GOBIERNO DE ESPAÑA MINISTERIO DE SANIDAD

COMMON PROTOCOL FOR HEALTHCARE SYSTEM ACTION AGAINST VIOLENCE IN CHILDHOOD AND ADOLESCENCE (2023)

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Contents

Abbreviations

- PHC: Primary Healthcare
- HC: Hospital Care
- CSV: Child Sexual Violence
- AACC: Autonomous Communities and Cities or Regions
- CRC: Convention on the Rights of the Child
- CEPIA for its Spanish acronym: State Council for Child and Adolescent Participation
- CoViNNA for its Spanish acronym: Commission against Violence in Children and Adolescents of the Interterritorial Council of the National Healthcare System
- EEVIA for its Spanish acronym: Strategy for the Eradication of Violence against Children and Adolescents
- ACE: Adverse Childhood Experiences
- BEC: Beneficial Experiences in Childhood
- PEPC: Public Entity for the Protection of Children (dependent on the AACC)
- SPF: security and police forces
- RF: Risk factors
- MR: Medical Records
- IMLCF: for its Spanish acronym Institutes of Legal Medicine and Forensic Sciences - STI: Sexually transmitted infection
- LGTBI: Lesbian, gay, transgender, bisexual, or intersex persons
- LOPIVI for its Spanish acronym: Organic Act 8/2021 of 4 June 2021 on the Comprehensive Protection of Children and Adolescents Against Violence.
- FGM: Female genital mutilation
- NICE: National Institute for Health Care and Excellence
- WHO: World Health Organisation
- RUMI: for its Spanish acronym Unified Child Abuse Register
- MSS: Municipal Social Services
- ADHD: Attention deficit hyperactivity disorder
- ASD: Autism spectrum disorders
- ICT: Information and Communication Technologies
- HSW: Healthcare Social Work
- HBV: Hepatitis B virus
- HCV: Hepatitis C Virus
- HIV: Human immunodeficiency virus
- HPV: Human papillomavirus
- NHS: National Health Service
- CS: Chemical Submission
- CS&V: Chemical Submission and Vulnerability
- CV: Chemical Vulnerability

1. Executive summary

Addressing violence against children and adolescents is not only a fundamental human rights obligation but also a critical public health concern. Violence and its consequences can be prevented or mitigated through systematic, evidence-based measures. This includes ensuring a comprehensive, multidisciplinary, and high-quality response from child and adolescent care services, including health services.

Experiencing violence in childhood has lasting effects on health and well-being throughout an individual's life. The stress associated with childhood violence adversely affects brain development, particularly during the early years and adolescence. This can lead to impairments in academic and professional performance, as well as potential issues with cognitive, language, and psychomotor development, etc. Additionally, it may disrupt attachment bonds, hindering social relationships and contributing to increased impulsivity and low self-esteem. Furthermore, other systems, including the endocrine, circulatory, musculoskeletal, reproductive, respiratory, and immune systems, are also impacted, with consequences that can persist throughout a lifetime. For this reason, and in recognition of their rights, comprehensive and interdisciplinary support should be provided to children and adolescents[1] who have experienced violence. This support must be delivered by trained professionals for as long as necessary, involving and assisting their caregivers throughout the process.

In Spain, official statistics are sourced from the National Unified Register on Violence against Children (RUMI), which recorded 21,521 notifications of suspected cases of violence against minors in 2021. However, like global trends, several prevalence studies indicate that such cases are significantly underreported.

In 2021, Organic Act 8/2021 of 4 June 2021 on the Comprehensive Protection of Children and Adolescents Against Violence (LOPIVI) was enacted. This law aims to establish a new paradigm for the prevention of violence and the protection of children and adolescents through a comprehensive

[1] In the context of this protocol, children and adolescents are defined as individuals under 18 years of age, regardless of their sex, sexual orientation, sexual identity, or gender expression.

approach that prioritizes their rights, while also considering the multidimensional nature of risk factors and the social determinants of health.

This protocol aims to standardize the healthcare response to violence against children and adolescents at the national level, in accordance with both international recommendations and the provisions outlined in LOPIVI. It is intended for professionals within the healthcare system, whether directly involved in care or not, as well as for all individuals responsible for the management and planning of health policies and resources. It addresses violence against children and adolescents, as defined by LOPIVI: "any action, omission or neglect that deprives minors of their rights and wellbeing, that threatens or interferes with their orderly physical, emotional or social development regardless of the ways and means in which it is committed, including through information and communication technologies, especially digital violence. It aims to systematize the promotion of fair treatment, prevention, detection, and a comprehensive approach to all cases of violence, emphasizing principles of equity, gender sensitivity, accessibility, non-discrimination, and a life course perspective. "

The promotion of fair treatment must identify the social determinants that contribute to creating safe and healthy environments. Additionally, it should involve individual-level actions that inform and train caregivers about the basic needs of children and adolescents, as well as their autonomy and capacity to achieve holistic and healthy development at each stage of growth. To achieve this, the promotion of fair treatment for children and adolescents must be integrated throughout the care process, beginning with pregnancy, and continuing through all interactions with the child and their family. This approach should respect their autonomy, promote their participation, and ensure that spaces and procedures are tailored to the individual characteristics, rights, and emotional circumstances of the children and their caregivers. Care should be provided in a manner that is respectful of their beliefs and customs, if these do not pose a risk to the health or integrity of the minor.

