STANDARD 21

[1] Health and child protection

[2] Child protection strategies should contribute to and maintain the good health of children, and similarly health activities need to be carried out in a safe and protective manner, and aim at reducing protection risks. [3] Health interventions play a central role in responding to major child protection risks in emergencies. [4] Child survivors of violence, abuse and exploitation, as well as survivors of explosive remnants of war (ERW) and landmines, are at the core of both child protection and health interventions. [5] An integrated approach is a model based on inclusion and complementarity, valid for all sectors and should be systematically applied.

**Standard**

[6] Child protection concerns are reflected in the assessment, design, monitoring and evaluation of health programmes. [7] Girls and boys have access to quality health services delivered in a protective way that takes into account their age and developmental needs.

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**Note to Reviewers**

This draft is an updated version of the 2012 standards in the CPMS. In this version, the text in **black** represents the changes from the 2012 text while the text in **blue** is the original text. (To see what has been deleted kindly check the current version of the standards.)

Please keep in the mind that the CPMS are **standards**. They are **not guidance on how to do programming**. The standards give the essential on what as a minimum needs to be achieved in a specific area of humanitarian child protection work. Practitioners should refer to guidance documents listed in the reference section for further information on how to achieve the standards.

Please note that this version might need to be edited down in length to keep the standards at their current total size.

When reading through this document, please consider: is this useful for practitioners? Is the language clear and easy to understand? Does it reflect best practice and evidence? What points are non-essential and can be deleted? Are they developed in the form of standards or leaning more towards guidance?

**How to provide feedback on this draft:** Please use the accompanying feedback back form that can be found [here](#).

Thank you for your contribution to improving the CPMS!
Key actions

KEY ACTIONS FOR CHILD PROTECTION ACTORS

21.1. [8] wherever possible conduct inter-sectoral assessments followed by joint sector analysis and strategies. [9] Share key CP principles and protective measures for children within health facilities, including for infectious disease contexts. [10] Ensure time is taken to coordinate and discuss common strategies and approaches for health and child protection and strategies for intervention;

21.2. [11] agree together which indicators should be used to track joint progress, and together identify which pre-existing forums (e.g. team or cluster meetings) are most useful for regular reviews of information on child protection and health;

21.3. [12] designate a child protection focal person to participate in health sector working group meetings as required, and work with the health sector to develop and disseminate Standard Operating Procedures for identification and referral of vulnerable children, including in health centres;

21.4. [13] consider health-related causes, consequences or motives during discussions with children, adolescents, caregivers and community members, and invite health workers to attend discussions wherever relevant and appropriate. [14] Also consider the situation of children in different care arrangements (e.g. children in residential care, child heads of households, children on the street, children with disabilities) and share this feedback with health partners;

21.5. [15] identify and work with primary health care workers, maternal child health specialists and community health workers specialized in working with children, including on integrated community case management;

21.6. [16] in settings of infectious disease outbreaks, seek recommendations from the health sector to ensure child protection interventions or services do not facilitate further transmission of disease. [17] Provide support to the health sector to determine if certain health interventions could lead to child protection concerns and advise on ways forward;

21.7. [18] in settings of infectious disease outbreaks, identify, train and mentor local health actors and officials who would likely be involved with responses to outbreaks on preventing family separation, identification and referral of unaccompanied and separated children, age-appropriate methods for interviewing children, alternative ways to comfort, support and interact with children, and adapted techniques for interviewing children in observation and treatment centres;

21.8. [19] together with health workers agree on clear, commonly agreed information on health services available, including those dealing with sexual and gender-based violence (e.g. post-exposure prophylaxis or PEP, prevention of mother-to-child transmission of HIV, etc.) and ERW and landmine incidents;

21.9. [20] ensure systems are in place within child protection projects to identify and refer cases of illness and injury safely and confidentially to appropriate health and HIV services;
21.10. in collaboration with mental health specialists strengthen or set up an appropriate screening and referral system for children who need psychological or clinical mental health support;

21.11. agree together with health sector on division of labour and coordination system for MHPSS (see Standard 10);

