offered. The health worker then gave Elena a prescription form to take a HIV test, but she said that she was not ready to take the test. The provider advises her that she must take it as it mandatory to test all survivors of violence as per the national guidelines and it will do her good.

#### DISCUSS:

1. What concerns do you have with Elena’s management at the health facility?
2. Do you think the principle of best interest of a child was observed?
3. Do you think the principle of evolving capacities was observed?
4. What could have been done differently to improve the quality of services that were offered to Elena?

If you have time, can you think of similar experiences from your area of work where these two principles have been bypassed and how you might react differently moving forward.



## REFERENCES & FURTHER READING

1. H. Lien Bragg. 2003. Child Protection in Families Experiencing Domestic Violence. Child abuse and neglect user manual series. <https://www.childwelfare.gov/pubPDFs/domesticviolence.pdf>
2. WHO. Health care for women subjected to intimate partner violence or sexual violence. A clinical handbook. 2014. <http://www.who.int/reproductivehealth/publications/violence/vaw-clinical-handbook/en/>



**RESPONDING  
TO CHILDREN  
WHO ARE AT  
RISK OR HAVE  
EXPERIENCED  
VIOLENCE**

## INTRODUCTION

This module provides information on the key responses needed to support children and seeks to help identify local sources of support. It does not give detail on intensive support to child survivors of violence, because this course is a simple introduction.



At the end of this module, the participants should have explored:

- The role of different actors in provision of VAC services;
- The minimum requirement that any health facility must have in place to provide VAC prevention and response services.
- The commodity and supplies required by health facilities to provide VAC prevention and response services.



## HANDOUT 1

### VAC prevention and response services overview

Violence requires interventions from multiple actors. Children may therefore have to talk to lots of different people, with different perspectives. It is essential that the core ‘best interests’ principle of participation is upheld, along with ‘do no harm’.

Children have a right to express opinions about their experiences, and to participate in decisions that affect their protection and care. Giving a child and family the space to speak out and make decisions promotes family strength and resilience. All decisions about how to respond to the situation should involve communication with a child.

Children should be told that they have the right to express a view, and that if they do not want to share their view, that is all right, too. A child can explain why she or he chooses not to share their viewpoint if they desire – for example, a child may reveal that answering a particular question makes him/her feel uncomfortable.

Families also have a right to participate and to express their wishes for the child, and discuss what support, if any, they feel that they have. It may sometimes be useful or necessary to provide a safe space for a child or family member to speak confidentially. Ensuring safety and guaranteeing confidentiality are essential for participation. Children and families have the right to receive information in an appropriate format so that the child understands what is happening throughout the case management process.

Children of different ages, maturity and capacity can make decisions in different ways. Even very young children are able to participate in decision making, although this may take time and the health or social worker will need to communicate with the child in an age-appropriate way to support the child in voicing her/his views.

Make sure that children know what is about to happen, who is responsible for making it happen, and how long it should take. Children should always know who they can contact and how they can do this, including in situations where children do not have access to phones.

## VAC Prevention Strategies

In 2016 WHO introduced the INSPIRE package, an evidence-based resource for everyone committed to preventing and responding to violence against children, for use from government to grassroots, and from civil society to the private sector. INSPIRE represents a select group of strategies based on the best available evidence to help countries and communities intensify their focus on the prevention programmes and services with the greatest potential to reduce violence against children. The seven strategies are outlined below. The strategies are not described in detail in this course however participants are encouraged to refer to the further reading sections for reference to INSPIRE package and the implementation manual developed in 2018.

### **INSPIRE : Seven Strategies for Ending Violence Against Children**



**Implementation and enforcement of laws**



**Norms and values**



**Safe environments**



**Parent and Caregiver Support**



**Income and economic strengthening**



**Response and support services**



**Education and life skills**



# HANDOUT 2

## VAC Response Strategies

A VAC response must be both immediate and longer-term, illustrated in the table below.



### Roles and Responsibilities of Health Care Professionals in Responding to VAC

The health care providers involved in providing clinical services to children who are at risk of or who have experienced violence include but are not limited to counsellors, nurses, midwives, clinicians, medical social workers and pharmacists.

It is important to note that the type of services that a health care provider offers should be determined by the trainings that they have received. In order to offer clinical response and prevention services health care providers need to attend a more detailed training as per their country national VAC clinical management guidelines.





## HANDOUT 3

### **VAC Prevention and Response Services at Different Levels of Health Facilities**

VAC services can be provided at all levels of the public health care system, from local health centers and clinics to national referral hospitals. Some aspects of medical care can be provided in non-clinical sites such as police stations. For example, in Zambia's Copper Belt Province, police officers from the Victim Support Units have been trained to provide services to sexual violence survivors and refer them to health facilities for further care (Keesbury & Thompson, 2010).

The type of service that can be offered to children who are at risk of or have experienced violence will vary depending on the capacity and resources available at the facility. National health policy and legal considerations also play a role.

It is important to determine what aspects of comprehensive care can be provided at a health facility, and when it will be necessary to refer survivors to resources outside the facility, both for further clinical care and for non-clinical protection and support services.

Table 4 below outlines the type of VAC services that can be offered by the various levels of health facilities.

FACILITY CAPACITY	MINIMUM REQUIREMENTS IN RESPONDING TO VAC	MINIMUM STAFFING REQUIREMENTS
DISPENSARY	<ul style="list-style-type: none"> <li>• Identification of children who are at risk of or have experienced violence</li> <li>• First line support</li> <li>• Refer children who are at risk of or who have experienced violence for further screening and management</li> </ul>	Trained Health Care providers <ul style="list-style-type: none"> <li>• Nurse</li> <li>• HTS counsellor</li> <li>• Social worker</li> </ul>
HEALTH CENTERS	<ul style="list-style-type: none"> <li>• Identification of children who are at risk of or have experienced violence</li> <li>• First line support</li> <li>• Management of children who are at risk of or have experienced violence</li> <li>• Refer child survivors of violence for further management</li> </ul>	Trained Health Care providers <ul style="list-style-type: none"> <li>• Nurse</li> <li>• HTS counsellor</li> <li>• Social worker</li> <li>• Clinician</li> </ul>
SUB COUNTY /COUNTY HOSPITAL	<ul style="list-style-type: none"> <li>• Identification of children who are at risk of or have experienced violence</li> <li>• Laboratory in is</li> <li>• Management of child experiencing VAC.</li> <li>• Internal/external referral when need be</li> </ul>	Trained Health Care providers <ul style="list-style-type: none"> <li>• Nurse</li> <li>• HTS counsellor</li> <li>• Social worker</li> <li>• Laboratory technologists</li> <li>• Clinician</li> <li>• Medical officers</li> <li>• Consultants</li> </ul>
REFERRAL HOSPITAL	<ul style="list-style-type: none"> <li>• Identification of children who are at risk of or have experienced violence</li> <li>• Internal referral for further diagnosis</li> <li>• Management of child survivors of violence.</li> <li>• External referrals when need be</li> <li>• Internal/external referral when need be</li> </ul>	Trained Health Care providers <ul style="list-style-type: none"> <li>• Nurse</li> <li>• HTS counsellor</li> <li>• Social worker</li> <li>• Laboratory technologists</li> <li>• Clinician</li> <li>• Medical officers</li> <li>• Consultants</li> </ul>

