Briefing Note

Strengthening Child Protection Practices in Healthcare Institutions in Lebanon

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وزارة الصحة العامة

Briefing Note

Strengthening Child Protection Practices in Healthcare Institutions in Lebanon

Knowledge to Policy Center K2P

Merit Review

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Executive Summary

Executive Summary

The United Nations Convention on the Rights of the Child in 1990 defined the child as any individual aged between 0 and 18 years.

Child abuse, be it physical, sexual, emotional, or neglect is recognized as an act that would expose the child to risk of mistreatment or threaten his or her health, well-being, morals, or development (UNICEF, 1989).

Purpose

The purpose of this briefing note is to shed light on the problem of child violence, neglect, exploitation and abuse in Lebanon, taking into account special consideration for children with special needs that are subject to or at risk of violence, neglect, abuse and exploitation, and the related health facilities' child protection arrangements. It also provides a synthesis of interventions that have shown to improve child protection practices and presents evidence-based, context-specific recommendations to improve child protection at healthcare facilities in Lebanon.

The Problem

Child violence, neglect, exploitation and abuse is associated with aggravated depression, psychosis, substance abuse, teen pregnancy, sexually transmitted disease, economic burden, and mortality. 10,825 child violence, neglect, abuse and exploitation cases who received child protection case management services were reported by the child protection sector in Lebanon in 2017, of which approximately 90% were of medium and high risk.

The limited availability of preventive interventions for child violence, neglect, exploitation and abuse, inadequate early identification and reporting of violence, neglect, exploitation and abuse in healthcare facilities and lack of coordination between sectors in the management of child violence, neglect, exploitation and abuse cases, compromise child protection practices in healthcare facilities in Lebanon.

Size of the Problem

In two local published studies 30%, 65%, 54%, and 15% of surveyed Lebanese children reported at least one incident of witnessing violence, psychological abuse, physical abuse, or sexual abuse respectively. Violent discipline is also common. According to the results of a household survey conducted by UNICEF in 2016, 82% of Palestinian refugees in Lebanon, 77% of Palestinian refugees from Syria, 65% of Syrian and 57% of Lebanese children age 1-14 years experienced to at least one form of psychological or physical punishment by household members during the past month. Moreover, 1149 child violence, neglect, exploitation and abuse cases were detected by himaya in Lebanon in 2017. Concomitantly, child

violence, neglect, exploitation and abuse is associated with adverse health outcomes such as higher incidence of mental health disorders, eating disorders, sexually transmitted diseases, and increased mortality. Child violence, neglect, exploitation and abuse is also associated with substantial economic burden at both the individual and system levels. Despite the magnitude of the problem, healthcare organizations in Lebanon are not systematically active as child protection agencies, and very few have comprehensive policies or structures that monitor, detect, or address child protection issues. Therefore, given the high prevalence of violence, neglect, exploitation and abuse among children and the long-term deleterious impact that child violence, neglect, exploitation and abuse can have on children and the healthcare system, there is an urgent need to take action to foster a child protection system in healthcare facilities, especially if Lebanon is to attain the SDGs by 2030.**Underlying Causes**

Published studies have identified a number of factors to be associated with or contributing to the problem of child violence, neglect, exploitation and abuse. As such, lack of adequate training of health professionals in the **early identification** of child violence, neglect, exploitation and abuse impedes proper diagnosis and management. As for reporting, the unfamiliarity of health professionals with the **reporting** guidelines, prior negative experiences with child protection services, fear of loss of the relationship with the child and family, and fear of physical or legal reprisal lead to improper reporting and therefore inadequate management of child violence, neglect, exploitation and abuse cases.

Local Context

A systematic local assessment was undertaken to uncover health system arrangements that contribute to the problem of child violence, neglect, exploitation and abuse.

Results of local assessment revealed that proper **reporting and referral** was hindered by the perceived voluntarily reporting among health professionals, the lack of penalties for not reporting, the limited access to training opportunities among health professionals, the improper dissemination of standardized reporting channels, poor reporter protection, and reporter fear of breach of professional secrecy and other repercussions of reporting.

At the **sociocultural level**, embarrassment and fear of social stigma might cause reluctance among caregivers to present their abused child to attention or to accept management. Regarding healthcare workers, knowledge deficit, lack of trust in the legal and social channels, unpleasant experiences with previous cases, ethical challenges, and cultural beliefs deter proper management of child violence, neglect, exploitation and abuse. As for organizations, there

seems to be an underestimation or misunderstanding of the problem of child violence, neglect, exploitation and abuse, and thus little efforts invested to tackle this problem.

The local assessment also revealed that **early identification and management** of child violence, neglect, exploitation and abuse is hindered by the limited availability of specialized training, staff, or interventions addressing child violence, neglect, exploitation and abuse. There is also a deficiency in the availability of standardized, validated and contextualized tools targeting various age groups or subtypes of child violence, neglect, exploitation and abuse.

As for **financing** of child protection services, the assessment revealed that specific coverage of child protection services are almost non-existent, particularly in the outpatient settings, whereby rehabilitative services are not reimbursed unless provided or mediated through a specific social institution or an NGO involved in child protection. On the other hand, inpatient services are covered similarly to any other medical condition.

Policy Recommendations

Recommendation 1› Strengthen child protection practices in healthcare organizations through related age/gender specific policies, procedures, standards, and resources.

This can be established through:

- Incorporating child protection into the new hospital and PHCs accreditation standard requirements and defining structure, process, and outcome-based standards. The standards will cover staff training and orientation on child protection, referral and management procedures for child violence, neglect, exploitation and abuse cases (including cases that occur in healthcare facilities), ethical framework(including appropriate behavior and communication with children) and the availability and quality of services on child protection and child abuse management
- Setting well-defined national executive decrees for child protection, which delineate and mandate unified channels for reporting and follow up of cases from healthcare facilities. Decrees should also provide reporter protection and account for the professional secrecy of medicine and the victims' right to privacy and confidentiality.

Recommendation 2› Develop and implement tools and strategies in healthcare organizations for child violence and abuse early identification and management.

This can be achieved by:

Early identification

- Adopting, adapting, and validating pre-designed flow charts and tools aiming at enhancing the diagnosis of diverse forms of child violence and abuse among various age groups, and the early identification of special populations who are at risk of abusing their children such as adolescent parents and parents with mental health disorders

Management

- Adopting shared decision making, in which the child is asked to participate in the management of the abuse case
- Establishing a specialized child abuse health response teams in hospitals emergencies aiming for a proper and optimal healthcare management
- Establishing child protection units or focal points in healthcare organization and facilities. The unit or focal point aim at improving awareness of staff regarding the child protection policy, enhancing safe identification and referral of cases identified by health care providers to social workers and caseworkers.

Recommendation 3› Enhance the knowledge and education of providers to recognize, refer or manage child violence and abuse.

This can be established by:

- Enhancing knowledge and awareness through both the integration of child protection in the educational curricula for healthcare workers and providers involved in child protection, such as nurses, doctors, and paramedical staff, with a focus on identifying signs of violence and abuse and safe referral of cases of child violence and abuse.
- Capacity building for social workers and healthcare providers on early identification and referral. Capacity building for psychologists on the early identification and management of violence and abuse cases. Capacity building for forensic doctors and emergency medical team on the early identification, referral, management of child violence and abuse cases and on the medical management of injuries and clinical management of sexual abuse inflicted to children victim in order to orient and support children throughout these medical processes.

Recommendation 4› Promote social behavioral change in relation to child protection.

This can be achieved by:

- Developing and evaluating evidence-based and context-specific behavioral change programs on child protection for children and parents. Programs can be provided by health care providers such as pediatricians, mental health professionals, nurses and midwives (i.e. Parental education on child raising skills, child development, and parenting; Abusive head trauma prevention programs; Multi-component interventions that include family support, preschool education, parenting skills and childcare; Media-based interventions)
- Delivering and monitoring the behavioral change programs provided to children and parents
- Advocating for the sustainable implementation and incorporation of those programs in primary healthcare centers.

الملخص التنفيذي

الهدف

إنّ الهدف من هذه المذكرة الموجزة *(Briefing Note)* هي تسليط الضوء على مشكلة العنف ضد الأطفال في لبنان، مراعيا الاعتبارات الخاصة للأطفال ذوي الاحتياجات الخاصة المعرضة لخطر العنف وإجراءات حماية الأطفال المتَّبعة في المؤسسات الصحية كافة" .

كما أن المذكرة الموجزة تقدم مجموعة من المداخلات، أثبتت وبعد تطبيقها، أنها تحسِّن من ممارسات حماية الأطفال، وتقدم توصيات مدعّمة بالإثباتات *evidence-based* ومحددة السياق *(context-specific)* لتحسين حماية الأطفال في المؤسسات الصحية في لبنان.

تعريف المشكلة

إن العنف ضد الأطفال مرتبط بالاكتئاب المتفاقم، الذهان، تعاطي المخدرات، حمل المراهقين، الأمراض المنقولة جنسياً، الأعباء الاقتصادية ومعدل الوفيات. في العام 2017، سجلّ "قطاع حماية الطفل" في لبنان، 10,825 حالة عنف، إهمال، سوء معاملة واستغلال أطفال، التي تلّقت خدمات لحمايتهم، حيث ما يقارب نسبة الـ90٪ منها، تراوحت حالتهم بين المتوسطة وعالية الخطورة.

إن محدودية توافر التدابير الوقائية للعنف ضد الأطفال، والتعرُّف والتبليغ غير الكافي لحالات العنف في المؤسسات الصحية، ونقص التنسيق بين القطاعات في إدارة قضايا العنف ضد الأطفال، يهدد ممارسات حماية الأطفال في المؤسسات الصحية في لبنان.

حجم المشكلة

كشفت دراستان محليتان شملتا أطفالا لبنانيين بأن:

- ← 30% شهدوا ممارسات عنفية مرة على الأقل.
- ← 65% اختبروا العنف النفسي مرة على الأقل.
- ← 54% اختبروا العنف الجسدي مرة على الأقل.
- ← 15% اختبروا العنف الجنسي مرة على الأقل.

إلا أنّ التأديب العنيف شائع أيضا. ووفقًا لنتائج مسح الأسر الذي أجرته اليونيسف في عام 2016 ، فإن 82٪ من اللاجئين الفلسطينيين في لبنان ، و 77٪ من اللاجئين الفلسطينيين من سوريا ، و 65٪ من السوريين ، و 57٪ من الأطفال اللبنانيين الذين تتراوح أعمارهم بين سنة و 14 سنة ، قد تعرضوا لشكل من أشكال العقاب النفسي أو البدني من قبل أفراد الأسرة خلال الشهر الماضي.

إضافةً إلى 1149/ حالة عنف ضد الأطفال تمَّ رصدها من قبل حماية في لبنان في 2016. وتزامناً ، فإن تعنيف الأطفال له إنعكاسات صحية سلبية، مثل الإضطرابات العقلية، الاضطرابات ا الغذائية، الأمراض المنقولة جنسياً، وزيادة الوفيات.

كما ترتبط ممارسات تعنيف الأطفال بالأعباء الإقتصادية الكبيرة على مستوى الفرد ومستوى النظام على حدٍ سواء.

وبالرغم من جسامة وأهمية المشكلة، فإنّ المؤسسات الصحية في لبنان غير فاعلة بطريقة ممنهجة كمؤسسات تملك الدور في حماية الأطفال، بحيث أن بعض من هذه المؤسسات لديها سياسات أو هيكليات شاملة، كفيلة بمراقبة ورصد، ومعالجة حالات التعنيف.

لذلك، وبالنظر إلى انتشار حالات العنف على الأطفال، وبالنظر إلى التأثيرات الضارة على الأمد البعيد التي تسببها على الأطفال أنفسهم وعلى النظام الصحي، فهناك حاجة طارئة لتبنّي نظام حماية للأطفال في المؤسسات الصحية، وبخاصةٍ إذا كان لبنان يصبو إلى تحقيق أهداف التنمية المستدامة في العام 2030 *(SDG)*.

الأسباب الكامنة

حدّدت الدراسات المنشورة، عدداً من العوامل المرتبطة أو المساهمة في إشكالية تعنيف الأطفال. مثلاً، النقص في التدريب المناسب للإختصاصيين الصحيين في **التعرُّف** على حالات العنف على الأطفال يعيق التّشخيص والمعالجة الملائمَين.

