Child Abuse & Neglect: Prevention and Response by Pediatricians & Allied Medical Professionals

Report of Meeting of Curriculum Development Expert Group

India Habitat Centre, June 9 and 10, 2018

Indian Child Abuse, Neglect & Child Labour (ICANCL) Group

Indian Academy of Pediatrics

UNICEF India

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Executive Summary

The UN Convention on the Rights of the Child (UN CRC), ratified by India in 1992, urges states to ensure the right of children to protection from abuse, violence, neglect and exploitation (1). India is home to the largest child population in the world, with almost 41 per cent of the total population under eighteen years of age. The health and security of the country's children is integral to any vision for its progress and development.

'*Child maltreatment*' is therefore a violation of the basic human rights of a child. It includes all forms of physical, emotional ill treatment, sexual harm, neglect or negligent treatment, commercial or other exploitation, resulting in actual harm or potential harm to the child's health, survival, development or dignity in the context of a relationship of responsibility, trust or power. This child maltreatment has serious and often lifelong consequences. For instance, victims of child maltreatment are at higher risk of depression, anxiety, post-traumatic stress disorder and suicidal behaviour throughout their lives. Child maltreatment affects cognitive and academic performance starting early in childhood and extending into adulthood. Later in adolescence and adulthood, it can lead to behavioural and social problems such as violence against peers, delinquency and crime, high-risk sexual behaviour, and increased risk of subsequent re-victimization, and, once the survivor becomes a parent, to the perpetration of child maltreatment. In developing countries such as India, with its adverse socio-economic situation and large population base, child abuse & neglect is a serious, widely prevalent public health problem. Poverty, illiteracy and poor access to health and family planning services often result in multiple births per family, which in turn leads to considerable pressure on families particularly in the middle-to-lower income groups and consequently to low availability of resources for the care of children during their early formative years. It thus places a heavy strain on health and criminal justice systems and social and welfare services.

In this scenario, doctors, particularly paediatricians, as first responders, have a critical role to play in identifying and managing cases of child maltreatment and providing relief to its victims. However, they often have a limited understanding on how to protect these vulnerable children. There is thus an urgent need for systematic training for medical and allied professionals in preventing, detecting and responding to cases of child abuse and neglect in clinical settings. Such training would raise awareness and increase the capacity of pediatricians and allied medical professionals to offer high quality services to children and to work together with professionals from other fields in maximizing the impact of a comprehensive multidisciplinary response to child maltreatment.

The Indian Academy of Pediatrics (IAP) was established in 1963 with the chief aims of developing excellence in curative and preventive services for children, education of pediatricians and other personnel. IAP has about 30,000 members across branches in various States of the country. It has several subspecialty groups & chapters, which have promoted availability of highly specialized care to children with complex and chronic problems. One

such group is the Indian Child Abuse, Neglect and Child Labour Group (ICANCL Group) (www.icancl.com) that was established more than 20 years ago, in 1996, within the framework of the IAP. Recognizing the impact of socioeconomic, cultural and environmental factors on child health, development and overall welfare, the ICANCL Group specifically focuses on comprehensive child welfare, child rights, abuse, neglect, exploitation and rehabilitation. The ICANCL Group has adopted a multidisciplinary approach to address the problems of Child Abuse and Neglect with other agencies and community organizations interested in child welfare. The group has committed its efforts to reach out to neglected, deprived and abused children for their comprehensive needs, which include health aspects, education, rehabilitation, protection and prevention.

With this objective, IAP-ICANCL and UNICEF have forged a partnership to provide this much-needed training to medical and allied professionals. The intended outcome is a curriculum that will enable prompt assessment, examination and management of victims of child abuse & neglect by medical professionals, along with a multidisciplinary child protection response team. In addition to this, the curriculum will provide detailed understanding of new legislations, including the Juvenile Justice (JJ) Act (2015) & the Protection of Children from Sexual Offences (POCSO) Act, 2012, and the role of pediatricians and allied professionals in ensuring protection of child victims of abuse. This curriculum will also be made available in an e-format so as to ensure its maximum outreach. Endorsement for this curriculum will be sought from the Ministries for Health and Family Welfare as well as Women and Child Development of the Government of India. It is envisaged that if successfully piloted, the curriculum will eventually be used to impart ongoing education through conferences, webinars & video conferencing for further intensive training of committed pediatricians & medical professionals, in order to enable them to become local child abuse 'experts' in their regions. This will be done in conjunction with the state offices in the 16 states where UNICEF currently maintains a presence.

