Save the Children

Photo credit: Allan Gichigi / Save the Children

Guidance

SAFEGUARDING CHILDREN IN OUR HEALTH WORK

February 2019

Guidance

Safeguarding Children

In our HEALTH work

The provision of basic, lifesaving, maternal newborn and child healthcare to communities is a key part of Save the Children's work in emergencies, as is communicable disease prevention and control, and sexual and reproductive health.

Improperly run health clinics, mobile clinics, vaccination campaigns, outreach or other health interventions can result in allow abuses to occur, or fail to prevent accidental harm to children and their families. Health facilities and mobile clinics can also be locations for sexual exploitation and abuse of children, perpetrated by our staff, partners, and community members.

The physical nature of clinical work (children being touched by adults) increases the opportunity for abuse (adults touching children). The need for children to be separated from their caregivers, and potentially isolated, also increases their vulnerability and potential exposure to abuse.

In addition to all this - chaotic humanitarian contexts with high staff turnover and high stress results in the opportunities for abuse to be increased, and all staff need to be acutely aware of this, in order to safeguard children.

This document will outline some potential child safeguarding risks of our health programmes, and give you suggestions on how to manage them to ensure children are as safe as possible. It is not an exhaustive list, but may help you think through a good risk management strategy.

Common types of harm & abuse in health programming

Physical & sexual abuse

Exploitation

Emotional abuse or bullying

Unsafe programming

Key things to remember

1. ***Eliminating opportunities for children to have isolated 1:1*** time with medical staff, partners and volunteers will dramatically reduce the likelihood of sexual abuse and exploitation occurring
2. There will be an ***unequal power dynamic*** between children and their caregivers who urgently need access to healthcare, and staff and partners who work in health facilities
3. Allowing adults and child patients to remain on the ***same ward overnight*** is high risk for sexual abuse – staff patrols must be in place
4. If frontline staff (e.g. midwives, nurses, doctors) are not ***trained to ask questions*** about potential sexual assault, abuse or exploitation they may miss the signs of abuse or cause harm by handling the case badly
5. ***Risk management is an active, on-going process*** that never stops! Don't be afraid to challenge each other to ensure children are safeguarded.

Possible 'people' risks

- Women and girls in the community may be unwilling to visit a health programme site if it means they will be alone with a man or men (e.g. in the waiting room, or they will be seen by a male doctor). Equally, in some places women may be unable to make decisions regarding health care without men in their family present
- An unequal power dynamic between children and their caregivers who urgently need access to healthcare, and NGO staff and partners who work in health facilities (possibility of sexual exploitation, especially sex-for-medicine)
- Children who are left alone with doctors or other health staff; and under guise of an examination, may be harmed – for example, sexual abuse can occur
- Untrained health staff and volunteers who do not understand the risks of unsafe health programming; who are willing to 'cut corners' in an emergency, or who do not prioritise the welfare and wellbeing of children
- Allowing adult and child patients to remain on the same ward overnight is extremely high risk for sexual abuse and should be avoided wherever possible; if unavoidable waking staff should patrol the wards at night

Guidance

- Caregivers may wish to remain with their children overnight and in some cases this can reduce risk (for example, if there are low staffing levels and a patrol is not possible), however, this should be carefully balanced against the risk posed by the caregiver to other children
- Peer-on-peer abuse is also a risk; this risk is increased where children of very different ages are left to mix unsupervised, for example overnight on a ward. In some places this can also be exacerbated due to ethnic/ clan/tribal tensions which may lead to abusive behaviour
- Untrained, unsupported or unsupervised community mobilisers and volunteers can pose a risk to children – both through accidental harm and deliberate abuse (for example: providing inappropriate advice, use of physical violence to discipline children, expecting sexual favours in return for health services)
- Untrained healthcare workers and support staff may respond inappropriately to survivors of sexual violence (for example: verbally shaming, belittling or blaming the survivor for the assault) or acting in a way that re-traumatises the survivor. This may result in a survivor not seeking appropriate healthcare and/or choosing not to report the abuse to the authorities
- Staff who think that no-one will report them, or think that children will not know their name are more likely to use physical violence to discipline children (for example telling children to leave a certain area of a clinic), and may be more likely to abuse children in other ways
- Children may arrive alone and unaccompanied at the clinic or health programme site. These children must be carefully looked after, both in terms of their health needs and their rights regarding their treatment and how to ensure informed consent to treatment.
- Medical staff, volunteers, other adults (including caregivers) may be experiencing trauma themselves (esp. in conflict response); and may need extra support to better help child patients
- Health facilities may be seen as appropriate site for parents and carers to abandon children, particularly babies, that they feel unable or unwilling to care for; these children will be particularly vulnerable, with the potential higher risk of illness due to malnutrition and neglect, previous abortion attempts by the mother and community stigmatisation