Table 4: VAC Services that can be offered at different level of health facilities

## Health Facility Requirements for Setting Up VAC Prevention and Response Services

When establishing VAC services, special care must be taken to ensure that the unique needs of children are fully taken into account. For example:

1. Make an effort to create a child-friendly space where children and adolescents can relax and feel safe; below are principles guidelines on how to make a child friendly space; A child-friendly service should:
  - Be safe and supportive to family and children's needs e.g. play area, needs of disabled children.
  - Have policies and standards on child protection including non-discrimination, confidentiality and privacy policies.
  - Have skilled health care providers in handling children e.g. listening skills, aware of children's rights in healthcare.
  - Be accessible to children with a variety of available services to respond to children's needs.
  - Ensure health care providers are non-judgmental and considerate in their dealings with children; and they have the competencies needed to deliver the right health services in the right way. Children want to be treated with respect and to be sure that their confidentiality is protected.
2. Ensuring that health care providers are specially trained to suspect and identify children who may be at risk or experiencing any form of violence;
3. Ensuring that health care providers have the appropriate skills to provide the appropriate response depending on their knowledge and skills and the capacity of the health facility
4. Understanding the unique dynamics of VAC and the challenges of disclosure;
5. Identifying relevant services for children, adolescents and caregivers available in the community;
6. Offering the appropriate referrals for VAC services and ensuring systems are in place to ensure linkage to the referral points.
7. Ensure health facilities have minimum requirements for setting up VAC services as shown in Job Aid 1.



### NOTE:

**Note:** According to the WHO guidelines for responding to children and adolescents who have been sexually abused, caution must be taken by health-care providers when conducting physical examinations and, where needed, forensic investigations. They should seek to minimize additional harms, trauma, fear and distress, and respect the autonomy and wishes of children or adolescents. These actions include the following: speculums or anosscopes and digital or bimanual examinations of the vagina or rectum of a pre-pubertal child are not routinely required, unless medically indicated; If a speculum examination is needed, sedation or general anesthesia should be considered.

The following sections will describe the specific interventions that health facilities can put in place in order to strengthen the integration of VAC prevention and response interventions into HIV services.

### Health facility-based actions:

- Strengthen the health systems to respond to VAC services (Table 5 lists the requirements for setting up comprehensive services). Where the comprehensive services cannot be offered, a good referral network should be developed to ensure linkage of a child survivor to the appropriate services.
- Train HIV health care providers to provide quality VAC services.
- Ensure availability of appropriate VAC data collection and reporting tools with the relevant HIV service delivery points.
- Ensure availability of VAC response guidelines and standard operating procedure within the relevant HIV service delivery points.
- Strengthen referral and linkage systems to ensure that children are linked to appropriate VAC interventions.

### Community-based actions:

- Create awareness in the community regarding availability of VAC services within the HIV clinic.
- Develop referral networks with other relevant service delivery providers to ensure ready access to comprehensive services by child survivors.
- Include VAC prevention messaging in HIV prevention peer, social worker or community health volunteer education programs.

**Structural actions:**

- Ensure protective laws and policies are in place and enforced to prevent and respond to VAC.
- Challenge harmful gender norms, roles, and behaviors, and reduce acceptance of VAC.



## JOB AID 1 Assessing VAC Services Readiness

QUESTIONS CHECKED (✓) ITEMS ARE MINIMUM REQUIREMENTS		READY? Y/N	
<b>SERVICE DELIVERY</b>			
✓	Are there written protocols/SOPs for provision of health care to children subjected to violence?		
	Is a minimum package of care being provided (that is, identification of survivors of violence, first-line support, clinical care for survivors of violence, basic psychosocial support)?		
<b>HEALTH WORKFORCE</b>			
	Are there health-care providers whose job descriptions assign them specific responsibilities to address Violence Against Children?		
✓	Have health-care providers received training on responding to Violence Against Children?		
	Are there mechanisms to provide ongoing mentoring, supervision and support to health-care providers?		
<b>INFRASTRUCTURE AND MEDICAL PRODUCTS</b>			
✓	Is there a space (for example, a room or area) available for private and confidential consultation (that is, that ensures the survivor cannot be seen or heard from outside)?		
	Are medicines, equipment and other supplies available?		
<b>LEADERSHIP, GOVERNANCE AND ACCOUNTABILITY</b>			
	Do health-care providers and health managers support addressing Violence Against Children (for example, willing to provide care, supportive of sending staff to training)?		
	Are there confidential mechanisms to receive feedback from children survivors of violence about services, including any grievances or violations of rights in the health facility (for example, a helpline, ombudsperson, complaint box)?		
	Is there a work-place policy addressing discrimination and violence, including sexual harassment faced by health-care providers themselves?		
<b>BUDGET &amp; FINANCING</b>			
	Is there a budget allocated for provision of care/ services (for example, for staff training, procuring specific commodities)?		
<b>MULTISECTORAL COORDINATION AND COMMUNITY ENGAGEMENT</b>			
✓	Is there a referral system in place across different health services and between health and other sectors (for example, a referral directory, information offered to survivors about available services)?		
	Have other services (for example, police) and organizations (for example, local NGOs working on Violence Against Children) been informed about available health services?		
<b>INFORMATION, MONITORING AND EVALUATION</b>			
	Are indicators and data to monitor the health response to Violence Against Children being collected, compiled and used to improve services?		
✓	Are there intake forms/registers and confidentiality mechanisms (for example, secure storage and removal of identifying information) for recording information about women's experience of violence and care received?		

NB: the checked boxes (✓) are the minimal requirements that any facility must have in place in order to provide VAC prevention and response services.

*Adapted from: Strengthening health systems to respond to women subjected to intimate partner violence or sexual violence: a manual for health managers. Geneva: World Health Organization; 2017. Licence: CC BY-NC-SA 3.0 IGO.*



## REFERENCES & FURTHER READING

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2. Levy, Marcy, Lyn Messner, Malia Duffy, and Jennifer Casto. 2016. Strengthening Linkages Between Clinical and Social/Community Services for Children and Adolescents who Have Experienced Sexual Violence: A Companion Guide. Arlington, VA: Strengthening High Impact Interventions for an AIDS-free Generation (AIDSFree) Project.
3. Responding to children & adolescents who have been sexually abused; WHO guidelines (2017): <http://www.who.int/iris/handle/10665/259270>.
4. Keesbury, Jill and Jill Thompson. 2010. "A step-by-step guide to strengthening sexual violence services in public health facilities: Lessons and tools from sexual violence services in Africa." Lusaka: Population Council. [http://www.popcouncil.org/uploads/pdfs/2010HIV\\_PEPFAR\\_SGBV\\_Toolkit.pdf](http://www.popcouncil.org/uploads/pdfs/2010HIV_PEPFAR_SGBV_Toolkit.pdf)
5. A Practical Guide to developing a Child Friendly Spaces. UNICEF. [https://www.unicef.org/protection/A\\_Practical\\_Guide\\_to\\_Developing\\_Child\\_Friendly\\_Spaces\\_-\\_UNICEF\\_\(2\).pdf](https://www.unicef.org/protection/A_Practical_Guide_to_Developing_Child_Friendly_Spaces_-_UNICEF_(2).pdf)