أما في ما يتعلّق بالتبليغ عن هذه الحالات، فإن عدم إلمام الإختصاصيين الصحيين بالمعايير التوجيهيّة المتّبعة للتّبليغ، والتّجارب السابقة السلبية في التعامل مع خدمات حماية الطفل والخوف من فقدان العلاقة مع الطفل والعائلة، والخوف من عمل انتقامي جسدي أو قانوني يؤدي إلى تبليغ غير سليم، وبالنتيجة إلى **معالجة** حالات العنف ضد الأطفال بطريقة غير مناسبة.

السياق المحلي

تمّ إجراء تقييم محلي وممنهج لكشف التدابير المتبعة في النظام الصحي والتي تساهم في إشكاليّة تعنيف الأطفال.

وأظهرت نتائج هذا التقييم بأن **التبليغ والإحالة** المناسبَين، قد أُعيقا بسبب: ما يُعتقده الاختصاصيين الصحيين أنّ التبليغ الطَوعي ، غياب العقوبات لعدم التبليغ، محدودية فرص تدريب الإختصاصيين الصحيين، التعميم غير الصحيح لآليات موحّدة للتّبليغ، الحماية غير الكافية للمُبلّغ، خوف المُبلّغ من نقض السرية المهنية والتّبعات الأخرى للتبليغ.

أما على **المستوى الاجتماعي والثقافي**، فإن الإحراج والخوف من وصمة عار إجتماعية، قد يسبب التردد لدى مقدمي الرعاية لجذب الإنتباه للطفل المعنَّف الموجود تحت رعايتهم أو قبولهم التوجيه . وفيما يتعلّق بموظفي القطاع الصحي، فإن قلة المعرفة ونقص الثقة بالقنوات الإجتماعية والقانونية، والتجارب غير الإيجابيّة في معالجة القضايا السابقة والتحديات الأخلاقية، والمعتقدات الثقافية تمنع المعالجة السليمة لحالات العنف ضد الأطفال.

أما بالنسبة للمؤسسات، يبدو أن هناك إستخفاف أو سوء فهم لإشكاليّة العنف ضد الأطفال، ولذلك هناك القليل من الجهود المبذولة لمعالجة هذه الإشكاليّة .

كما أظهر التقييم المحلي، أنّ محدودية التدريب المختصّ ووفرة الموظفين أو آليات التّدخّل التي تعنى بتعنيف الأطفال تحول دون التعرّف والإدارة المناسبتين لحالات العنف ضد الأطفال. كما أنّ هناك نقص في توافر الوسائل الموَحّدة والمصدّقة والمرتبطة بالسياق المحلّي، والمناسبة لفئات عمرية مختلفة وأنواع العنف ضد الأطفال.

أما بالنسبة **لتمويل** خدمات حماية الأطفال، فقد أظهر التقييم أن التغطية المخصّصة لخدمات حماية الأطفال هي شبه غير متوفّرة ، خصوصاً في مراكز العيادات الخارجية حيث خدمات إعادة التأهيل لا يُعوَّض عنها، إلا إذا قدمتها أو توسطت لها مؤسسات إجتماعية محددة أو منظمة غير حكومية معنية بحماية الأطفال. وفي المقابل عند دخول المستشفى، هذه الخدمات تكون مغطاة تماماً كأي حالة صحية أخرى.

التّوصيات

التّوصية الأولى

تدعيم ممارسات حماية الأطفال في المؤسسات الصحيّة من خلال السّياسات، والإجراءات والمعايير والموارد متماشية مع عمر الأطفال و نوعهم الاجتماعي .ويمكن تحقيق هذا الهدف من خلال:

- ← إدراج برامج حماية الأطفال في معايير الإعتماد للمستشفيات ومراكز الرعاية الأوليّة، على المستوى الهيكلي، العملي والنتائجي لتوجيه وتدريب الموظفين على حماية الطفل وإجراءات الإحالة والمعالجة لحالات العنف ضد الأطفال (بما في ذلك الحالات التي تحدث داخل المراكز الصحية)؛ والإطار الأخلاقي (بما في ذلك السلوك والتواصل المناسبين مع الطفل) وتوافر الخدمات ونوعيتها في معالجة حالات العنف ضد الأطفال وحمايتهم .
- ← وضع مراسيم تنفيذية محدّدة لحماية الطفل، والتي تحدّد وتكلّف قنوات موحّدة للتبليغ والمتابعة للحالات المحوّلة من المراكز الصحية. بحيث يجب على المراسيم أن توفّر الحماية للمُبلّغ وتُراعي السّرية المهنيّة وحق الضحية في الخصوصيّة والسريّة.

التّوصية الثّانية:

إعداد وتطبيق الأدوات والاستراتيجيات في المؤسسات الصّحية للكشف المبكّر ومعالجة حالات تعنيف الأطفال. ويمكن تحقيق هذا الهدف من خلال:

الكشف المبكّر:

- ← تبنّي وتطويع وتوثيق مخطّطات مصمّمة *(flowcharts)* مسبقاً والأدوات التي تهدف إلى تعزيز تشخيص الأشكال المختلفة للعنف ضدّ الأطفال بين الفئات العمرية المختلفة، والكشف المُبكر للفئات التي من المحتمل أن تعرّض أطفالها للعنف مثل الأهل المراهقين، أو الأهل ذوي الاضطرابات العقلية.

الإدارة

- ← بناء مفهوم المشاركة في اتّخاذ القرار، والتي من خلالها يُطلب من الطفل المشاركة في إدارة حالة العنف.

- ← إنشاء فريق إستجابة صحية متخصّص في إدارة حالات تعنيف الأطفال في المستشفيات وأقسام الطوارئ، والذي يهدف إلى تحقيق إدارة سليمة ومُثلى.
- ← إنشاء وحدات في المؤسسات الصحيّة لحماية الأطفال، تهدف إلى تعزيز وعي الموظفين حول سياسة حماية الأطفال، وكشف وإحالة حالات تعنيف الأطفال الآمنَيْن إلى الإختصاصيين والمرشدين الاجتماعيين.

التّوصية الثّالثة

تعزيز المعرفة والثقافة لمقدمي الرعاية الصحية، للتعرّف أو إحالة، أو معالجة حالات العنف ضد الأطفال. ويمكن تحقيق هذا الهدف من خلال:

- ← تعزيز المعرفة والوعي من خلال إدراج موضوع حماية الطفل في المناهج التّعليمية للعاملين في القطاع الصحي ومقدمي الرعاية الصّحية والمشاركين في حماية الطّفل مثل، الممرضين والأطباء والمساعدين الطبّيين، مع التّركيز على التعرُّف على علامات العنف والإحالة الآمنة لحالات العنف ضد الأطفال.
- ← بناء القدرات للإختصاصيين الإجتماعيين ومقدّمي الرعاية الصّحية في التعرُّف والإحالة للإختصاصيين النفسيّين في التعرُّف وإدارة حالات العنف؛ وللأطباء الشرعيّين والفريق الطبي في قسم الطوارىء في التّعرّف والإحالة وإدارة حالات العنف على الأطفال، كذلك، المعالجة الطبيّة للإصابات والمعالجة السريرية للإعتداء الجنسي على الأطفال الضحايا من أجل توجيههم ودعمهم خلال خضوعهم للإجراءات الطبية.

التوصية الرابعة:

تعزيز تغيير السّلوك الإجتماعي المتعلّق بحماية الطّفل. . ويمكن تحقيق هذا الهدف من خلال:

- ← تطوير وتقييم برامج تغيير سلوك ذات سياق محدّد و مستند عال الأدلّة و البراهين في موضوع حماية الطّفل والموجّهة للأطفال والأهل، والتي يوفّرها مقدّمو الرّعاية الصّحية، مثل: أطباء الأطفال، إختصاصيو الصّحة العقليّة، الممرّضون والقابلات القانونيّات (مثال: تثقيف الأهل في موضوع مهارات تربية الأطفال، نموّ الأطفال، الأبوة والأمومة، برامج الوقاية من صدمات الرأس المسيئة؛ تدخلات متعدّدة العناصر والتي

تتضمن الدّعم العائلي، التّعليم ما قبل المرحلة الأساسية، مهارات التّربية ورعاية الأطفال؛ مداخلات من قبل وسائل الإعلام).

- ← تقديم و رصد برامج تغيير السّلوك المقدّمة للأطفال والأهل.
- ← المناصرة من أجل التنفيذ المستدام لهذه البرامج ومأسستها في مراكز الرعاية الصّحيّة الأوليّة.

Content

Briefing Note

Purpose

Preventing and managing child violence, neglect, exploitation and abuse is critical to attaining Goal 16 of the Sustainable Development Goals (SDGs): "Promote peaceful and inclusive societies for sustainable development, provide access to justice for all and build effective, accountable and inclusive institutions at all levels". Failing to develop a comprehensive child protection system puts Lebanon at risk of not achieving the SDGs.

The purpose of this policy document is to shed light on the prevalence of child violence, neglect, exploitation and abuse and the related child protection arrangements in Lebanon with a focus on healthcare facilities. It also provides a synthesis on what has been done locally and internationally to improve child protection practices at the level of prevention, early identification, and management; and aims at presenting evidence-based and context-specific recommendations to ensure child protection practices in healthcare facilities in Lebanon.

The Problem

Child violence, neglect, exploitation and abuse is associated with aggravated depression, psychosis, substance abuse, teen pregnancy, sexually transmitted disease, economic burden, and mortality. 10,825 child violence, neglect, abuse and exploitation cases who received child protection case management services were reported by the child protection sector in Lebanon in 2017, of which approximately 90% were of medium and high risk.

Background to Briefing Note

A Briefing Note quickly and effectively advises policymakers and stakeholders about a pressing public issue by bringing together global research evidence and local evidence.
A Briefing Note is prepared to aid policymakers and other stakeholders in managing urgent public health issues.

A Briefing Note describes priority issues, synthesizes context-specific evidence, and offers recommendations for action.

The preparation of the briefing note involved six steps:

1) *Identifying and selecting a relevant topic according to a predefined criteria*
2) *Appraising and synthesizing relevant research evidence*
3) *Drafting the Briefing Note in such a way as to present concisely and in accessible language the global and local research evidence;*
4) *Undergoing merit review*
5) *Finalizing the Briefing Note based on the input of merit reviewers.*
6) *Submitting finalized Briefing Note for translation into Arabic, validating translation and disseminating through policy dialogues and other mechanisms.*

The limited availability of preventive interventions for child violence, neglect, exploitation and abuse, inadequate early identification and reporting of violence and abuse in healthcare facilities and lack of coordination between sectors in the management of child violence and abuse cases, compromise child protection practices in healthcare facilities in Lebanon.