EXAMPLE: A 13 year old girl named Promise arrives at a primary healthcare centre run by Save the Children. She has abdominal pain and bruising. The male doctor examines her, and asks if she has been spending time "loving her boyfriend" and tells her that her family will be angry at her. Promise feels ashamed, thinks she is to blame, and runs away from the clinic. She never tells anyone that she is being raped by her Uncle.

- If survivors of sexual violence are supported or referred through the health programme, there is a significant risk that the health staff who examine them may verbally shame, belittle or blame the survivor for their own assault, or that their surroundings trigger feelings of helplessness or pain. This may result in a survivor deciding not to report their assault to the Police; or not seeking any further help.
- An unequal power dynamic between recipients of healthcare (children and their families) and healthcare workers and other support staff may increase the risk of exploitation (for example: sex-for-medicine)
- Untrained staff maybe unaware of the importance of informed consent
- Unaccompanied children may lack capacity to give informed consent

Photo credit: Fredrik Lerneryd / Save the Children

Guidance

How can we manage these risks?

- Consult with local healthcare workers and key community stakeholders to help identify community practices and beliefs that may impact on the local community's acceptance and utilisation of health services
- Ensure that the local community (including boys and girls, women and men) are consulted in a meaningful way on the health programme; from the design phase onwards; and given regular opportunities to feedback on any concerns
- Ensure a waking staff presence 24hrs a day on all in-patient wards; and that they regularly patrol or monitor the wards during the night
- Try to ensure a gender balance in staffing, with appropriately trained staff to deal with the expected population needs; when gender appropriate healthcare staff are not available try to offer gender appropriate advocates who can support the patient and chaperone consultations
- Ensure clinicians recognize the signs and symptoms of abuse (physical, sexual and emotional), and that all staff and partners are briefed on the basics of SGBV; and understand how to approach survivors in a compassionate, careful way

Photo credit: Saman Saidi / Save the Children

- Wards/inpatient accommodation should be provided for families, single women, single men and unaccompanied children (with separation of adolescent girls and boys). However, separation of individuals from their social supports should be done with sensitivity to both their social support needs and the potential risks of exploitation, e.g. by providing separate accommodation but communal living during the day
- Ensure that all staff, volunteers, and visitors to the health programme site sign in and out; and that the exits and entrances are carefully monitored
- Consider separate waiting areas (male/female)
- Employ female health staff members with skills and experience working with women
- Ensure that boys and girls, women and men are consulted in a meaningful way on the health programme from the design phase onwards. Give people regular opportunities to feedback on any concerns.
- Install an anonymous feedback mechanism to learn about accessibility, safety, and security related to services and facilities and to identify any safeguarding risks.
- Ensure that no child is left alone with a member of staff or a volunteer – remember the 'two adult rule'. If examining a child, a chaperone must be present in the room.
- Support children, adults and medical and support staff supporting children and adults to ***develop coping mechanisms to deal with trauma,*** for example by engaging children and adults in mindfulness exercises
- Ensure all staff, volunteers and other representatives are trained and engaged on child safeguarding and understand the importance. Spend additional time with your frontline staff (e.g midwifes) on the importance of spotting and responding to potential abuse.
- Where feasible, clearly demarcated and clearly communicated wards for boys and girls, women and men; consider colour coding areas for clarity – so it is immediately obvious if someone is somewhere that they shouldn't be. This will not be possible in all health settings.
- Reduce anonymity – always wear a Save the Children t-shirt when working; unless staff are in a health environments in which there are particular uniform expectations and hygiene imperatives which may make Save t-shirts inappropriate e.g. use of scrubs.
- Challenge staff members alone, or seeking to be alone, with children.

