8

CHILD SEXUAL ABUSE

8. CHILD SEXUAL ABUSE

PREPARATION AND MATERIALS

OBJECTIVES

- Learn how to provide first line support and medical care to child survivors of rape and sexual abuse
- Gain knowledge and skills to provide care and support to children who experience rape and sexual abuse
- Describe the guiding principles of caring for child survivors
- Describe how to create a safe environment for child survivors
- Explain why it is impossible to test for virginity.
- Explain at what age a girl should be offered ECP if vaginal penetration has occurred.
- Describe what treatment you would offer for a child survivor.
- Demonstrate how to advise parents or guardians on a child's possible reactions to sexual assault.

AVAILABLE TRAINING RESOURCES

Presentation
8. Child sexual abuse

Facilitator guide
8. Child sexual abuse

Activities
8.1 Definition of child sexual abuse
8.2 Matching activity – Key terms related to child sexual abuse
8.3 Vote with your feet – Child sexual abuse
8.4 Discussion on barriers to care for child survivors of sexual abuse
8.5 Guiding principles when supporting child survivors
8.6 Case studies on medical care for survivors of child sexual abuse
8.7 Case studies on medical care for survivors of child sexual abuse Risks and safety

Videos
8.1 Welcoming child survivors
8.2 Informed consent
8.3 Assessing the child alone
8.4 Medical history of a child
8.5 History of the incident with a child
8.6 General exam of a child
8.7 Genital exam of a child
8.8 Talking about virginity with adolescents
8.9 Preventing pregnancy for adolescents
8.10 Medical treatment and care of children
8.11 Psychosocial support for children
8.12 Enhancing safety with children
8.13 Connecting children with social support

Participant handouts
8.1 Pathways of care for child or adolescent survivors of sexual abuse
8.2 Why children do not disclose sexual abuse
8.3 Sexual Abuse impacts across age and developmental stages
8.4 Guidelines for communicating with children
8.5 Interview guidelines based on age and developmental stage
8.6 Mandatory reporting requirements for children

REQUIRED SUPPLIES & MATERIALS

- Wall space to post papers
- Tape
- Pen and blank paper workbook for each participant
- Signs with the words “agree” or “disagree” written on them
- Flip chart, markers
- Print outs of statements and case studies for activities– depending on which activities you choose

KEY MESSAGES

- Ensure care for children and adolescents is:
    - provided in a safe, child-friendly space
    - promotes their best interest and evolving capacities
    - enhances their safety

FURTHER RESOURCES FOR FACILITATORS (OPTIONAL)

- WHO (2019) Clinical management of rape and intimate partner violence survivors: Developing protocols for use in humanitarian settings, Part 6: Caring for child survivors, pg 36-39
- IRC, UNHCR (2012) Caring for Child Survivors of Sexual abuse Guidelines
- World Health Organization (WHO) (2016). Clinical guidelines for responding to children and adolescents who have been sexually abused. Geneva
- WHO (2018) Eliminating Virginity Testing: An Interagency Statement

CARING FOR CHILD SURVIVORS FACILITATOR GUIDE

INTRODUCTION

Slide 1 Introduction

CORE CONCEPTS ON CHILD SEXUAL ABUSE

Slide 2-3 Introduction

Activity 8.1 Definition of child sexual abuse
And/or
Activity 8.2 Matching activity of key terms related to child sexual abuse

SLIDES 5-6

Slide 5 notes

- A **child** is defined by the United Nations Convention on the Rights of the Child as any person under the age of 18 years.
- **Child sexual abuse** as involvement of a child or an adolescent in sexual activity that he or she does not fully comprehend and is unable to give informed consent to, or for which the child or adolescent is not developmentally prepared and cannot give consent, or that violates the laws or social taboos of society.
- Child sexual abuse involves the intent to gratify or satisfy the needs of the perpetrator or another third party including that of seeking power over the child.

Slide 6 notes

- There are two main types of child sexual abuse:

1 CONTACT SEXUAL ABUSE:	2 NON-CONTACT SEXUAL:
• May involve sexual intercourse (i.e. sexual assault or rape, sexual touching of a child's breast, genitals, buttocks or other body parts or forcing a child to sexually touch another person	• Abuse may involve threats of sexual abuse, verbal sexual harassment, sexual solicitation, indecent exposure, exposing the child to pornography, showing their sexual parts to a child for sexual purposes (masturbating in front of a child), forcing a child to watch sexual acts or sexual movies, read stories or look at sexual images, taking pictures or videos of a child in sexual positions.
• May exclude sexual intercourse but involving other acts such as inappropriate touching, fondling and kissing.	