Size of the problem

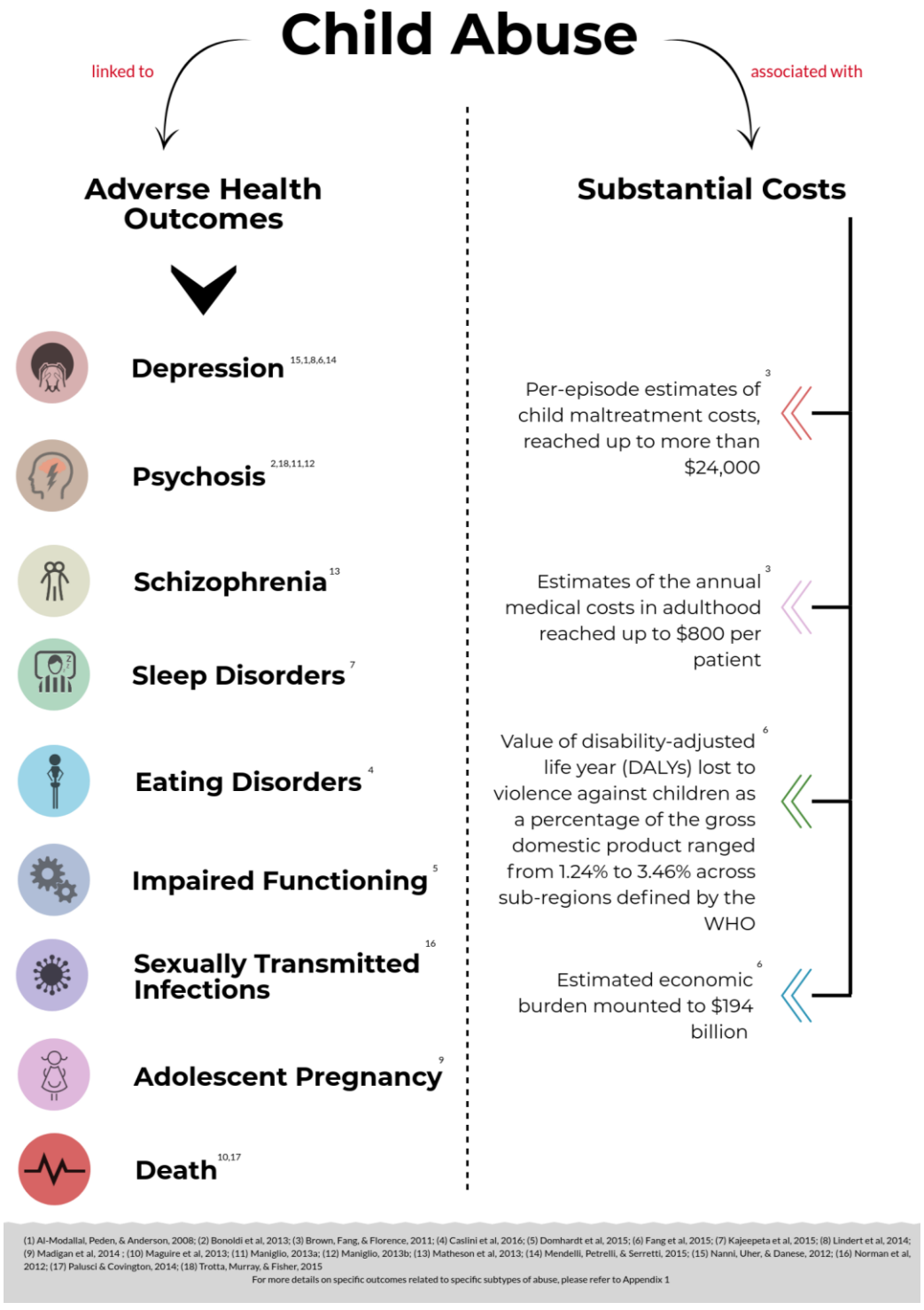
Child violence and abuse is a global issue associated with adverse health outcomes and substantial costs on countries (Figure 1). In fact, one out of four adults worldwide was physically abused as a child (WHO, 2016).

In Lebanon, two published studies conducted on 1,028 Lebanese children aged 8-17 showed that nearly 30% of the children reported at least one incident of witnessing violence, 65% reported at least one incident of psychological abuse, 54% reported at least one incident of physical abuse (Usta, Farver, & Danachi, 2013), and 16% admitted experiencing at least one form of sexual abuse (Usta and Farver, 2010).

Violent discipline of children appears to be quiet common. In 2016, United Nations Children's Fund (UNICEF) undertook a national household survey aiming at providing an overview of the living conditions of women and children in Lebanon. The survey included questions that addressed violence against children. According to survey results, 82% of Palestinian refugees in Lebanon, 77% of Palestinian refugees from Syria, 65% of Syrian and 57% of Lebanese children age 1-14 years experienced to at least one form of psychological or physical punishment by household members during the past month. Psychological aggression and physical punishment were the most common practices employed across all population groups, while the most severe forms of physical punishment such as hitting the child on the head, ears or face or hitting the child hard and repeatedly were relatively less common (UNICEF Lebanon Baseline Survey, 2016).Moreover, according to the Global School-based Student Health Survey 2011, 39% of children aged 13-17 reported being seriously injured at least once in the past year (WHO, 2011). Although the survey does not differentiate accidental injuries from injuries due to maltreatment, child violence and abuse was found to be intensely widespread in schools. In a study involving 1,177 school children, it was found that 76.4% had experienced physical abuse and 81.2% had experienced emotional abuse at least once at school (El Bcheraoui, Kouriye & Adib, 2012).

On the other hand, very few healthcare organizations have comprehensive policies or structures related to the prevention, early identification, management and referral of child violence and abuse cases. Therefore, given the high prevalence of violence, neglect, exploitation and abuse

among children and the long-term deleterious impact that child violence, neglect, exploitation and abuse can have on children and the healthcare system (figure 1), there is an urgent need to take action to foster a child protection system in healthcare facilities, especially if Lebanon is to attain the SDGs by 2030.



Underlying Causes

According to published studies, there are several causatives and protective factors for child violence, neglect, exploitation and abuse at the health-system level (figure 2).

System-related factors

Causative Factors

- Lack of adequate training of health professionals in the identification of Child Abuse & Neglect (CAN) impedes proper diagnosis and management (Flaherty et al, 2008; Jones et al, 2008)

The following factors were found to hinder reporting:

- Unfamiliarity of health professionals with the precise guidelines for reporting (Ward et al, 2004)
- Prior negative experiences of health professionals with child protection services (Flaherty et al, 2012; Jones et al, 2008)
- Fear of loss of the relationship with the child and family (Flaherty et al, 2006; Asnes & Leventhal, 2010)
- Fear of physical or legal reprisal (Flaherty et al, 2012)

Protective Factors

- Training programs improve self-reported knowledge, have a favorable impact on the confidence of professionals dealing with cases of CAN (Carter et al, 2006), increase reporting to child protection services by ten times (Flaherty et al, 2008), and improve health professionals' knowledge of legislation and relevant clinical skills (Alvarez et al, 2010).

Neutral Factors

- No direct effect was observed by mandating reporting on the occurrence of child abuse (Ainsworth, 2002; Ho, Gross, & Bettencourt, 2017).

Figure 2 Causative and Protective Factors for Child Abuse & Neglect (CAN)

Health system arrangements in Lebanon contribute to the deficiency in tackling the problem of child violence, neglect, exploitation and abuse in healthcare organizations. A systematic local assessment was undertaken to uncover such arrangements.

At the **level of reporting and referral**, several laws, regulations and initiatives were set forth to support child protection practices in Lebanon. Yet, current challenges in the regulatory framework (i.e. laws) on child protection , the system of accountability and collaboration among stakeholders for child protection, and the culture of reporting child violence, neglect, exploitation and abuse in Lebanon pause challenges to reporting and referring child violence and abuse.

Several laws and regulations support child protection in Lebanon. For instance by virtue of the Lebanese law 422/2002 aiming to protect children from risk or harm, the judicial system is obliged to intervene according to any report presented to it. In 2015, the Ministry of Social Affairs (MOSA), University of Saint Joseph (USJ), and United Nations Children's Fund (UNICEF) developed 'Standard Operating Procedures (SOPs) for Juvenile Protection in Lebanon' to support the implementation of the law 422/2002 . The SOPs defines referral channels to be followed whenever a case of child violence and abuse is identified (MoSA, UNICEF, USJ, 2015). The tools suggested in the SOPs aimed at guaranteeing a unified case management service by the different actors from private and civil society sectors. The SOPs also defines the role of MoSA vis- avis case management under the non-judicial pathway and explains the judicial pathway stipulated in law 422/2002.

As per the Lebanese Code of Medical Ethics 240 22/11/2012, physicians are mandated to report witnessed or suspected violence and abuse. Furthermore, the MOPH issued an amendment to circular number 58 on June 26, 2012, stating that doctors and health professionals should be concerned about maintaining confidentiality in cases of rape or sexual assault and must discuss with the victims the option of reporting to legal authorities (MOPH, 2015). Moreover, extensive work has been done to amend the penal code 186 which brought at hand the removal of the tolerance to disciplinary hitting by teachers.

However, despite the presence of these legislative documents, reporting can be easily described as voluntarily. There is no mandate that legally or administratively- through accreditation- compels hospitals and primary healthcare centers

Local Assessment Methodology

Assessment of the current mandates guiding child protection was performed through a review of the laws, policies, accreditation standards, and any regulatory document guiding child protection, with a special focus on those pertaining to healthcare facilities. The assessment aimed to identify bottlenecks and loopholes in the mandates and pinpoint deficient or overlooked areas in the current regulatory arrangements.

Assessment of the role of key stakeholders involved in child protection was carried out by identifying and interviewing a set of key informant stakeholders. Interviews were conducted using a semi-structured questionnaire. The assessment aimed at exploring current child protection services and reporting channels, challenges in early identification and referral, and areas of improvement. For a list of participating stakeholders, please refer to appendix 2a.

Assessment of the current status of child protection at health facilities was performed through identification and surveying, based on a sampling criteria, a set of hospitals and primary healthcare centers. For a list of participating health facilities, please refer to appendix 2b.

(PHCs) to report on child violence and abuse. In addition, confusion surrounding the necessity of reporting is made worse by penal code 186 which clearly states that disciplinary hitting by the child's parents is tolerated. Rendering corporal punishment permissible by law makes it harder for health professionals to differentiate between corporal punishment and child violence and abuse.

Notably, none of the reviewed mandates declare well-defined penalties for not reporting child violence and abuse. And more importantly, there is no immunity to protect healthcare professional reporting on child violence and abuse. In this regard, fear of breach of professional secrecy (although law 422 does stipulate that professional secrecy is waived when there is a report) and the perceived repercussions of reporting such as verbal, physical, or legal reprisal, loss of relationship with the family, or simply the time wasted while going over the reporting procedures have been mentioned by many health professionals as obstacles in the face of proper reporting.

In addition, there are no standardized reporting and referral channels. Based on an assessment of Law 422/2002 art. 24, 25, 26, 27; Lebanese Penal Code art. 186, 399, 400, 492, 493, 495, 496, 497, 523; Law 293/2014; Labor law 1946 art. 22, 23; Decree No. 700; Medical Ethics Law 240 22/11/2012, the Lebanese mandates do not identify a standardized and comprehensive reporting and referral system. Concurrently, many organizations such as Union for the Protection of Juveniles in Lebanon (UPEL), Ministry of Social Affairs, Internal Security Forces (ISF), and Non-Governmental Organizations (NGOs) dealing with child violence and abuse receive child violence and abuse complaints and/or cases. However, the role of each of these organizations is still largely ambiguous to the majority of healthcare staff working in the surveyed institutions. As a result, cases are managed arbitrarily in healthcare facilities, depending on the personal preference, judgment, and knowledge of the healthcare provider encountering the abused child, particularly in healthcare organizations with no child protection policies or programs. The initiative to develop the 'Standard Operating Procedures (SOPs) for Juvenile Protection in Lebanon' in 2015 was necessary in the child protection sector; however, as reported by various stakeholders, the SOPs are neither adequately circulated nor adopted by any legal authority, and thus are not lawfully binding.

Several stakeholders are involved in child protection with no clearly defined functions or borders, thus creating an overlap in roles at times and managerial gaps at others (appendix 2a). The two-tiered relationship between healthcare organizations and stakeholders involved in child protection is also poorly defined and lacks directives. Despite the presence of training opportunities, many healthcare workers in need of child protection skills are unable to access such services as a result of poor coordination and communication. In this regard, many stakeholders suggested having a three tier-system of accountability for child protection: a governing body to monitor

implementation of SOPs and laws and supervise the role of a lead agency; a lead agency responsible for the coordination of efforts and activities among stakeholders and partners involved in child protection; and institutions and NGOs identifying and referring cases to the lead agency.

At the sociocultural level, there are several challenges to recognizing and dealing with child violence and abuse. At the family level, embarrassment and fear of social stigma might cause reluctance among parents to present their child for attention or provide consent to proceed with the management of violence and abuse. Fear of retaliation by family and community (honor killing, exclusion from community, etc.). At the healthcare workers level, knowledge deficit, lack of trust in the legal and social channels, unpleasant experiences with previous cases, ethical challenges and cultural beliefs (i.e. acceptance of violence) (Borimnejad & Khoshnavay Fomani, 2015) deter proper management of child violence and abuse. At the organizational level, there seems to be an underestimation or misunderstanding of the problem of child violence and abuse. As an illustration, some of the surveyed health centers failed to acknowledge that child violence and abuse, with its varying degrees and subtypes, is a prevalent public health problem in Lebanon. Such centers lacked the basic resources for early identification such as the screening tools or human resources training as well as clear reporting and referral procedures.

At the **level of early identification and management of child violence and abuse**, training availability of staff/providers and specialized interventions remain limited and insufficient to provide comprehensive child protection services.

Training opportunities for improving the early identification and management of child violence and abuse are available; albeit training is non-standardized and not widely disseminated.