Guidance

Informed consent in healthcare settings:

For consent to be valid, it must be ***voluntary*** and ***informed***, and the person consenting must have the ***capacity*** to make the decision.

- ***voluntary*** – the decision to either consent or not to consent to treatment must be made by the person themselves, and must not be influenced by pressure from healthcare workers, friends or family
- ***informed*** – the person must be given all of the information in terms of what the treatment involves, including the benefits and risks, whether there are reasonable alternative treatments, and what will happen if treatment doesn't go ahead
- ***capacity*** – the person must be capable of giving consent, which means they understand the information given to them and they can use it to make an informed decision; in the case of children giving consent

Informed consent for children:

Consent can be obtained from children if the clinical staff are satisfied that they have enough capacity, intelligence and understanding to fully comprehend their treatment. If clinical staff are not satisfied that a child has sufficient capacity to understand, caregivers/parents should give consent.

In a situation where treatment is vital and waiting to obtain parental/carer consent would place the child at risk, treatment can proceed without consent.

All treatment should be explained to children in their local language to ensure complete understanding. No decisions about the child's treatment should be made in isolation of the child.

All patients or recognised caregivers/parents should sign a consent form before treatment is given.

- Support staff wellbeing and reduce stress to a manageable level – stressed, under pressure staff may not notice risky behaviour or risk factors
- Child protection mechanisms should be in-place to support unaccompanied children

Train healthcare staff in the importance of informed consent, and how to access capacity to give informed consent (see box on left!)

- Ensure that staff are trained to work with individuals with intellectual disabilities and mental health issues, including on how to ensure proper confidentiality and informed consent.
- Train and engage staff and community members responsible for physical locations on spotting the signs of abuse, and how to report concerns (and reassure that it's safe to do so) – drivers, guards, cleaners, caretakers, distribution manager, camp leader, local elders, religious leaders
- An area dedicated to child wellbeing (for example, a Child Friendly Space) should be set up in hospitals, and this can also display simple child safeguarding materials, including a display of children's rights, in appropriate languages

Programme & process risks

- Significant time pressures on the building of physical structures (for example: latrines) may increase risk through failure to adhere to health and safety processes during construction and/or poor quality or incomplete work
- Health programming carried out through partners or funding external health projects, leading to lower levels of oversight
- Poor maintenance or damage to cold chain storage; or failure to utilise equipment appropriately
- Medications and medical supplies can unintentionally harm children if taken improperly or inadequate instructions provided – for example, we may think we are helping by distributing aqua tabs to provide clean water, but these can be very harmful if not used properly
- Not setting up robust referral processes to ensure that survivors of SGBV are prioritised
- High risk, health facilities such as an Ebola Treatment Centre carry unique and high levels of associated risks and will therefore require a separate risk assessment and management plan
- If any Health/WASH infrastructure has been damaged, destroyed or poorly maintained, this can increase the

risk of contamination in health facilities and other locations

- Informed consent for media/communications work is difficult to achieve in health settings, as there is a clear power dynamic – i.e Save the Children may be providing life-saving care, so patients feel they must agree to be interviewed or photographed. This can result in a great deal of emotional and physical harm to children, especially if the topic is sensitive, traumatic or controversial
- Ensure that an information sharing protocol is established so that a survivor of abuse will not need to repeat their story, potentially exposing them to further trauma; and all efforts are made to ensure his or her confidentiality (but do not promise to keep secrets – you will need to tell someone who can help)
- Handling of medicines and vaccines that require cold chain storage or similar increases the risk profile of the intervention
- If the response includes movement of people (e.g. ambulance service, or use of pooled taxis as an ambulance service) this increases both risk of death or injury in road traffic accidents and driver abuse of very vulnerable children
- Staff on health sites (e.g. guards, cleaners) do not understand positive discipline techniques and instead use physical and humiliating punishment to deter children from playing on or near the site

Photo credit: Kristiana Marton / Save the Children

- If sites for health facilities do not take into account the risk of sexual exploitation and abuse while walking to/from the site; children and adults can both be at increased risk of assault
- If robust referral processes to ensure that survivors of SGBV are prioritised are not in place, survivors can be made even more vulnerable; and may not seek help again

How can we manage these risks?