Activity 8.3: Vote with your feet

SLIDE 8-12 UNDERSTANDING CHILD SEXUAL ABUSE AND DISCLOSURE

Slide 8 notes

- Child sexual abuse is often carried out **without physical force,** but rather with **manipulation, intimidation, and psychological, emotional or material pressure.**
- Children can be abused by adults or other children in a **position of responsibility or trust or power**
- Children can be sexually abused by both adults and other children who are – by virtue of their age or stage of development – in a position of responsibility or trust or power over the victim.
- The **most common perpetrator** is a male family member. Abuse by teachers, childcare workers, family friends, religious leaders, and neighbors are also common.

- Adolescents may also experience sexual abuse at the hands of their peers, including in the context of dating or intimate relationships.
- It may occur on a frequent basis over weeks or even years, as repeated episodes that become more invasive over time.
- It can also occur on a single occasion.

Slide 11 notes
- Indirect disclosure may include someone may find out from the child becoming pregnancy or contracting an STI
- Learn if the child wanted the CSA to be discovered, if the child trusts those they disclosed it to, and if the primary caregiver is aware.

Slide 12 notes
- Children who have been sexually abused are most likely to come to your attention through a caregiver or another adult; abused children rarely seek help on their own.
- **Disclosure** may be a process, with children trying to explain or hinting that sexual abuse occurred to see how their caregiver or a trusted person may respond. If trusted adults show negative reactions (anger or blame) towards the child, the child may stop talking or later deny that the abuse occurred. This may result in the child refusing to share further information or even deny the abuse altogether in subsequent interviews because he/she does not feel safe. If a child perceives angry or accusatory reactions, the child may experience deeper levels of shame, anxiety and sadness. While a calm, affirming and supportive reaction will foster the child's feeling of safety and acceptance—helping recovery and healing.

Activity 8.4 Discussion on barriers to care for child survivors of sexual abuse

SLIDE 14-15 BARRIERS TO DISCLOSURE AND POTENTIAL SIGNS

Slide 14 notes
- The child **may not disclose due to:** guilt, shame, fear of not being believed, of revenge on family, of discrimination or dismissal, feeling physically threatened, or because they believe they will be taken away from their families or blamed for shaming the family or involving outside authorities. They may believes it's their fault, and they will be blamed. The child may want to protect the perpetrator and/or family in some way, especially if the perpetrator is close to the child and his/her family. The child may not have the knowledge or awareness to realize it is wrong: they may be too young to know, not have words for what happened, not know how to communicate the issue
- The perpetrator may tell the child that the parent/caregiver won't love the child anymore when parent/caregiver hears what the child has done, or threaten the child.
- Children may not understand what is happening to them or they may experience fear, embarrassment or shame about the abuse, which affects their willingness and ability to talk to service providers.

Slide 15 notes
- Other concerning physical signs include pregnancy, or STIs.
- The **majority of signs and symptoms are behavioral and emotiona**l in nature. It's important to consider the child's age and developmental stage to determine whether their behaviour is abnormal.
- Any one sign or symptom does not mean that a child has been abused, but the presence of several signs may suggest that a child is at risk. It is important to believe reports of sexual abuse no matter what you observe about the child. Also there is a need to be cautious – you cannot assume abuse, but if certain signs and symptoms are identified, it may be worth observing the situation, and posing certain questions. It is important to consider other causes of signs and symptoms (maternal to infant transmission of STIs, fungal infection, accidental/unintentional traumatic injury, psychological reactions to other traumatic events such as conflict, displacement).

GUIDING PRINCIPLES FOR WORKING WITH CHILD SURVIVORS

SLIDE 16-23

Slide 16 notes
- The role of a health-care provider is the same for child survivors of sexual abuse and for adults – to provide quality first-line support and medical care. However, the needs and capacities of children and the ways of responding to those needs differ.

Slide 19 notes
- There are **limits to confidentiality,** you may need to breach confidentiality to protect a child's physical and/or emotional safety.

Slide 20 notes

- Determine what the **best interest** of the child or adolescent is by carefully considering the child's situation. This can be done by having a meaningful discussion with the child and their non-offending caregiver about what they believe is the child's best interest, evaluating the positive and negative consequences of actions, with participation from the child and their caregiver, and seek the least harmful course of action. The children's or adolescent's physical and emotional safety, well-being and ongoing development in the short and long term should not be compromised.

Slide 21 notes

- Speak in a way that the child understands.