To contribute to the prevention of violence from a healthcare perspective, this protocol aims to reduce the prevalence of risk factors through primary prevention, which includes the assessment of psychosocial risk. This encompasses evaluating both Adverse Childhood Experiences (ACEs) and Benevolent Childhood Experiences (BCEs), enabling the identification and assessment of the vulnerabilities and strengths of the child and their environment. Additionally, the protocol facilitates the early identification of potential violence risk situations (secondary prevention) and the

implementation of necessary support to address or mitigate these risks in a comprehensive and coordinated manner (tertiary prevention). Additionally, this protocol recommends various interventions to address risk factors and prevent violence, including: early access to prenatal and postnatal services for at-risk pregnancies; home visits from prenatal stages through the first two years of age; individual and group positive parenting programs; treatment programs for caregivers who were victims of abuse during childhood; assessment of all children who have witnessed or experienced violent acts; addressing the addictions or psychiatric disorders of caregivers through appropriate treatment options; access to family therapy; and other relevant interventions.

A comprehensive approach to violence begins at the point of detection or suspicion of a potential case of violence. Health services are a vital setting for the early detection of violence during childhood and adolescence, given their frequent and close contact with children and their families. However, for this to be effective, health professionals must be trained to recognize the indicators of suspicion for each type of violence. Additionally, they should consider that the identification of any case will always necessitate an assessment of other children living in the household. This protocol outlines the key indicators of suspicion for cases of neglect, emotional or psychological violence, physical violence, sexual violence, as well as child trafficking and exploitation. Additional documents may be developed at a later stage to further explore other types of violence in greater detail.

Once a potential case has been detected, it is essential to conduct a comprehensive medical and social records, as well as perform the necessary tests and examinations to ensure an accurate differential diagnosis that can confirm or rule out the suspicion. If this is confirmed, it is essential to assess both the clinical severity of the injuries and the potential life-threatening nature of those injuries, as well as the child's safety and risk of being unprotected. This assessment will inform whether to adopt an urgent or standard procedure.

The entire process of detection, assessment, care, follow-up, and recovery for minors who are victims of violence must be conducted by a team consisting of at least medical, nursing, and healthcare social work professionals (HSW). This team should collaborate with other specialists or specialized units, including forensic experts, psychologists, and professionals in the fields of protection and justice, as appropriate.

This protocol also outlines and explains the notification process, detailing when, to whom, and how notifications should be made. The primary objective is to fulfil the duty of mandated reporting as outlined in LOPIVI. This special duty to report applies to individuals who, by virtue of their position, profession, trade, or activity, have the responsibility to assist, care for, educate, or protect children and adolescents. Individuals in these roles must report any instances of violence against children that come to their attention in the course of their duties.

In terms of intervention and follow-up, the protocol establishes essential recommendations to ensure comprehensive, multidisciplinary, tailored, and specialized therapeutic care in child-friendly environments. This care, regardless of any judicial proceedings that may arise from the circumstances, must be public, free, and universal, in accordance with corresponding legislation. Action is guided by the best interests of children and adolescents, guaranteeing their right to health, life, and full development, and protecting their right to be free from any form of violence or abuse. It is also important to recognize that children who perpetrate violence require specialized care. It is essential to standardize and systematize the recording of cases in the electronic medical record, ensuring confidentiality. This will facilitate case follow-up and enable the collection of data on the prevalence of violence among children and adolescents, allowing for effective monitoring and evaluation of both the public health issue and this protocol specifically.

For an effective approach to violence, it is necessary to establish communication and coordination channels both within and between healthcare institutions, as well as with other entities involved in the process. This includes municipal social services (MSS), public child protection agencies (PEPC) in each AACC, judicial bodies such as the Institutes of Legal Medicine and Forensic Sciences (IMLCF) and the Public Prosecutor's Office, security and police forces (SPF), and educational institutions, among others. To this end, it is recommended that procedures be established to ensure coordination among professionals in public administrations responsible for addressing violence during childhood and adolescence. This will lead to improved assistance and effective protection in situations of risk of violence, neglect, or lack of protection, while also preventing secondary victimization of the children and adolescents receiving care.

Associations and community resources will also play a vital role in the comprehensive approach to violence, focusing on both prevention and the promotion of fair treatment, as well as subsequent care and support. This involvement aims to foster networks that encourage fair treatment.