- Provide information about services and where to raise any concerns, in both verbal and written form, ensure local languages are used, and contextually appropriate images.
- Clearly state and re-state organisational rules (the Child Safeguarding Policy, the Code of Conduct) that govern behaviour

> EXAMPLE: Save the Children is running a clinic for the treatment of people living with HIV. One day a conflict breaks out nearby and the clinic and all staff are evacuated. An armed militia takes over the clinic, uses it as a base and easily finds detailed information about people living with HIV and survivors of sexual violence, including their addresses. The data has not been secured. They use the information to shame the patients into leaving the villages, and the patients are exposed to extreme levels of abuse.

- Ensure that staff are trained to work with individuals with intellectual disabilities and mental illnesses, including on how to ensure proper confidentiality and informed consent.
- Staff should be trained and capable of providing psychosocial support to reduce trauma. If staff are not trained, they should have the information to refer patients to these services.
- Staff should ensure the confidentiality of survivors and respect the wishes about the care provided.

> EXAMPLE: a team member from the media team is visiting a Save the Children clinic in the middle of an emergency. She interviews children who are recovering from cholera. The children are extremely weak but agree to be interviewed. When the children leave the clinic, they are scared to find their image on the TV, linked to a western NGO. In their culture, this is dangerous. Their parents are very angry with Save the Children, beat their children for being filmed, and vow never to go back to the clinic.

- Ensure appropriate reporting structures in place for actual or suspected incidence of abuse or harm to children, including 'near miss' events

Guidance

- Train health staff to identify and respond to traditional harmful practices (for example, FGM, early child marriage)
- Set up referral networks for services required in response to instances of abuse and exploitation in line with best practice.
- Consider the use of taxis for transport to/from health sites; and ensure that all drivers are trained on child safeguarding and appropriate behaviour – ensure that children are not transported alone, without another adult
- Work with local traditional healers to improve access to services and also to ensure that children and communities are aware of the behaviour they can expect from NGO workers, and how to share any concerns that they have
- Do not use plastic bags to give medicine to young children (risk of suffocation by small children)
- Post clear instructions on sharing feedback in health programme sites, in local languages, supported by illustrations
- Regular child safeguarding briefings on site with the health team, partners and any volunteers, vet any contractors, and work with contractors to create a code of conduct
- Do not allow comms and media work to occur in sensitive health settings; unless approval has been given by Child Protection and/or Child Safeguarding colleagues. Always get informed consent from a caregiver as well as the child.
- Create a daily tracker that all staff and volunteers should sign in to access the health facility or site.
- Give all health staff and contractors regular opportunities to report concerns, without fear of losing their jobs
- Robust contract management with clear expectations around child safeguarding and child safety for contractors (e.g. construction of health sites)
- Clearly state and re-state organisational rules (the Child Safeguarding Policy, the Code of Conduct) that govern behaviour
- Clear display of child and community-friendly reporting mechanisms at all health programme sites
- When considering your exit strategy, ensure that responsible actors and child-focused systems are in place

Photo credit: Save the Children

Risks in the physical space

- Proximity to threats such as building sites, water, traffic, limited shade, unexploded ordinance
- Cross-infection if children are hospitalized within the same facility as other children with infectious diseases.
- Any areas within clinics or intervention sites which are isolated, obstructed or poorly supervised (could be used for abuse), including showers, latrines
- Ambulance condition – risk of accidents, injury or death on the road due to poor equipment; or drowning if a boat ambulance is in use
- Unmonitored or uncontrolled access by adults (staff and others) to clinics or site
- Lack of appropriate areas for examination and history taking, which may lead breaches of privacy and confidentiality (for example: curtains and screens can provide physical privacy but will not prevent conversations being overheard)
- The healthcare environment may also trigger feelings of helplessness or pain.
- Any site left unsupervised by staff that could be used as a location for abuse or that might attract both children and adults (e.g. a hospital tent with a TV)
- Unsafe or poor quality materials used for equipment (e.g. weighing equipment, bed that allow children to roll out in the night)
- Poor maintenance or build of clinics and other sites; for example where toilets have been built some distance from clinics or programme sites