Slide 22 notes

- Ensure children and adolescents are **given age-appropriate information** and explanations, and are involved in their care. **Ask child's or adolescent's opinions,** take their opinions into account. **Respect the child's opinions,** beliefs and thoughts. Encourage them to participate in decision-making that have implications for their lives and express willingness to participate. **Do not force children** to do a history and interview, examination, receive medical care or to share their information with others – unless absolutely necessary for life saving medical care.
- While service providers may not always be able to follow the child's wishes (based on best interest considerations), they should always empower and support children and deal with them in a transparent manner with maximum respect.
- Parents or legal guardians are typically responsible for giving informed consent on behalf of the child for relevant clinical care. However, in situations where it is in the best interests of the child or adolescent, informed consent should be sought from the child or adolescent themselves.

Activity 8.5: Guiding principles when supporting child survivors

SLIDE 25-26 MANDATORY REPORTING

Slide 25 notes

- **Mandatory reporting:** is legislation passed by some countries or states that requires designated individuals, such as health-care providers, teachers or social workers, to report (usually to the child protection agency or the police) known and reasonably suspected cases of specified types of child abuse and neglect, normally including child sexual abuse.
- If it is obligatory to report cases of child abuse in your setting, obtain a copy of the national child abuse management protocol (and reporting form) and information on customary police and court procedures.
- Mandatory reporting requirements can raise **ethical and safety concerns,** and may risk further harm. For example, investigators may show up to a child's home, therefore, potentially breaching a child's confidentiality at the family or community level (prompting retaliation). In addition, services for children may be non-existent, thus creating additional risk (e.g., separation from family, placement in institutions, or confiscation of private records). The local authorities may themselves be abusive or they may simply be ignorant of best practice procedures or guiding principles.

Slide 26 notes

- Evaluate each case individually – in some settings, reporting suspected sexual abuse of a child can be harmful to the child if protection measures are not possible.
- Use these questions to guide decision-making:
  - Will reporting increase risk of harm for the child?
  - What are the positive and negative impacts of reporting?
  - What are the legal implications of not reporting?
- Involve your supervisor and to make a decision together with the child, non-offending caregiver and supervisor. Develop an action plan that first considers the child's safety and then the legal implications of not reporting.
- If you are reporting, before reporting share the following information to the child survivor and caregivers
  1. The agency/person to which/whom you will report
  2. The specific information being reported
  3. How the information must be reported (written, verbal, etc.).
  4. The likely outcome of the report
  5. The child's and family's rights in the process
- Some, not all information, may need to be shared to protect the child. Consider how much and what to share together with the child, non-offending caregiver and supervisor.

DISCUSS

Ask what questions or concerns the participants may have.

ENGAGING AND COMMUNICATING WITH CHILD AND ADOLESCENT SURVIVORS

SLIDE 28-30

Slide 29 notes

- Your initial reaction will impact their sense of safety and willingness to talk, as well as their psychological well-being. A positive, supportive response will help abused children to feel better. A negative response (such as not believing the child or getting angry with the child) could cause them further harm.

LISTEN	INQUIRE ABOUT NEEDS	VALIDATE
Listen actively, respectfully, and empathically to the child, and believe them when they speak.	Do no harm: be careful not to traumatize the child further. Do not become angry with the child, force the child to answer a question they are not ready to answer, force the child to speak about the sexual abuse before they are ready, or have the child repeat their story of abuse multiple times to different people.	Be nurturing, comforting and supportive.
Pay attention to non-verbal communication. A child may demonstrate feelings of distress by crying, shaking or hiding their face, or changing their body posture. Be aware of your body language as well.	Respect the child's opinions, beliefs and thoughts.	Validate and reassure the child that they are not at fault for what has happened to them and that you believe them.
	Take into account the different needs of boys and girls and different ages and development stages.	Offer an empathetic, validating and non-judgemental response that reassures them that they are not to blame for the abuse
		Comfort, encourage and support them
		Believe their disclosure and never blame them in any way
		Make children feel safe and cared for

Slide 30 notes

- **Introduce yourself** to the child. Reassure the child that **you are there to help.** Tell the child why you are talking with them.
- Sit at eye level and maintain eye contact. Use appropriate eye contact, a friendly face, soft gentle voice
- Assure the child that he or she is **not in any trouble.**
- **Build trust and rapport** by asking about neutral topics before delving into direct questions about the abuse; Ask a few questions about neutral topics, such as school, friends, whom the child lives with, favourite activities.
- Have toys available if possible, especially for younger children.
- Help the child to feel safe.
- Children should be **interviewed briefly on their own** (i.e. separately from caregivers), while offering to have another adult or trusted person (such as a trained health worker) – present for support. Always ask the child for consent or assent according to their age, developmental stage and capacity to consent. Always ask the child whom they would like to be present, and respect their wishes. Remember that it is possible that an accompanying family member is the perpetrator of the abuse. Empower the child to know they can be interviewed and examined on their own - as some parents may expect or place pressure to be there. Some adolescents may want to be alone and this should be considered based on their evolving capacities.
- **Involved a trusted, supportive caregiver with the child's permission.**
- Choose appropriate people to help. In principle, only female service providers and interpreters should speak with girls about sexual abuse. Boy survivors of abuse should be offered the choice (if possible) to talk with a female or male provider, as some boys are likely to feel more comfortable with a female service provider. The best practice is to ask the child if he or she would prefer to speak with male or female trained staff.

