— if UPA or LNG are not available, then offer combined oral estrogen–progestogen contraceptives (COCs): split dose (one dose of 100 µg ethinyl estradiol plus 0.50 mg LNG, followed by a second dose of 100 µg ethinyl estradiol plus 0.50 mg LNG 12 hours later); these should be offered with anti-emetics if available.

- The risk of ECPs on the market is negligible to zero; they are extremely safe and well tolerated and meet the criteria for over-the-counter provision (i.e. medical eligibility criteria category 1 *(134)*). Moreover, the harms (e.g. risk to the mother's health, stigma) of an unplanned or unwanted pregnancy for this age group as an outcome of rape very likely outweigh the risks.
- A copper-bearing intra-uterine device (Cu-IUD) can also be used as an emergency contraceptive measure, with no restrictions for girls who have attained menarche (i.e. post-menarche) if there is a low risk of STI. In the case of a high risk of STI, the use of a Cu-IUD as an emergency contraceptive is usually not recommended unless other more appropriate methods are not available or acceptable. The Cu-IUD can be inserted up to 120 hours after unprotected sexual intercourse.
- Ideally, emergency contraception (UPA, LNG or COC ECPs) should be initiated as soon as possible after exposure, in order to maximize its effectiveness, although it can be given up to 5 days (120 hours) after exposure. Based on her capacity to understand the information provided, the adolescent girl and/or her non-offending caregivers should be advised that the effectiveness reduces with the length of the interval between exposure to penetration and taking the emergency contraception.
- A pregnancy test is not required, but if one is done and the result confirms pregnancy, emergency contraception should not be provided.

GP5: GOOD PRACTICE STATEMENT 5 (existing) *(39, 135)*[1]

If a girl is pregnant as a result of the rape, she should be offered safe abortion to the full extent of the law.

Remarks

- Administrative requirements (e.g. forensic evidence or police reports) for obtaining safe abortion should be minimized, with clear protocols established with the police and the health-care providers, in order to facilitate timely referral and access to safe abortion within the gestational time limits.
- Where abortion is not permitted, or if the pregnancy is too advanced for abortion at presentation, the pregnant girl should be supported through her pregnancy and delivery, and other options such as adoption should be explored with her.

E. Post-exposure prophylaxis for curable and vaccine-preventable sexually transmitted infections

Children and adolescents who experience sexual abuse may become infected with a STI. A systematic review carried out for this guideline included 23 publications reporting on the detection of STIs among children and adolescents in LMICs who were suspected of having experienced sexual abuse, most of which were retrospective studies *(136–158)*. Studies reported

Evidence summary

Existing WHO guidelines for post-traumatic stress (2013) recommend individual or cognitive behavioural therapy (CBT) with a trauma focus (see glossary), or eye movement desensitization and reprocessing (EMDR), for children and adolescents with PTSD *(172)*. WHO guidelines for responding to intimate partner violence and sexual violence against women (2013) recommend CBT and EMDR for adult women exposed to sexual assault *(39)*. The UK National Institute for Health and Care Excellence guidelines (2017) recommend trauma-focused cognitive behavioural therapy (TF-CBT) for children with chronic PTSD, including those who have been sexually abused *(177)*. However, the evidence in these prior guidelines included all populations of children exposed to different types of trauma and PTSD and/or was not specific to children or adolescents who had been sexually abused. Therefore, evidence was updated for the present guideline, focusing on studies conducted with children or adolescents who had been sexually abused. Interventions that also included non-offending caregivers were also considered. A systematic review was conducted to answer two PICO questions:

- *Among children and adolescents who have or may have been exposed to sexual abuse and who are diagnosed with mental disorders (P), do any psychosocial interventions (e.g. psychological counselling or psychotherapeutic interventions) (I), as compared to no or any other psychosocial interventions (C), improve the child's or adolescent's mental health outcomes (e.g. emotional, behavioural disorders, PTSD, depression, subjective well-being, daily functioning) and/or parent/caregiver outcomes (O)?*
- *Do psychosocial support interventions (I) involving children/adolescents who are likely to have been sexually abused, and their non-offending parents/caregivers (P), as compared to no or any other intervention (C), improve the psychological well-being of parents/caregivers (e.g. stress, stigmatizing behaviours, healthy parent–child interactions, uptake of services) and/or mental health of children (O)?*