Guidance

- Lack of shelter and clean drinking water for mothers and children having to wait for treatment
- Unmanaged or risky WASH construction site as part of the health site (e.g. half-finished latrines left uncovered overnight or unguarded, or pits that have insufficient or easily removable covers)
- Dangerous medicines or vaccines that can be accessed by children
- Unmonitored or uncontrolled access by adults (staff and others) to WASH facilities can increase the risk of sexual exploitation and abuse
- Proximity of health facilities to armed actors (including militias, police forces, armed guards) can increase protection risks
- WASH facilities in the health site that are not separated for children and adults, boys and girls can – increases risk of abuse
- Poor vehicle maintenance will increase the risk of accidents, injury or death on the road due to poor equipment; or drowning if a boat ambulance is in use
- Unsafe or poor-quality materials used for equipment (for example; weighing equipment, beds that allow children to roll out in the night)

How can we manage these risks?

- Identify areas in and around the clinic that could be potentially unsafe like dark alleys, proximity to the bush and mount lights or place security around them.
- Consider installing lights near health centres, if lighting is not possible consider alternatives such as providing torches
- Ensure that the location of health facilities and routes to them are away from actual or potential threats such as violence; especially the risk or threat of gender-based violence, and attacks from armed groups. It is important to consult the community and potential beneficiaries about their preferences.
- Discuss with all representative samples of society (e.g. men, women, girls, boys, the elderly, ethnic groups, persons with disabilities) that should have access to the services.
- Consider how seasonal environmental conditions can prevent access to secondary health care centres and hospitals (e.g. floods, landslides). Ensure transport mechanisms are in place to make access possible in different conditions.
- If some individuals cannot access the services, ensure that special arrangements are made to make them available (e.g. mobile health teams).
- Increase the 'natural surveillance' of the staff in the hospital – for example by ensuring that nurses, sitting at their desk, can see into each ward and entrance/exits. This helps to prevent abuse by reducing unsupervised areas
- If you are operating boat ambulances; ensure that staff operating the ambulance can swim; and that floatation devices are included within the kit for the boat
- Review layout of clinic area and identify and mitigate areas of risk (especially to be areas that are private/lockable) with good lighting and by restricting access.

Photo credit: Mohammed Awadh / Save the Children

- If running a hospital or clinic that may deal with survivors of torture, special consideration must be given to the design of rooms, type of furnishings and equipment etc. that are in the examination/consultation rooms. This should be considered in design phase, and should be designed to avoid possibility of re-traumatization.
- If the clinic or health site may support survivors of sexual violence, ensure that the patients can maintain confidentiality
- Ensure that the location of health facilities and routes to them are away from actual or potential threats such as violence; especially the risk or threat of gender based violence, and attacks from armed groups.
- Physically separate and label the latrines "male" & "female". Have separate latrine/toilets for males and females, boys and girls and make sure they are labelled clearly for all literacy levels.