Video 8.1: Welcoming child survivors
Explain that they are actors, explain that the child survivor is actually older but is acting as younger child.

Video 8.2: Informed consent

Discuss the video:
- What did the physician do well?
- What was missing? What could be improved?

Explain that the health care provider should also speak directly to the child, provide information to the child, involve the child in decision making and encourage her participation. The child should also express willingness to participate, not only her mother.

Video 8.3: Assessing the child alone

HISTORY TAKING WITH CHILDREN AND ADOLESCENTS

SLIDE 32-35

Slide 32 notes
- For younger children, make sure that there are dolls, crayons or other toys to keep them busy during the conversation.
- Be patient; go at the child's pace and do not interrupt. Observe whether the child becomes upset or distressed, and allow time for breaks.
- Provide age-appropriate information in an age- appropriate manner and environment.
- Speak in a way that the child understands.
- Tell the child why you are talking with them.

Slide 33 notes
- Begin the interview by **asking open-ended questions,** such as "What brings you here today?" or "What were you told about coming here?" to get information about the incident.
- Use questions or statements such as: "Has anyone ever touched you in a way that makes you confused or frightened? Where were you touched on your body?"
- **Avoid asking leading or suggestive questions.**
- Do not ask "Did he put his hands on your breasts?"
- Instead say: "Tell me what happened next." "Can you tell me more about..." "What do you mean by...." "Give me an example of..."
- Ask closed (yes/no) questions only for the clarification of details.
- Asking why can seem judgmental.

Slide 34 notes
- Use **dolls**
  1. To learn and use the words the child uses for male and female body parts and to have a correct understanding of the incident. Take the time to clarify the words and phrases used by children to ensure an accurate understanding of children's statements.
  2. To learn about the sexual assault. Ask children to show you what happened, where on the doll he or she was touched or hurt.
  3. Do not point to a child or the dolls's breast, vagina, penis or other body part and asking, "Did he touch you here?" Children may want to please the person asking and could answer "yes" when, in fact, the answer is "no."
- Children find it easier to **express emotions through drawings or stories.**
  1. Invite the child survivor to draw a picture or tell a story, without specific directions about what.
  2. Ask child to draw a picture "of their happiest memory" or a draw of "who lives in their house".
- Pay attention to **non-verbal communication.** A child may demonstrate feelings of distress by crying, shaking or hiding their face, or changing their body posture. Be aware of the cues your body language is giving as well, to gain the child's trust.
- Adapt interviewing techniques based on age, maturity and developmental stage, disability.
- **Potential challenges** may include:
  - **If a child refuses to talk,** consider: Is there somebody in the room the child does not feel safe speaking in front of? Are you acting in a way that is making the child uncomfortable? Is the interview place safe for the child to speak?
  - **If the child denies the abuse,** stay neutral, get more facts, be patient and do not force or pressure the child to speak if they are not ready.

Slide 35 notes

- Ask about **medical history** – including vaccination history.
- Ask girls ask about **menstrual and obstetric history.** Be mindful not to ask about sexual history in front of parents or caregivers.
- Ask **open ended questions** about **the abuse**
  - "Has anyone ever touched you in a way that makes you confused or frightened?"
  - "Your mum said something happened to you, can you tell me about what happened?"
  - "Share with me how you were touched" "Can you tell me what happened next?" "Can you tell me more about that..?"
  - "Can you give me an example of..?" or "Can you describe for me..?"
  - "Go on.." "And then what happened..?" "Anything else?"
  - "Is there anything else you think I should know about what happened?"
  - "Is there anything else you'd like to talk about?"
- Ask about the abuse – **when** did it happen, **type** of abuse (penetration), if it has **happened before,** how many times
- Sexual abuse of children is often **repeated** abuse.
- To get a clearer picture of what happened, try to obtain information on:
  - the home situation, whether the child has a safe place to stay
  - how the sexual assault was discovered
  - who did it, and whether he or she is still a threat ("Is the person who did this someone you know?" "Do you know where he is?")
  - if this has happened before, when the abuse began, how many times and the date of the last incident
  - if any siblings are at risk
  - whether there have been any physical symptoms (e.g. bleeding, dysuria, discharge, difficulty walking, etc.)
- There is a difference between adults and children, that with adults if they feel safe, not judged and blame they may just start to tell you the story, but with children we need to be sensitive to asking open-ended questions to gain information about the incident, children may not know what information you will find important.