The present consultation was held with the aim of gathering inputs from experts, which will contribute to a curriculum for this training. The report below is based on the discussions and dialogue held over the course of the two-day consultation. The consultation was structured in a round-table format, with each session scheduled including a presentation of 10-15 minutes by the facilitator followed by a moderated discussion.

While it is impossible to summarize all the rich ideas that were shared at the forum, we have reproduced below some of the key outputs and learning that occurred.

List of expert participants

1. Dr. Rajeev Seth, President, ICANCL
2. Dr. Anjali Saxena, Joint Secretary and Treasurer, ICANCL
3. Dr. J.P. Kapoor, ICANCL
4. Dr. R. N. Shrivastav, ICANCL
5. Dr. Digant Shastri, President-Elect, IAP
6. Ms. Aastha Saxena Khatwani, Joint Secretary, Ministry of Women and Child Development, Government of India
7. Mr. Ramesh Negi, Chairperson, Delhi Commission for Protection of Child Rights
8. Ms. Vidya Reddy, Executive Director, Tulir CPHCSA, Chennai
9. Dr. Gayatri Bezboruah, Professor & Head, Department of Pediatrics, at Gauhati Medical College
10. Dr. Jagadeesh N. R., Professor of Forensic Medicine, Vaidehi Medical College, Bengaluru
11. Mr. Javier Aguilar, Chief of Child Protection, UNICEF
12. Ms. Tannistha Datta, Child Protection Expert, UNICEF
13. Ms. Japreet Grewal, Child Protection Consultant, UNICEF
14. Dr. Bidisha
15. Ms. Rita Panicker, Executive Director, Butterflies
16. Ms. Roma Bhagat, Advocate
17. Dr. Sabrina Sabarwal, Chairperson, Child Welfare Committee (Delhi South-West)
18. Dr. T. S. Jain, Max Healthcare

Summary of Discussions

Introductory Remarks

The consultation began with welcome remarks by **Dr. Rajeev Seth**, President ICANCL group and Convenor of the Project. Dr. Seth mentioned that this was the first time child abuse and neglect had been featured in IAP's presidential plan. Dr. Seth warmly thanked UNICEF for its support and gave an overview of the project activities, reiterating that the ultimate aim was to have Trainings of Trainers (TOTs) in each region of the country so that those trained can in turn conduct further trainings and take the curriculum to more and more doctors. The idea of this workshop is to collect ideas from experts and then to incorporate those in the curriculum for doctors.

Dr. Seth's remarks were followed by those of **Mr. Javier Aguilar** from UNICEF. He mentioned that mental health and prevention are acknowledged as an important part of child rights and called it a moment of transformation in India, with international organisations and local NGOs coming together to work for solutions and take action for children. He gave a broad overview of some common scenarios where violence against children occurs and is thereby normalised. He called attention to the Indian context, where there is incredible pressure on our children to perform well, which also may be viewed as a form of violence. He also highlighted the problem of male privilege, starting from sex selection to the dangerous trend of higher child mortality amongst girls but then also child marriage, anemia etc., which he labelled an institutionalized form of violence and the genesis of sexual abuse of children. He acknowledged that there is no concrete review on child abuse, no scientific equivalent or certainty on what works and especially what works in India. He ended with a call for assistance from doctors, who are revered and influential in society, in engaging in the most meaningful way possible with public opinion and with various sectors of the government.