### Further Reading

1. WHO (2016) INSPIRE: seven strategies for ending violence against children. World Health Organization, Geneva. Retrieved from <http://apps.who.int/iris/bitstream/handle/10665/207717/9789241565356-eng.pdf?sequence=1>
2. Caring for Child Survivors of Sexual Abuse Guidelines for health and psychosocial service providers in humanitarian settings (IRC UNICEF, 2012) <https://www.icrc.org/en/download/file/12251/irrc-894-schopper.pdf>
3. Guidelines for medico-legal care for victims of sexual violence (WHO, 2003) <http://apps.who.int/iris/bitstream/handle/10665/42788/924154628X.pdf?sequence=1>
4. The clinical management of children and adolescents who have experienced sexual violence technical considerations for PEPFAR programs <https://aidsfree.usaid.gov/resources/prc-tech-considerations>
5. Responding to children & adolescents who have been sexually abused; WHO guidelines (2017): <http://www.who.int/iris/handle/10665/259270>.



**REFERRAL,  
LINKAGE AND  
FOLLOW-UP FOR  
VAC SERVICES**

## INTRODUCTION

This module provides an overview of all the different actors that play a role in supporting a child who is at risk of or experiencing violence. An effective referral system requires that each actor knows their roles and responsibilities and communicates clearly with other people in the referral system. A strong referral system requires that every health worker knows what support is available at different service delivery points within the health sector, and what support is available outside the health center. A strong referral system requires clear lines of reporting and documentation, to ensure that the child receives the necessary care.



At the end of this module, the participant should:

- Understand the wide range of formal and informal actors who play a role in referrals;
- Explore what is already working well and areas for improvement in coordination of existing referral processes;
- Be familiar with any already existing referral mechanisms locally;
- Create a referral directory for supporting children at risk of or experiencing violence in his or her own workplace.





## HANDOUT 1

### Referrals, linkages and follow-up



#### Terminology used in referrals for VAC services

- 1. Referral:** a procedure by which a service provider sends a child who is at risk of or has experienced violence, because they cannot, at their level (expertise, experience or responsibility level) respond to the child's needs) to the most appropriate service point where the child can receive the required service.
- 2. Follow up:** making contact with a child or caregiver at a later, specified date to check on the child's progress since the last appointment.
- 3. Referral system:** a system that facilitates good coordination (organization, preparation, adequate and timely support) and good collaboration between actors and service providers for a child who is at risk of or has experienced violence.
- 4. Counter referral:** the response or return action or the feedback that the referral service delivery point gives the referring facility about the services that are provided to the referred child. It is initiated by the structure receiving the referred child.
- 5. Case management:** a process utilized within social and health services, especially those targeting vulnerable children and families. The goal of case management is for children and households to achieve a state of wellbeing where they are stable and secure enough to meet their needs (e.g. financial, protection, social, emotional, health, and education) and resilient enough to withstand modest shocks. Case management includes the processes of and related tools for identifying, assessing, planning, referring and tracking referrals, and monitoring the delivery of services in a timely, context-sensitive, individualized and family-centered manner to achieve a specific goal or goals (e.g. child protection and wellbeing). (4Children, 2018).

#### Rationale for referral

The process of reporting violence can be complicated. In almost all scenarios, the needs of the child survivors are beyond the health care offered within health facilities. They need comprehensive multisectoral services such as safety, social support, housing and legal protection. During this process, multiple forms and documents may be required; repeated statements may be requested; and evidence transported back and forth between institutions. To make comprehensive services for violence available, a well-coordinated, multisectoral response from all actors, those within health care facilities and in the community, is necessary. This also provides the opportunity for expert follow-up and monitor the health of the child.

The multisectoral actors who provide VAC services are expected to be:

- Readily available;
- Express caring and reassurance;
- Uphold the client's privacy and confidentiality;
- Have knowledge on VAC identification and care;
- Be suitably trained on communication skills when dealing with child survivors;
- Follow informed consent procedures according to local laws and age/developmental stage of a child; and
- Have knowledge on the laws and regulations relating to child protection.

NB: If referral is not done well, it could result in poor communication, fragmented treatment, and frustration all around particularly for the children survivors seeking medical help.



## HANDOUT 1

### Types of referrals for VAC services

#### Referrals within the health facility

This is where the child is referred from one service delivery point to the next for provision of the appropriate prevention or response services within the health facility.

During routine clinical services, health care providers in HIV clinics and other clinical settings may identify children at risk of or those undergoing violence. The health care providers will refer children to the service delivery points listed in Figure 12 below as appropriate within the health facilities where VAC services are offered.