Video 8.4: Medical history with a child

Discuss the video:

- What did the physician do well?
- What was missing? What could be improved?

Explain that the health care provider should also speak directly to the child, provide information to the child, involve the child in decision making and encourage her participation. The child should also express willingness to participate, not only her mother.

Video 8.5: History of the incident with a child

Discuss the video:

- What did the physician do well?
- What was missing? What could be improved?

Explain that the health care provider should ask open-ended questions "Are you comfortable sharing with me about what happened? Can you tell me what he did to you? Can you show me where?"

DO NOT ASK "Did he touch you using his penis?" "Did he touch you with his hands? Did he touch you with his private parts?". These are leading questions, can make a child feel that they are pressured to provide answers that are desired for the nurse. Instead ask open ended questions such as "How did he touch you, what did you touch you with, did you tell anyone, who did you tell?"

EXAMINATION

Slide 37 General examination

- The child should **only undergo 1 examination.** If you are not competent in examining a child, do not examine the child and await a skilled colleague.
- Seek to minimize additional harms, trauma, fear and distress, and respect the autonomy and wishes of children or adolescents.
- With adequate preparation, most children will be able to relax and participate in the examination.
- If the child cannot relax, this may be because he or she is in pain. If this is a possibility, give paracetamol or other simple painkillers, and wait for them to take effect.
- As for adult examinations, in addition to the survivor and the health-care provider there should be a **support person** or trained health worker whom the child trusts in the examination room with them.

- Consider positions that **minimize physical discomfort and/or psychological distress.** Small children can be examined on the mother's lap. Older children should be offered the choice of sitting on a chair or on the mother's lap, or lying on the bed.
- **Encourage the child to ask questions** about anything he or she is concerned about or does not understand at any time during the examination.
- **Explain** what will happen during the examination, using words and terms the child can understand.
- It is useful to have a doll hand to demonstrate procedures and positions. Show the child the equipment and supplies, such as gloves, swabs, etc.; allow the child to use these on the doll.
- **Never restrain or force** a frightened, resistant child to complete an examination. Restraint and force are often part of sexual abuse and, if used by those attempting to help, will increase the child's fear and anxiety, and may worsen the psychological impact of the abuse.
- If the child is highly agitated: In rare cases, a child cannot be examined because he or she is highly agitated. Only if the child cannot be calmed down, and physical treatment is vital and life saving, the examination may be performed with the child under sedation using medications.
- Sedation does not provide pain relief. If you think the child is in pain, give simple pain relief first. Wait for this to take effect. Oral sedation will take 1–2 hours to fully take effect. In the meantime, allow the child to rest in a quiet environment.

Video 8.6: General exam of a child
Explain that you should conduct a full head to toe exam, however the video just shortened it for time.

SLIDE 39-40 GENITAL EXAM OF A CHILD

Slide 39 notes
- **Do not** use a **speculum to examine prepubertal girls;** it is extremely painful and may cause serious injury.
- A speculum may be used only when you suspect a penetrating vaginal injury and internal bleeding. In this case, a speculum examination of a prepubertal girl should be done under general anaesthesia. Depending on the setting, the child may need to be referred to a higher level of health care.
- **DO NOT** carry out **a digital examination of the vagina** (i.e. inserting fingers into the vaginal orifice to assess its size or laxity).
- **DO NOT** carry out **a digital examination of the anus** to assess anal sphincter tone.

Slide 40 notes
- **Genital examination in girls:** Note the location of any fresh or healed tears in the vulva, and vagina by holding the labia at the posterior edge between index finger and thumb and gently pulling outwards and downwards, look for vaginal discharge.
- **Genital examination in boys:** check for injuries to the frenulum, foreskin, prepuce (head of the penis, foreskin, and for anal or urethral discharge).
- **Anal examination in boys and girls:** examine the anus with the child in the supine or lateral position; consider avoiding the knee- chest position, as assailants often use it, do not carry out a digital examination to assess anal sphincter tone, note that reflex anal dilatation (opening of the anus on lateral traction on the buttocks) can be indicative of anal penetration, but also of constipation.
- Consider alternative explanations for injuries or examination findings – such as alternative traumatic injuries, fungal infections, maternal to neonatal STI transmission, etc. Be mindful not to make assumptions or statements proving that sexual abuse occurred. Instead, make observations about injuries.
- **The absence of injuries does not mean that abuse did not occur.**

Video 8.7: Genital exam of a child

Discuss the video:
- What did the nurse do well?
- What was missing? What could be improved?