Guidance

- Ensure latrine design accounts for children (e.g. size of pits may present a safety risk for children)
- Ensure examination rooms are well separated from public spaces or the waiting area.
- If separate rooms cannot be provided, consider establishing a dry-wall or at least put up a curtain.
- Identify areas in and around the clinic that could be potentially unsafe like dark alleys, proximity to the bush and mount lights or place security around them.
- Consider installing lights near health centres, especially if lighting is not possible, consider alternatives such as providing torches for each household.
- To reduce the risk of cross-contamination, consider using red and green 'zones' to reduce this risk – painting the walls of the zones and getting staff active in those zones to wear the same colour
- Ensure the facilities are safe and covered – consider the risk posed from both the sun and any rain/landslides (especially in rainy season)
- Ensure latrine design accounts for children (e.g. size of pits may present a safety risk for children)
- Always cover water tanks and partially built latrines near the health site – anything with a danger of children falling or drowning in. Remember that communities may try to remove covers, especially if they need material to repair homes, so make sure it's not easily removable
- Ensure that the locations of WASH facilities within health sites are safe, well-lit and secured by a secondary enclosure to ensure privacy (e.g. adequate and separate space for women/girls, people with disabilities)
- services we provide. If necessary, adapt the location to reduce the distance and to ensure that the most vulnerable/marginalized have access. Consider how seasonal environmental conditions can prevent access to secondary health care centres and hospitals (e.g. floods, landslides). Ensure transport mechanisms are in place to make access possible in different conditions.
- If some individuals cannot access the services, ensure that special arrangements are made to make them available (e.g. mobile health teams).
- Always cover water tanks and partially built latrines near the health site – anything with a danger of children falling or drowning in. Remember that communities may try to remove covers, especially if they need material to repair homes, so make sure it's not easily removable
- Ensure that the locations of WASH facilities within health sites are safe, well-lit and secured by a secondary enclosure to ensure privacy (e.g. adequate and separate space for women/girls, people with disabilities)
- Socket outlets and wiring are at least five metres away from running water outlets

Photo credit: Ellery Lamm / Save the Children

Data protection risks

- Poor data management structures or processes – could lead to re-victimisation or stigmatisation; especially in sensitive cases (e.g. SGBV, HIV)
- Sharing of sensitive identifiable information without the consent of the beneficiary (e.g. names, addresses, or traits and characteristics about the case) can lead to identification, and stigma or other repercussions
- Remember that information about SGBV incidents is extremely sensitive and confidential. The inappropriate sharing of any information about any incident can have serious and potentially life threatening consequences for the children and adults involved, including those helping the child.
- Data can be stolen, or taken from health facilities, for example during a conflict.

Guidance

How can we manage these risks?

- Ensure all staff members have completed the mandatory data protection training
- Do not share identifiable information unless consent has been given by the beneficiary (e.g. names, addresses, or traits and characteristics about the case that can lead to identification, etc.).
- If requesting consent to collect and use data, make sure it is properly informed and that the beneficiary has the capacity to give consent (e.g. children or persons with intellectual disabilities may give consent without fully understanding or having the capacity to do so)
- Do not share identifiable information unless consent has been given by the beneficiary (e.g. names, addresses, or traits and characteristics about the case that can lead to identification, etc.).
- If requesting consent to collect and use data, make sure it is properly informed and that the beneficiary has the capacity to give consent (e.g. children or persons with intellectual disabilities may give consent without fully understanding or having the capacity to do so)
- Make all staff aware that they should only collect information that is needed to contribute towards promoting the well-being of the individual
- Be open and honest with the person (and/or their family where appropriate) at the outset about why, what, how and with whom information will, or could be shared, and seek their agreement, unless it is unsafe or inappropriate to do so. Where anonymised data is shared (for example, to desegregate beneficiary statistics) there is no requirement for individual consent
- Make sure that data storage is secure and that contingency plans are in place to secure, move or destroy the data in the event that the area must be evacuated.

For more info or to feedback on this briefing:
Cat.Carter@savethechildren.org or
Rachael.Cummings@savethechildren.org.uk

For Child Safeguarding support, please contact:

Middle East: Mubarak Maman (MEEE Regional Child Safeguarding Director)
Mubarak.Maman@savethechildren.org

West & Central Africa: Ma-Luschka Colindres (WCA Regional Child Safeguarding Director) Ma-Luschka.Colindres@savethechildren.org

Asia: Menaca Calyaneratne (Asia Regional Child Safeguarding Director)
Menaca.Calyaneratne@savethechildren.org

East & Southern Africa: Latha Caleb (ESA Regional Child Safeguarding Director)
Latha.Caleb@savethechildren.org

Latin America & Caribbean: Abdiel Cabrera (LAC Regional Child Safeguarding Coordinator)
Abdiel.Cabrera@savethechildren.org

Global level: Susan Grant (International Child Safeguarding Director)
Susan.Grant@savethechildren.org