21.12. strengthen or develop links between systems of social welfare, injury surveillance and health to make sure referrals happen quickly, and deliver multi-disciplinary services to children in collaboration with health sector;

21.13. where relevant, link birth registration with reproductive health (for example postnatal care and referral for vaccinations);

21.14. work with health workers for inclusion of relevant health messages in community-based child protection activities, including on menstrual regulation;

21.15. support health-service providers (including community health workers) to detect, respond to and refer cases of violence, neglect, abuse, and exploitation of children to the appropriate providers;

21.16. work with health sector to ensure emergency referral protocols consider the needs of children and ensure caregivers are able to remain with children during referrals and admissions;

21.17. identify and tackle the different barriers preventing girls and boys from accessing health services, including children with disabilities, LGBTI children or other excluded groups of children;

21.18. where needed, advocate for specialised age-appropriate emergency medical, surgical, and – where possible – longer-term physical rehabilitation and ortho-prosthetic services for child survivors of ERW and landmines and children with disabilities; and

21.19. lobby for, and carry out, joint health and child protection evaluations and resource allocation processes, for instance within the Post Disaster Needs Analysis or the Post Conflict Needs Analysis.

KEY ACTIONS FOR HEALTH ACTORS

21.20. wherever possible conduct inter-sectoral assessments followed by joint sector analysis and strategies. Ensure time is taken to discuss affected population common for health and child protection and strategies for intervention;

21.21. agree together which indicators should be used to track joint progress, and together identify which pre-existing forums (e.g. team or cluster meetings) are most useful for regular reviews of information on child protection and health;

21.22. include the safety of the affected population, including children, as a sub-objective of each health intervention;

21.23. ensure health workers working with children have access and know key child protection principles and protective measures for children within health facilities;

21.24. ensure to include in the target population children who are particularly at risk of violence, exploitation, abuse and neglect. This may include those in residential care, children who have lost one or more caregivers, child caregivers, child heads of
households, children on the street, LGBTI children and children with disabilities.

[38] Ensure their inclusion does not put them at further risks;

21.25. [39] work with child protection actors to strengthen, adapt or develop child-friendly and disability-inclusive procedures for admitting, treating and discharging unaccompanied children;

21.26. [40] in infectious disease settings, advise child protection actors on ways to ensure child protection interventions or services do not facilitate further transmission of disease;

21.27. [41] in infectious disease settings, designate a focal person to participate in relevant child protection working group meetings, and work with the child protection sector to develop and disseminate [42] Standard Operating Procedures for identification and referral of vulnerable children, including in health centres;

21.28. [43] in collaboration with MHPSS specialists from the child protection sector strengthen or set up an appropriate screening and referral system for children who need psychological or clinical mental health support, promote the recruitment of social workers and child psychologists, where possible and appropriate, and support community health workers to identify and refer cases;

21.29. [44] agree together with the CP sector on division of labour and inter-sectoral coordination system for MHPSS;

21.30. [45] put in place child-friendly, safe, accessible and confidential services to respond to child victims and survivors of violence, abuse, exploitation and neglect (including GBV), that includes links and referrals to relevant services (for example, HIV testing, menstrual regulation and reproductive health services);

21.31. [46] ensure clinical health staff understand child protection case management of children survivors of sexual violence, and that auxiliary non-clinical staff have sufficient knowledge and understanding about the confidentiality and protection elements of work related to sexual violence;

21.32. [47] in areas contaminated by ERW and landmines, put in place specialised and age-appropriate emergency medical, surgical and – where possible – longer-term physical rehabilitation and ortho-prosthetic services for child survivors and children with disabilities;

21.33. [48] ensure health workers understand basic child protection as relevant to their work, including prevention of separation;

21.34. [49] ensure access to, and information about, sexual and reproductive health services for all relevant children, including married children who may be isolated;

21.35. [50] ensure that those working in health have signed up to and been trained in a code of conduct or other policy which covers child safeguarding; and

21.36. [51] lobby for, and carry out, joint health and child protection evaluations and resource allocation processes, for instance within the Post Disaster Needs Analysis or the Post Conflict Needs Analysis.
Measurement