Despite the availability of several training efforts, the quality, context-appropriateness, and impact of such training need to be determined. Some of the training provided by stakeholders and institutions include;

- MOSA and USJ with the support of UNICEF developed SOPs for child protection and accordingly MOSA appointed 57 social workers to implement the SOP
- MOSA with USJ provide training to MOSA internal staff and external NGOs and institutions.
- 10 hours of training by MoSA on early identification and referral for frontliners was provided to 310 frontliners from 2016-2017
- 30 hours of training by MoSA on SOP case management was provided to 260 case managers from 2016-2017 and 168 from 2017-2018

- At the Lebanese Red Cross, training is done internally, adopted from international guidelines, and adapted to local context. There are some efforts by the Lebanese Red Cross to design training for Emergency Medical Services staff.
- himaya provides training to healthcare workers when approached, but still not extensive and upon demand only.
- Basic theoretical education on child violence and abuse is incorporated into the curriculum of social workers in the Lebanese University. Other educational curricula are not assessed.
- WHO provided training aiming at the identification of developmental delays among children at PHCs and screening for violence and abuse in vulnerable populations

As of yet, the Order of Physicians, Order of Nurses, Order of Lawyers, and Syndicate of Psychotherapist and Psychoanalysts do not have strategies for continuing education on child protection. Moreover, the majority of judges, forensic doctors, and Internal Security Forces staff dealing with abused children do not have specialized training on child violence and abuse.

Deficiencies in training are also pronounced at the level of healthcare organizations. There is a lack or inadequacy of services especially when it comes to capacity of health staff (soft skills, empathy, communication, confidentiality), infrastructure (services could be stigmatizing, non-girl or child friendly), affordability of services. Healthcare workers in Lebanon come from varying academic backgrounds, and not all of them have received specialized training that enables them to recognize and manage cases of child violence and abuse. Moreover, the availability of post-graduate training to fill in such gaps is limited. Unpublished data from a survey of pediatricians in 2017 in one of the hospitals that lacked a child protection policy revealed that 64% of pediatricians never received specialized training to recognize child violence and abuse cases and 82% believed that they might be frequently missing child violence and abuse cases; with the referral decision being clear to pediatricians in only 27% of cases.

Besides the training deficiencies tackled earlier, there is a shortage of specialized staff needed to recognize and manage cases of child violence and abuse in hospitals and PHCs. In fact, positions for social workers and psychotherapists were absent in some of the surveyed institutions. Even when available, they do not always assume an active, effective role in child protection. For example, the Syndicate of Social Workers reported that the role of social workers remains dependent on the job description provided by the employing healthcare organization. In some organizations, their function is limited to paperwork, with no major role played in the early identification, referral, or management of cases. Moreover, according to the Order of Nurses, the national

shortage of nurses could impede expanding nurses' duties to take share in the early identification and management of child violence and abuse.

Beyond the borders of healthcare organizations, limited availability of specialized staff also inflicts other sectors such as the social workers at the MOSA and the judiciary body involved in juvenile protection. This, in turn, places a burden on the available social workers and judges and may hinder appropriate and timely management of cases.

The availability of specialized interventions for the diagnosis and management of child violence and abuse remains inadequate in Lebanon. There is limited availability of standardized, validated and contextualized tools for risk assessment and the early identification of the various forms of violence and abuse; thus allowing many cases to pass unrecognized. In addition, management targeting specific subtypes of violence and abuse, such as sexual abuse or abusive head trauma, remains limited. Furthermore, even health centers that have developed child protection programs, the available child protection interventions such as training, protocols, and medications, are not age-specific.

As for sexual abuse, the Clinical Management of Rape (CMR) task force (CMR TF), created by United Nations Population Fund in 2012, has been leading the coordination of CMR services at a national level to provide a better medical response to sexual assault survivors. The CMR TF has been coordinating with the MOPH and several local organizations and UN agencies to agree on a roadmap and action points for building capacities, strengthening CMR services, including early identification, diagnosis, treatment and referral of cases, and enhancing awareness.

Healthcare organizations that had already implemented a child protection program or policy developed their systems by making use of the experiences of former centers in this field. Despite modest efforts at providing specialized protection services, the degree to which these interventions are evidence-based and the impact of such interventions still need to be carefully assessed.

At the level of **financing child protection services**, specific coverage of child protection services is almost non-existent, particularly in the outpatient settings. Many health care centers face difficulties in getting reimbursed for basic procedures needed to diagnose child violence and abuse; this includes X-rays or simple blood tests, particularly when the caregivers are reluctant or unable to cover such expenses. Outpatient rehabilitative services provided by social workers and psychotherapists are not reimbursed unless provided or mediated through a specific social institution or NGO involved in child protection. Inpatient services are financially handled similarly to any other medical condition, i.e. depending on the coverage scheme of the third party payer reimbursing the patient's bill.

Recommendations

Policy Recommendations

Based on the local assessment and the evidence surrounding the interventions that target child violence and abuse, measures that cover interventions at the system, organizational/institutional, and professional/individual levels can be effective for addressing child violence and abuse in Lebanon:

Recommendation 1

Strengthen child protection practices in healthcare organizations through related age/gender sensitive policies, procedures, standards, and resources.

This can be established through:

- Strengthen linkages between MOSA/MOPH/MOJ, civil society, syndicates (hospitals, mental health professionals, social workers, mid-wives) and academia (medical schools) to develop inter-sectoral policies and strategies
- Strengthen links between the MOPH child protection related policies with the different child protection policies/referral mechanisms developed or being developed by different line ministries
- Setting well-defined national executive decrees for child protection, which delineate and mandate unified channels for reporting and follow up of cases from healthcare facilities. Decrees should also provide reporter protection and account for the professional secrecy of medicine and the victims' right to privacy and confidentiality.
- Incorporating child protection into the new hospital and PHCs accreditation standard requirements and defining structure, process, and outcome-based standards. The standards will cover staff training and orientation on child protection, referral and management procedures for child violence and abuse cases (including cases that occur in healthcare facilities), ethical framework(including appropriate behavior and communication with children) and the availability and quality of services on child protection and child violence and abuse management
- Conduct and analysis of access to/utilization of public versus private health care providers that takes into account age and gender and look at barriers and opportunities for children subject to or at risk of violence, neglect, abuse and exploitation in accessing public versus private health care services.

⇢ Develop policies that remove barriers to girls and boys subject to or at risk of violence, neglect, abuse and exploitation from accessing services and looking at barriers relevant to each gender.

Table 1 **Key findings from systematic reviews and single studies**

Intervention	Setting	Rationale	Country	References
Hospital and Primary Healthcare Accreditation	Hospital and Primary Healthcare Centers	2 systematic reviews, 2 literature reviews and 1 quantitative study reported that healthcare accreditation promotes change, professional development and team involvement (Chuang & Inder, 2009; Greenfield & Braithwaite, 2008; Greenfield et al., 2012; Nicklin, 2015; El-Jardali et al., 2014) 1 systematic review and 1 literature review found that accreditation has a positive impact on clinical outcomes, quality of care and nursing care especially in the management of trauma (Alkhenizan & Shaw, 2011; Chuang & Inder, 2009). 1 literature review reported that the implementation of accreditation programs enhances the use of ethical frameworks (Nicklin, 2015)	USA, UK, Philippines, Australia, South Africa, Taiwan, Lebanon, Egypt, Zambia, Denmark, Korea, Japan, Canada, Singapore	(Chuang & Inder, 2009; Greenfield & Braithwaite, 2008; Greenfield et al., 2012; Nicklin, 2015; El-Jardali et al., 2014; Alkhenizan & Shaw, 2011)
A policy to ask adults presenting with mental health problems, drug or alcohol misuse, or violence whether there are children living at home	Acute hospital services	One single study reported that a policy to ask adults presenting with mental health problems, drug or alcohol misuse, or violence whether there are children living at home resulted in the identification of a substantial proportion of abused children, whereby 40% of all child abuse notifications were triggered by parents' presentation to acute hospital services.	England	Gonzalez-Izquierdo et al, 2014

Table 2 **Implementation considerations for Recommendation 1**

Barriers	Counterstrategies
Complicated law development/amendment process may discourage legislators to change the laws on child protection in Lebanon (Harper, Jones & Tincati, 2010)	Establish a national committee (composed of lawyers, judges, health professionals, administrative staff from ministries and NGOs) to study the current laws and mandates guiding child protection and propose reforms. Extensive advocacy for law reform could persuade policymakers for law change. In some cases, public pressure could be ideal to push laws onto policymaker's agenda (Snyder & Oshiro, 2006).
Noncompliance of healthcare organizations to laws and regulations, due to resource shortages, insufficient political will, lack of public awareness (Harper, Jones & Tincati, 2010; Jones & Villar, 2008)	Ensure public awareness and political will of the reformed/ revised laws and regulations through awareness and advocacy campaigns (Jones & Villar, 2008) and sufficient trained human resources to implement the laws and regulations. Supplement implementation of policies guiding child protection with implementation plans and monitoring procedures
Noncompliance of healthcare professionals to laws and regulations on child protection	Conduct regular monitoring of healthcare professionals and performance appraisals at the institutional level to ensure compliance of professionals to laws and regulations on child protection (Lewis et al., 2007)
Resistance of some healthcare professionals to implementation of child protection related accreditation standards or viewing standards as impractical (Alkhenizan & Shaw, 2011; Brusamento et al., 2012)	Provide training and education to healthcare professionals prior to accreditation implementation to ensure healthcare provider understanding of the importance of the standards to healthcare practice and patient safety and their compliance to these standards (Alkhenizan & Shaw, 2011) Change management and support for change at the healthcare facility are critical to reducing opposition to change among staff (Connolly, 2012)
Insufficient experience and knowledge of social worker/psychologist to report or work with child abuse cases (Connolly, 2012)	Train social worker/psychologist working in child abuse to improve their competencies (i.e. knowledge of legislation, risk assessment, multidisciplinary work) and their ability to become active members of the child protection team in hospitals and PHCs (Connolly, 2012)

Recommendation 2

Develop and implement tools and strategies in healthcare organizations for child violence and abuse early identification and management.

This can be established through:

Early identification

- Adopting, adapting, and validating pre-designed flow charts and tools aiming at enhancing the diagnosis of diverse forms of child violence and abuse among various age groups, and the early identification of special populations who are at risk of abusing their children such as adolescent parents and parents with mental health disorders

Management

- Ensure proper human resources skills in working with children subject to violence, neglect, exploitation and violence and abuse and ensure child friendly service provision as part of the standards
- Adopting shared decision making, in which the child is asked to participate in the management of the violence and abuse case
- Establishing a specialized child violence and abuse health response teams in hospitals emergencies aiming for a proper and optimal healthcare management
- Establishing child protection units or focal points in healthcare organization and facilities. The unit or focal point aim at improving awareness of staff regarding the child protection policy, enhancing safe identification and referral of cases identified by health care providers to social workers and caseworkers.

Table 3 **Key findings from systematic reviews and single studies**

Intervention	Setting	Rationale	Country	References
Family Stress Checklist by prenatal care providers	Adolescent-oriented maternity program in a hospital	One single study reported that family Stress Checklist by prenatal care providers was able to identify adolescents who are at risk for mistreating their children and who subsequently might be in need of additional support services.	USA	Stevens-Simon, Nelligan, & Kelly, 2001
Decisional flow charts for suspected	Not specified	One systematic review showed that decisional flow charts for suspected physical abuse	USA, UK	Newton et al, 2010

Intervention	Setting	Rationale	Country	References
physical abuse		increased the documentation of non-accidental physical injury by 69.5%.		
Hospital based screening tools				
Screening for physical abuse among babies less than 1-year-old presenting with fractures using the NAT screening guideline, with the rationale that implementing a guideline for screening would attenuate the racial and socioeconomic status bias	Pediatric trauma center emergency department	After implementation, screening was no longer associated with socioeconomic status of the patient's family, although final determination of child abuse was still associated with socioeconomic status.	USA	Higginbotham et al, 2014
Screening for physical abuse among children ‹ 6 years	Emergency department	Records of compatibility of history with injury and consistency of history increased from less than 2% to more than 70% (P‹0.0001). More children were referred for further assessment, although the difference was not significant (6 (0.6%) versus 14 (1.4%), P=0.072). The general level of awareness and vigilance increased, even for children whose records did not contain the flowchart.	United Kingdom	Benger & Pearce, 2002
Screening for physical abuse among children ‹ 7 years	Emergency department	The tool was associated with a high rate of false negatives, false positives, and serious adverse effects.	Netherlands	Sittig et al, 2011
Screening for physical abuse	Pediatric intensive	The tool was found to have a sensitivity of 97% and	USA	Pierce et al, 2010