Slide 42 Virginity testing
- Virginity testing has no medical or scientific validity, is a harmful practice, increases distress and physical, physiological and social harms to those examined and is a violation of their human rights.
- **DO NOT** perform virginity testing.

Video 8.8: Talking about virginity with adolescents

Explain why it is not possible to determine virginity. Have an open dialogue. Carefully, respectfully provide medically accurate information to patients and caregivers, including dispelling myths and misconceptions during consultations or among colleagues. Clearly communicate what your responsibilities are – to provide medical care and first line support.

SLIDES 44-45 CASE STUDY

Slide 44
Question: A 12-year-old female presents to the clinic 12 hours after being vaginally raped by her teacher. She complains of vaginal soreness and a few drops of blood on her underwear. The pelvic exam reveals bruising at her vaginal opening. And minor lacerations along the posterior opening of the vagina.

What is the appropriate message to convey to the patient in terms of her injuries?
A. Explain that the blood was caused by a minor cut on her vagina.
B. Encourage her to agree to a vaginal speculum exam.
C. Reassure her that her genitals will look normal once the injuries heal.
D. Do not discuss the patient's genital injuries, to avoid making her uncomfortable.
E. Both answers A and C are correct

Slide 45
Answer: E. Both answers A and C are correct – Explain that the blood was caused by a minor cut on her vagina. Reassure her that her genitals will look normal once the injuries heal. Explain to the patient that the assault caused a small tear in the vaginal opening. This wound is similar to a cut on the inside of the mouth that she might have experienced after biting her own cheek while chewing, and it will heal with similar speed. No one will be able to tell from looking at her genitals that she was raped. A speculum exam is not indicated because she is not actively bleeding and the source of the prior bleeding was found.

SLIDE 46-47 CASE STUDY

Slide 46
Question: Grace is a 14 year old girl. She comes to your clinic with her mother and stepfather. The mother tells you that she wants to you examine the daughter to determine if she is a virgin. Grace is looking down at the ground and crying. You ask the parents to step outside, so that you can speak to Grace alone. After helping her feel safe and comfortable, Grace tells you that the stepfather has been forcing her to have sex with him over the past 6 months. The last incident was 2 days ago. She has never told her mother. She discloses that her menses are 2 weeks late.

Do you conduct a virginity test upon the mother's request?
A. Yes
B. No

Slide 47
Answer: B No. Health care providers should not perform virginity testing. It is a not a medically valid practice and causes harm.
Additional question for discussion: How do you explain your reason to the mother?
Answer: Provide medically accurate information to patients and caregivers that does not reinforce harmful practices. Carefully and respectfully communicate medically accurate messages, including dispelling myths and misconceptions during consultations or among colleagues. Meet the requests with open dialogues and clearly communicate what your responsibilities are. Explain that your profession prohibits virginity testing. Discuss with your colleagues the reasons or motivations for requests for virginity testing in your context and how to respond in culturally appropriate, respectful ways.

DISCUSS

Ask the participants:
- Have you ever been asked to perform a 'virginity test'?
- How did you deal with it?
- How should you deal with it if a 'virginity test' is requested?

Explain that we should provide medically accurate information to patients and caregivers that does not reinforce harmful practices. Carefully and respectfully communicate medically accurate messages, including dispelling myths

and misconceptions during consultations or among colleagues. Meet the requests with open dialogues and clearly communicate what your responsibilities are. Explain that your profession prohibits virginity testing. Discuss with your colleagues the reasons or motivations for requests for virginity testing in your context and how to respond in culturally appropriate, respectful ways.

DOCUMENTATION

SLIDE 49-50 DOCUMENTATION

Slide 49 notes

- **Accurately, completely document** detailed findings of the medical history, physical examination and any other relevant information, for the purposes of appropriate follow-up and supporting survivors in accessing police and legal services if they choose to.
- Use a **structured format** for recording the findings;
- Record **verbatim statements** for accurate and complete documentation;
- Include **both the child and caregivers account**
- Note down **discrepancies** between the child's or adolescent's and the caregivers' account, if any, without interpretation;
- Record a detailed, accurate description of the **symptoms and injuries;**
- Where no physical injuries are found, **noting that absence of injuries does not mean that abuse did not occur;**
- Document the child's or adolescent's **emotional state,** while noting that no particular state is indicative of sexual abuse;
- Handle all collected information **confidentially.**

Slide 50 notes

- Use the pictograms to document injuries.