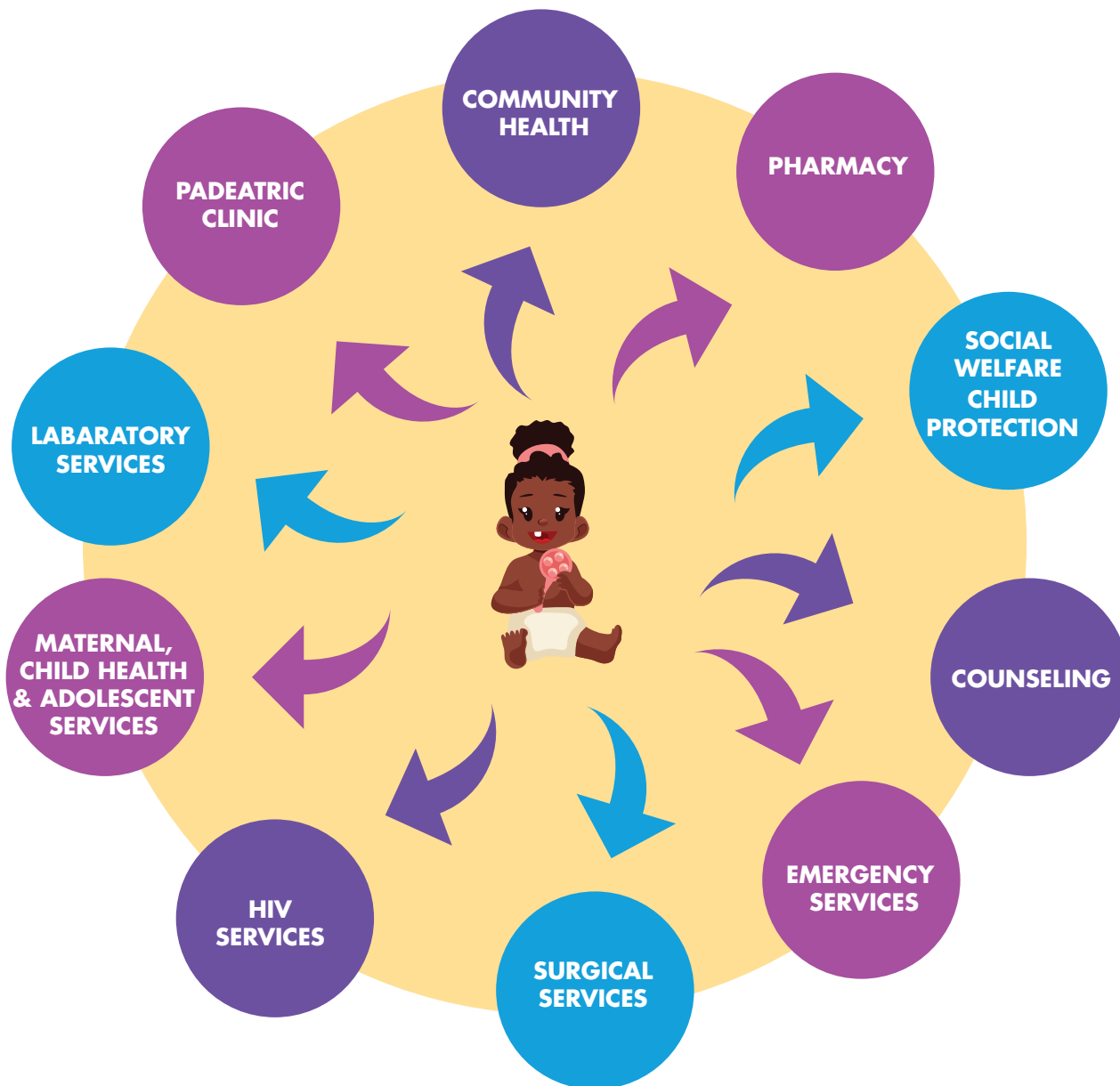


Figure 12 Service delivery points within health facilities where VAC services can be offered

### Referrals outside the health facility

Delivery of comprehensive VAC services requires a multisectoral response. This means that a multidisciplinary team of professionals from the medical, police, psychological, child protection, social, legal, and educational fields participate in the provision of wide variety services that are needed by the child. While all team members may not be involved in every case, it is important that this team work collaboratively and in the best interest of the child.

In addition to healthcare care services, children who have been subjected to violence often need services in other non-clinical sectors as illustrated in Figure 13.

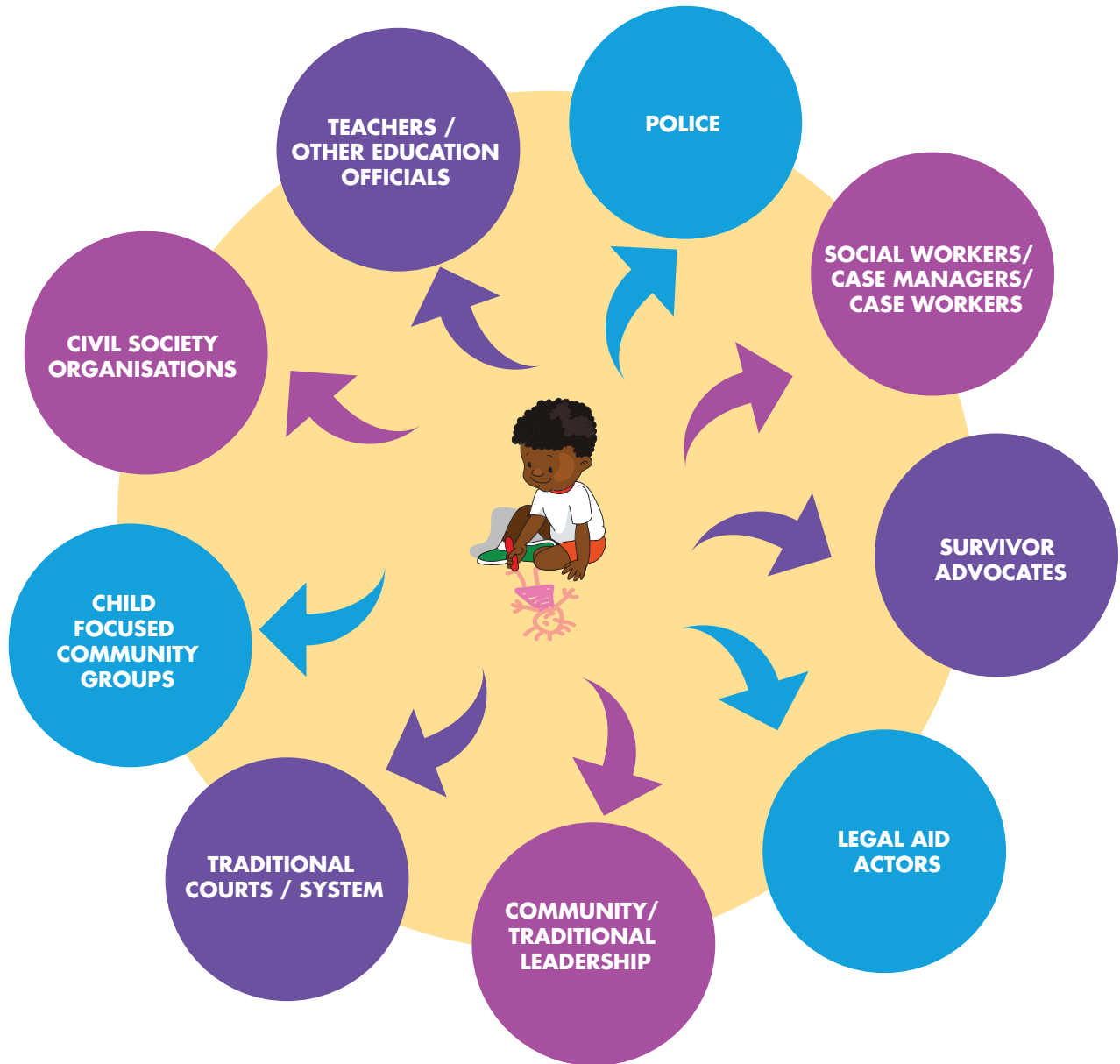


Figure 13: Duty bearers or actors within the community where VAC services can be offered



NOTE:

A good referral and counter-referral system will operate in a framework ensuring:

1. Holistic care for a child who is at risk of or has experienced violence, through professional provision of a varied scope of services: psychosocial assistance, health monitoring and health care, orientation toward a relevant educative and/or professional system, legal/judicial assistance, socio-economical support, etc.
2. Services that are offered by qualified, supervised and adequate staff;
3. Service providers that work in synergy, encouraging sharing and exchange of skills and lessons learned;
4. Services offered are documented in a well-structured manner and services have appropriated referral tools;
5. Team spirit: the providers from the different service delivery points need to know each other, show a sense of solidarity and moral and psychological support to each other as they serve the child.

### Criteria for Setting an Effective VAC Referral System

#### **Start with community Mapping**

Conduct community mapping of potential referral points that provide relevant services, including government and nongovernmental resources. Determine which resources have stable, long-term funding, and which may be more precarious (this activity could be conducted with other stakeholders). Remember that traditional and informal community structures play a tremendous important role in supporting children, adolescents, and their families; too often these groups are excluded from formal systems.