Intervention	Setting	Rationale	Country	References
among trauma-inflicted children aged less than 48 months	care unit	specificity of 84% for predicting abuse.		
Screening for sexual abuse among children 2-12 years of age	Pediatrics clinic	Cronbach alpha (a measure of internal validity) was 0.71 with construct discriminant validity.	Brazil	Salvagni & Wagner, 2006
The Escape instrument is a 6-item tool that can be completed for each child	Emergency department	One or more ticked answers in the dark boxes indicate the possibility of an increased risk of child abuse with a sensitivity of 80% and specificity 98%.	Netherlands	Louwers et al, 2014
Risk-stratification of children of parents with mental illness and early intervention	Emergency department	Risk-stratification of children of parents with mental illness and early intervention increased the proportion of patients asked by the emergency department personnel about dependent children and improved the quality of information received by the social services child protection team.	England	Kaye et al, 2008
Sexual assault response program (SART) for the care of sexually abused children	Hospital	Menarchal girls were more likely to undergo testing for sexually transmitted infections and pregnancy ($P < 0.01$) and to be offered pregnancy, sexually transmitted infection, and HIV prophylaxis ($P < 0.01$). Development of a SART program supported the majority of eligible patients undergoing forensic evidence collection and a substantial number of patients had evidence of injury on examination. Findings underscore the importance of having properly trained personnel to support emergency department care for pediatric victims of acute sexual assault.	USA	Goyal et al, 2013

Intervention	Setting	Rationale	Country	References
Shared decision making	Not specified	In a literature review of 17 studies (4 systematic reviews and 13 single studies), shared decision making, in which the child is asked to participate in the management decision, was found to be the most effective. This mode of decision-making revealed positive effects on immediate safety and well-being, increased the success of out-of-home placement, reduced maltreatment recurrence, and resulted in better outcomes in discipline and emotional care of children. Other less effective modes of decision-making are detailed in Appendix 4c.	Not reported	Bartelink, Yperen, & Ten Berge, 2015
Introduction of a specialized team and crisis center to standardize practice	Not specified	One systematic review showed that the introduction of a specialized team and crisis center to standardize practice had little effect on physician chart documentation of case details but improved overall documentation through increased documentation of child protective services involvement by 22.7% and discharge status by 23.7%.	USA, UK	Newton et al, 2010
In-hospital child protection teams guided by roundtable discussions	Hospital	The Safra Child Protection Team has reviewed over 1,500 cases since its establishment in 1991, approximately two-thirds of which have been referred to the authorities. In a hospital staff survey, participants were more likely to express the opinion that family violence requires attention within the hospital setting and not just by welfare or police authorities. Most respondents were aware of hospital policy regarding child abuse cases and		Chen et al, 2008

Intervention	Setting	Rationale	Country	References
		expressed willingness to act when suspicions arise. Very few expressed fear of personal safety or legal entanglement.		

Table 4 **Implementation considerations for Recommendation 2**

Barriers	Counterstrategies
Shortage of human resources to provide child protection in-hospital services (Harper, Jones & Tincati, 2010)	Develop human resources plans in hospitals to recruit, motivate and retain healthcare professionals (Zurn, Dal Poz, Stilwell & Adams, 2004)
Limited availability of culturally specific tools aiming at the identification and risk assessment of child abuse cases (Harper, Jones & Tincati, 2010)	Improve collaboration among health professionals, academicians and researchers to identify, adapt, pilot test and validate tools to screen child abuse; followed by tool dissemination to healthcare facilities (Abessa et al., 2016)
Lack of familiarity with shared decision making (Gravel, Légaré & Graham, 2006)	Training healthcare professionals on shared decision making (Gravel, Légaré & Graham, 2006)
A culture of permissible violence and perceived child inferiority that hinders optimal management of cases and adoption of shared decision making (Gravel, Légaré & Graham, 2006)	Providing healthcare professionals with information on the importance and impact of shared decision making (including child) for child protection (Gravel, Légaré & Graham, 2006)
Healthcare facilities may not perceive child protection programs as a priority in their organization	Raising the awareness of healthcare organizations on the importance of child protection programs and advocating for the development of the programs may raise a need for child protection programs in facilities (Snyder & Oshiro, 2006). Shared experience from hospitals that have already implemented a child protection policy could support the call for the programs and replicate success factors and avoid pitfalls in healthcare organizations.
Limited reimbursement for child protection services, whether delivered within the realms of the health facility or within the context of outreach programs (Harper, Jones & Tincati, 2010)	Allocate a budget for child protection practices for its implementation and sustainability (UNICEF, 2012)

Recommendation 3

Enhance the knowledge and education of providers to recognize, refer or manage child violence and abuse.

This can be established by:

- Enhancing knowledge and awareness through both the integration of child protection in the educational curricula for healthcare workers and providers involved in child protection, such as nurses, doctors, and paramedical staff, with a focus on identifying signs of violence and abuse and safe referral of cases of child violence and abuse.
- Capacity building for social workers and healthcare providers on early identification and referral. Capacity building for psychologists on the early identification and management of violence and abuse cases. Capacity building for forensic doctors and emergency medical team on the early identification, referral, management of child violence and abuse cases and on the medical management of injuries and clinical management of sexual abuse inflicted to children victim in order to orient and support children throughout these medical processes.
- Capacity building and training on basics of child protection and protection from gender based violence to all medical/para-medical and admin staff that could be in contact with beneficiaries

Table 5 **Key findings from systematic reviews and single studies**

Intervention	Setting	Rationale	Country	References
Self-instructional education	Not specified	In a systematic review, self-instructional education improved physician knowledge for both physical abuse and sexual abuse.	USA, UK	Newton et al, 2010
Chart checklists paired with an educational program	Emergency department	In two systematic reviews and one single study, chart checklists paired with an educational program increased physician consideration and documentation of clinical information. One systematic review and one study showed that it improved referral to social services. One systematic review showed that despite the increase in the rate of suspected child abuse by 180%, the number of confirmed cases of child abuse showed no	Japan, Spain, UK, USA Canada, Netherlands	Carter et al, 2006; Newton et al, 2010; Benger & McCabe, 2001; Clark, Tepper, & Jenny, 1997; Louwers et al, 2010

Intervention	Setting	Rationale	Country	References
		significant increase.		
Sexual assault response program (SART) for the care of sexually abused children	Hospital	Menarchal girls were more likely to undergo testing for sexually transmitted infections and pregnancy (P < 0.01) and to be offered pregnancy, sexually transmitted infection, and HIV prophylaxis (P < 0.01). Development of a SART program supported the majority of eligible patients undergoing forensic evidence collection and a substantial number of patients had evidence of injury on examination. Findings underscore the importance of having properly trained personnel to support emergency department care for pediatric victims of acute sexual assault.	USA	Goyal et al, 2013
The social worker as a key player and coordinator of child protection	Hospital	Benefits of this model include more efficient use of staff resources and a better fit with statewide policy requirements for integrated service delivery that is "everyone's business." Systematic data was not collected prior to implementation; therefore, it is difficult to fully understand the implications.	Australia	Connolly, 2012

Table 6 **Implementation considerations for Recommendation 3**

Barriers	Counterstrategies
Limited availability of standardized and specialized child protection training resources targeting the diverse set of professionals involved in child protection	Encourage professional associations to design and incorporate child protection training in their continuing education programs and to disseminate a list of available local child protection training resources targeting a variety of health professionals
High turnover and burnout of staff trained and working in child protection (Connolly, 2012)	Support staff, financially and non-financially, to avoid turnover of specialized staff and providers in healthcare organizations (Connolly, 2012)

Recommendation 4

Promote social behavioral change in relation to child protection.

This can be achieved by:

- Developing and evaluating evidence-based and context-specific behavioral change programs on child protection for children and parents. Programs can be provided by health care providers such as pediatricians, mental health professionals, nurses and midwives (i.e. Parental education on child raising skills, child development, and parenting; Abusive head trauma prevention programs; Multi-component interventions that include family support, preschool education, parenting skills and childcare; Media-based interventions). The approach to behavioral change should take the child as well as a "rights holder" by himself and the level of participation and engagement should vary depending on his/her age.
- Enhancing the role of health care professionals in supporting and raising awareness on birth registration
- Link Social/Behavioral change in the policy work/strategy of MOPH to other initiatives and the work of other ministries and actors
- Delivering and monitoring the behavioral change programs provided to children and parents
- Advocating for the sustainable implementation and incorporation of those programs in primary healthcare centers.

Table 7 **Key findings from systematic reviews and single studies**

Intervention	Setting	Rationale	Country	References
Early home visitation programs (administered prenatally, before discharge, or within 2 weeks of discharge, through which healthcare professionals perform visits to parents/caregivers	At home	In a systematic review of reviews, early home visitation programs were found to be effective in reducing risk factors for child maltreatment, but whether they directly reduce child abuse is less clear-cut. Five systematic reviews reported home visitation programs demonstrated positive effects in terms of prevention of child abuse,	Chile, USA, Ireland, Jamaica, Bangladesh, South Africa, UK Canada, USA Germany	Mikton & Butchart, 2009; Peacock et al, 2013; Goyal, Teeters, & Ammerman, 2013; MacMillan et al, 2009; Ayerle, Makowsky, & Schucking,

Intervention	Setting	Rationale	Country	References
of children)		reducing behavioral and developmental problems, enhancing appropriate weight gain, reducing incidence of low birth weight, improving parent-infant interaction, and decreasing morbidity.		2012; Barlow et al, 2007
Parental education on child raising skills, child development, and positive child management strategies	Pediatrics' Clinics	In one systematic review of reviews, mixed results were obtained regarding the effect of parental education on the prevention of child abuse; whereas in another systematic review behavioral interventions and counseling for families with children aged 5 years or younger reduced physical assault, Child Protective Services reports, non-adherence to medical care, and immunization delay among screened children.	Not reported	Mikton & Butchart, 2009; Selph et al, 2013
Abusive head trauma prevention programs	Mainly hospital-based. Some programs also included home visits and media campaigns	One systematic review of reviews showed that abusive head trauma prevention programs were found to reduce the incidence of abusive head trauma (Mikton & Butchart, 2009). One systematic review and two single studies reported that education delivered by the neonatal nurse resulted in an increase in parental knowledge and a decrease in the incidence of abusive head trauma and shaken baby syndrome(Nocera et al, 2016; Deyo, Skybo, & Carroll, 2008; Stewart et al, 2011).	USA	Mikton & Butchart, 2009 ; Nocera et al, 2016 ; Deyo, Skybo, & Carroll, 2008; Stewart et al, 2011
Multi-component interventions that include family support, preschool education, parenting skills and childcare	Multiple settings	One systematic review of reviews reported mixed evidence regarding the ability of multi-component interventions in reducing risk factors for child maltreatment.	Not reported	Mikton & Butchart, 2009

Intervention	Setting	Rationale	Country	References
Media-based interventions	Media	One systematic review of reviews demonstrated mixed results regarding the ability of media-based interventions in reducing risk factors for child maltreatment.	Not reported	Mikton & Butchart, 2009
Psychological treatment and pharmacotherapy of sexual abusers of children	Not specified	One systematic review showed insufficient evidence regarding the association of psychological treatment and pharmacotherapy of sexual abusers of children and the risk of reoffending.	Not reported	Langstrom et al, 2013
Psychotherapy	Not specified	One systematic review showed that psychotherapy improved functionality for maltreated children (Skowron & Reinemann, 2005). Another systematic review reported that psychotherapy was associated with improved self-esteem and overall functioning for the caregiver and child inflicted with sexual abuse.(Harvey & Taylor, 2010)	Not reported	Skowron & Reinemann, 2005; Harvey & Taylor, 2010
Home visiting program in which a trained professional shared information or provided services, case management, or referral to community services	Home	One systematic review mentioned home visiting program in which a trained professional shared information or provided services, case management, or referral to community services that resulted in a favorable effect on family involvement with child protective services, percentage of parents who went to the hospital for accidents, injury, or accidental poisoning, parents' report of physical assault, physical punishment, parenting behaviors, rate of sexual abuse, healthcare encounters for injuries or ingestions, and substantiated abuse or	Not reported	Avellar & Supplee, 2013

Intervention	Setting	Rationale	Country	References
		neglect.		
Managing the emotional distress of child victims of extra-familial sexual abuse and their families in a university medical facility and off-campus outpatient child abuse center.	Outpatient child abuse center	Progress observed in children after participation in group treatments included a significant decrease in sleep disturbances (nightmares, night terrors, and waking up), angry outbursts, moodiness, clinging behaviors, separation anxiety, fearfulness, emotional fragility, and belligerence. Parents reported improvement in children's self-esteem, self-confidence, school performance, and relationships with parents, siblings, and peers. Mothers reported improvement in sleep disturbances, regressive behavior, feelings of fear and unhappiness, and crying.	USA	Grosz, Kempe, & Kelly, 2000