SPECIAL CONSIDERATIONS IN MEDICAL CARE FOR CHILDREN AND ADOLESCENTS

SLIDE 52-54 MEDICAL CARE

Slide 52 notes

- Examine for any **injuries** and manage accordingly.
- Where the patient has not been vaccinated, or there is doubt, **offer tetanus vaccine.** It is safe to use.
- Children have the same prevention and treatment needs as adults but may require different doses.
- **HIV PEP** should be offered, as appropriate, to children and adolescents who have been raped involving oral, vaginal or anal penetration with a penis, and who present **within 72 hours** of the incident.
- Offer **emergency contraception** to girls who have been raped involving peno-vaginal penetration and who present **within 120 hours (5 days)** of the incident.
- Ask pre-pubertal adolescent girls whether they have started menstruating. If so, they may be at risk of pregnancy. EC pills can be offered to girls who have attained menarche and also those who have reached Tanner Stage 2 or 3 – who are in the beginning stages of puberty, who have not started menstruating, and who have onset of secondary breast development – as they may face risk of unwanted pregnancy if they ovulate before the onset of menstruation.
- Offer presumptive (or prophylactic) treatment for gonorrehoea, chlamydia and syphilis for children and adolescents who have been sexually abused involving oral, genital or anal contact with a penis, or oral sex.
- For children and adolescents who have been sexually abused and who present with clinical symptoms, syndromic management is suggested for vaginal/ urethral discharge (gonorrhoea, chlamydia, trichomoniasis), and for genital ulcers (herpes simplex virus, syphilis, and chancroid)
- Offer **Hepatitis B vaccination** according to the vaccination schedule.
- Pre-vaccination serological testing is not recommended as routine practice. Testing may not be available in humanitarian settings, therefore offer the vaccine.
- However, in settings where laboratory facilities are available, quick and are cost effective, if it is not known whether the child or adolescent has been vaccinated against hepatitis B, blood should be taken for hepatitis B status prior to administering the first vaccine dose.
- **HPV vaccination** should be offered to girls in the age group 9–14 years, as per national guidance. HPV vaccine may be administered concomitantly with hepatitis B vaccine. If HPV vaccine is given at the same time as another injectable vaccine, the vaccines should always be administered at different injection sites using separate syringes.

Slide 53 notes
- **Check weight** to decide on which dose to give.

Slide 54 notes
- **Check weight** to decide on which dose to give.
- The choice of HIV PEP regimen should consider the antiretroviral medications already being procured within national HIV programmes. This is the WHO-recommended preferred regimen for HIV PEP for adults and adolescents. Dolutegravir is recommended as the third medication for HIV PEP. When available, atazanavir plus ritonavir, darunavir plus ritonavir, lopinavir plus ritonavir and raltegravir may be considered as alternative third medication options.

Video 8.9: Preventing pregnancy for adolescents

- **Explain** that health care workers should speak directly to the patient – not only to their parent. Remind them to ask if there are any questions. Review the reason to give a girl who has not yet started menstrual periods.

Video 8.10: Medical treatment and care of children

Discuss the video:
- What did the physician do well?
- What was missing? What could be improved?

Explain that the health care provider should explain what the HIV PEP side effects are, and how to manage them.
Review the HIV PEP is for 28 days, and STI prophylaxis depending on the medication used is most often 1 single dose or a 7 day treatment. This was somewhat unclear in the video.
Remind the participants that health care providers should talk directly to children, and involved children to participate in their own health care.

SLIDE 56-57 CASE STUDY

Slide 56
Question A 12-year-old female named Nadia presents to the clinic 12 hours after being vaginally raped by her teacher. She complains of vaginal soreness and a few drops of blood on her underwear. The pelvic exam reveals minor lacerations along the posterior opening of the vagina. The patient has not yet begun menstruation.

Should you offer EC to this patient?
A. Yes
B. No

Slide 57
Answer: A. Yes. Emergency contraception is indicated for this child even though she has not officially begun menstruation. There are cases where the first ovulation results in pregnancy. Given the safety and efficacy of ECP, all females between puberty and menopause should be given ECP if they are possibly fertile and come in within 120 hours.

SLIDE 58-59

Slide 58
Question Grace is a 14 year old girl. She comes to your clinic with her mother and stepfather. Grace tells you that the stepfather has been forcing her to have sex with him over the past 6 months. The last incident was 2 days ago. She discloses that her menses are 2 weeks late.