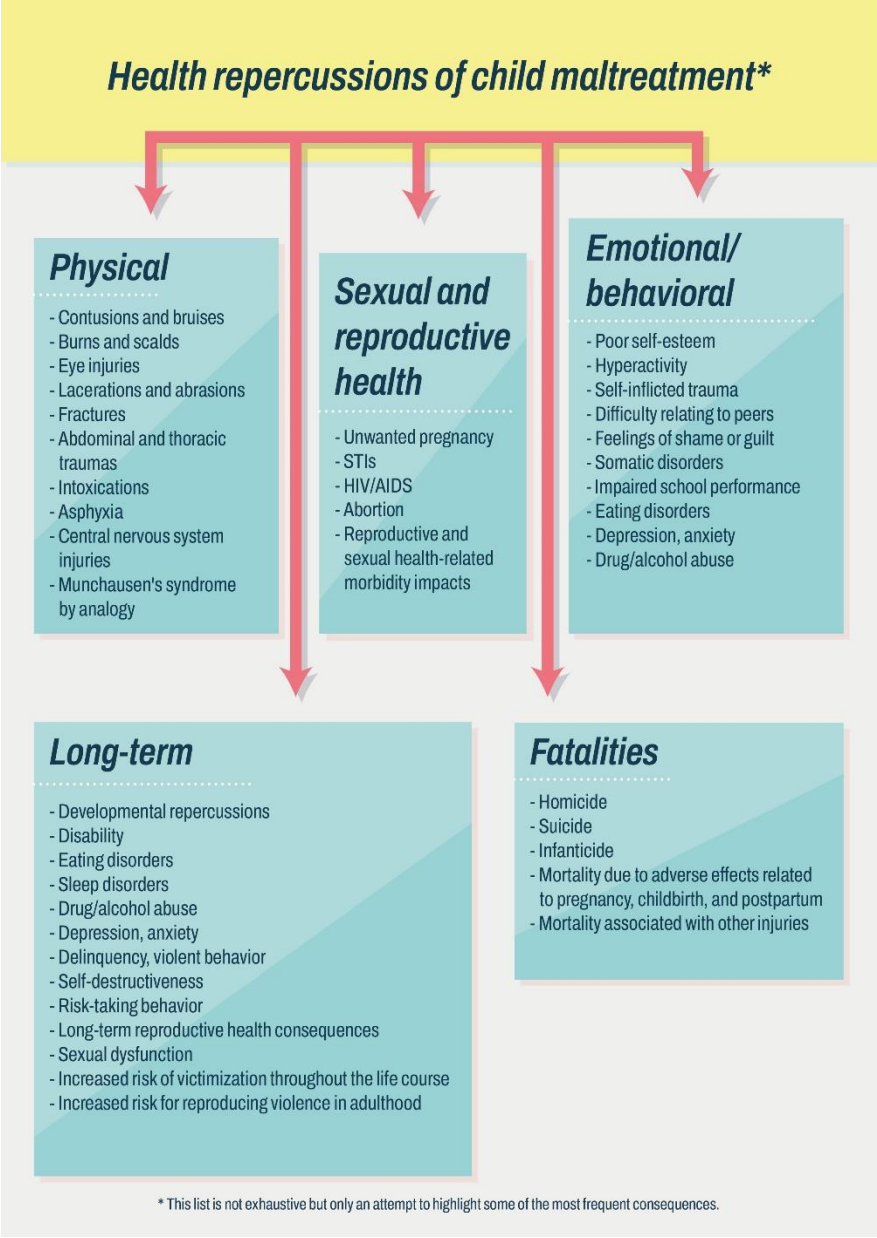
Finally, while the specific indicators for this purpose will be developed at a later stage, this protocol includes provisions for the monitoring and evaluation of both the implementation and outcomes related to the quality of care, protection, and recovery of essential life projects. They should be evaluated using indicators that measure their impact and degree of compliance, allowing for corrective measures to be implemented as needed.

2. Justification of the document

The fight against violence in childhood and adolescence is a human rights imperative and a priority obligation of public authorities, as recognized in Article 39 of the Spanish Constitution and at the international level in the 1989 Convention on the Rights of the Child, which was ratified by Spain in 1990.

This violence impacts health and well-being across the life course, representing a significant public health issue. The stress associated with this violence affects brain development, particularly during the early years of life and adolescence. It can disrupt attachment, lead to cognitive and language difficulties, impact psychomotor development, increase impulsivity, and lower self-esteem, ultimately impairing academic and professional performance. Furthermore, other systems, including the endocrine, circulatory, musculoskeletal, reproductive, respiratory, and immune systems, are also impacted, with consequences that can persist throughout a lifetime. Although difficult to quantify, it is important to recognize the economic costs associated with addressing violence in childhood and adolescence. The estimated annual expenditure in Spain for addressing only sexual violence against children exceeds 979 million euros, not accounting for spending on violence prevention, awareness-raising, and education[1].

Illustration 1: Health impacts of child abuse



Source: adapted from Consultation on Child Abuse Prevention (1999: Geneva, Switzerland) [2]

Unfortunately, this phenomenon is present worldwide. In Spain, official statistics from the Unified Register of Child Abuse (RUMI) recorded 21,521 reports in 2021, reflecting a 37.18% increase compared to the previous year[3]. However, as is the case internationally, various prevalence studies indicate that these figures are likely underreported.

Violence against children can be prevented through systematic, evidence-based measures, including ensuring an adequate response from care services, which aligns with the objectives outlined in this protocol.

Recognizing this serious issue, Organic Act 8/2021 of 4 June 2021 on the Comprehensive Protection of Children and Adolescents Against Violence (LOPIVI), was enacted in 2021 [4], *which* aims to establish a new paradigm of prevention and protection through a comprehensive approach, taking into account the multidimensional nature of its risk factors and the social determinants of health. The regulation establishes measures for promoting fair treatment, prevention, protection, early detection, notification, assistance, restoration of violated rights, and recovery for victims. These measures are directed at all administrations, particularly the Healthcare System, which, due to its accessibility and continuous relationship with citizens—especially in primary healthcare—serves as an appropriate setting for implementing these actions. It is essential to consider co-responsibility and coordination with other sectors, such as education, protection, and justice, to ensure a comprehensive approach that minimizes the risk of secondary victimization.

To coordinate and plan all measures related to the health sector, the LOPIVI establishes the creation of the Commission against Violence against Children and Adolescents (CoViNNA) of the Interterritorial Council of the National Healthcare System, created on 6 April 2022 and constituted on 6 May 2022. Among its functions is the development of a common healthcare system action protocol to evaluate and propose the necessary measures for the effective implementation of the law, as well as any other measures deemed essential for the healthcare sector to contribute to the eradication of this violence. This protocol has been developed based on the consensus of a group of experts appointed by CoViNNA, following a review of national and international protocols and scientific literature. It was created in collaboration with the Autonomous Communities and Cities (CCAA), representatives from the Ministries of Youth and Childhood, Equality and the Presidency, Justice, and Parliamentary Relations, as well as experts and professional societies in the socio-health field. Additionally, it involved consultations with the State Council for the Participation of Children and Adolescents (CEPIA) and associations representing victims and children, as detailed at the end of the document.

The scope of action of the protocol encompasses the healthcare system at all levels of care, from Primary Health Care (PHC) and community care to Hospital Care (HC), including out-of-hospital emergency services and community care, in both public and private sectors.

It is intended for healthcare system professionals who interact with children and adolescents, including healthcare providers (such as medical and nursing staff in paediatrics, family and community

medicine, gynaecology and obstetrics, midwifery, psychiatry, and emergency care, as well as psychologists, health social workers, physiotherapists, occupational therapists, oral health professionals, and auxiliary nursing staff) and non-healthcare professionals (such as administrative staff and public health officials). Additionally, it targets individuals responsible for the management and planning of health policies and resources.