Table 8 **Implementation considerations for Recommendation 3**

Barriers	Counterstrategies
Shortage and limited time of human resources to provide child protection in-hospital services (Harper, Jones & Tincati, 2010; Hardcastle, Bellis, Hughes & Sethi, 2015)	Develop human resources plans in hospitals to recruit, motivate and retain healthcare professionals (Zurn, Dal Poz, Stilwell & Adams, 2004) Conduct face to face meetings with the frontliners to identify their needs to implement the prevention programs (Hardcastle, Bellis, Hughes & Sethi, 2015)

Next Steps

Next Steps

The aim of this policy document is to foster a dialogue with key stakeholders informed by the best available evidence. The intention is not to advocate specific recommendations or close off the discussion. Further actions will flow from the deliberations that the Briefing Note is intended to inform. These may include:

- Deliberation amongst policymakers and stakeholders regarding the recommendations described in this Briefing Note.
- Refining the recommendations, for example by incorporating, removing or modifying some components

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Annexes

Annexes

Annex I. Health Outcomes Associated with Various Subtypes of Child Abuse

Maltreatment (any form)	⇢	**Depression** [1 systematic review (Nanni, Uher, & Danese, 2012)], **psychosis** [2 systematic reviews (Bonoldi et al, 2013; Trotta, Murray, & Fisher, 2015)], **schizophrenia** [1 systematic review (Matheson et al, 2013)], **worsening of bipolar disease** [1systematic review (Daruy-Filho et al, 2011)], **suicide** [1 systematic review (Fry, McCoy, & Swales, 2012)], **impaired cognition** [2 systematic reviews (Masson et al, 2015; Masson, East-Richard, & Cellard, 2016), **sleep disorders** [1 systematic review (Kajeepeta et al, 2015)], **eating disorders** [1 systematic review (Caslini et al, 2016)], **obesity** [4 systematic reviews (Danese & Tan, 2014; Hemmingsson, Johansson, & Reynisdottir, 2014; Vamosi, Heitmann, & Kyvik, 2010; Wang et al, 2015)], **chronic inflammation** [1 systemic review (Coelho et al, 2014)], **asthma** [1systematic review (Exley, Norman, & Hyland, 2015)], and **death** [1 single study from US reporting system (Palusci & Covington, 2014)].
Physical abuse	⇢	**Depression** [2 systematic reviews (Al-Modallal, Peden, & Anderson, 2008; Lindert et al, 2014)], **perinatal depression** [1 systematic review (Alvarez-Segura et al, 2014)], **anxiety** [1 systematic review (Lindert et al, 2014)], **suicide attempts** [2 systematic reviews (Norman et al, 2012; Miller et al, 2013)], **drug abuse** [1 systematic review (Norman et al, 2012)], **risky sexual behavior** [1 systematic review (Norman et al, 2012)], **sexually transmitted infections** [1 systematic review (Norman et al, 2012)], **adolescent pregnancy** [1 systematic review (Madigan et al, 2014)], **obesity** [1 systematic review (Midei & Matthews, 2011)], and **death** [1 systematic review (Maguire et al, 2013)].
Emotional abuse	⇢	**Depression** [2 systematic reviews (Norman et al, 2012; Mendelli, Petrelli, & Serretti, 2015)], **suicide attempts** [2 systematic reviews [(Norman et al, 2012; Miller et al, 2013)], **drug abuse** [1 systematic review (Norman et al, 2012)], **sexually transmitted infections** [1 systematic review (Norman et al, 2012)], and **risky sexual behavior** [1 systematic review (Norman et al, 2012)].
Sexual abuse	⇢	**Depression** [1 systematic review (Lindert et al, 2014) and 1

		systematic review of reviews (Maniglio, 2010), **anxiety** [1 systematic review (Lindert et al, 2014) and 1 systematic review of reviews (Maniglio, 2013c)], **post-traumatic stress disorder** [2 systematic reviews (Maniglio, 2013a; Maniglio, 2013b)], **psychosis** [2 systematic reviews (Maniglio, 2013a; Maniglio, 2013b)], **bipolar disorder** [2 systematic reviews (Maniglio, 2013a; Maniglio, 2013b)], **conduct disorder** [2 systematic reviews (Maniglio, 2014; Maniglio, 2015)], **suicide attempts** [4 systematic reviews (Devries et al, 2014; Maniglio, 2013a; Maniglio, 2013b; Miller et al, 2013)], **substance abuse** [4 systematic reviews (Draucker & Mazurczyk, 2013; Maniglio, 2013a; Maniglio, 2013b; Maniglio, 2011)]; **risky sexual behavior** [1 systematic review (Draucker & Mazurczyk, 2013)]; **unprotected sex** [1 systematic review (Homma et al, 2012)], **multiple sexual partners** [1 systematic review (Homma et al, 2012)], **pregnancy involvement** [1 systematic review (Homma et al, 2012; Noll, Shenk, & Putnam, 2009)], **adolescent pregnancy** [1 systematic review (Madigan et al, 2014)], **development into sexual offenders** [1 systematic review (Jespersen, Lalumiere, & Seto, 2009)], **impaired functioning** [1 systematic review (Domhardt et al, 2015)], **general health complaints** [1 systematic review (Irish, Kobayashi, & Delahanty, 2010) and 1 systematic review of reviews (Maniglio, 2009)].
Neglect	⇢	**Depression** [2 systematic reviews (Norman et al, 2012; Mendelli, Petrelli, & Serretti, 2015], **suicide attempts** [2 systematic reviews (Norman et al, 2012; Miller et al, 2013)]; **drug abuse** [1 systematic review (Norman et al, 2012)], **sexually transmitted infections** [1 systematic review (Norman et al, 2012)], **risky sexual behavior** [1 systematic review (Norman et al, 2012)].

Appendix 2 Participating Stakeholders and Health Facilities

Appendix 2a List of Participating Stakeholders

Ministries
Ministry of Public Health
Ministry of Social Affairs
Ministry of Justice
Ministry of Labor
Non-Governmental Organizations
Union for the Protection of Juveniles in Lebanon
himaya
Red Cross
Professional Associations
Order of Physicians
Order of Nurses
Order of Lawyers
Order of Psychotherapists and Psychoanalysts
Syndicate of Social Workers
International Organizations
UNICEF
WHO

Appendix 2b List of Sampled Hospitals and Primary Health Care Centers

Hospitals	**Primary Health Care Centers**
American University of Beirut Medical Center	Saint Antonios Center - Jdaideh
Centre Hospitalier Universitaire - Notre Dame de Secours	Makhzoumi Medical Center
Ain Wazein Medical Village	Howard Karagheusian Association for Child Welfare in Lebanon
Rafik Hariri University Hospital	Alkarameh charity center
Iranian Red Crescent Society/Sheikh Ragheb Harb Hospital	Imam Al Sader Foundation - Chhabieh PHC center
Islamic Hospital	Jbaa Primary Care Center

Appendix 3a Interventions Targeting Prevention of Child Abuse

Author, Year (Type)	Country	Intervention	Impact
		Prevention	
Mikton & Butchart, 2009 (systematic review of reviews)	NA	Home visitation Parent education Child sexual abuse prevention Abusive head trauma prevention Multi-component interventions Media-based interventions Support and mutual aid groups	⇢ Reviews on home visiting suggest that early home visitation programs are effective in reducing risk factors for child maltreatment, but whether they directly reduce child abuse is less clear-cut. ⇢ Two of the meta-analyses on parent education programs reported small and medium effect sizes on both risk factors and direct measures of child maltreatment. Five other reviews concluded that while the evidence shows improvements in risk factors for child maltreatment, evidence of an effect on actual child maltreatment remains insufficient. ⇢ School-based interventions to prevent child sexual abuse are effective at strengthening protective factors against this type of abuse, such as knowledge of sexual abuse and protective behaviors. Evidence about whether such programs reduce actual sexual abuse is lacking. ⇢ Abusive head trauma prevention program was found to reduce the incidence of abusive head trauma. However, because of methodological flaws in existing studies, it remains unclear whether interventions to reduce abusive head trauma are effective. ⇢ Multi-component interventions, such as family support, preschool education, parenting skills and child care, have mixed evidence regarding their ability to reduce risk factors for child maltreatment. ⇢ Media-based interventions demonstrated mixed results regarding the reduction of risk factors for child maltreatment.

Author, Year (Type)	Country	Intervention	Impact
			⇢ Support and mutual aid groups demonstrated mixed results regarding the reduction of risk factors for child maltreatment.
Peacock et al, 2013 (systematic review)	Chile, USA, Ireland, Jamaica, Bangladesh, South Africa, UK	Home visitation	Home visiting programs delivered by paraprofessionals resulted in: ⇢ Prevention of child abuse, particularly when the intervention is initiated prenatally ⇢ Developmental benefits in relation to cognition and problem behaviors, and less consistently with language skills ⇢ Reduced incidence of low birth weights and health problems in older children ⇢ Increased incidence of appropriate weight gain in early childhood. ⇢ Overall home-visiting programs are limited in improving the lives of high-risk children who live in disadvantaged families.
Goyal, Teeters, & Ammerman, 2013 (systematic review)	Canada, USA	Home visitation for preterm infants	⇢ Six studies demonstrated a pooled standardized mean difference of 0.79 (95% confidence interval 0.57 to 1.02) in Home Observation for Measurement of the Environment Inventory scores (which is dependent on 5 outcome domains: infant development, parent-infant interaction, morbidity, abuse/neglect, and growth/nutrition) at 1 year in the home-visited groups versus control
Macleod & Nelson, 2000 (systematic review)	NA	Home visitation and other community-based interventions	⇢ The lowest effect sizes for home visitation programs on child maltreatment were for programs with 12 or fewer visits and less than a 6-month duration.
Ayerle, Makowsky, & Schucking, 2012 (single study)	Germany	Midwives home visits to vulnerable families from pregnancy up to the first birthday of the child, to provide health promotion, maternal and infant	⇢ Significantly higher mean scores were observed regarding parent-child relationship and maternal care for child after 6 months of the intervention.

Author, Year (Type)	Country	Intervention	Impact
		care, and multidisciplinary support geared towards early prevention of child neglect and abuse	
Barlow et al, 2007 (single study)	UK	Home visiting program	⇢ At 12 months, differences favoring the home-visited group were observed in outcomes regarding maternal sensitivity and infant cooperativeness. ⇢ A non-significant increase in the likelihood of intervention group infants being the subject of child protection proceedings, or being removed from home, and one death in the control group were found.
Casillas et al, 2016 (systematic review)	NA	Home visitation implementation factors	Team members ⇢ There was no significant difference among teams that were composed of paraprofessionals, teams that combined paraprofessionals and professionals, and teams composed of solely professionals in terms of effect size. Training ⇢ Role play during initial home visitor training was associated with higher effect sizes (unweighted ***d*** = .21) than trainings with no role play (***d*** = .12) ⇢ Requiring practice cases during training had a reduced unweighted effect sizes. ⇢ There was no significant effect of direct observation on effect sizes. Supervision ⇢ Reflective supervision yielded a higher mean effect size (***d*** = 0.21) than supervision addressing only administrative issues or case management (***d*** = 0.02). ⇢ Supervision involving observation of home visitors yielded a higher effect size (***d*** = 0.23) than supervision with no observation (***d*** = 0.12).