Mr. Aguilar was followed by **Ms. Aastha Khatwani** from the Ministry of Women and Child Development, who spoke about the role of the government in work on child rights and protection. She mentioned that the most important resource in India is the demography of youth – the human resource dividend that we hope to reap. To do that, we need to look at what we are doing now. She pointed out that while there is a benchmark for age appropriate behavior for children, this is equally true of adults, and the growing evidence of child abuse is a serious question. She agreed with the need to train medical professionals on how to deal with child abuse but also to develop a preventive component which we should

put in the curriculum. She assured those present of her ministry's support and pointed out that the government has the advantage of wide impact, and that the efforts of small groups like the present one could be taken to scale with its support.

Ms. Tannistha Datta of UNICEF then called the meeting to order and gave a brief overview of the objectives of this work, i.e. to broaden horizons from CSA to neglect and other types of abuse, and from just response to also prevention. For instance, she stated that while examining a child in poorer areas, simple questions can give you a background, a child's vulnerabilities and what kind of referrals can be made, such as who can be alerted to the child's circumstances. The idea here is to use the influence and reach that doctors have to create some materials for what parents and caregivers can do in terms of being able to detect early signs of abuse, neglect, and mental health problems.

Child Neglect

The first thematic discussion on Child Neglect was initiated by a presentation by **Dr. (Prof) R. N. Shrivastav**, who emphasised that the problems of children in our country have to be seen in totality. He pointed out that of the 29 million children born each year, the majority are underprivileged, and as the parents can often not provide care, it is for the proximate community to step up; ultimately the state is answerable. Early Childhood Care and Development (ECCD) is the key to a full, productive life and the progress of a nation. It is important to provide antenatal, newborn and early childhood care as a child is most vulnerable in the first few years of life. Parental substance abuse in urban and rural areas and the resultant domestic violence are all common, and emotional abuse is also rampant. He called attention to government health programs such as the National Rural Health Mission and pointed out that the target beneficiaries must be made aware of their entitlements under these schemes so that they can demand services. Lastly, he reiterated that adults have to respect children as rights-holders rather than as beneficiaries of their largesse, and society cannot be a passive observer to the maltreatment of children.

The session was followed by a discussion amongst those present. Dr. Sabrina Sabarwal, Chairperson CWC South West, pointed out that ensuring that each child goes to school could resolve many problems of abuse and neglect as school provides a learning environment but also the child can be given medical facilities there. Ms. Khatwani assured the gathering that the concern about schooling had been deliberated in the Ministry as to how to synergise efforts, and that MWCD is working with the Human Resource Development Ministry so that all these services are in one place like school, *anganwadis*, health care etc. issues of street children, substance abuse and sex education were also briefly mentioned and discussed.

Child Sexual Abuse

The following session was initiated with a short presentation on child sexual abuse by **Ms. Vidya Reddy**, who spoke about the experiences of children with the medico-legal system. She mentioned that in many cases when her organisation had looked at medical records, they had realised that doctors did not even know how to document technical findings. The responsibility and role of health professionals comes under discussions from the time a child enters the health system, and the behaviour of each person from the receptionist to the nurse matters. She pointed out that the usual cases are of systematic repeated abuse of a child by a known person in a familiar system where it is likely that the child may unintentionally disclose the abuse as part of the medical exam, and that doctors must be sensitised to this. She called for anticipatory guidance that can enable conversations with parents about safety, so that parents are vigilant and have willingness to put safeguards in place. There is also a need to train doctors in preventive interventions and educate paediatricians on dealing with unintentional disclosure or more rarely intentional disclosure. She also pointed to the value of the Adverse Childhood Experiences study and the need to see child sexual abuse as a medical emergency.

This was followed by a lively discussion, with those present agreeing that paediatricians need to be taught how to talk to children, as well as skills including medical interviewing: disclosure v. non-disclosure; verbal vs. non-verbal communication especially amongst younger children; etc. It was also agreed that communication with children with disabilities was another specialized area of communication and must be covered. The counseling for trauma also should be documented.