The beneficiaries of this protocol include children under 18 years of age, their families, and social environments, as well as the broader community.

It aims to serve as a practical summary of the key actions from the perspectives of equity, gender, accessibility, non-discrimination, and the life course. The implementation will be adapted to each territory according to its characteristics and context. In the future, additional training and awareness-raising materials will be developed and made available on the website[2].

3. Definition of violence during childhood and adolescence

According to LOPIVI: *"For the purposes of this law, violence is understood to be any action, omission or neglect that deprives minors of their rights and wellbeing, that threatens or interferes with their orderly physical, emotional or social development regardless of the ways and means in which it is committed, including through information and communication technologies, especially digital violence.*

In any event, violence will be understood to be physical, psychological or emotional mistreatment, physical, humiliating or degrading punishment, neglect, threats, insults and slurs, exploitation, including sexual violence, corruption, child pornography, prostitution, school bullying, sexual harassment, cyberbullying, gender-based violence, genital mutilation, trafficking of human beings for any purpose, forced marriage, unwanted access to pornography, sexual extortion, public dissemination of private data and the presence of any violent behaviour in their family circle.."

[2] Violence Against Children and Adolescents. Ministry of Health.
https://www.sanidad.gob.es/areas/promocionPrevencion/prevencionViolencia/infanciaAdolescencia/home.htm

While this document, like LOPIVI, aims to address violence in all its forms, it utilizes the term "maltreatment," which, according to the WHO, refers to the violence and neglect experienced by individuals under 18 years of age within the context of a relationship characterized by responsibility, trust, or power. This includes all types of physical or psychological abuse, child sexual violence (CSV), neglect, and commercial or other forms of exploitation that may cause or are likely to cause harm to a child's health, development, or dignity, or that may endanger the child's survival[2][5]. Exposure to gender-based violence is also considered one of the forms of child maltreatment[6][7]. Therefore, the terms 'violence' and 'abuse' are distinguished by the context or relationship to the perpetrator and will be used interchangeably throughout this document.

Table 1. Classification of Violence Against Children and Adolescents

Classification of Violence Against Children and Adolescents	
Types of violence	Negligence
	Emotional or psychological violence
	Physical violence
	Sexual violence
	Trafficking and exploitation of children (Including Sexual Exploitation)
	Gender-based violence
	Female genital mutilation (FGM)
	Perinatal violence
	Violence between minors
	Caregiver-induced factitious disorder (formerly known as Munchausen syndrome by proxy)
	Violence through ICTs
	Institutional Violence (Including Institutional, Professional, and Secondary Victimization)
	Other Practices Affecting the Health, Integrity, or Rights of Minors (e.g., Forced or Early Marriage, Hate Violence, and Discrimination)
Environments Where Violence Occurs	Familial
	Extra-familial
Type of Health Procedure Required in Cases of Violence	Urgent
	Ordinary

Source: own elaboration based on General comment No. 13 (2011): The right of the child to freedom from all forms of violence, 18 April 2011, UN: Rights of the Child (CRC).[8]

4. Epidemic situation.

Data are available from the RUMI[3], where only 8% of the records come from the health sector, probably due to the poor adaptation of reporting systems to the dynamics of health. Furthermore, it is important to note that the reported incidence and prevalence depend on the detection capabilities of professionals, the level of training they receive, and the availability of tools for the notification of

suspected cases.

According to this register, in 2021 there were 21,521 reports of suspected violence against children (48.66% female and 51.34% male). The most prevalent form of violence was neglect (42.75%), followed by emotional violence (30.75%), physical violence (19.91%), and sexual violence (9.59%). Although sexual violence is the least frequent type, it has experienced a significant increase of 133.66% compared to the data from 2020. In all types of violence, more suspicions are reported for females than for males, except for neglect, where the highest number of reports comes from males. The most significant difference between the two sexes is observed in cases of sexual violence, where 57.61% of the total notifications are attributed to females. Seventy percent of the registered cases involve individuals of Spanish nationality, with over 50% corresponding to adolescents aged 11 to 17. Notably, 32.01% of the cases are in the 11 to 14 age group. However, this does not necessarily indicate that these are the age groups with the highest incidence, as detecting victims of violence in the zero to six age range is particularly challenging.

Despite the fact that disability is a risk factor for violence and that, according to research, the overall prevalence of violence against children with disabilities is 31.7%[9], it is only being detected in 3.02% of cases, and there is insufficient information to determine whether this is due to difficulties in detection or to a lower incidence.

Additional data on violence experienced by children and adolescents can be obtained from various sources beyond the Strategy to End Violence against Children and Adolescents (EEVIA)[10]. Finally, data can be obtained through research studies[11][12] [13] [14] [15] [16] [17] [18] [19].

5. Promoting effective treatment, development, health, and children's rights.

LOPIVI (art.1.3) defines fair treatment is understood to be any that, while respecting the fundamental rights of children and adolescents, actively promotes the principles of mutual respect, the human being's dignity, democratic coexistence, peaceful conflict resolution, the right to equal protection of the law, equal opportunities and prohibition of discrimination of children and adolescents.. Within the healthcare system, effective treatment is understood as the collection of actions undertaken by professionals and healthcare institutions to promote the bond of attachment, affection, care,

upbringing, support, and socialization that children and adolescents should receive from their families and social environments. This approach ensures the necessary conditions to fulfil their rights, meet their basic needs, and support their overall development—affective, psychological, physical, sexual, intellectual, social, and cultural. In order to carry out interventions to promote fair treatment, it is necessary to know the needs of children[3] differentiated by each stage of development [20] [22].