The outcomes that were considered to be critical included PTSD; depression; internalizing disorders; externalizing disorders; anxiety; school functioning; and child subjective well-being. To address both the PICO questions, a systematic review was conducted updating the 2013 Agency for Healthcare Quality (AHRQ) report on child exposure to trauma, to specifically focus on child sexual abuse and expand to include adolescents who had been sexually abused, including those who experienced sexual abuse from peers *(178)*. The review for the first PICO question above resulted in 10 articles with eight randomized controlled trials that met the inclusion criteria *(179–188)*. Only two of these trials were conducted in LMIC settings. The review included interventions that addressed CBT with a trauma focus, prolonged exposure therapy, stress inoculation training and gradual exposure (SIT), and individual and group psychotherapy. The studies compared CBT with a trauma focus to wait list; TF-CBT to community control; CBT with a trauma focus to EMDR; SIT to conventional therapy; prolonged exposure to conventional therapy; and individual psychotherapy to no treatment or to group psychotherapy. In a majority of studies involving CBT with a trauma focus, the therapy was found to have medium to large benefits for PTSD and small to medium benefits for other symptoms (e.g. depression, internalizing or externalizing symptoms) among children or adolescents who had been exposed to sexual abuse. However, the evidence was considered to be of very low certainty/quality (see Web Annexes 5, 5a and b for the full report, evidence-to-decision table and GRADE table).

For the second PICO question, which also included interventions with a caregiver component, the systematic review found 18 articles with 10 randomized controlled trials (none from LMICs) that met the inclusion criteria *(184, 186, 187, 189–203)*. Most of the included studies assessed a form or component of CBT with a trauma focus or a combination of CBT with a trauma

focus along with other programme components. The studies compared risk reduction through family therapy (RRFT) with treatment as usual; CBT with a trauma focus with a wait-list control or TF-CBT with non-CBT interventions; TF-CBT with compared to without a trauma narrative; CBT with supportive counselling; and family/network meetings combined with or without group work. The findings suggest an overall medium benefit for the different types of psychological interventions, and medium to large benefits specifically of TF-CBT on PTSD symptoms as compared to non-CBT-type therapies. The evidence was graded as low certainty/quality. Limited evidence from Australia and the UK showed high costs for providing CBT and TF-CBT. For example, one cost–utility study from the Australian mental health-care system showed that the per person cost for TF-CBT for a 12-month period after adjusting for incremental cost for quality-adjusted life years, was Australian $ 22 790 *(204)*. In the UK, a study from 2006 suggested that the cost of CBT for adults is approximately £750 per person (see Web Annexes 6, 6a and 6b for the full report, evidence-to-decision table and GRADE table) *(205)*.

From evidence to recommendation

In formulating the recommendations, the adverse mental health consequences of child and adolescent sexual abuse are an important consideration.

- For psychological interventions aimed at children or adolescents only, the GDG considered the evidence that there are more included studies of CBT with a trauma focus with evidence of medium-to-large benefits on PTSD, along with promising evidence (from one study) of other CBT-type therapies that include a trauma component (e.g. prolonged exposure). No studies provided information about potential harms of this intervention, although the GDG highlighted the importance of safety of the child or adolescent who has been sexually abused. On balance, the evidence was in favour of recommending CBT with a trauma focus for this population.
- However, there is very low certainty/quality of the evidence overall, owing to serious concerns about the risk of bias; small sample sizes; and imprecise effect sizes. Moreover, there is evidence of large costs, limited feasibility and limited cost effectiveness for implementing CBT with a trauma focus. There is also evidence of other barriers to implementation (e.g. lack of specialized and trained health-care providers; effort to train, mentor and supervise lay personnel; costs of transport; loss of wages of caregivers; and time required for frequent visits). All of these considerations make it challenging for CBT with a trauma focus to be applicable everywhere. Therefore, the strength of the recommendation is rated as conditional.
- Limited evidence suggests that the interventions may be acceptable to health-care providers, but young people receiving the intervention may be concerned with stigma. It also suggests that in different cultural contexts there may be reluctance on the part of caregivers to allow their children to be given information about sexual intercourse; and to change culturally accepted parenting skills.
- For the psychological interventions that include a child or adolescent as well as a caregiver component, the GDG considered the evidence that CBT with a trauma focus, particularly Cohen's TF-CBT *(8)*, showed medium to large benefits over non-CBT-type therapies for PTSD. The evidence also showed small to medium benefits for other symptoms (e.g. depression, anxiety, internalizing and externalizing symptoms). The balance favoured recommending CBT with a trauma focus that involved the non-offending caregiver, for treatment of PTSD. The potential harms are also linked to safety which have to be addressed, but the balance remains in favour of the intervention as above.

