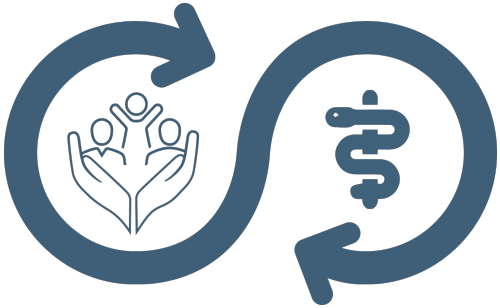
STANDARD 24: HEALTH AND CHILD PROTECTION

The following should be read with this standard: Principles; Standard 7: Dangers and injuries; Standard 9: Sexual and gender-based violence; Standard 18: Case management; Standard 25: Nutrition and child protection; and Standard 26: Water, sanitation and hygiene and child protection.



Health and child protection programming play critical and related roles in ensuring the safety and well-being of children in humanitarian action. Supporting children's health increases children's protective factors, while supporting children's protection can, and should, improve children's physical health and well-being. An integrated approach to health and child protection is one that is:

- Safe;
- Protective;
- Inclusive;
- Systematic;
- Complementary;
- Valid for all sectors; and
- Participatory for children, families and communities.

STANDARD

All children have access to quality protective health services that reflect their views, ages and developmental needs.

24.1. KEY ACTIONS

KEY ACTIONS FOR CHILD PROTECTION AND HEALTH ACTORS TO IMPLEMENT TOGETHER

24.1.1. Collaborate to adapt existing assessment and monitoring tools, methodologies and indicators for joint identification, analysis, monitoring and response of households at risk of health and/or child protection concerns:
- All monitoring and assessments should include children's own perceptions.
- Data should be disaggregated by gender, age and disability, at a minimum.
- Integrate health and child protection issues into each other's assessments and analyses.

24.1.2. Identify common areas of concern to health and child protection.

24.1.3. Agree upon the most effective information-sharing mechanisms.

24.1.4. Include interventions that address the links between health and child protection throughout all phases of the programme cycle.

24.1.5. Document the impacts of (a) health interventions on children's safety and well-being and (b) child protection interventions on children's health.

24.1.6. Address any unintended negative consequences and reproduce promising practices.

24.1.7. Collaborate with children and other stakeholders to design, establish, implement and monitor joint, child-friendly, accessible and confidential feedback and reporting mechanisms for child protection concerns.

24.1.8. Ensure that all health and child protection staff are trained on and sign safeguarding policies and procedures.

24.1.9. Train health care staff on child protection concerns, principles and approaches so they can correctly prevent, identify, mitigate and/or refer child protection cases.

24.1.10. Train child protection staff on health concerns, principles and approaches so they can correctly prevent, identify, mitigate and/or refer health issues.

24.1.11. Collaborate during infectious disease outbreaks to:
- Apply disease control protocols to any face-to-face child protection activities;
- Prevent health interventions from increasing child protection risks; and

- Train child protection actors on early detection of disease and health care referral mechanisms.

KEY ACTIONS FOR CHILD PROTECTION ACTORS

24.1.12. Include information and referrals for health services in child protection activities that:
- Protect the personal data of referred households; and
- Maintain the confidentiality of children and families.

24.1.13. Facilitate linkages between child protection and health services and mitigate any gaps, bottlenecks or barriers to children's access.

24.1.14. Consider the impact of living situations and health concerns when interacting with the affected population and invite health workers to join consultations wherever appropriate.

24.1.15. Collaborate with health actors in a multisectoral coordination system for mental health and psychosocial support and case management. (See Standard 10.)

24.1.16. Establish connections between birth registration and reproductive health (such as postnatal care and vaccinations).

24.1.17. Work with health actors to keep caregivers and children together during referrals and admissions if possible and appropriate.

24.1.18. Advocate for appropriate, tailored, inclusive and accessible medical, surgical, rehabilitative and ortho-prosthetic services for all children.

KEY ACTIONS FOR HEALTH ACTORS

24.1.19. Include child protection and children's participation in all phases of the health programme cycle.

24.1.20. Establish a mechanism for health care workers to safely and efficiently refer child protection cases.

24.1.21. Include child protection messages in health interventions where appropriate.

24.1.22. Ensure assistance reaches all members of the affected population by:
- Using assessments to identify children and families who may have difficulty accessing health services;
- Collaborating with child protection actors to identify and implement strategies to overcome barriers children are facing; and
- Registering all child heads of households and children who are unaccompanied or separated.