Physical Abuse

The following session on Physical Abuse was moderated by **Dr. Gayatri Bezboruah**, who began by stating that the context for abuse varied across the country and there is therefore a need for flexibility even in standard practice. Thus, she gave the example of tea garden workers from Assam, where 40 per cent of under-15s are mothers, and this itself is a form of neglect and abuse. She also pointed out that in Assam, due to trafficking, female children are much in demand – male children are neglected. She noted that many parents and caregivers often give a history of abuse as an excuse for becoming perpetrators. It is therefore important to ask the right questions and often open-ended is the best way. Pediatricians need to start thinking about prevention in a different way, as for any other disease - when there is a repetitive pattern of injury, when there is an inconsistency in the account given or the parents behave unusually. The parents bring the child in when there is a massive injury that needs management, not otherwise, but it is necessary to watch for the presence of additional signs of abuse. She pointed out that while there could be differential diagnosis and it is necessary

to distinguish accidents from abuse, it is also necessary to keep the child's motor and cognitive age in mind. Where there are inconsistencies and improbabilities in the account, the account of the injury will not match the injury itself. She also pointed out that abuse was usually not isolated: where there is emotional abuse, sexual abuse may also creep in. She pointed to behavioural indicators of child abuse and encapsulated the role of doctors as being to protect, suspect, intervene and control.

Her session was followed by a discussion in which participants agreed that doctors are aware but often due to medicolegal aspects they don't want to report. This has to be addressed.

Emotional and Psychological Abuse

The final session for the day, on emotional abuse, was taken by **Dr. Rajesh Sagar,** who reiterated that emotional abuse is not just a standalone form of abuse but also a certain outcome of any other kind of abuse and therefore accounts for the highest proportion of abuse. He mentioned that incidents of attempted suicide are often missed by doctors; these are more in those who are maltreated as children and doctors should be trained to be vigilant for these red flags. He also spoke about the ACE Study and the impact of trauma, pointing out that trauma is linked not just with psychiatric conditions but also with physical conditions. Dr. Sagar called for training in psychosocial history-taking and need for assessment through an approach including rapport building, assessment of lethality (provide crisis management), and inculcation of a therapeutic relationship as a precursor to the process of disclosure and healing. He pointed to the need for training in history-taking, and reiterated that the patient should always be given a chance to ask questions and that assessment would help to plan a trauma intervention while periodic reassessment is necessary to tailor interventions. He concluded with a brief description of trauma-informed care, which includes awareness, understanding and responsiveness to the trauma; creating a favourable environment, building relationships and connections, and supporting and teaching emotional regulation.

In the discussion that followed, participants agreed on the need to include emotional abuse in the curriculum but also to have a component on vicarious trauma. They also pointed to the need for training doctors on when to refer to a psychiatrist and when to send the child to psychologist, and where the social worker fits in.

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Forensic and Medico-Legal Aspects