- However, there is low-certainty/quality evidence, owing to serious concerns about the risk of bias and indirectness of evidence. Evidence also showed large costs of implementing the intervention and limited cost effectiveness for TF-CBT. Other barriers are similar to those for child- or adolescent-only interventions. Therefore, the strength of the recommendation is rated as conditional.
- There is not enough evidence from this population group to recommend psychotherapy broadly for emotional disorders,[1] or for behavioural disorders.[2] However, sexual abuse of children and adolescents is frequently accompanied by other adversities that are also risk factors associated with emotional disorders and some types of behavioural disorders. Therefore, existing mHGAP recommendations for emotional and behavioural disorders are applicable for this population (see below) *(206)*.

R13: Recommendation 13 (existing) *(206)*

RECOMMENDATION	QUALITY OF EVIDENCE	STRENGTH OF RECOMMENDATION
Psychological interventions, such as CBT, may be offered to children and adolescents with behavioural disorders, and caregiver skills training to their non-offending caregivers.[a]	Low	Conditional

[a] While child sexual abuse may not have anything to do with caregiver skills, this component nonetheless may help in the recovery of the child or adolescent.

R14: Recommendation 14 (existing) *(206)*

RECOMMENDATION	QUALITY OF EVIDENCE	STRENGTH OF RECOMMENDATION
Psychological interventions, such as CBT and interpersonal psychotherapy (IPT), may be offered to children and adolescents with emotional disorders, and caregiver skills training to their non-offending caregivers.	Low	Conditional

Remarks

- The choice of psychological or behavioural intervention and how it is implemented should be based on the type of behavioural disorder(s) or emotional problem(s) respectively, and on the age and developmental stage of the child or adolescent *(206)*.
- In adolescents, to assess other mental disorders including risk of suicide, self-harm, depression, alcohol and drug-use problems and their management/treatment, follow the mhGAP intervention guide for mental, neurological and substance use disorders in non-specialized health settings, version 2.0 (2016) *(5)*.

G. Ethical principles and human rights standards for reporting child or adolescent sexual abuse

Requirements to report child or adolescent sexual abuse to child protection agencies (or other relevant authorities) vary across countries, but may be present in up to three forms. In some settings, health-care providers may have a legal requirement to report (i.e. mandatory reporting) known or suspected cases of sexual abuse of children or adolescents to designated relevant authorities, such as the police or child protection/welfare agencies. Secondly, there

may be a policy requirement to report to a designated person established by the health-care providers' employers or by an industry body. Third, health-care providers may be bound by an ethical obligation, whether derived from a personal belief or a professional norm, to report cases of child or adolescent sexual abuse. The issue of whether or not mandatory reporting of child or adolescent sexual abuse is effective was considered by the GDG to be beyond the scope of this guideline. Instead, the focus is on the guiding principles and practical dos and don'ts to guide health-care providers with respect to reporting of child and adolescent sexual abuse in a range of settings – i.e. whether there is a legal or policy requirement or no formal obligation, but an ethical duty, to report.

GP7: GOOD PRACTICE STATEMENT 7

Whether health-care providers have to comply with a legal or policy requirement, or are guided by an ethical duty to report known or suspected cases of child or adolescent sexual abuse, they should balance the need to take into account the best interests of that child or adolescent and their evolving capacity to make autonomous decisions. These actions include the following:

- assessing the implications of reporting for the health and safety of that child or adolescent and taking steps to promote their safety; there may be situations in which it may not be in the best interests of the child to report the abuse;
- protecting the privacy of the child or adolescent (for example, in dealing with the media);
- taking steps to promote the child or adolescent's health, by providing immediate medical care and first-line support;
- providing information to that child or adolescent (before interviewing or taking the history from them), and to their non-offending caregivers, on:
  - the obligations to report the situation;
  - the limits of confidentiality;
  - what information will be reported and to whom;
  - what may happen next, practically and legally;
- documenting the reporting and maintaining confidentiality of the documented information with extra precautions where the perpetrator is a caregiver who could access the child's or adolescent's file;
- in cases where the sexual abuse has been committed by another child or adolescent, referring them to appropriate health or other (e.g. welfare or social) services as needed.