If you are unsure of where services are offered, this is an opportunity to find out .

#### **Hold Consultations with Children and Adolescents**

Hold consultations with children and adolescents themselves to learn about their priorities, needs and gaps. These consultations can give programs insight in how to better serve these groups while fostering informal “word of mouth” about the upcoming available services. Like community mapping, consultations offer an important opportunity to solicit community input; identify social, economic, and physical barriers to services and ways to mitigate against them; and identify opportunities for accessing services. As importantly, consultations create opportunities to learn more about how to support and serve the most vulnerable, such as children and adolescents living with disabilities or HIV.

#### **Invite/Engage Community Advocates**

Invite/engage community advocates conducting prevention/awareness activities/campaigns to regular meetings to discuss ways to better coordinate (i.e., to identify opportunities for advocates to include information about available services in their campaigns; to invite advocates to leave literature regarding violence prevention/awareness-raising literature in the waiting room at your center; to hold monthly meetings with advocates regarding pressing community issues, etc.). This engagement should include both formal leadership (i.e., Community Protection Committees) and informal structures (traditional leaders, those involved in informal justice systems) that engage with children and adolescents.

#### **Incorporate Combined Training**

Incorporate combined training of those in the system, including health care personnel, formal and informal community groups, service site workers, police, and criminal justice system/legal teams. This will help foster a culture of working together, build trust and understanding, and broadly increase capacity in caring for and managing victims/survivors. Mixed training can also help different cadres understand how other sectors function, and encourage dialogue and networking to improve standards of care for children and adolescents.

1) Levy, Marcy, Lyn Messner, Malia Duffy, and Jennifer Casto. 2016. *Strengthening Linkages between Clinical and Social/Community Services for Children and Adolescents who Have Experienced Sexual Violence: A Companion Guide*. Arlington, VA: Strengthening High Impact Interventions for an AIDS-free Generation (AIDSFree) Project.

### Conduct Specific Outreach

Conduct specific outreach with persons who regularly interact with children/adolescents (teachers, pastors, community leaders, sports coaches, etc.), invite them to visit the center/facility and ensure that they know how to handle cases of suspected child/adolescent sexual violence; are familiar with the services offered at your center; and are aware of opportunities to refer children/adolescents. This engagement should include both formal and informal leadership/structures who might engage with children and adolescents.

Important points to remember when making referral

## IMPORTANT POINTS TO REMEMBER WHEN MAKING REFERRAL

### When you make a referral, it is ALWAYS important to remember to:

- Refer clients only to services or support within a reasonable distance: in an emergency, ensure there is a means of transportation for the client;
- Call ahead to sensitize the service organization to the future referral;
- Go with the child/family to the service; Know the services provided and the staff providing the services;
- Ensure that someone has the overall responsibility to follow up with the child and service providers so that the child's needs are met;
- Systematically check the client's progress within the service organization

### When you receive a referral, it is ALWAYS important to remember to:

- Understand the referral that has been asked – what does the service provider ask you to do – and ask for clarification if there is not enough information.
- Make sure the child and the family understand the reason for and are satisfied with the referral;
- Give feedback to the agency making the referral.
- Evaluate if the client has additional needs and requires referral to other services

## Strengthening community referral systems

Community participation is key to delivering health services that meet people's needs. To provide children-centered care, it is critical to engage with children and their guardian's/parents directly in order to learn what matters to children who experience violence. You will know whether your services address children's needs only by asking them, listening to them and adapting accordingly.

Community engagement requires **participatory planning, advocacy and accountability**.

- 1. Participatory** planning involves engaging the community, and particularly children (especially older children) from the community, in the design, planning, delivery and monitoring of the services. This can be done through community dialogue, by consulting with advisory groups and by involving local community organizations in coordination mechanisms and work planning processes.
- 2. Advocacy** includes raising awareness with communities as well as with children who come to clinics for general health care and HIV services about available services to address violence against children and the need to seek timely health care. It is also important to challenge elements of stigma in the community that prevent guardians and children themselves from seeking post violence care. You and your staff should engage communities in discussions about violence against children with simple messages (see Job aid 4 below). Advocacy activities can be carried out through community outreach workers, development and dissemination of information, education and communication (IEC) materials and community meetings, in partnership with community-based organizations. Displaying IEC materials in the clinic can also make information available and in a manner promoting safety.

## COMMUNITY ENGAGEMENT MESSAGES

- What is violence against Children?
- What are its health consequences?
- How can violence against Children be prevented?
- How should community members respond to Children subjected to violence?
- What health services are available for Children subjected to violence, where are they located and when do they operate?
- What are the obligations of health-care providers to respond to Children subjected to violence?
- Why is it important for Children who are sexually abused to seek care as soon as possible?
- What rights do children subjected to violence have with respect to health care, and what redress and grievance mechanisms are there if these rights are violated?
- What is the process to undertake legal action?

**3. Accountability** involves mechanisms for monitoring and evaluation of services as well as for feedback from the community about the quality of services. It also includes redress if health facilities fail to provide adequate services or if they mistreat children who seek care.



### NOTE:

#### **Use of IEC materials**

Educational materials may serve several purposes in a health center. They promote the services provided, offer support, send messages about the unacceptability of violence against children and provide information for individuals in high-risk situations who may need to conceal the information. Materials that children and guardians' / parents can take home must be small and easily concealed (for example, brochures, small cards, unmarked merchandise with numbers of helplines). Children must be made aware of the possible risk to their safety of carrying such information



## HANDOUT 3

The diagram below sets out the types of linkages that you may wish to make. In the workshop, you will work with colleagues to develop your own referral pathways.

This tool can be used with colleagues back at your facility to develop your own referral resource directory.

<b>STEP 1</b> Identify focal point person for reporting all cases of VAC at your health facility. (List name)	
<b>STEP 2</b> List the key entry points within your health facility where VAC cases are served.	
<b>STEP 3</b> List key players within other sectors that you will work with to ensure that child survivors of violence receives a comprehensive service.	
Social Services	Community
Civil Society	
<b>STEP 4</b>	 COORDINATOR
Write down name and contact of the person in your health facility that will coordinate the VAC referrals and linkages	





## REFERENCES & FURTHER READING

### References

- 1) Levy, Marcy, Lyn Messner, Malia Duffy, and Jennifer Casto. 2016. Strengthening Linkages Between Clinical and Social/Community Services for Children and Adolescents who Have Experienced Sexual Violence: A Companion Guide. Arlington, VA: Strengthening High Impact Interventions for an AIDS-free Generation (AIDSFree) Project.
- 2) A Practical Guide to developing a Child Friendly Spaces. UNICEF. [https://www.unicef.org/protection/A\\_Practical\\_Guide\\_to\\_Developing\\_Child\\_Friendly\\_Spaces\\_-\\_UNICEF\\_\(2\).pdf](https://www.unicef.org/protection/A_Practical_Guide_to_Developing_Child_Friendly_Spaces_-_UNICEF_(2).pdf)

### Further Reading

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3. Guidelines for medico-legal care for victims of sexual violence (WHO, 2003) <http://apps.who.int/iris/bitstream/handle/10665/42788/924154628X.pdf?sequence=1>
4. 4Children. (2018). Standard Operating Procedures for Case Management. (available at [www.ovcsupport.org](http://www.ovcsupport.org))



**DOCUMENTATION  
AND REPORTING  
OF VAC SERVICES**

## INTRODUCTION

Health workers have an obligation to accurately record the details of VAC services and interventions offered to children survivors who present at health facilities.