The promotion of effective treatment for children should be integrated at every stage of the healthcare process and during all interactions with the child and their family, whether in response to specific requests or as part of programmed care and community action. The following objectives should guide this integration:

1. Promote compensatory or protective factors, such as secure attachment, while preventing the emergence of risk factors, particularly through the promotion of validated positive parenting tools[4,5][23].
2. Inform and train caregivers[6] through health education, upbringing, and positive parenting programs about the basic needs of children at various developmental stages. This includes addressing potential special needs and support resources required due to illness or disability. Training should encompass individual, group, and community healthcare actions, reinforcing autonomy and capabilities, facilitating community participation, and fostering safe and protective environments.
3. Identify social determinants and accessibility barriers within the child's environment, and work to promote safe, accessible, and healthy settings, whether in family or institutional contexts.

[3] Basic needs include breathing, eating, evacuating, resting, sleeping, moving, maintaining cleanliness, staying warm and clothed, and transcending mere survival by engaging in communication, fostering human relationships, learning, working, playing, and recreation. [20][21]

[4] **Positive Parenting Programme** by the Ministry of Health. Available at: https://www.sanidad.gob.es/areas/promocionPrevencion/estrategiaSNS/programaParentalidadPositiva/home.htm

[5] **Familias en Positivo**: an online platform developed by the Ministry of Social Rights and Agenda 2030, together with the Spanish Federation of Municipalities and Provinces. Its objective is to promote positive parenting and enhance support for positive parenting within public policies and services provided by local governments and associations. Available at: www.familiasenpositivo.es

[6] Throughout this text, the term *caregivers of children and adolescents* encompasses mothers, fathers, legal guardians, educators, and all individuals entrusted with the care of children and adolescents.

It is also essential to adapt communication spaces and environments—both face-to-face and virtual—as well as healthcare procedures, to align with the personal characteristics, rights, disabilities, and emotional situations of children and their caregivers. This includes ensuring universal accessibility and providing support resources for individuals with disabilities. Comprehensive care should be offered, along with monitoring and respectful support for families, while giving special consideration to cultural and religious diversity, provided it does not pose a risk to the child's health and well-being. The following recommendations should be considered:

1. Children have the right to participate in the healthcare process. Their autonomy and wishes should be respected to the greatest extent possible. They should be provided with information and participation options that ensure full accessibility in accordance with their evolving capacities and/or disabilities, enabling them to engage in decision-making throughout their care process. This includes ensuring informed consent and/or assent as appropriate. In the adaptation of healthcare spaces and procedures gender issues will be taking into account to ensure that children can make decisions on an equal basis.
2. Support from a trusted person must be guaranteed.
3. Services, spaces, and procedures must be designed to be accessible, adapted, child-centred, and well-known to children. They should be effectively disseminated and publicized, ensuring safety, sensitivity, confidentiality, and the presence of trained staff. Additionally, these services should respect each child's sex, sexual orientation, identity, and gender expression, with particular attention to disabilities, support and communication needs, as well as cultural and ethnic differences. Furthermore, the impact of social determinants that may lead to situations of vulnerability must also be considered[24].
4. Possible language, cultural or communication barriers must be taken into account, with the availability of translation and interpretation services, mediation or qualified staff during care, as well as resources to support hearing and oral communication, and knowledge of the different augmentative and alternative forms of communication such as the use of alphabet notebooks or communication boards, syllabic, by words, pictograms[7], photographs, mixed, yes or no answers, or

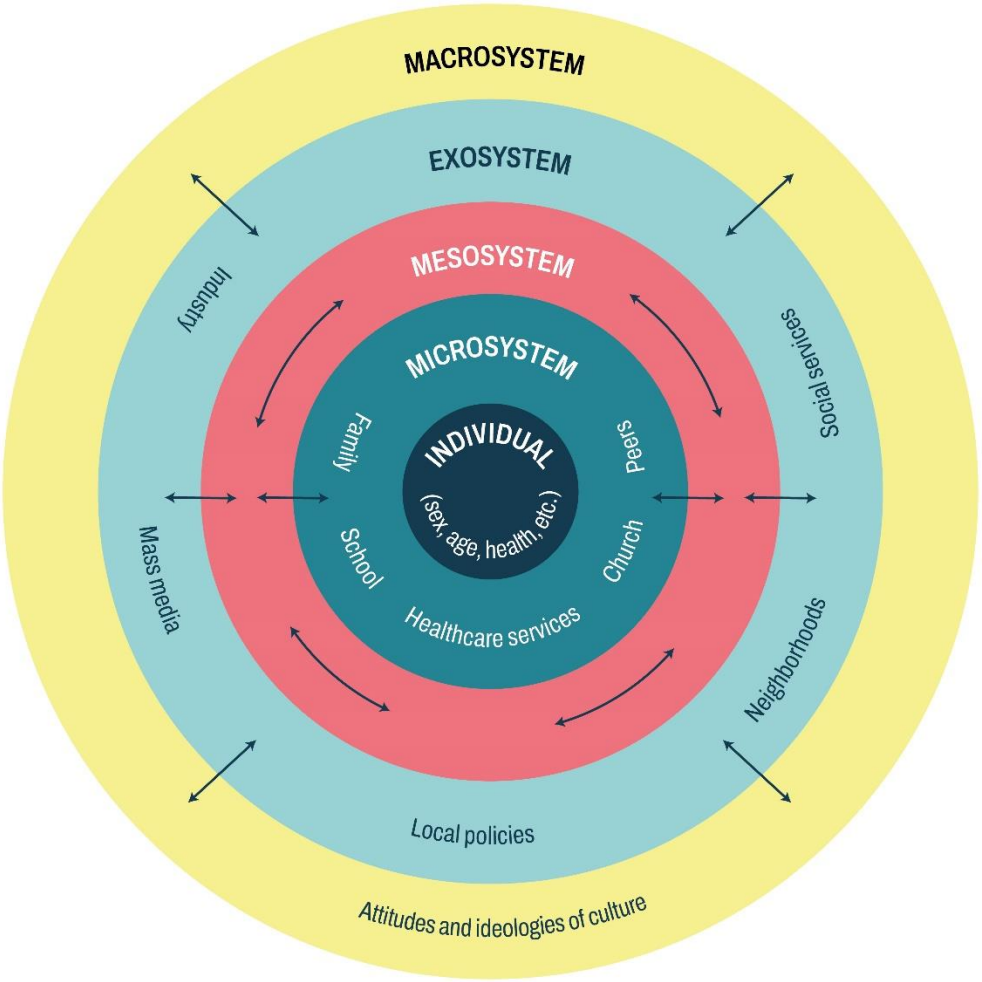
[7] **Pictograms and Resources for Augmentative and Alternative Communication (AAC)**: Provided by the Aragonese Centre for Augmentative and Alternative Communication. Available at: *AAC Symbols and Shared Resources - ARASAAC*.