Health managers and policy-makers should:

- be aware of any legal requirements to report known or suspected cases of child or adolescent sexual abuse. In situations where there are no functioning legal or child welfare/protection systems to act on a report, or where the perpetrator is part of the formal system, the usefulness of mandatory reporting may be reduced *(207)*. In such situations, health managers may need to balance the need to comply with reporting requirements with considerations of and steps for mitigating potential harms of reporting;

- facilitate health-care providers to receive training on the guiding principles for reporting, and whether, when, to whom and how to report;
- address health-care providers' beliefs and values that can adversely affect their reporting practices; these include stigma and cultural taboos related to sexual abuse; attitudes perpetuating gender inequality and blaming victims; and disapproval of consensual sexual activity between adolescents;
- establish systems and policies for record-keeping and information-sharing that ensure that information is kept confidential and relevant information is only shared with persons who need to know;
- recognize that reporting occurs within a systemic response involving multiple actors and formal and informal systems, and work with different agencies or institutions, including the child protection and police services, in order to coordinate an appropriate response.

Actions that are not in line with applying the principle of evolving capacities include:

- reporting clearly consensual sexual activity between adolescents (i.e. non-abusive sexual relations),[1] unless the adolescent's safety is at risk;
- informing parents or caregivers or seeking parental/caregiver consent, where adolescents, depending on their age and maturity, express their preference to not involve or notify their parents/caregivers, unless the adolescent's safety is at risk.

Evidence summary

A systematic review of the literature was commissioned to answer the following four questions:

- *What are the values and preferences of health-care providers or health-care institutions that are required by either law or policy to report, or that may otherwise wish to report?*
- *What are the values and preferences of children or adolescents and their caregivers or parents with respect to reporting of sexual abuse?*
- *How do/should the age of sexual consent or statutory rape laws shape reporting practices of health-care providers, and what is good clinical practice in these situations?*
- *What are the ethical, safety and human rights principles that are relevant in guiding clinical practice?*

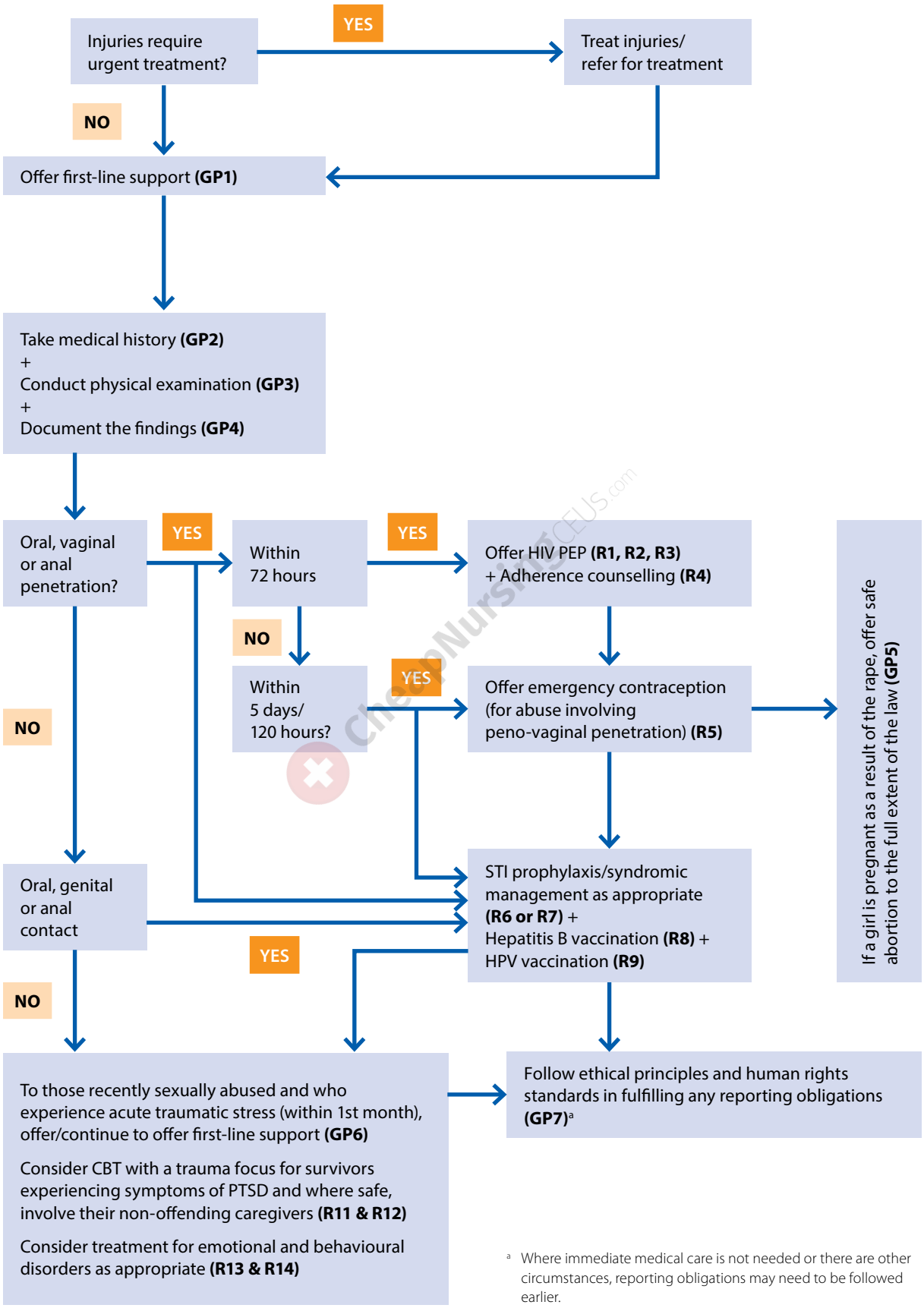
The review yielded one qualitative and 10 quantitative studies that addressed the values and preferences of health-care providers regarding the reporting of child or adolescent sexual abuse – all except one from high-income country settings *(208–218)*. These studies found that the factors that shaped a higher likelihood of health-care providers reporting child or adolescent sexual abuse included the following: health-care providers perceived sexual abuse of children or adolescents to be a serious problem; health-care providers expressed a strong intention or previous history of reporting such cases; and health-care providers had strong attitudinal support for a duty to report child or adolescent sexual abuse. Some of the studies also provided information about the barriers and ethical dilemmas faced by health-care providers in reporting. For example, one study highlighted how health-care providers felt