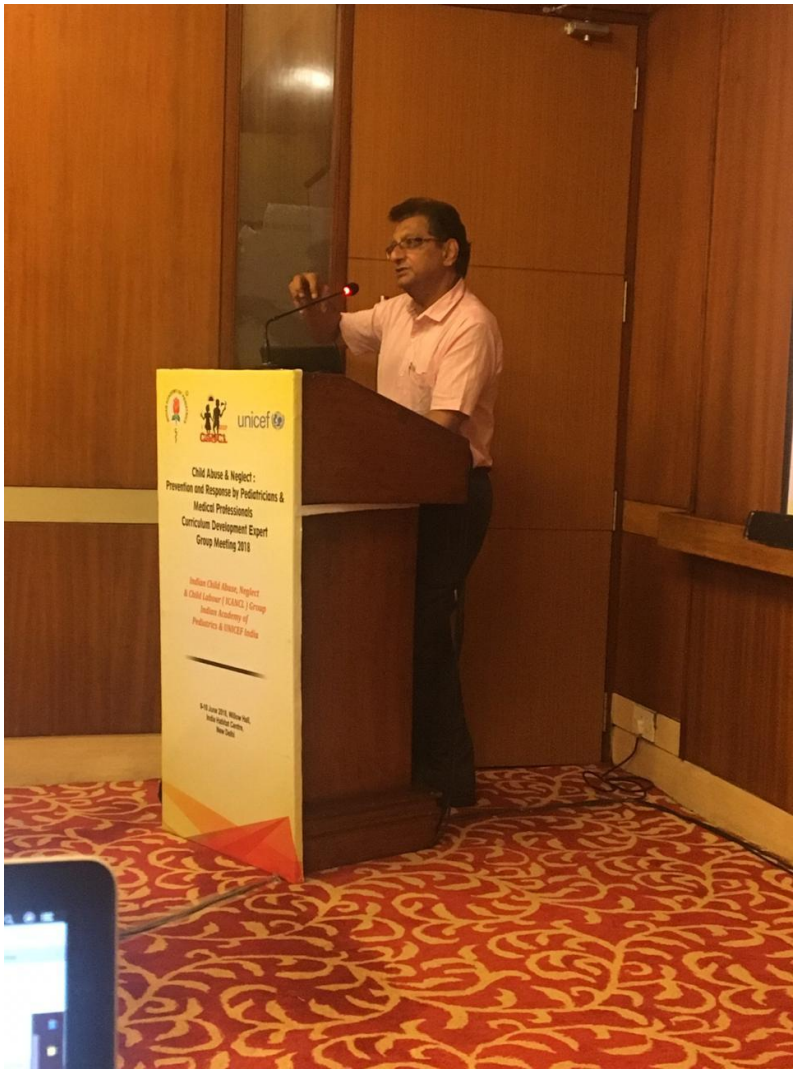
The second day of consultations commenced with a much-awaited presentation by **Dr. Jagadeesh Narayanreddy.** He agreed that the attempt to look at child rights as a whole does not usually find a place in the normal curricula of medical colleges unless the teacher is sensitive or there is a case in front of them that demands out of the box thinking. As a result there is no uniformity in this discussion across India. He mentioned that consultations such as these could help change dated curricula, citing the successful example of Maharashtra where there is now a gender-mainstreamed curriculum as of this year. He noted that the average medical professional does not realise that free and compulsory education is a fundamental right; that the law on child labour is quite old; that child marriage is thought of as a personal issue and child trafficking and adoption, both large fields of study, are routinely neglected. He then presented a series of case studies to bring out the nuances of the medical dilemmas commonly arising with respect to these issues. Thus, he addressed very important medico-legal issues such as age estimation and whether there is a need to blindly fulfil a police requisition for ossification tests in every case even where there is documentary evidence of age; mandatory reporting by doctors under the POCSO Act as well as whether it exists under the Child marriage restraint Act; and the quandary that doctors face as to whether the legal requirement is more pressing than their duty of providing therapeutic care. He reiterated that

doctors should understand that they should not forget their primary role of therapeutic care due to the legal complications and that the former has to be provided regardless of the latter. He noted that as a doctor is one comes across anyone who is involved in a crime, they are bound to inform the police and make a medico-legal case. He spoke then about doctors' role in adoption, where he has to provide a medical fitness certificate in respect of the adopted child; he noted that normally it is the orphaned, abandoned and surrendered children but also the disabled children who can be taken on priority under CARA guidelines. But the information of disability has to be given to the adoptive parent. Thus, where someone is accepting a sick child, a screening certificate cannot be given that all is well. Thus, even under a law that doctors may not even be aware of, they have an important role. He also discussed issues of consent and informed refusal in medical examinations and reiterated that the doctor must always act in the best interest of the child. He concluded with some pointers on the assessment of forensic evidence in sexual assault cases, warning against a paternalistic view as evidence of sexual assault may not always be available.