using friendly or easy-to-read documents, especially in cases of intellectual or sensory disability [5][25][26][27] or mental health problems.

5. It is recommended to establish spaces that foster and support the health and development of children and adolescents from an early age. Appropriate spaces for breastfeeding and designated areas for play activities should be available in all healthcare settings. Additionally, environments that promote learning and play during children's admission must be provided, always ensuring proper cleaning and disinfection.
6. Spaces designated for the care of children should be distinct from those intended for adults across numerous services and specialties.
7. It is essential to ensure the preparation and training of healthcare professionals, the development of appropriate skills and competencies, and the quality of care provided. Professional self-care is also essential, considering the significant emotional burden associated with detecting and intervening in cases of violence against children and adolescents.

Promote longitudinally[28] in social and health care, understood as the stable relationship maintained over time between a professional and his/her patients. It should be borne in mind that violence is not an individual problem, it is influenced by the social determinants of health [29][30], so in addition to individual measures, it is essential to address these determinants in an intersectoral, integrated and coordinated way, from a population perspective. Based on Ecological Systems Theory[31], the approach can include actions on the environmental, economic and social conditions known to increase this risk and enhance protective conditions. Health promotion and prevention activities for children and adolescents should also encompass the extra-familial environment. To achieve this, it is essential to raise public awareness, train professionals and policymakers, and implement structural changes aimed at establishing and executing plans, programs, and strategies with the necessary resources for effective implementation.

Illustration 2: Ecological Systems Theory



Source: Adapted and translated from "*The ecological theory of human development*". [31].

6. Prevention of violence against children and adolescents in the health sector.

Primary prevention targets the general population in order to reduce the prevalence of risk factors (RF) and prevent an episode of violence from occurring[32]. It also includes raising awareness and providing education to empower children with the personal tools needed to identify, communicate about, and address situations of violence or abuse. Traditionally, within the healthcare sector, the mental health of caregivers, the socio-economic situation of the family, and intimate partner violence have been regarded as the most common risk factors for intra-family child abuse [33][34][35][36,37].

Similarly, disability should be considered a potential risk factor. It is important to clarify that the presence of risk factors does not necessarily guarantee that adverse events will occur in the lives of these children. Their resilience, along with familial and social strengths, can promote healthy development [38].

In this sense, the assessment of psychosocial risk is fundamental[38][39]this will include the assessment of both Adverse Childhood Experiences and Beneficial Childhood Experiences (Annex 1). This enables the visualization and assessment of the vulnerabilities and strengths of the child and their environment, facilitates the early identification of risk situations for violence, allows for the implementation of necessary support to correct or mitigate the identified risks, and aids families in difficulty. The assessment should preferably occur during scheduled visits for clinical examinations and other activities included in the Child Health Programme, conducted by paediatric and primary care nursing teams. However, it can also be carried out at any time during healthcare interactions, allowing for independent evaluations. The PHC teams[8] will not only be responsible for assessment and follow-up, but also for referral and coordination, if necessary, to social services, child and adolescent mental health, hospital paediatric social unit or another specialised unit if required. Several clinical tools have been published for identifying psychosocial risk in children and adolescents[40]. In many cases, multiple risks or vulnerabilities may coexist, making it essential to consider them when organizing activities aimed at promoting fair treatment and prevention, as well as providing care in instances of suspected maltreatment, with a focus on the needs of children.

Additional interventions to address risk factors and prevent violence against children include:

A. Ensure early access to prenatal and postnatal services in pregnancy, especially if there are risk factors or situations of violence[41].
    1. Integrate a screening process into the pregnancy monitoring program to identify situations of special vulnerability and detect any circumstances that may adversely affect the health and well-being of both the pregnant individual and the foetus.

[8] The primary health care team required to implement the actions outlined in this protocol shall include, at a minimum, professionals in paediatrics or family and community medicine, nursing, and health social work.

2. Implement screening for gender-based violence and establish dedicated pathways and resources during pregnancy, in accordance with the Common protocol for a healthcare response to gender violence.
3. Promote psychoprophylaxis programs during pregnancy and the postpartum period, incorporating activities that reinforce and support parents.
4. Promote postpartum care programs both in hospitals and in primary care settings.
5. Encourage the development of support networks.

B. Facilitate timely access to pre- and post-adoption or foster care services, including psychoprophylaxis programs, particularly in cases involving factors or situations that pose a risk of violence.

C. Promote home visits from prenatal to two years of age[37][43].

D. Refer family members to evidence-based individual and group positive parenting education programs aimed at enhancing caregivers' psychosocial functioning and skills. These programs should focus on fostering secure attachment and bonding, conflict resolution, and the establishment of rules and boundaries, as well as improving family dynamics and reducing parenting stress and children's behavioural problems. Implement tailored follow-up care based on the specific needs of the child or family. This should include establishing clear health education objectives, providing support and respite measures, and enhancing the caregivers' capacity to nurture their children. Additionally, efforts should focus on modifying attitudes and beliefs regarding discipline and addressing psycho-emotional needs.