Author, Year (Type)	Country	Intervention	Impact
			⇢ Programs involving training in supervision having a higher effect size (***d*** = 0.24) than those with no supervisor training (***d*** = 0.07). Fidelity ⇢ Frequency of fidelity monitoring had a significant relationship to effect size, with one-time or occasional monitoring having a higher effect size (***d*** = 0.31) than no fidelity monitoring (***d*** = 0.11) or ongoing fidelity monitoring (***d*** = 0.15). ⇢ Studies with fidelity ratings by independent observers had significantly higher effect sizes (***d*** = 0.22) than those that did not have independent fidelity ratings (***d*** = 0.16). ⇢ There were no significant effects for fidelity monitoring by home visitors, supervisors, or clients. ⇢ Fidelity monitoring addressing home visitors' quality showed a higher mean effect size (***d*** = 0.22) than monitoring that addressed only content (***d*** = 0.11). Organizational ⇢ There were no significant effects of ties to school, social service, mental health, or medical systems.
Allen, 2014 (systematic review)	NA	Education delivered by the neonatal nurse that taught parents why infants cried, how to calm the infants, ways to cope with inconsolable infants, and how to develop a plan for what to do if they could not cope anymore.	⇢ Only 2 out of 10 studies calculated pre and post-intervention abusive head trauma rate. The first study was able to identify a decrease from 8.2 cases per year to 3.8 cases per year; whereas the second study revealed a decrease from 4 cases in a 5-year period 2 cases in a 3-year period.
Nocera et al, 2016 (single	USA	In-person or online training sessions of maternity nursing	⇢ Regardless of training modality, participants perceived information provided in the training session as

Author, Year (Type)	Country	Intervention	Impact
study)		staff aiming at prevention of abusive head trauma	useful (Mean 4.58, SD = 0.728) and helpful for parents (Mean 4.72, SD = 0.593). ⇢ Nursing staff indicated that the training provided some new information (Mean = 3.27, SD = 0.973) and reported increased knowledge (Mean 4.07, SD = 0.945), with attendees at the in-person training sessions reporting higher mean scores for these items than those who completed online training ($p < 0.001$). ⇢ At six months following program implementation, most nurses reported delivering each of the key teaching points, with the most consistently delivered messages were that crying is normal (97.3%) and that shaking a baby is dangerous (93.6%). ⇢ Nurses reported discussing that infant crying peaks at two to three months of age at 84.8% of the sessions and reminding parents to read the program booklet at 71.2% of sessions. ⇢ There was high reported compliance of 91.2% to telling parents to share this information with others who would care for their child.
Deyo, Skybo, & Carroll, 2008 (single study)	USA	"Love Me…Never Shake Me" program for prevention of shaken baby syndrome, administered by nurses to women in their postpartum phase, included watching a video, receiving educational material, and signing	⇢ 96% of mothers knew of the dangers of shaking, 97& found the intervention helpful, and 98% and recommended shaken baby syndrome education for all parents - 79% of mothers practiced infant soothing techniques provided in the education ⇢ 36% of women practiced self-coping techniques and 9% accessed community support services

Author, Year (Type)	Country	Intervention	Impact
		a commitment statement not to shake their infant	
Stewart et al, 2011 (single study)	England	A triple-dose shaken baby syndrome prevention program, included in-hospital parents education by trained nurses, home visits, and media campaigns	⇢ Registered nurses learned new information on crying patterns and shaken baby syndrome, with a 47% increase in knowledge post-training ($p < 0.001$). ⇢ Over 10,000 parents were educated in-hospital, with a 93% education compliance rate. ⇢ 93% of parents rated the program as useful, and only 6% of families needed to be educated during home visits.
Selph et al, 2013 (systematic review)	NA	Behavioral interventions and counseling	⇢ Behavioral interventions and counseling for abuse and neglect in pediatric clinics for families with children aged 5 years or younger reduced physical assault, Child Protective Services reports, non-adherence to medical care, and immunization delay among screened children. ⇢ Ten trials of early childhood home visitation generally demonstrated reduced Child Protection Services reports, emergency department visits, hospitalizations, and self-reports of abuse and improved adherence to immunizations and well-child care.
Langstrom et al, 2013 (systematic review)	NA	Medical and psychological treatments for preventing sexual abusers of children from reoffending	⇢ Evidence was for interventions aiming at reducing reoffending in identified sexual abusers of children. ⇢ For adult offenders, evidence from five trials was insufficient regarding both benefits and risks with psychological treatment and pharmacotherapy. ⇢ For adolescent offenders, limited evidence from one trial suggested that multisystem therapy prevented re-

Author, Year (Type)	Country	Intervention	Impact
			offense (relative risk 0.18, 95% confidence interval 0.04 to 0.73). ⇢ Evidence was inadequate regarding effectiveness of treatment for children with sexual behavioral problems in the one trial.
MacMillan et al, 2009 (systematic review)	NA	Various interventions to prevent child maltreatment and associated impairment	⇢ Home-visiting program were shown to prevent child maltreatment and associated outcomes such as injuries. ⇢ In-hospital and clinic strategies show promise in preventing physical abuse and neglect. ⇢ Mother-child therapy for families with intimate-partner violence shows promise in improving behavioral outcomes. ⇢ Cognitive-behavioral therapy for sexually abused children with symptoms of post-traumatic stress shows the best evidence for reduction in mental-health conditions. ⇢ For maltreated children, foster care placement can lead to benefits compared with young people who remain at home or those who reunify from foster care.
Stevens-Simon, Nelligan, & Kelly, 2001 (single study)	USA	Family Stress Checklist use by prenatal care providers to identify adolescents who are at risk for mistreating their children	⇢ As per the results of the checklist, high-risk 1-year-olds were 8.41 (95% CI: 1.77-40.01) times and high-risk 2-year-olds were 5.19 (95% CI: 1.99-13.60) times more likely to have been mistreated than their low-risk counterparts.

Appendix 3b: Interventions Targeting Early Identification of Child Abuse

Author, Year (Type)	Country	Intervention	Impact
Early Identification			

Author, Year (Type)	Country	Intervention	Impact
Newton et al, 2010 (systematic review)	USA, UK	Professional interventions for improving child protection in the emergency room	⇢ Results supported self-instructional education kits as a means to improve physician knowledge for both physical abuse (mean +/- standard deviation [SD] pretest score = 13.12 +/- 2.36; mean +/- SD post-test score = 18.16 +/- 1.64) and sexual abuse (mean +/- SD pretest score = 10.81 +/- 3.20; mean +/- SD post-test score = 18.45 +/- 1.79). ⇢ Compared to standard practice, chart checklists paired with an educational program increased physician consideration of non-accidental burns in burn cases by 59%, documentation of time of injury by 36%, and documentation of consistency and compatibility of reported histories by 53% and 55% respectively. ⇢ Decisional flow charts for suspected physical abuse increased documentation of non-accidental physical injury by 69.5% and had a similar significant effect as checklists on increasing documentation of history consistency and compatibility when compared to standard practice. ⇢ No improvements were noted for documentation of consultations or current status with child protective services. ⇢ The introduction of a specialized team and crisis center to standardize practice had little effect on physician documentation, but increased documentation of child protective services involvement by 22.7% and discharge status by 23.7%. ⇢ Referral to social services increased by 8.6% in one study following the introduction of a chart checklist.
Carter et al, 2006 (systematic	Japan, Spain, UK, USA	Child protection training and procedural	⇢ No rigorous impact assessment was performed certain procedural interventions, such as the use of

Author, Year (Type)	Country	Intervention	Impact
review)		interventions	checklists and structured forms, can result in improved recording of important clinical information and may also alert clinical staff to the possibility of abuse. ⇢ Few pre- and post-studies suggest improvements in a range of attitudes necessary for successful engagement in the child protection process with innovative training programs.
Makoroff et al, 2002 (single study)	USA	Training of physicians to recognize child sexual abuse	⇢ There was poor agreement between the pediatric emergency medicine physicians and the physicians with training in child sexual abuse. ⇢ The physicians with training in child abuse concluded that only 17% of girls whose examinations were interpreted as abnormal by the pediatric emergency medicine physicians showed clear evidence of abuse. Normal findings were noted in 70% of such children, nonspecific changes were noted in 9%, and 4% had findings that are more commonly seen in abused children than nonabused children but are not diagnostic for abuse.
Hoft & Haddad, 2017 (literature review of 8 hospital-based tools)	USA, Netherlands, UK, Brazil	Tools for identification of child abuse	A review of the available tools published between 1995 and 2017 revealed 8 hospital-based screening tools: ⇢ The impact of 2 of these tools was not formally tested (Rogstad & Johnston, 2015; Henry, Black-Pond, & Richardson, 2010). ⇢ One tool was only designed to screen for physical abuse among babies less than 1-year-old presenting with fractures to the emergency room. Pre-implementation of algorithm, patients on government subsidies more likely to be screened for abuse. Post-implementation, bias removed, but final determination of abuse remained influenced by socioeconomic status

Author, Year (Type)	Country	Intervention	Impact
			(Higginbotham et al, 2014). ⇢ One tool was designed to screen for physical abuse among children ‹ 6 years. Records of compatibility of history with injury and consistency of history increased from less than 2% to more than 70% (P<0.0001). More children were referred for further assessment, although the difference was not significant (6 (0.6%) v 14 (1.4%), P=0.072). The general level of awareness and vigilance increased, even for children whose records did not contain the flowchart (Benger & Pearce, 2002). ⇢ One tool was designed to screen for physical abuse among children ‹ 7 years presenting to the emergency department. No conclusive evidence detected by this tool to identify physical abuse . Tool was associated with a high rate of false negatives, false positives, and serious adverse effects (Sittig et al, 2011). ⇢ One tool was designed to screen for physical abuse among trauma-inflicted children aged less than 48 months admitted to the pediatric intensive care. Tool was found to have a sensitivity of 97% and specificity of 84% for predicting abuse (Pierce et al, 2010). ⇢ One tool was designed to screen for sexual abuse among children 2-12 years of age. Cronbach alpha (measure of internal validity) was 0.71 with construct discriminant validity (Salvagni & Wagner, 2006). ⇢ The Escape instrument, is a 6-item tool than can be completed for each child presenting to the emergency. One or more ticked answers in the dark boxes indicate the possibility of an increased risk of child abuse with a

Author, Year (Type)	Country	Intervention	Impact
			sensitivity of 80% and specificity 98% (Louwers et al, 2014).
Louwers et al, 2010 (systematic review)	Canada, Netherlands, UK	Checklist of indicators of risk for child abuse	⇢ The rate of detected cases of suspected child abuse increased by 180% (weighted mean in three studies). ⇢ The number of confirmed cases of child abuse, reported in two out of four studies, showed no significant increase.
Benger & McCabe, 2001 (single study)	UK	Reminder checklist for early identification of abusive burns and scalds, in addition to improving education and awareness	⇢ There was a statistically significant increase in recording the time the injury occurred, the consistency of the history, the compatibility of the injury with the history given, the consideration of the possibility of non-accidental injury, the general state and behavior of the child, and the presence or absence of any other injuries. ⇢ The rate of referral for a further opinion regarding the possibility of non-accidental injury witnessed a non-statistically significant increase from 0 to 3%.
Clark, Tepper, & Jenny, 1997 (single study)	NA	Checklist of 13 factors associated with abusive burns into the history and physical examination of all burn victims presenting to the emergency department	⇢ The use of the checklist increased effective social service referral for burn abuse from 3% to 12.1%.
Macleod et al, 2009 (single study)	USA	Telemedicine consultations with child abuse experts to assist remote providers in the examination of sexually assaulted children presenting to rural,	⇢ The consultations resulted in changes in interview methods in 47% of cases, the use of the multi-method examination technique in 86% of cases, and the use of adjunct techniques in 40% of cases. ⇢ 89% of acute sexual assault telemedicine consults resulted in changes to the collection of forensic

Author, Year (Type)	Country	Intervention	Impact
		underserved hospitals	evidence. ⇢ Rankings of practitioners' skills and the telemedicine consult effectiveness were high, with the majority of cases scoring ≥5 on a 7-point Likert scale.
Miyamoto et al, 2014 (single study)	USA	Telemedicine consultations with child abuse experts to assist remote providers in the examination of sexually assaulted children presenting to rural, underserved hospitals	⇢ Hospitals with telemedicine had significantly higher quality scores in the general exam, the genital exam, documentation of examination findings, the overall assessment, and the summed total quality score ($p<0.05$ for each). ⇢ Hospitals with telemedicine also had significantly higher scores in several domains including photo/video quality, completeness of the examination, and the summed total completeness and accuracy score ($p<0.05$ for each).
Gonzalez-Izquierdo et al, 2014 (single study)	England	Policy to ask adults presenting with mental health problems, drug or alcohol misuse, or violence whether there are children living at home. The need for safeguarding can arise if maltreatment is suspected.	⇢ 40% of all child abuse notifications were triggered by parents' presentation to acute hospital services. ⇢ Given the policy to ask adults about children at home, a substantial proportion of children notified for child safeguarding were recognized through presentations to acute healthcare by their parents.

Appendix 3c: Interventions Targeting Management of Child Abuse

Author, Year (Type)	Country	Intervention	Impact
		Management	
Kaye et al, 2008 (single study)	England	A system developed by the local social services child protection team to identify and risk-stratify children of parents with mental	⇢ The proportion of patients asked by the emergency department personnel about dependent children increased and the quality of information received by the social services child protection team improved.