At the end of this module, the participants should be familiar with:

- The importance of documentation of VAC services;
- The tools used at health facilities to collect data from children who are at risk of or have experienced violence;
- Data quality assurance methods.



## HANDOUT 1

### Documentation and reporting for VAC – an overview

#### Importance of Documentation for VAC Services

Recording accurate and complete data is important for the following reasons:

- The health record will alert health care workers on important facts to assist them in providing appropriate follow-up care.
- The medical records may be used as evidence in the court of law. This is especially critical in cases of sexual violence. Documenting the consequences of sexual violence may help the court in decision-making.
- Documentation can provide health administrators and policy makers with an estimate trends of the incidence and prevalence of VAC. This can be used to inform decisions about resource allocation.

#### Data Collection for VAC Services

It is important to familiarise yourself with your country specific data collection tools and learn how to use them appropriately and accurately. VAC services are documented using various data collection tools at health facilities.

These include the following:

- i. Client Information Form:** A number of countries have structured standard forms or pro-formas for recording details of the medical consultations specifically for cases of violence. This form should collect information on key bio-data; the presenting complaint or the providers observations; date of incident ; providers details and signature ( see teaching AID 7 )
- ii: VAC Daily Activity register:** This is a data collection tool used to compile information from the client information on a monthly basis. The documented information is transcribed from the client information form ( see teaching AID 8) and includes action taken by health worker
- iv. Client referral form:** This form is filled by the health worker to give a summary of information to help the service provider at next service delivery point give appropriate additional support

#### VAC Data Reporting Tools

All health facilities providing VAC services should generate a monthly report using a standard VAC reporting summary form, see Module 9 Handout 2: Sample VAC Reporting Summary Form).

This form is filled by consolidating information from the VAC register (Annex 2: Sample VAC Register). It is filled on a monthly basis and collects information on key bio data; the incident (date, time, and place of violence, alleged perpetrator, and type of violence, symptoms and circumstances of incident); emergency treatment etc. It is used to transmit data from the facility to the national reporting system.

#### Data Quality Assurance and Storage of VAC Data

##### Data Quality Assurance

It is critical for health care providers to ensure that the information collection from the child during the consultation process is accurate and complete in order for it to be useful for decision making. The following processes can be undertaken routinely by assigned personnel to ensure that the data is regularly audited and cleaned.

1. Monthly data reviews of client documentation forms and the VAC register to ensure completeness and accuracy.
2. Corrective measures should be put in place (where possible) for all forms and registers that are found to be incomplete or containing erroneous information. The corrective measures include data verification from source documents and reconstruction where possible.
3. Continuous training of health care providers on importance of collecting quality data, maintaining confidentiality of data and protecting private and personal information.

### Storage of Data

Information collected from the child at every service delivery point must be treated with utmost confidentiality and privacy. Health care providers should reassure the child and/or caregiver that the information will be kept safely and will only be available to hospital personnel who are directly involved in providing services to the child.

All filled data collection tools that contain the child's confidential and legal information must be securely stored. This can be in a dry and safe place under key and lock, in a store or office cabinet etc.

### Best Practice for Documentation of VAC Services

Figure 16 below outlines the procedures that should be observed by health care providers to document accurately the information identified and provided by the care giver or the child.

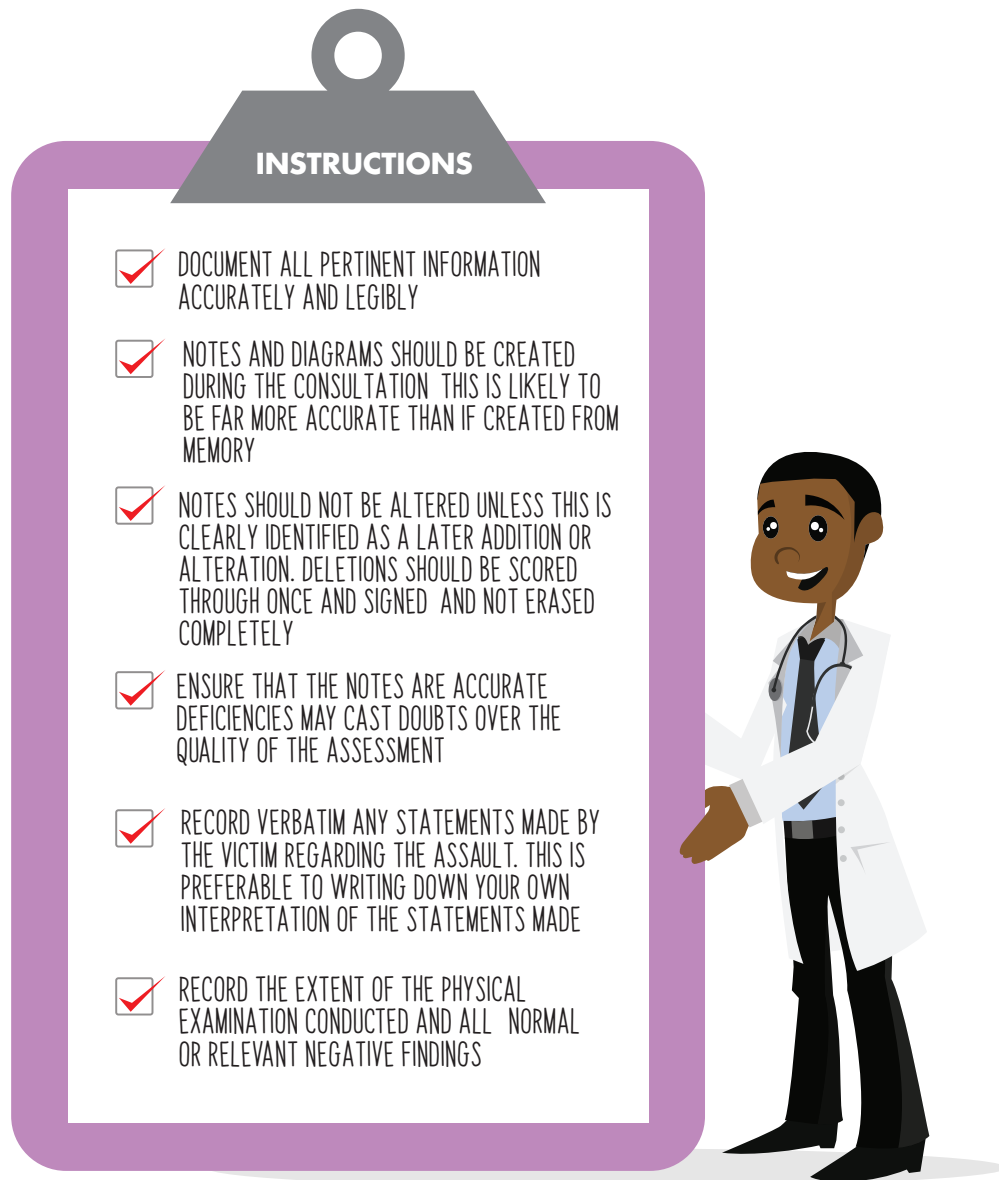


Figure 16 Procedures for ensuring accurate documentation patients History and Examination findings by health care providers.