that they were not adequately trained or prepared to handle reporting *(208)*. Another study flagged that health-care providers may subscribe to some of the cultural values, including beliefs about parental rights, family integrity and privacy and the desire not to disrupt family relationships *(209)*.

The lack of, or ineffective, child welfare agencies was also found to be a barrier to reporting. Additionally, two reviews highlighted the cultural barriers for children and adolescents to disclose the sexual abuse they experienced, including the stigma and shame that would be brought to the survivors and their families (e.g. notions of family dishonour linked to girls losing their virginity, or blaming of girls for inviting abuse) *(219, 220)*. Such barriers may also create ethical dilemmas for health-care providers regarding reporting abuse if disclosed or identified. No studies were found that addressed the values and preferences of children, adolescents or their caregivers with respect to reporting the abuse, and no studies were found that addressed the issue of age of sexual consent in shaping the reporting practices of health-care providers (see Web Annex 7 for the full report).

The recommendations and good practices in section 4 are summarized in Fig. 1, in a flowchart depicting the pathways of care that can be used as a job aid by health-care providers.

Fig. 1. Pathways of care for child or adolescent survivors of sexual abuse



[a] Where immediate medical care is not needed or there are other circumstances, reporting obligations may need to be followed earlier.

5. Implementation considerations

This guideline focuses on recommendations and good practices for clinical aspects of care provision aimed at health-care providers. The scope did not include policy recommendations. However, some implementation considerations that enable health-care providers to deliver appropriate clinical care are included here. Two areas that were flagged by the GDG as being particularly important are: (i) facilitating the timely uptake of services by child or adolescent survivors of sexual abuse; and (ii) creating a supportive and enabling service-delivery environment for health-care providers.

A. Facilitating timely uptake of services

Timely uptake of services for those who have experienced penetrative sexual abuse is critical, in order to provide certain treatments such as HIV PEP, which is only effective if provided within 72 hours, or emergency contraception if provided within 120 hours.

GP8: GOOD PRACTICE STATEMENT 8

Health-care providers, including those working in communities, should facilitate the timely uptake of services by children and adolescents who have been sexually abused. These actions include the following:

- raising public awareness of risk, signs and symptoms and health consequences of sexual abuse and the need to seek timely care;
- making available comprehensive and integrated care that reduces the need for visiting several places for different aspects of services;
- publicizing the availability of services, once services are established and available, through concerted efforts including community-based and media campaigns and outreach activities. Such efforts also need especially to reach out to minority, indigenous or marginalized communities who may have less access and who need culturally tailored care;
- working with communities, survivors and their families to address the stigma of sexual abuse and of seeking mental health care; and to improve the acceptability of services and trust in health-care providers;
- advocating with policy-makers and management to reduce policy-level and practical barriers to accessing care (for example, requiring police reports as a condition for providing medical care and psychological support, or cost-related issues);
- strengthening referrals within and between health services and other sector services (for example, police, child protection and legal services).