E. Refer caregivers who experienced any form of violence during their childhood to appropriate treatment programs as needed.

F. Assess the ACE/BEC BCE of children and adolescents and their caregivers for the referral of cases selected for their complexity to the social paediatric units of the referral hospitals or other specialised units.

G. Assess all children who have witnessed or experienced violence and refer them to specialized child and adolescent mental health services as needed.

H. Assess and address the mental health issues, including anxiety and addictions, of those caregivers responsible for children and adolescents through various comprehensive approaches and from a community-based perspective. Refer to family therapy and/or peer support groups as appropriate.

I. Provide specialized information and training through organizations for people with disabilities to families prior to the birth of a child with disabilities.

J. Refer families in need to community resources for psychological support for both adults and minors, as well as social, employment, or financial assistance.

K. Collaborate and coordinate with Municipal Social Services or the Public Child Protection Agency in defining objectives, plans, strategies, and support tailored for each at-risk family.

L. Within the Healthcare System child health program, promote specific workshops to encourage fair treatment aimed at both caregivers and children, utilizing educational centres and family associations.

The effectiveness of violence prevention activities in different care settings, especially PHC, has been analysed in several studies that go beyond the scope of this protocol[5][44][45] [46]. Work should be carried out in a multidisciplinary team, recommending that the HSW coordinate the actions. The follow-up will preferably be conducted by the PHC team of reference for the child or adolescent[9] or by the professional who has detected the situation. Coordination and referral mechanisms should be established with social services, child and adolescent mental health services, hospital paediatric social services, and other specialized units. Additionally, it is essential to gather information from educational institutions, organizations specializing in the care of individuals with disabilities, and relevant entities such as child protection agencies and courts, as needed.

In addition, it is especially relevant to identify and address situations that create or increase the vulnerability of children and adolescents to violence such as those listed in EEVIA "*having a disability, being between zero and three years old, having a diverse racial, ethnic or national origin, a situation*

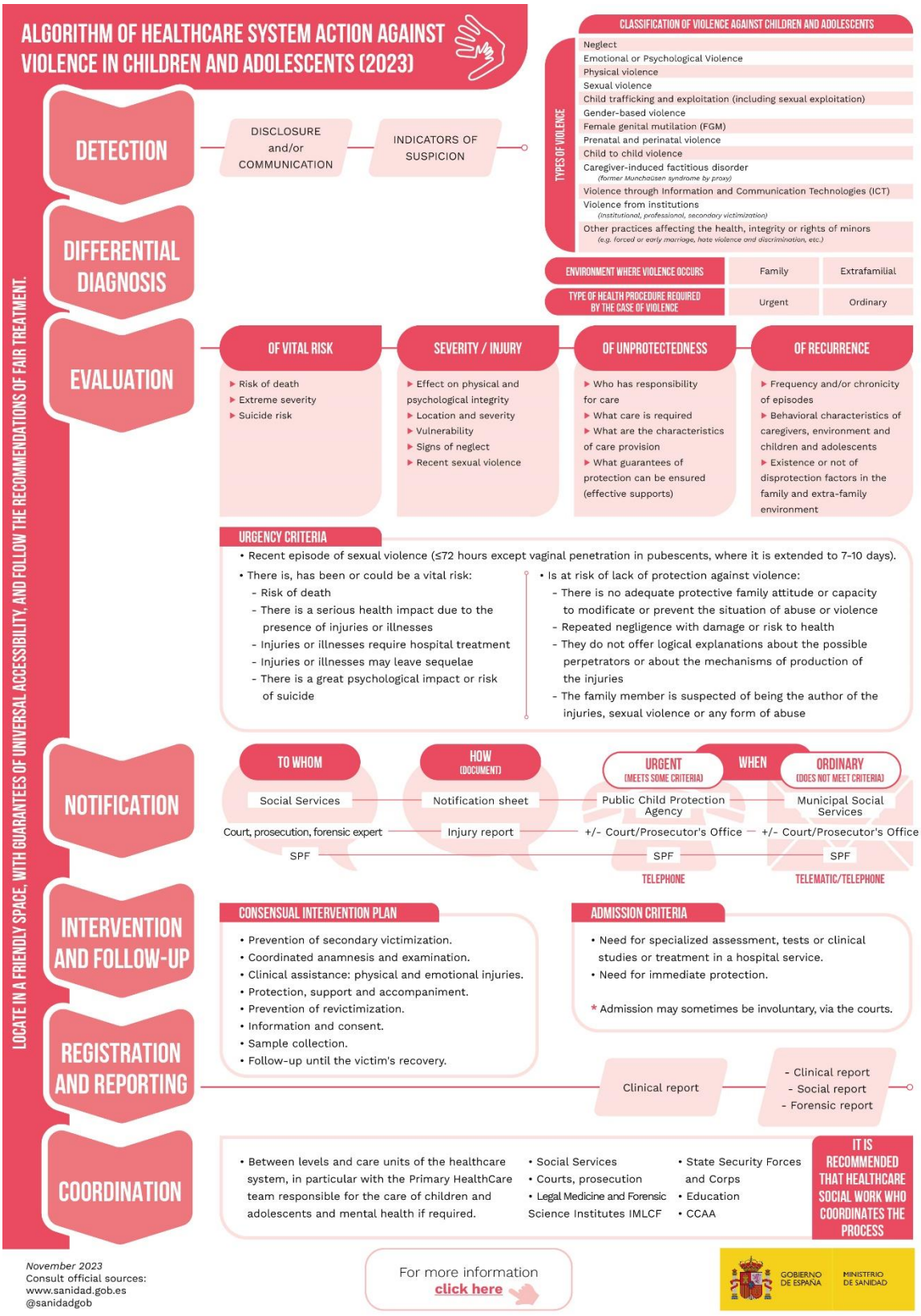
[9] See footnote 8 on page 19.

of economic disadvantage, belonging to the LGTBI collective, having a diverse gender orientation or identity, being a refugee or asylum seeker or subsidiary protection and lacking parental care "or others such as belonging or having belonged to a family with a previous history of abuse of children, being in a situation of neglect, suffering from certain illnesses [47] .