Source WHO guidelines for medico-legal care for victims of SV 2003



## Client information Form- Sample

DATE:

### CLIENT INFORMATION FORM

NAME:

AGE:

SEX:

LOCATION:

NATIONALITY

PARENT/GUARDIAN:

### INSTRUCTIONS:

1.This form should be filled by a health care provider for all child survivors identified positive for violence upon use of CPET.

2. Information written on this form should not be diagnostic  
Presenting complaint (This information should be as stated by the client/guardian)

DATE OF INCIDENCE (DD/MM/YY):

Observation (This information should be informed by questions in the CPET):

REFERRAL

YES

NO

### DETAILS OF SERVICE PROVIDER:

NAME:

CADRE:

DATE:



### Sample VAC daily activity register

#### SAMPLE VAC DAILY ACTIVITY REGISTER

NAME OF FACILITY:

MFL CODE:

REGION

SUB REGION

SN. NO	NAME	AGE	SEX	LOCATION	VIOLENCE SUSPECTED (YES OR NO)	DATE OF INCIDENCE	REFERRED	COMMENTS	NAME OF STAFF	INITIALS /SIGNATURE

DATE: \_\_\_\_\_

**SAMPLE REFERRAL AND COUNTER REFERRAL FORM**

Contact Person (If Known) And Name Of Organisation Referred To

Dear Colleague,

The client listed below has been a client of this Ministry/ organisation, and needs additional services. I am referring him / her to your organisation for the necessary support based on the background information provided below.

Please complete the attached feedback page and return it to me. Please contact me if required.

Client's surname:	First name:	Date of birth:	Sex:
Tel/Cell:	Contact of Client's Details (Physical Address):		
Best way to reach client / family:	<b>Contact Details Of Child's Parent / Guardian / Caregiver If A Minor</b>		
	Name:		
	Tel/cell:		
	Address:		

**Details of the additional clients (adult / children concerned):**

Surname:	First name	Date of birth	

Summary of problems / issues:

Reasons for referral / recommendations or expected results:

These have been identified and discussed with client:  Yes  No

Other information that may be helpful to this referral:

**Contact Details of Person Referring:**

Name:	Contact details:
Signature:	Official date stamp

Referring organisation's details:



DATE:

I \_\_\_\_\_ (service provider receiving referral) \_\_\_\_\_, hereby acknowledge  
the receipt of the referral for \_\_\_\_\_ (client's name) \_\_\_\_\_,  
case number: \_\_\_\_\_ (if known) \_\_\_\_\_

for follow up services. We thank you for bringing this client to our attention.

Case is receiving attention and further investigations are being made:

We are able to, or have provided requested services:

Did not provide requested services because (explain in brief):

We value your interest in this client and sincerely appreciate your contribution to improving the lives of others.

Yours sincerely,

Name of Staff / agency :

Signature:

Telephone number:

Official date stamp



**SUPPORT FOR  
VAC SERVICE  
PROVIDERS**

## INTRODUCTION

Health workers are often engaged in helping children who have experienced violence. Counselors do this on a day to day basis. Child survivors of violence share stories involving trauma or human suffering; stories that sometimes are difficult to forget about and can lead to burnout and in some cases secondary trauma.



At the end of this module, the participant should learn about:

- Issues that service providers go through while providing VAC services;
- Mitigating secondary trauma, burn out and stress using debriefing sessions and other strategies.



## HANDOUT 1

### Secondary Trauma

A person's response to an event may involve intense fear, helplessness or horror. In children the response at times involves disorganized or agitated behavior.

Some traumatic experiences narrated by the child survivors of violence may include physical violence, sexual abuse, human trafficking, abandonment and neglect as well as being witness to any of these occurrences, (Covington, 2012).

Research indicates that half of all professionals who work with children who have experienced violence report feeling distressed while almost one third of trauma psychotherapists report experiencing "extreme distress". This distress is exacerbated by the fact that around one third of psychotherapists have experienced trauma during their own childhood, (Kohlenberg, 2006).



### Concepts applied in supporting providers of VAC service

#### **Burnout ("All I do is work, I don't have a life.")**

This is as a prolonged response to chronic emotional and interpersonal stressors on the job which consists of three components:

1. Exhaustion,
2. Depersonalization (defined as: disengagement or detachment from the world around you) and
3. Diminished feelings of self-efficacy in the workplace. It reflects a form of "energy depletion".

Burnout is associated with depression and secondary (vicarious) traumatization. It may arise from feeling either permanently overworked or under-challenged, being time-pressured, or having conflicts with colleagues. Over-commitment that leads people to neglect their own needs may also significantly contribute to burnout.

#### **Secondary Trauma ("I feel hurt and afraid, too!")**

Secondary trauma is defined as "transformation in the inner experience of the health care provider that comes about as a result of empathic engagement with clients' traumatic material." This concept describes the reactions to the emotional demands on health care providers from exposure to trauma survivors' terrifying, horrifying, and shocking images; strong, chaotic affect; and intrusive traumatic memories. This term is often used interchangeably with Secondary Traumatic Stress (STS)

#### **Secondary Traumatic Stress (STS) ("I am so tired of caring for everyone else!")**

This refers to the adverse reactions of health care providers who seek to aid child survivors of violence. This concept is also known as Compassion Fatigue.

#### **Countertransference**

This concept implies that the helper's response is influenced by the helper's own unresolved issues (e.g., lingering impact of the helper's victimization experiences). This may lead to avoidance and over identification with the child. The helper may take on a protective role for the child, becoming the "champion" of the child and adopt a role of "rescuer".

#### **Vicarious Resilience**

In contrast to the concepts of Vicarious Traumatization, Burnout, Secondary Traumatic Stress, and Countertransference, it is important to keep in mind that trauma-focused psychotherapists can also become strengthened and more resilient as a result of working with traumatized clients who have experienced post-traumatic stress disorder (PTSD).

## Common Manifestations of Secondary Trauma Among Health Care Providers

Health care providers need to be on the alert for these immediate stress responses and/or long-term effects: Figure 17 provides some of the common manifestations.