Evidence summary

A systematic review of the literature identified 17 studies that responded to the question: "*What are good practices for providing information and education about sexual abuse to children, adolescents and their caregivers, in order to increase the timely uptake of health services?*" *(54, 56, 137, 221–234)*. Of these, a majority (*n* = 12) were from high-income countries and the rest (*n* = 5) from LMICs. The common relevant themes identified across these studies included the need to improve public awareness of the signs and risks of sexual abuse and availability of services; implement coordinated services; work with marginalized groups in communities to develop culturally appropriate services; and reduce barriers to timely provision of services, such as requiring police reports as a prerequisite to providing health services. The GDG also emphasized the importance of strengthening referrals within health services and with other services, including the police and justice sectors. They also noted the importance of addressing the double burden of stigma associated with abuse, as well as seeking mental health services for those who might need the latter (see Web Annex 2 for the full report).

B. Creating a supportive and enabling service-delivery environment for health-care providers

For health-care providers to provide clinical care effectively and implement the recommendations from this guideline, they need to be supported by ongoing training, mentoring and supervision, as well as resource allocation for provision of care, and standardized protocols to guide care provision and strengthened multisectoral linkages.

GP9: GOOD PRACTICE STATEMENT 9

Health managers and policy-makers should create an enabling service-delivery environment and support health-care providers in carrying out their tasks and responsibilities related to caring for children and adolescents who have been sexually abused. These actions include the following:

- making available and prioritizing the provision of high-quality care in health-care settings for children and adolescents who have been sexually abused;
- facilitating ongoing training, supervision and mentoring:
  - emphasis needs to be on general assessment, child- or adolescent-centred first-line support and medical history/interviewing as minimum requirements in low-resource settings;
  - skills or competencies in assessing, examining and managing sexual abuse in a gender-sensitive and child- or adolescent-friendly manner, and in documentation, including how to interpret examination findings, need to be provided to all health-care providers who see children or adolescents; the exact cadre of health-care providers to be trained will vary depending on the context;
  - training needs to address attitudes of health-care providers, including those perpetuating gender inequality, stigmatizing adolescents based on their sexual orientation or gender identity, or blaming the survivor. It also needs to address health-care providers' reluctance to be involved in the care and management of children or adolescents who have been sexually abused;
  - training needs to address the nature of health-care provider obligations to report child or adolescent sexual abuse (see **Good practice statement 7**).

— ideally, multidisciplinary teams can be trained together, with a clear delineation of roles, responsibilities and expectations;

— for training to be sustainable, it needs to be integrated into pre-service and in-service curricula for medical, nursing, midwifery and other health providers' education and involve the relevant professional bodies.

- addressing needs for adequate staffing, with attention to retention of trained staff, along with adequate infrastructure, supplies and financial resources, including budgets, in order to support provision of services in a timely manner;
- supporting health-care providers who provide care for children and adolescents who have been sexually abused and who are called upon to give evidence in court. It is important to also provide a working environment to prevent burnout and support coping with burnout and vicarious trauma. This can be done by making available specialists on sexual abuse and medical evaluation, for advice and to reduce professional isolation. In some settings, this kind of professional support has been facilitated online or through peer support, or a helpline for professionals and mobile health (mHealth) approaches;
- strengthening referrals and linkages with other allied services can facilitate a multi-disciplinary and multisectoral approach and improve access to comprehensive care;
- developing protocols or clinical care pathways which can be useful tools or job aids for health-care providers in systematically guiding care provision;
- conducting monitoring and evaluation of care provision, including by providing tools for collection of age-disaggregated data.

Evidence summary

The systematic review of the literature identified 43 studies that addressed the question: "*What strategies can create supportive or enabling health systems for health-care providers to provide care to children and adolescents who have or may have been sexually abused?*". Of these, a majority were from high-income countries (n = 35) *(47, 48, 56, 58, 59, 61, 62, 67, 104, 105, 107, 223, 227, 235–264)*. The most relevant issues identified were providing ongoing, high-quality training to health workers, particularly in examination, interpretation of findings and documentation; making experts on sexual abuse available; adequately staffing, supplying and financing the facilities; establishing multidisciplinary care teams that are coordinated; establishing protocols for management of the abuse; and supporting the care providers who may suffer burnout. The GDG highlighted additional points about the training of health-care providers that included an emphasis on addressing attitudes, skills and competencies; improving sustainability of training by integrating it into pre- and in-service training curricula; and helping them fulfil any reporting obligations. They also raised the issue of monitoring and evaluation and providing tools for assessing the quality of care provision, including age-disaggregated data (see Web Annex 2 for the full report).