24.1.23. Conduct a risk analysis during programme design that:
- Provides baseline data on children's health and protection status;
- Identifies requirements for child recipients of specific health care services;
- Assesses the best timing for health interventions (considering education and other childhood activities); and
- Determines the needs of specific groups of children.

24.1.24. Share relevant health information with child protection actors.

24.1.25. Work with child protection actors to (a) discourage families from intentionally separating to access additional benefits and (b) avoid making children targets of theft or exploitation.

24.1.26. Collect disaggregated data for health and injury surveillance systems on the number of children killed or injured, by what/whom, when, where and why (what were the circumstances). (See Standard 7.)

24.1.27. Work with child protection actors to implement accessible, trauma-sensitive and child-friendly procedures for admitting, treating and discharging children who are unaccompanied.

24.1.28. Train child protection actors on health care referral mechanisms and early detection of disease.

24.1.29. Collaborate with child protection actors to promote the recruitment of social workers, child psychologists and mental health experts with expertise in addressing the needs of children, where appropriate.

24.1.30. Work with child protection actors in multisectoral coordination systems for mental health and psychosocial support and case management. (See Standards 10 and 18.)

24.1.31. Work with child protection actors to ensure all children have accessible, inclusive and age-appropriate sexual and reproductive health services, supplies and information on:

- Adolescent sexual and reproductive health;
- Sexual and domestic violence and consent;
- Marriage;
- Pregnancy; and
- Parenting.

24.2. MEASUREMENT

All indicators about children should be disaggregated by sex, age, disability and other relevant diversity factors. The indicators below measure progress against the overall standard. Indicators and targets can be contextualised with

the goal of meeting the indicative targets below. Additional related indicators are available *online*.

Indicator		Target	Notes
24.2.1.	# and % of healthcare workers in target location trained on identification of children affected by abuse, neglect, exploitation or violence.	80%	Training should include physical, psychological and emotional signs of abuse, neglect, exploitation or violence. A timeframe should also be added in-country ('within one month of hire').
24.2.2.	% of births per health facility that are officially registered.	100%	
24.2.3.	# and % of healthcare facilities in target location providing child-friendly services.	100%	A checklist of services considered child-friendly should be developed when mapping facilities.

24.3. GUIDANCE NOTES

24.3.1. CHILDREN AT RISK

Child protection and health care workers should coordinate efforts to identify children at risk of abuse, neglect, exploitation or violence. Children who are most vulnerable to health risks or who face the greatest barriers to accessing health care might include children who are unaccompanied, separated or in alternative care arrangements; children with disabilities; children engaged in the worst forms of child labour (WFCL); children who identify as a sexual/gender minority (lesbian, gay, bisexual, transgender and intersex [LGBTI]); children associated with armed forces or armed groups; and girls, including those living in child marriages. When conducting assessments and monitoring, it is important to remember that the 'household' may not be a relevant unit of measurement for all children.

24.3.2. INTEGRATED CHILD PROTECTION AND HEALTH INTERVENTIONS

Child survivors of abuse, neglect, exploitation or violence must receive individualised health services. Female health care providers should be available for children who prefer (or are culturally required) to interact with female service providers.

All health-related facilities and services should be accessible, appropriate and inclusive for all children and should typically include:

- Emergency contraception and post-exposure prophylaxis (disease prevention) for HIV that are adapted for children;
- Child-appropriate emergency first aid supplies for survivors of explosive ordnance and other physical dangers; and
- Family planning services to prevent unplanned pregnancies.

24.3.3. CHILD SURVIVORS OF SEXUAL AND GENDER-BASED VIOLENCE

Children often find it difficult to report sexual violence and abuse. Service providers can provide a safe space to disclose (or identify) abuse by:

- Being attentive to common signs and symptoms;
- Using child-friendly communication skills;
- Asking for and listening to children's views;
- Responding compassionately, professionally, confidentially and calmly to children's disclosures; and
- Informing children about the purpose and potential outcomes of any proposed response actions.