Role of Statutory Child Protection Mechanisms

Dr. Jagadeesh's session was followed by a short presentation by **Mr. Ramesh Negi** on the perspective of institutions such as statutory child protection agencies. He noted that in this context, child abuse has three scenarios: first, pre-offence reporting; second, until investigation; and third, after the chargesheet is filed. The doctor's role may come in all three. Where there is violence within families, the doctor has a huge role and a role for vigilance; many a time, the aspect of abuse may not come to the mind of the doctor unless he is trained to be cognisant of the warning signs for it. He noted that post-investigation, when the chargesheet is filed, there seems to be very less care. In fact, the doctor also has a role in bringing the child back to normal social or psychological level; one feels contented and the case is often closed once the chargesheet is filed, but that is not true when it comes to the therapeutic aspect. The child is often isolated even within the family and needs medical and therapeutic support at this stage. He noted that the government had also devised a program for this. In Delhi, he informed, the DCPCR has started a program to map child abuse cases at police stations, and the idea is then to create a support group for these children in collaboration with NGOs and other agencies. Sexual abuse is still viewed through the traditional lens – penetrative, presenting medical evidence of injuries and assault, etc.; thus sensitisation is also required for associated agencies like the police. Further, doctors have to be careful not just in giving treatment and care but also in preserving evidence so that the justice process does not get frustrated.

Role of Government Agencies and Programs



This session was followed by that of **Dr. J. P Kapoor**, Director in the Department of health of the Government of Delhi, who noted that the medical system starts from ASHAs and then grows towards hospitals. He informed the participants about the *Ayushman Bharat* program, which has a component to promote school health which includes child sexual abuse so that doctors who are interacting with school children are also aware about this. He noted that support and awareness were needed not just with regard to treatment but also the protection aspect to which doctors need to be sensitised to pick up these issues at the very earliest. The counselling element is also very important, and doctors should be able to counsel not just the child but also the caregivers, parents included. He reiterated the important role of Primary Health Centres for prevention.

In the discussion that followed, participants agreed that an overview of national programs could be included in the curriculum as doctors also have to reach families directly in their own communities and practices.

The last presentation for the day was given by Dr. Digant Shastri of IAP, who conceded that IAP as a professional and academic entity can be effective in efforts to bring down incidences of abuse. It has over 30,000 members and a huge network of branches. Its mission is to improve the health and well-being of all children, and it does so through professional education and skill development, support for paediatricians, its membership service, and education for parents and public consultation. He supported an enhanced role of medical professionals. He suggested that the curriculum should be case based; have flow charts; there should be a section on relevant laws; proformas for reporting to authorities; and SOPs for common conditions. He stated that IAP plans to have national action plans for child safety with

modules for home, school, at public places and virtual spaces and that there would also be a school health service module, health and lifestyle guidelines, activity-based life skills education modules.

Violence against Children

The day ended with a virtual interaction with Dr. Shanti Raman, a pediatrician based in Sydney who has recently completed a paper on violence against children (VAC) and was able to give a valuable overview of the issue. The need of the hour is to roll out training programs go come up with modules to increase awareness amongst child health professionals that should be based on a child rights approach and broaden the understanding of VAC; this is as important as vaccines, malnutrition and other medical issues. It is also necessary to think about domestic and family violence – children are very much in the frontline there. Similarly, bullying, corporal punishment and other manifestations of violence at school are big issues. Further, she mentioned that children exposed to conflict are also especially vulnerable, to exploitation, slavery, and abuse. She echoed the sentiment of all those present that ultimately, every MD Pediatrics should be able to recognize and respond to abuse against children.

Recommendations

1. Provide **simple and clear definitions of child abuse and neglect**, and provide clear guidelines on **signs of neglect and different types of abuse** that doctors, particularly pediatricians, should be vigilant for and be able to identify.
2. Reiterate that child maltreatment is a **public health crisis and a medical emergency** rather than a societal or family problem, and that doctors have a **therapeutic role as well as legal obligations** in this situation. The specific role of pediatricians ("protect, suspect, intervene, control") must be explained in detail.
3. Include **information on social and familial factors** that may engender neglect and abuse; specifically, parental substance abuse in urban and rural areas and resultant domestic violence targeting children is common. Similarly, the prevalence of early marriage and pregnancy is also a risk factor for neglect and abuse. This social context is significant not only in providing preventive care but also in treatment, for instance, when examining injuries.
4. Educate pediatricians on how to talk to children for **medical history-taking, handling disclosures of abuse** (intentional or unintentional) and understanding verbal as well as non-verbal communication, especially amongst younger children.
5. Include some specific guidelines on **communication with children with disabilities** and/or special needs.
6. Include a component on **Early Child Care and Development** and guidelines on how to detect, prevent and treat neglect and abuse in very young children.
7. Clarify the **difference between situations that call for referral** to psychiatrist and psychologist, as well where there may be a need to engage the services of a social worker.
8. Give clear guidelines on **differentiating accidental and intentional injuries**. This includes differentiation in clinical and diagnostic features; but also when the parents or caregivers present inconsistent accounts of how the injury occurred, or when the account of the injury is improbable in light of the child's motor and cognitive development, or when there are additional signs of abuse (including behavioral indicators) or there is a repetitive pattern of injury or other unusual behavior from the child, parent or caregiver.
9. Educate doctors on the issue of **Violence against Children** and its intersectionality with child maltreatment
10. Draw attention to the **influence of technology** in the commission of violent crimes against children and educate doctors on the need to ask relevant questions during history-taking to draw this out.
11. Encourage an **approach based on trauma-informed care**. In order to do this, the curriculum should contain an overview of the impact of trauma caused by neglect and/ or abuse on a child, give guidelines that will aid in recognizing the signs and symptoms of trauma, and provide guidelines on how the medical care giver can avoid