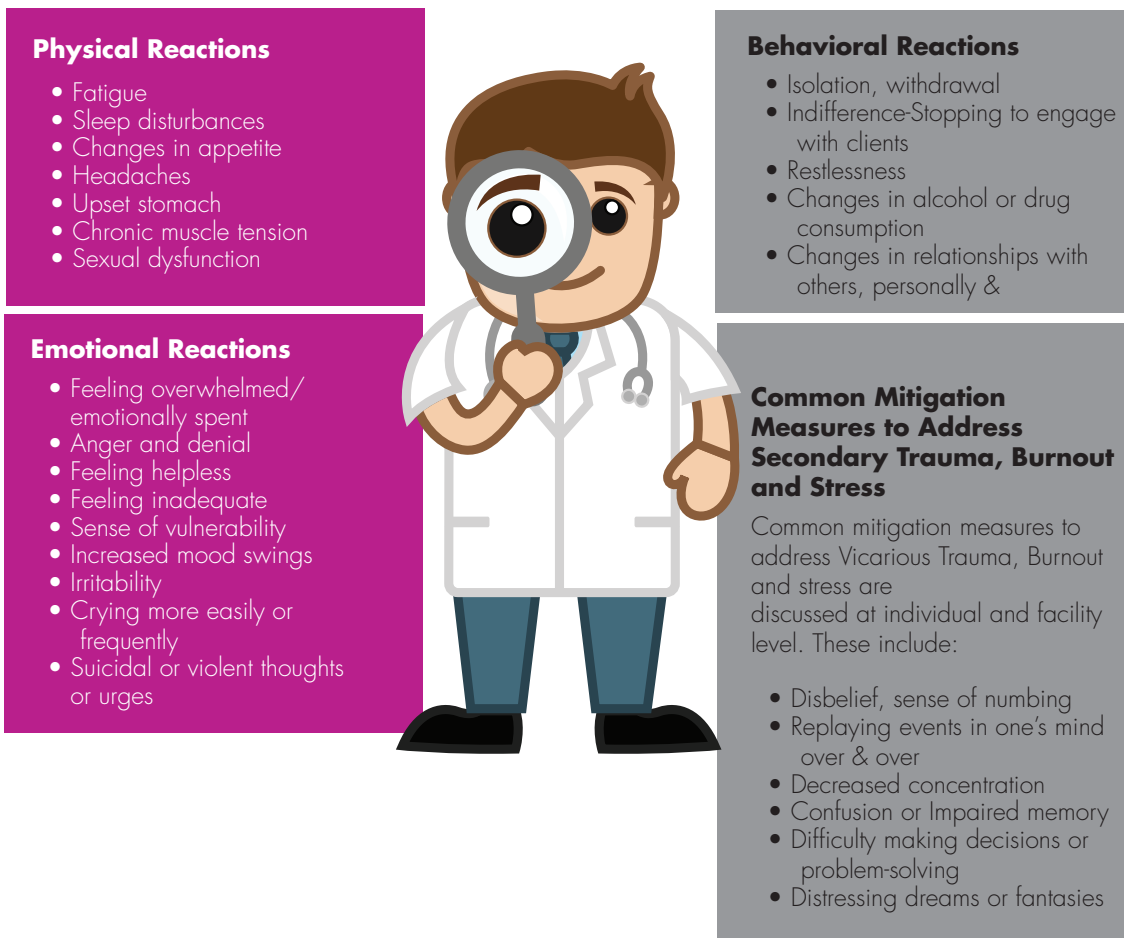


Figure 17 Common Manifestations of Secondary Trauma among Health Care Providers Common Mitigation Measures to Address Secondary Trauma, Burnout and Stress Common mitigation measures to address Vicarious Trauma, Burnout and stress are discussed at individual and facility level. These include:

### Individual level

#### Self-Care

When working with children who are at risk or have experienced violence the health care providers should routinely use the following self-care tips to prevent secondary stress:

- Be aware of their own emotional reactions and distress when confronting others' traumatic experiences, and know what traumatic material may trigger them.
- Connect with others by talking about their reactions with trusted colleagues or others who will listen.
- Maintain a balance between their professional and personal lives, with a focus on self-care (e.g., relaxation, exercise, stress management, etc.) to prevent, and lessen the effects of, workplace stress.

**Other practical strategies for preventing and reducing secondary traumatic stress at work include:**

- Diversifying tasks at work, or vary caseload, to the extent that one can
- Take breaks during workday
- Take vacation days
- Use relaxation techniques (e.g., deep breathing) as needed
- Talk with colleagues about how your work affects you
- Seek out, or establish, a professional support group
- Recognize personal limitations; set limits with patients and colleagues
- Identifying clients' resilience and strength;
- Continuing education in the area of trauma
- Share or split job roles during a shift with co-workers.
- Recognize stress and be honest with yourself.
- Separate work from personal life, be fully present in both
- Live a full and enjoyable life
- Attend workshops and career enhancing opportunities
- Practice good self-care: including emotional, physical, spiritual, intellectual, social, relational, and safety/security
- Adequate sleep, nutrition, exercise, relaxation, hobbies & recreation
- Spiritual self-care—meditation, prayer, or attend mosque/church

**Facility level**

The facility managers need to allocate resources for service care providers to undergo debriefs and support supervision, as well as support the outcomes of these sessions. These sessions are conducted on a needs basis or as agreed by the teams in the facilities.

**a) Debriefing**

This is emotional-first aid for those who have experienced a traumatic, emotionally upsetting or stressful experience. Its goals are to discuss the actions and thought processes involved in dealing with a child at risk of or who has experienced violence, encourage reflection on those actions and thought processes, and incorporate improvement into future performance. The function of debriefing is to identify aspects of team performance that went well, and those that did not. The discussion then focuses on determining opportunities for improvement at the individual, team, and system level.

**b) Supportive supervision**

This is a facilitative approach of supervision that promotes mentorship, joint problem solving and communication between supervisors and supervisees. Supervision also enables health care provider to develop their skills and knowledge on an ongoing basis with a focus to ensuring effective delivery of services to child survivor of violence. Ongoing professional supervision is crucial to developing health care providers' case management skills, as well as preventing vicarious traumatization and burnout.

The type and frequency of supervision as indicated in Figure 18 is determined by the functions performed by health care providers.

**Health care provider should also have access to case debriefing and support outside of supervision to help them with particularly difficult cases or cases that have a direct emotional impact on them. Organizations can help to reduce stress by putting in place the following support and policies:**

- Limiting shifts to no more than 12 hours and encouraging work breaks
- Rotating first responders' tasks to ensure they are not constantly exposed to the most stressful activities.
- Ensuring time off
- Ensuring that people work with partners or in teams
- Encouraging staff to have appropriate boundaries to protect themselves from getting over-involved by, for example, taking victims home to stay with them

### The importance of health care provider supportive supervision

- It facilitates the personal and professional development of the health care provider and helps relieve burnout
- The educative function supports the development of health care provider competencies.
- Promotes provision of quality services.

### Supportive supervision can be done in any of the following ways:

1. Self
2. One to one



Figure 18 Type and frequency of supervision



## REFERENCES & FURTHER READING

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Coordinating Comprehensive Care for Children (4Children) is a five-year 2014-2019), USAID-funded project to improve health and well-being outcomes for Orphans and Vulnerable Children (OVC) affected by HIV and AIDS and other adversities. The project aims to assist OVC by building technical and organizational capacity, strengthening essential components of the social service system, and improving linkages with health and other sectors. The project is implemented through a consortium led by Catholic Relief Services (CRS) with partners IntraHealth International, Pact, Plan International USA, Maestral International and Westat.