Author, Year (Type)	Country	Intervention	Impact
		illness. This allows intervention upon early identification of children at immediate risk of harm and insurance that social services are aware of the potential risk to all children in this group.	
Harvey & Taylor, 2010 (systematic review)	NA	Psychotherapy for sexually abused children	⇢ Psychotherapy for victims of child sexual abuse resulted in symptom reduction and improved self-esteem and overall functioning for the child and non-offending caregiver. ⇢ Most effects were maintained at follow-up more than six months after treatment. ⇢ Large effect sizes were found for global outcomes (g = 1.37) and post-traumatic stress disorder and trauma symptoms (1.12), with moderate effect sizes for internalizing symptoms (0.74), self-esteem (0.63), externalizing symptoms (0.52), and sexualized behavior (0.49). ⇢ Small to moderate effect sizes were found for coping/functioning (0.44), caregiver outcomes (0.43), and social skills (0.39).
Skowron & Reinemann, 2005 (systematic review)	NA	Psychological interventions	⇢ Treated participants were better off than 71% of those in control groups. ⇢ Treatment increased the improvement rate for participants by 28%.
Avellar & Supplee, 2013 (systematic review)	NA	Home visiting program in which a trained professional shares information or provides services, case management, and referral to community services	Favorable effect on: ⇢ Family involvement with child protective services ⇢ Percentage of parents who went to the hospital for accident, injury, or accidental poisoning → Parents' report of severe or very severe physical assault ⇢ Physical punishment at 36 months

Author, Year (Type)	Country	Intervention	Impact
			→ Parenting behaviors, such as corporal punishment, self-reported serious physical abuse, and aggression ⇢ Rate of sexual abuse report by the child's seventh birthday ⇢ Health care encounters for injuries or ingestions and substantiated abuse or neglect 15 years after program enrollment
Bartelink, Yperen, & ten Berge, 2015 (literature review of 4 systematic reviews and 13 single studies)	NA	Modes for deciding on child maltreatment management: - Structured Decision Making (use of instruments) - Risk Assessment (assessment of future risk of child maltreatment) - Shared Decision Making - Family Group Decision Making	**Structured Decision Making** ⇢ In one systematic review, assessment was more structured and practitioners made better analyses of complex situations. The impact of the framework on child development and child welfare was not assessed (Léveille & Chamberland, 2010) ⇢ Another systematic review concluded that evidence for these instruments is limited and that some might have indicated unintended harmful consequences when the use is not accompanied by essential infrastructure and organizational change such as training, supervisory and management support, and the involvement of supervisors and line managers in the implementation process (Barlow et al, 2012). ⇢ Other studies concluded that decision-making process had clearly become more systematic and more transparent; however, rationales for judgments and decisions were often still absent (De Kwaadsteniet et al, 2013). Moreover, there was limited inter-rater agreement on decision making (Bartelink et al, 2014). **Risk Assessment** ⇢ One systematic review concluded that the evidence for these instruments is currently limited (Barlow et al, 2012) ⇢ Other single studies found mixed results

Author, Year (Type)	Country	Intervention	Impact
			regarding the use of actuarial instruments for risk assessment (Baumann et al, 2005; Bolton & Lennings, 2010; Herman, 2005) **Shared Decision Making** ⇢ One systematic review revealed positive effects of child participation on immediate safety and well-being, and successfulness of out-of-home placement (Vis et al, 2011). ⇢ Other single studies revealed positive results on child maltreatment recurrence, out-of-home placement, as well as better outcomes in discipline and emotional care of children (Lee & Ayon, 2004; McLendon et al, 2012). ⇢ Studies on motivational interviewing and solution-focused casework showed positive results on child safety and parenting skills (Antle et al, 2012; Connell et al, 2007; Dishion, Nelson, & Kavanagh, 2003; Dishion et al, 2008). **Family Group Decision Making** ⇢ One systematic review revealed that family group decision making does not reduce child maltreatment recurrence or out-of-home placement (Shlonsky & Saini, 2011). ⇢ In another systematic review, children participating in a family group conference did not have better outcomes than children who did not participate (Vis et al, 2011). ⇢ Another study revealed that children receiving family group decision-making were not worse or better off than children receiving traditional child welfare services, whereby results for safety, permanency and stability were the same for the control and experimental group (Berzin et al, 2008) ⇢ In another study, it was found that

Author, Year (Type)	Country	Intervention	Impact
			children receiving family group decision-making were more often re-referred to child protection services due to child maltreatment than children in the control group and stayed longer in out-of-home care (Sundell & Vinnerljung, 2004).

Appendix 4: Studies Exemplifying Comprehensive Approaches

Study	Approach	Benefits/Harms/Uncertainty
Model 1: The social worker as a key player and coordinator of child protection		
Author, Year: Connolly, 2012 **Type**: Single Study **Country**: Australia	As an active member of the healthcare team, **social workers**, after consulting their supervisor or senior staff, are required to: ⇢ Undertake a **comprehensive psychosocial** assessment through which they report concerns about likelihood or actual neglect or physical injury to the statutory child protection agency ⇢ Provide written reports for court proceedings, when necessary ⇢ Inform medical and nursing staff of any Children's Court Orders and document in the medical file ⇢ Provide emotional and practical support to the child and family Procedural guidelines require that medical or nursing staff refer suspected or actual children with abuse to the allocated unit social worker. If the social worker is concerned about a child's well-being, a referral should be made to Child FIRST, the central referral system for family support services. If the social worker believes that a child may have sustained physical abuse, the social worker, and the treating medical team shall consult the forensic pediatric medical service. When protective intervention is	Benefits of this new process include more efficient use of staff resources and a better fit with statewide policy requirements for integrated service delivery that is "everyone's business." Systematic data was not collected prior to implementation; therefore, it is difficult to fully understand the implications.

Study	Approach	Benefits/Harms/Uncertainty
	required, the social worker notifies the statutory child protection agency as soon as possible. When a child is admitted to the hospital because of suspected abuse or neglect, hospital procedures require that a case conference with statutory child protection agency, police, and the multidisciplinary team be held within 24 hours of the child's admission. After the statutory child protection agency has been informed of actual or suspected abuse, the ongoing role of the social worker includes continued communication with the statutory agency and support of the child and family. Under the new model, suspected cases of child abuse and neglect were referred to the Social Work Department instead of hospital specialist child abuse team. Sexual abuse cases continue to be managed by the specialist team.	
Model 2: In-hospital child protection teams guided by roundtable discussions		
Author, year: Chen et al, 2008 **Type**: single study	The Ministry of Health has mandated that each hospital should establish a **child protection team (CPT)** that is responsible for assessing cases of suspected child abuse or neglect. The CPT at Safra Children's Hospital, Sheba Medical Center, comprises a social worker, child psychiatrist, pediatrician, and nurse. In cases of suspected child abuse or neglect, the child is hospitalized, regardless of medical condition. This period is necessary to allow the CPT to collect medical and psychosocial data from clinical examinations, observations, and interviews with parents and community-based services to determine whether there is a reasonable basis for suspicion. If so, the case is reported to a child	⇢ The Safra CPT has reviewed over 1,500 cases since its establishment in 1991, approximately two-thirds of which have been referred to the authorities. ⇢ In a hospital staff survey, participants were more likely to express the opinion that family violence requires attention within the hospital setting and not just by welfare or police authorities. ⇢ Most respondents were aware of hospital policy regarding child abuse cases and expressed willingness to act when suspicions arise. ⇢ Very few expressed fear of personal safety or legal entanglement.

Study	Approach	Benefits/Harms/Uncertainty
	protection officer (court-authorized social worker), the police, or both. To improve staff members' skills, the Safra CPT established a program of **weekly roundtable sessions**, to which all hospital workers and students-in-training are invited. Cases are presented and integrative analysis of all findings. The social worker acts as the team leader and presents an overview of the case, emphasizing the initial reason for suspicion. The physician addresses medical findings, the nurse reports on behaviors observed, and the social worker or psychiatrist present behavioral and emotional findings.	
Model 3: A hospital 'No Hit Zone' implemented through multiple educational interventions		
Author, year: Frazier, Liu, & Dauk, 2014 **Type**: single study **Country**: USA	The Kosair Child Abuse Task Force is a **multi-disciplinary group** that includes nurses, social workers, child life therapists, public relations managers, hospital advocacy representatives, chaplains, child abuse pediatricians, pediatric psychiatrists, and general pediatricians. A **No Hit Zone** is an environment in which no adult shall hit a child, no adult shall hit another adult, no child shall hit an adult, and no child shall hit another child. When hitting is observed, it is everyone's responsibility to interrupt the behavior as well as communicate system policy to those present. An educational PowerPoint presentation was created by the child abuse task force. A Web-based **education** module was also created that can be accessed remotely by all employees. Social workers, child life therapists, and chaplains presented the PowerPoint education presentation at their departmental	No formal impact assessment published. The subjective success of the program is demonstrated by high demand for the 'No Hit Zone' program beyond the initial pilot facilities.

Study	Approach	Benefits/Harms/Uncertainty
	meetings. Live sessions were promoted by the chief nursing officer and given to any interested hospital staff members by physicians and nurse educator champions. Education for physicians was accomplished via multiple noon conferences attended by residents and attending physicians.	
Model 4: Sexual assault response program for the care of sexually abused children		
Author, year: Goyal et al, 2013 **Type**: single study **Country**: USA	**Sexual assault response program**, which included **writing protocols for evaluation and treatment of patients, obtaining appropriate equipment, training specialized nurse examiners, and educating the entire emergency department staff** (physicians, nurses, technicians, child life workers, and social workers) around the care of the acutely sexually assaulted patient. The training was based on the standard pediatric sexual assault nurse examiner certification training, which is coordinated and administered by an emergency department pediatric nurse practitioner. A multidisciplinary team consisting of faculty in emergency medicine and general pediatrics, social workers, child life specialists, pediatric emergency medicine nurses, and administrative staff provides additional oversight for the program. Once a patient meets criteria for evaluation, a structured history is obtained, a complete physical examination is performed with photo documentation, pain control is provided as needed, and forensic evidence is collected. Furthermore, when indicated, sexually transmitted infections, pregnancy, and drug testing is conducted, and medical treatment is provided. The Department of Human Services and police reports	⇢ 184 patients met criteria for SART evaluation within a 2 years period, of whom 87.5% were female; mean age was 10.1. ⇢ The majority of patients underwent forensic evidence collection (89.1%), which varied by menarchal status among girls ($P < 0.01$), but not by sex. ⇢ Evidence of acute anogenital injury on physical examination was found in 20.6% of patients. ⇢ Menarchal girls were more likely to undergo testing for sexually transmitted infections and pregnancy ($P < 0.01$) and to be offered pregnancy, sexually transmitted infection, and HIV prophylaxis ($P < 0.01$). ⇢ Development of a SART program supported the majority of eligible patients undergoing forensic evidence collection and a substantial number of patients had evidence of injury on examination. ⇢ These findings underscore the importance of having properly trained personnel to support emergency department care for pediatric victims of acute sexual assault.

Study	Approach	Benefits/Harms/Uncertainty
	are then filed. Finally, all patients evaluated by the SART are provided with psychological and mental health resources and follow-up, including follow-up with their primary care provider.	
Model 5: Managing the emotional distress of child victims of extrafamilial sexual abuse and their families		
Author, year: Grosz, Kempe, & Kelly, 2000 **Type**: single study **Country**: USA	Child victims of extrafamilial sexual abuse and their families are evaluated after investigative interviews by law enforcement agencies were completed. A treatment plan is developed based on clinical assessment. Families participate in **crisis counseling, individual treatment for the child victim and parent**, children's treatment groups, parent support groups, or are referred to other resources. Clinical assessment of treatment progress includes weekly case review by child and parent therapists, video analysis and observation of children's treatment Group sessions, and consultation with parents and collateral contacts.	⇢ Progress observed in children after participation in group treatments included a significant decrease in sleep disturbances (nightmares, night terrors, and waking up), angry outbursts, moodiness, clinging behaviors, separation anxiety, fearfulness, emotional fragility, and belligerence. ⇢ Parents reported improvement in children's self-esteem, self-confidence, school performance, and relationships with parents, siblings, and peers. ⇢ Mothers reported improvement in sleep disturbances, regressive behavior, feelings of fear and unhappiness, and crying.

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