re-traumatization of the child.

12. Encourage an approach that that includes rapport building, assessment of lethality (including crisis management), and **inculcation of a therapeutic relationship** as a precursor to the process of disclosure and healing.
13. Reiterate the **need for periodic reassessment of therapeutic interventions** in order to ensure that the child is continuing to benefit from treatment.
14. **Document counseling for trauma.** It is necessary to make clear that all types of neglect and abuse include an element of emotional/ psychological abuse. Doctors must be given information that enables them to watch for stress-related trauma, rape accommodation syndrome and other manifestation of mental distress.
15. Include findings of the **Adverse Childhood Experiences Study** and the long-term effects of neglect and abuse in childhood on the physical and mental well-being of the individual.
16. Document how specific **medico-legal issues** must be addressed in the best interest of the child. These include age estimation, issues of consent and informed refusal in medical examinations, and assessment of forensic evidence in sexual assault cases.
17. Explain the **legal obligations of medical professionals**, particularly with regard to mandatory reporting and preparation of Medico-Legal Certificates, and provide a broad **understanding of the child protection system** in India (including the Integrated Child Protection System, Childline, Child Welfare Committees, and National/ State Commission for Protection of Child Rights)
18. Provide **anticipatory guidance** that can enable conversations with parents about safety, so that parents are vigilant and have willingness to put safeguards in place, and so that they can watch out for non-routine behavior and see if everything is alright with the child. Doctors should be able to counsel not just the child but also the caregivers, parents included, to view the child as rights-holders.
19. Doctors must be given an **overview of the international context but also be given a deeper understanding of the Indian context**. In this regard, it is important to include an overview of national (government) programs such as the National Rural Health Mission in the curriculum as doctors also have to reach families directly in their own communities and practices. Target beneficiaries must be made aware of their entitlements under government health programs such as the National Rural Health Mission so that they can demand services.
20. Include a component on **vicarious trauma,** i.e. the secondary trauma that medical professionals may experience as a result of frequent interaction with and duty of care to children who have suffered abuse and neglect.
21. Make the **curriculum** case-based; include flow charts; also include proformas for reporting to authorities; and some Standard Operating procedures for common conditions.

Revised Curriculum

Based on the recommendations received at the consultation, the revised curriculum for medical professionals will be as follows:

Aims & Objectives

- Learn the basics of the concepts of child maltreatment, including abuse and neglect;
- Understand the role of medical and allied professionals in identification and management of cases of child neglect and abuse;
- Identify and communicate with families at risk for abuse or neglect and provide appropriate intervention;
- Conduct interviews for obtaining effective medical history;
- Obtain an overview of methods of evidence-collections in cases of abuse;
- Understand how to work with allied professionals vis-à-vis a multidisciplinary approach;
- Understand how to work with government agencies, including Child Welfare committees, Childline; Police and legal systems;
- Understand role of doctors in preventing abuse and receive information on providing anticipatory guidance;
- Receive guidance on dealing with vicarious trauma.