<table>
<thead>
<tr>
<th>OUTCOME INDICATOR</th>
<th>OUTCOME TARGET</th>
<th>NOTES</th>
</tr>
</thead>
<tbody>
<tr>
<td>21.1. [52] Percentage of health staff that has received training on identifying and referring children affected by violence (including sexual and physical violence), neglect, abuse and exploitation</td>
<td>80%</td>
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<tr>
<td>ACTION INDICATOR</td>
<td>ACTION TARGET</td>
<td></td>
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<tr>
<td>21.2. [53] Percentage of surveyed health facilities that have a direct link with birth registration facilities and staff</td>
<td>100%</td>
<td></td>
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<tr>
<td>21.3. [54] Percentage of victims of sexual violence and children in need of mental health services, disaggregated by sex and age, and registered in a case-management system, who received health services</td>
<td>100%</td>
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<tr>
<td>21.4. [55] Percentage of health staff familiar with procedures to prevent children being separated from their families</td>
<td>90%</td>
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<tr>
<td>21.5. [56] MHPSS guidelines included in the health-sector strategy and delivering health services</td>
<td>Yes</td>
<td></td>
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<tr>
<td>21.6. [57] An analysis has been conducted on barriers to accessing child-friendly health services for boys and girls of different ages</td>
<td>Yes</td>
<td></td>
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<tr>
<td>21.7. [58] Percentage of health and ortho-prothetic services for survivors of landmines that include special considerations for the needs of child survivors</td>
<td>50%</td>
<td></td>
</tr>
</tbody>
</table>

Guidance notes

21.1. [59] Integrated child protection and health interventions:
[60]Girls and boy survivors of violence (including sexual or psychological violence, injury and maiming), neglect, abuse or exploitation require special considerations in the provision of health
Studies have shown that children with disabilities are at a greater risk of violence, abuse, health issues and neglect. In many places, girls admitted to medical services would be more comfortable, or only be allowed to, being cared for by female staff, while boys survivors of sexual violence do not always prefer to speak with male service providers.

Provision of supplies for health centres, or integrated health/child protection centres should typically include:
- Emergency contraception and medication like post-exposure prophylaxis (disease prevention) for HIV
- Supplies to allow child-appropriate emergency first aid to be given to victims of landmines/UXOs/explosive weapons, etc.
- Family planning services to prevent unwanted pregnancies.

Improving integrated protective responses for children during emergencies may have lasting effects on strengthening the child protection and health systems in the longer term. This could be in the form of strengthened legal framework, child-friendly health centers and interventions and strong coordination between protection and health actors.

21.2. Child survivors of sexual and gender-based violence

Girls and boys survivors of sexual violence and abuse willingness to disclose abuses depends on reactions and attitudes from the adult world. Both girls and boys may also fear consequences such as ostracism, blame or abandonment. Most children remain silent. It is therefore essential for service providers to be attentive to common signs and symptoms, and respond to any testimonies with compassion, professionalism, care and calm, and speak in a way the child understands. Children’s own opinions, beliefs and thoughts also need to be respected, they need to feel safe, and they have the right to adequate information and understanding purpose of treatments. A child’s best interest is central to good care. Abuse may also be discovered through other ways, e.g. through medical treatment of STDs or pregnancy.

It is important for both child protection, MHPSS and health providers to understand national and international laws and policies around sexual violence and abuse against children, including mandatory reporting requirements, confidentiality protocols and best interest assessments.

21.3. Child protection and Health case management

Case management in Child Protection or social services is a systematic way of organising and carrying out work to address an individual child’s (and their family’s) protection and/or welfare needs in an appropriate, systematic and timely manner through direct support, local support systems and/or referrals, and in accordance with a project or programme’s objectives. Medical case management is an approach to health care delivery that focuses on the complex needs of the patient and emphasizes the coordination and prioritization of all needed services. An integrated approach to health and child protection should typically include efforts to ensure these systems can interact, including protocols for information sharing and confidentiality.