6. Research implications

Important knowledge gaps were identified in the process of developing this guideline that need to be addressed through research. However, these do not represent a comprehensive assessment of research gaps. All the new recommendations developed for this guideline are based on evidence that has been labelled "very low" or "low" quality, indicating the need for further research. In some areas (e.g. STIs), direct evidence from evaluated interventions was unavailable. Hence, indirect evidence in the form of descriptive studies or case reports had to be used. Most of the evidence is from a handful of high-income countries, with LMICs being underrepresented. There are also gaps in:

- knowledge of the prevalence of child and adolescent sexual abuse in many regions, including risk and protective factors and help-seeking behaviours;
- information about the longer-term impacts of child and adolescent sexual abuse, including the long-term health service needs; these are not understood and require longitudinal studies;
- understanding of the different needs for services or care, barriers faced and impacts of interventions on girls and boys, across different age groups and among those facing discrimination (e.g. on the basis of sex, race, ethnicity, religion, sexual orientation or gender identity, disability or socioeconomic status). Much less evidence was available for boys and LGBTI adolescents as compared to girls. Such information will help improve access to services and tailor interventions.

For each area considered in this guideline, additional topics requiring further research are presented under following headings.

A. Child- or adolescent-centred care/first-line support

- Explore how first-line support strategies can take into account the different needs and experiences of children and adolescents from different groups that may face discrimination (as in previous bullet point).

B. Medical history, physical examination and documentation of findings

- Identify approaches or practices that promote child- or adolescent-centred and sensitive interviewing, examination and documentation techniques and also how to counter harmful (e.g. two-finger or virginity testing) or incorrect practices.

C. HIV post-exposure prophylaxis treatment and adherence

- Identify how to improve adherence counselling and support and evaluate its effectiveness in child and adolescent survivors of sexual abuse.
- Conduct research to understand the barriers to PEP adherence among survivors of sexual assault, including adolescents and children.

D. Post-exposure prophylaxis for curable and vaccine-preventable sexually transmitted infections

- Include systematic laboratory STI testing among children and adolescents who have been sexually abused and who are asymptomatic when providing prophylactic treatment of STIs.
- Improve collection of data on STI rates among children and adolescents from LMICs who have been exposed to sexual abuse.

E. Psychological and mental health interventions in the short term and longer term

- Identify and evaluate psychological and mental health interventions that can be implemented in low-resource settings, as most of the evidence is based on interventions from high-resource settings and interventions that are resource intensive.
- Assess the scalability and how to scale up psychological and mental health interventions that have shown efficacy on a small scale, particularly in low-resource settings.

F. Ethical principles and human rights standards for reporting child or adolescent sexual abuse

- Collect information on the values and preferences of children, adolescents and their parents/caregivers about reporting of sexual abuse.
- Conduct research on the benefits and harms of mandatory reporting of child and adolescent sexual abuse, as well as on non-reporting.
- Conduct research on the effectiveness of mandatory reporting practices.
- Conduct policy reviews on the impact of requirements to obtain police reports in order to be able to provide care to survivors.
- Conduct research on the impact of statutory rape laws or laws on the age of sexual consent on health-care providers' reporting practices and on how these laws shape access to health services for children and adolescents who have been exposed to sexual abuse.

G. Implementation considerations

Facilitating timely uptake of services

- Conduct evaluations of strategies, especially from LMICs, to increase timely uptake of services. While the literature suggests that simply providing comprehensive care could increase uptake, research is required to explore this association.
- Conduct research to understand better who is accessing services, how are they learning about services and which communities are being left out.
- Evaluate different models of care and service delivery, to assess how they improve uptake and access.

Creating a supportive and enabling service-delivery environment for health-care providers

- Evaluate different training modalities and their effectiveness.
- Identify how innovations such as offering access to experts through online approaches can contribute to strengthening health-care-provider capacity.
- Assess how to promote the well-being of, and address burnout or vicarious trauma among health-care providers involved in this work.
- Assess how to strengthen provision of care in private as well as public-sector services.
- Identify how to strengthen intersectoral coordination by working together with other sectors (e.g. child welfare/protection, education) and improve options and outcomes for children and adolescents who are referred to other services.
- Document and evaluate field-based practices of programme implementers that could offer valuable lessons learnt about implementation of services.