What medical care will you provide Grace?
A.Assessment for pregnancy
B.Offer Emergency contraception pill
C.Offer HIV testing
D.Offer HIV PEP
E.Offer STI prophylaxis
F. Offer vaccination for Tetanus
G.Offer vaccination for Hepatitis B
H.Offer vaccination for Human Papilloma Virus

Answer

A. Assessment for pregnancy
B. Offer Emergency contraception pill – Do a pregnancy test. if the pregnancy test is positive, we do not provide emergency contraception pill.
C. Offer HIV testing – and offer her to return in 3 months for follow-up HIV testing.
D. Offer HIV PEP
E. Offer STI prophylaxis
F. Offer vaccination for Tetanus
G. Offer vaccination for Hepatitis B
H. Offer vaccination for Human Papilloma Virus

Activity 8.6 Case studies – Medical care for child survivors of sexual abuse

SPECIAL CONSIDERATIONS IN PSYCHOSOCIAL SUPPORT FOR CHILDREN AND ADOLESCENTS

SLIDES 61-64

Slide 62 notes

- Begin by a statement such as, "Other children who experienced situations like what you experienced sometimes act differently and feel differently from before it happened. I'd like to ask you some questions about your (or your child's) day-to-day activities now. Is that okay?"
- Assess the child's psychosocial status, emotional state and functioning.

Slide 63 notes

- Assess these areas helps to determine if the child and/or caregiver perceives significant changes following the experience of abuse.
- Ask
  - What are your main problems or worries?
  - Has the child stopped attending school?
  - Has the child stopped leaving the house?
  - Has the child stopped playing with friends?
  - Does the child feel sad or hopeless most of the time?
  - Has the child exhibited changes in sleeping or eating habits?
- Has the child had any other major challenges or difficulties.
- Also assess the strengths of the child and family. While children are deeply affected by the experience of sexual abuse, it is important to remember that children are strong and resilient.

Slide 64 notes

- Building on children's interests helps to reengage them in activities that bring happiness and joy to their daily lives, thus facilitating the healing process.
- Ask
  - What do you do when you are scared?
  - Who are some people you feel safe with?
  - What do you do to make yourself feel safe?
  - What are your interests?
  - What activities do you enjoy?

Video 8.11: Psychosocial support for children

Slide 66 LIV(ES) for children and adolescents

- **Enhance safety:** Child sexual abuse is often perpetrated by someone known and trusted and is often ongoing. Children may be at risk of ongoing sexual abuse
- **Assess the risk** of ongoing sexual abuse of the child and **discuss a safety plan**
  - Is the child safe at their home?
  - Is the child fearful of family members?
  - Can the perpetrator easily access the child where they live?
  - What is the ability of the caregiver(s) to protect the safety of the child and meet the needs and best interest of the child?• Ask and consider the opinions, feelings, wishes of the child and focus on the child's **safety** and **best interest**
- Discuss how to recognize danger and risk with the child
- Discuss with the child who they feel safe with and who they can go to for help
- Discuss with the parent what they can do to protect the child
- If the parent cannot protect the best interest and safety of the child, explore family, neighbours or community members, community or government agencies, NGOs, alternative care arrangements as safety resources together with your colleagues and manager.

- **Facilitate social support:** Social support is crucial for healing and recovery. At the family level support can include: positive attitudes and involvement on the part of parents/caregivers, family cohesion. At community level support can include involvement in community life, peer acceptance, and supportive mentors, and access to quality schools.
- The caregiver can decrease the child's emotional distress by spending time with their child and providing opportunities for their child to play with other children, create a supportive environment, understand their child's concerns, give the child space to talk, ask questions and play.
- Ask
  - Who did the child trust the most in the family before the abuse happened? Who does the child trust after the abuse? Is the child happy at home? Does the child have basic needs met (food, clothing, education, protection)? Is the child treated differently from other children in the family? Is the child able to play freely?

- However **non-offending caregivers also need support** in coping with their own feelings related to the CSA, in order to support their child.
- Caregivers may have many feelings:
  1. Blame themselves.
  2. Being in disbelief, shock, worry, sadness, or fear.
  3. Not knowing what to do or where to seek help.
  4. May become angry and scold or beat the child.
  5. They may choose not to enquired more, think they misunderstood the child or the situation as they don't want the problem to exist.
  6. Conflicting emotions especially if perpetrator is someone trusted.

The child will need the caregiver's support and attention to facilitate their own healing. Explain them their importance in the child recovery and that believing their child is crucial.

Video 8.12: Enhancing safety with children

Video 8.13: Connecting children with social support

Explain that both of these videos are brief, the conversations to enhance safety and connect with social support may be more in depth that these.

Activity 8.7: Case studies on enhancing safety and facilitating support for survivors of child sexual abuse

Slide 69 Key messages