21.4. Infectious disease outbreak settings

Infectious diseases are caused by pathogenic microorganisms or microbes, such as bacteria, viruses, parasites or fungi that can be spread, directly or indirectly, from one person to another. The prevention and response requires close coordination and collaboration between several sectors, including health WASH and child protection. Particular efforts should be made to standardise the documentation of cases (including age, sex and disability disaggregated data) and develop protocols for information sharing and date protection, and cross-sectoral life-saving messages should be phrased in a manner that avoids causing undue distress to children or their caregivers.
All service providers should be aware of and mitigate secondary risks for children, like sexual violence and family separation, when children’s natural protective environment weakens or collapses. Safe alternative care arrangements should be provided for children who accompany their caregivers to treatment centres, including observation centres in case quarantine is required, and kinship care for children who are able to return to a family environment. Additional financial and material assistance may be needed for families whose income opportunities are curtailed by quarantine, illness or death. During infectious disease outbreaks, children may experience distress for a variety of reasons.

When family members fall ill, children may be unable to visit them in treatment centres, and may not receive regular updates on their condition. They may also lose their regular support networks due to placement in alternative care or rejection by neighbours, extended family and community members. The collective anxiety and grief that a community experiences can impact heavily on children. Limited public knowledge of the disease may further trigger misinformation, rumours and panic.

For some infectious diseases, the mode of transmission means children cannot be comforted through touch. Children temporarily separated from their parents in quarantine may be helped through provision of video calls or pre-recorded videos, preferably according to predictable time schedules. Children may be separated from their caregivers during infectious disease outbreaks due to the death of a caregiver, deliberate actions of caregivers (such as sending the child away to stay with others) or as a result of public health measures to control the spread of the disease. Young children are at particular risk of losing track of their families if they are admitted to observation or treatment centres on their own, or if they accompany caregivers who are admitted and subsequently die, as they often do not know their village of origin or the names and contact details of family members.

Infectious disease outbreaks are often accompanied by a public sense of panic, driven by fear of infection and uncertainty as to how diseases are transmitted. Children who become sick, or whose caregivers or other family members have contracted the disease, may be discriminated against or isolated by the community and their peers, even after the victim has recovered from the illness.

### 21.5. Integrated approaches to UXO/ERW injuries

Children are more prone than adults to pick up unexploded ordinance and face severe injury and disability as a result of using explosive weapons and coming into contact with explosive remnants of war. UXO/ERW emergencies often result in more complex injuries and damage to children’s organs and tissue, and in injuries that are more difficult to treat. Children, whose injuries result in amputated limbs need more complicated rehabilitation, must have prostheses made more often as they grow, and will require corrective surgery for changing stumps. Providing children with information to protect them from UXOs/ERWs, including what they can look like, where they can be located and what the consequences may be, can save many children’s lives.

### 21.6. Medical reports

In situations in which illness, injury, or death is the result of a criminal act (for example, rape, torture, or assault), the doctor has to create an individual medical report confirming the results of the medical examination. If the doctor needs the child’s informed consent to do the medical examination, consent forms will be required. In certain cases, the doctor has a legal obligation to send these documents to judicial authorities. However, in situations of conflict or crisis, sending this information automatically could put the victim’s life in danger. As a result, the doctor must,
where legally possible, first defend the principles of medical secrecy and doctor-patient confidentiality, and then write the report with the best interest of the child or patient in mind. As a result, the report must be given to the victim. Medical workers should work with child protection partners to understand the legal requirements, to assess the best interest of the child and decide the best the best way forward, to ensure protection of the concerned children.

21.7. **Evacuation**

Humanitarian workers, military personnel, local organisations and communities should be advised not to medically evacuate a child, parent or caregiver or admit them to a medical facility without making sure that a record of the child’s family is kept, and that children are cared for to avoid the family being separated. Specific procedures should be put in place to prevent separation.

**References**

- [WHO (2004). Immunisation in Practice: A practical resource guide for Health Workers](#)
- [www.clinicalcare.rhrc.org](#)
- [IRC and UNICEF (2012) Caring for child survivors of sexual abuse guidelines](#)