7. Dissemination, implementation, monitoring and evaluation

The dissemination and implementation of this guideline will build on the work that has gone into disseminating and implementing the WHO guideline for responding to intimate partner violence and sexual violence against women (2013) *(39)*. The guideline for women has been widely rolled out through several regional dissemination workshops, including in countries from east and southern Africa, Asia-Pacific, the Middle-East, north Africa and the Caribbean. Several countries have used the 2013 guidelines to update their national guidelines or protocols, and have requested guidance to address child and adolescent sexual abuse, which provides an entry point for disseminating and implementing this guideline.

A formal knowledge-to-action framework will also be used to disseminate the guideline for responding to children and adolescents who have been sexually abused. This guideline will be disseminated through a broad network of partners, including ministries of health; other United Nations agencies (e.g. United Nations Children's Fund [UNICEF], United Nations Population Fund [UNFPA]); nongovernmental organizations; global initiatives on violence against women (e.g. Essential Services Package for violence against women and girls) and on violence against children (e.g. Together for Girls, Global Partnership to Prevent Violence against Children, PEPFAR's DREAMS initiative and the Adolescent Girls and Young Women Catalytic Initiative of the Global Fund for AIDS, TB and Malaria), as well as on adolescent health and reproductive health (e.g. implementing best practices or IBP); professional associations; and WHO collaborating centres. It will also be published on the WHO Reproductive Health Library and disseminated through webinars, as well as through relevant conferences.

To facilitate the uptake of this guideline, derivative products will be developed, including an update of the clinical handbook for responding to intimate partner violence and sexual violence against women *(265)* that will include specific considerations for children and adolescents who have been sexually abused. The recommendations contained in this guideline will also be included in the consolidated guidelines for responding to child maltreatment (i.e. addressing physical abuse, emotional abuse and neglect) under development by the WHO Department for Management of Noncommunicable Diseases, Disability, Violence and Injury Prevention.

A systematic and formal knowledge-to-action framework will be applied to the implementation of this guideline, which involves the following steps:

- introduction of the guideline to national stakeholders through a participatory and consensus-driven process, which involves identifying whether existing national guidelines or protocols need to be updated or new guidelines need to be developed;
- adaptation of the guideline to context, based on inputs from national stakeholders so that it can meet the needs of the country and take into account available human and financial resources, the organization of the health system, national laws and policies, clinical guidance and cultural and social factors. It is important that the adaptation process and any changes made, including to those recommendations that are conditional, are explicit and conducted in a transparent manner;

- use of updated or adapted national guidelines to train health-care providers in selected sites;
- monitoring of whether the knowledge and skills of health-care providers has improved, and documenting lessons learnt and barriers faced;
- on the basis of lessons learnt, identifying with national stakeholders how to further roll out the guideline; it is important that such a process identifies and addresses barriers that need to be addressed for creating an enabling environment for health-care providers to deliver clinical care.

The aim of such a process is to ensure a systematic approach to facilitate uptake and scale-up of guidelines, and to identify lessons learnt that can be applied in other settings. The monitoring and evaluation of the implementation process is a critical component of ensuring not only that health-care providers are improving their knowledge and skills but also that the health system is delivering quality care to children and adolescents experiencing abuse. Information can be gathered through periodic evaluations of service delivery, including by assessing how children and adolescents experience the care they receive and whether there has been improved and timely uptake of services over time. As much as possible, indicators that are to be reported internationally *(266)* are to be based on existing agreed indicators, and these include:

- the number of countries that have developed or updated their national guidelines or protocols or standard operating procedures for the health-system response to intimate partner violence and/or sexual violence and/or child maltreatment, consistent with international human rights standards and WHO guidelines;
- the number of countries that provide comprehensive post-rape care in a medical facility/department in every territorial and/or administrative unit, consistent with WHO guidelines.

8. Updating the guideline

This guideline will be updated in 7–10 years, or following the identification of new evidence that reflects the need for changing any recommendations. Where possible, the timing of the updates will also consider any opportunities to produce consolidated guidelines for children and adolescents and the response to violence. WHO welcomes suggestions regarding additional topics for inclusion in future guidelines. Please email these to:

reproductivehealth@who.int.