Child protection, mental health and psychosocial support and health providers must take action based on:

- The best interests of the child;
- Confidentiality;
- Mandatory reporting requirements; and
- National and international laws related to physical or sexual violence and abuse against children. (See Standards 9 and 10.)

24.3.4. CASE MANAGEMENT

Case management is a way of organising and implementing interventions that supports the protection, health and/or well-being of individual children and their families in an appropriate, holistic, systematic and timely manner. An integrated approach to health and child protection should include protocols that ensure safe, confidential referral and information sharing between the two sectors. (See Standard 18.)

24.3.5. INFECTIOUS DISEASE OUTBREAKS

The prevention of and response to infectious disease outbreaks requires close coordination and collaboration between several sectors. At a minimum this

should include health; water, sanitation and hygiene; and child protection. They should implement:

- Standardised procedures for disaggregating, documenting and tracing cases;
- Common protocols for sharing information and protecting data; and
- Clear, coordinated, child-friendly community messaging on children's unique risks and vulnerabilities in the relevant outbreak.

All service providers should be aware of and mitigate the secondary risks children face in infectious disease outbreaks. Safe alternative care arrangements, preferably kinship care, should be provided for children who are separated from their parents for reasons such as death, illness or public health measures. Children who are temporarily separated from their parents for any reason may find comfort and support through phone calls or pre-recorded videos, preferably occurring at predictable times. Children, families and communities may require mental health and psychosocial support during and after the crisis to overcome the fear, separation, discrimination, loss and other stressors related to the outbreak. Special measures must be put in place to maintain the psychosocial well-being of children in observation or treatment centres, quarantine or isolation.

24.3.6. INJURIES

(See Standards 7, 8, 9, 11 and 12.)

The risk of experiencing physical injury varies with gender, age, disability, location, socio-economic status and hazard. Child protection and health actors can work together to minimise children's risk of injury by:

- Teaching children, families and communities to prevent common injuries;
- Providing all injured children with appropriate and inclusive emergency medical aid, trauma surgery, rehabilitation services and mental health and psychosocial support; and
- Collecting and sharing, where appropriate, anonymised and disaggregated data on injuries, maiming and impairment to inform preventative interventions. In addition to gender, age and disability, data should ideally be disaggregated by cause of injury/death, location and circumstances.

24.3.7. MEDICAL REPORTS

Doctors often have a legal responsibility to inform legal authorities of any illness, injury or death that results from criminal actions. In some settings, reporting such incidents can expose the survivor (or witnesses or their family) to further

danger. To minimise the survivor's risk, humanitarian health care providers must, where legally possible:

- Maintain doctor-patient confidentiality;
- Observe the principle of do no harm;
- Write medical reports according to the best interests of the patient;
- Give medical reports directly to the survivor or their caregiver; and
- Collaborate with child protection actors to assess and prioritise the child's needs and potential interventions.

24.3.8. EVACUATION AND MEDICAL ADMITTANCE

Humanitarian workers, military personnel, local organisations and communities should not medically evacuate or admit a child, parent or caregiver to a medical facility before:

- Collecting detailed identification information on the child and caregiver (full names, dates of birth, next of kin, villages of origin, current residence, place of evacuation, etc.);
- Giving copies of these records to all parties; and
- Making suitable care arrangements for children who cannot remain with their caregivers.

REFERENCES

Links to these and additional resources are available *online*.

- *'Health'*, *The Sphere Handbook: Humanitarian Charter and Minimum Standards in Humanitarian Response*, Sphere Association, 2018.
- *Manual for the Health Care of Children in Humanitarian Emergencies*, WHO, 2008.
- *Caring for Child Survivors of Sexual Abuse: Guidelines for Health and Psychosocial Service Providers in Humanitarian Settings*, International Rescue Committee and UNICEF, 2012.
- *Inter Agency Guidelines for Case Management and Child Protection*, Child Protection Working Group (CPWG), 2014.
- *Guidance Note: Protection of Children During Infectious Disease Outbreaks*, The Alliance for Child Protection in Humanitarian Action, 2018.
- *Clinical Care for Sexual Assault Survivors: A Multimedia Training Tool (Facilitator's Guide)*, IRC, 2008.