Content Outline

1. **Introduction to child maltreatment:** Definitions and Social and Cultural aspects

    - definition and prevalence of child abuse and neglect;
    - child maltreatment as a public health issue and medical emergency;
    - risk factors for child abuse and neglect (individual and community) and the relation of child abuse and neglect to other forms of family violence;
    - consequences of child abuse and neglect (including findings of the ACE Study).

2. **Understanding the types of child maltreatment and identifying signs and effects of abuse:** Neglect, Physical Abuse, Sexual Abuse and Emotional Abuse

    - **Neglect:** Signs of neglect; managing neglect in the context of poverty; Early Childhood Care and Development, malnutrition and failure to thrive, ICDS & Government Guidelines
    - **Physical Abuse:** signs – how to recognise historical and physical findings to include abuse in the differential diagnosis; examples of physical abuse;

clinical indicators; common diagnoses; nature and circumstance of injuries; related medical findings – behavioural indicators and factors in a child's medical history that help professionals identify abuse; physical examination of the child; distinguishing abuse from accidental injury, abusive head trauma, cutaneous injuries, bruises, burns, muscle-, skeletal trauma & visceral injuries, dental injuries, ENT & eye injuries), corporal punishment and bullying.

- **Sexual Abuse:** indicators of sexual abuse**;** dealing with intentional and unintentional disclosure; medical examination in cases of sexual violence; consent; management of Sexually Transmitted Diseases
- **Emotional Abuse:** Signs of emotional abuse; intersectionality of emotional abuse with child neglect and other forms of child abuse; recognizing the signs and symptoms of trauma; trauma-informed care approach; need for rapport-building and assessment of lethality; guidelines on referral to mental health professionals.

3. **Medical history-taking and interviewing guidelines** in child maltreatment cases – sensitive interviewing methodologies, special considerations for children with disabilities and special needs; interaction with parents/ caregivers; guidelines on obtaining full medical history (including prenatal and postnatal care, diet, immunizations, major illnesses, growth curve, developmental milestones, hospitalizations, previous physician visits) and psychosocial history (e.g., family composition, domestic violence, job status, use of drugs and alcohol in the home, past involvement with police or child protection agencies)
4. **Forensic aspects of medical management of child maltreatment** – protocols for evidence collection and guidelines for documentation
5. **Child Death Review and Documentation of Child Fatalities**
6. **Legal aspects** - understanding the statutory obligations of medical professionals [including medico-legal cases, mandatory reporting, age estimation, and consent; guidelines for testifying in court]
7. **Understanding the multi-disciplinary team approach,** including Child Protection Systems, role of Child Welfare Committees, functioning of One Stop Centre, and Child Response Units in hospitals to ensure adequate evaluation, treatment, and follow-up of a potentially abused child
8. **Prevention of child maltreatment and anticipatory guidance** – role of doctors in preventing child neglect and abuse: how to give information on nutrition, injury prevention, behavior management, developmental stimulation, safe and unsafe touch, and general health education
9. **Ethical considerations in child maltreatment cases and duty of providing therapeutic care**
10. **Vicarious Trauma** – symptoms and suggestions

Format of Curriculum

Based on the recommendations received at the consultation, the curriculum will include the following:

1. Case-based information on legal protocols, for instance, issues of consent in medical examination;
2. Explanation of concepts wherever possible through flowcharts (for instance, concept of multidisciplinary teams and role of various professionals in providing care to the child)
3. Standard Operating Procedures for the medical professional in commonly-presented cases (for instance sexual assault of a minor by an unknown perpetrator)
4. Use of interactive methodologies such as role playing to provide guidance on concepts wherever possible during the training (for instance, medical interviewing and history-taking techniques)
5. Inclusion of pre- and post-training questionnaires in the curriculum for assessment of improvement in understanding of those trained.

Conclusion

The consultation concluded with a broadening of the participants' understanding of the issue of child abuse and neglect and a consensus on the issues that must be incorporated in the forthcoming curriculum. Most importantly, participants agreed to continue to commit their time and efforts to this very important project and agreed to send academic and practical materials for incorporation in the curriculum.