Children with disabilities are at particular risk of violence, higher in girls and adolescents, estimated by some studies to be 3.7 times more likely to be victims of any type of violence, 3.6 times more likely to be physically abused and 2.9 times more likely to be victims of CSV[5][25][26]. They also have greater care and resource needs, which is why the healthcare sector must provide services that are tailored to the needs of individuals with disabilities and their families, ensuring accessibility and appropriate support.

Attention needs to be paid to young people in residential care as a large percentage have suffered exposure to violence and traumatic events [48][49][50][51].

7. Summary of care intervention. Algorithm.



8. Detection or suspicion of the situation of violence

Detecting a potential situation of violence involving a minor is the crucial first step in facilitating intervention and support for the child and their family. This allows for the activation of necessary protection measures, minimizes consequences, addresses any aftereffects, and helps prevent future occurrences. It should therefore occur as early as possible.

Healthcare services play a crucial role in detecting situations of violence during childhood and adolescence, given the various moments and circumstances in which care is provided throughout their development. Screening can be conducted by any healthcare system professional—such as those in medicine, nursing, social work, psychology, occupational therapy, physiotherapy, and oral and dental health units—across various settings, including primary healthcare, hospital care, and out-of-hospital emergency services. This can occur during any of the numerous situations in which children and their families engage with the healthcare system.

Efforts must be approached from a biopsychosocial and equity perspective, ensuring universal accessibility and gender equality. It is important to recognize that certain children and adolescents, such as those with disabilities, chronic illnesses, or those within the child protection system, may be at an increased risk of violence and more vulnerable to its effects. Their circumstances often mask these risks, compounded by communication difficulties and barriers that hinder detection.

Stigmatization should be avoided, as abuse or violence can occur in all family structures, regardless of socio-economic, educational, or cultural backgrounds, as well as in environments outside the family.

Experiencing one form of violence can increase the likelihood of becoming a victim of another type, and multiple forms of violence may occur simultaneously. Different forms of violence can be interconnected, creating a cycle that is often challenging to break free from[52].

The detection of a possible situation of violence towards a minor can be generated by:

- Explicit communication from the child, or from anyone in the child's environment who has witnessed or is aware of a potential situation of abuse—including other children—can be crucial. Non-verbal cues, such as gestures, facial expressions, or body posture, may also

indicate distress or a need for support.

- Communication from professionals in other fields who interact with the child—such as educators, social services, early intervention centres, sports programs, leisure activities, security and police forces, and those involved in addressing gender violence—can also play a vital role in identifying potential situations of abuse.

- The identification of suspicious indicators observed during healthcare interactions.

Recognizing a potential abusive situation is not always straightforward:

- At times, specific and clear indicators may not be present. Injuries that appear consistent with maltreatment may have other causes, which should be excluded through a thorough differential diagnosis (refer to Section 10 on the initial assessment of violence in children and adolescents).
- There is significant heterogeneity in manifestations, and diverse types of abuse are often interconnected. At times, victims may provide inconsistent or contradictory accounts, or even recant their statements; this should be understood as a common behaviour among those who have experienced violence.
- In certain cases, particularly with children under two years of age or those with severe disabilities, it is essential to actively seek out warning signs and indicators. This may involve employing specific and indirect techniques, such as graphic projective methods or storytelling, along with utilizing human and material resources that ensure access to augmentative and alternative communication.

Furthermore, it is important to note that the detection or suspicion of violence against a child should always involve an assessment of other minors and cohabitants within the household.

It is recommended that the process of detection, care, and follow-up for child victims of violence be conducted by a multidisciplinary team, comprising at least medical, nursing, and healthcare social work professionals. Coordination of actions should be prioritized whenever possible, and collaboration with other specialists or specialized units should be integrated as appropriate.

Indicators of suspected violence are those signs and symptoms presented by possible victims and/or perpetrators, when they are the aggressors, which should alert us to the possible situation of

violence. These findings may include physical, psychological, and/or behavioural indicators in the child or adolescent, as well as observations related to the conduct of the caregivers. The presence of one or more indicators, the accumulation of multiple indicators, or specific injuries should prompt any professional to consider the potential existence of a situation of violence.

There are several non-specific indicators that should be considered during consultations, particularly if they occur repeatedly, such as:

- Frequent failure to attend scheduled or follow-up consultations.
- Failure to provide reports when requested.
- Frequent changes of professionals in the healthcare system without justification.
- Visiting the clinic for no apparent reason.
- Inability to collect data on family life in the clinical interview.

Below are definitions of the most common typologies of violence, along with tables of indicators. These are not exhaustive lists but should be regarded as warning signs to be assessed within a holistic framework. Violence can be ruled out as a cause of the detected symptoms or signs if another cause or mechanism is objectively demonstrated, as detailed in the assessment section. In cases of doubt, it is advisable to consult with other professionals who have experience in handling violence and/or alternative diagnoses[7].

Many of the recommendations and indicators in this protocol focus on violence occurring within the family environment, as the available scientific evidence, manuals, and protocols primarily address domestic abuse, which is the most prevalent form. However, many of these indicators and recommendations can also be applied to other types of violence outside the family context.

8.1. Negligence

Neglect or abandonment refers to the failure of a caregiver to meet a child and adolescent's basic needs for health, education, emotional support, nutrition, shelter, and safe living conditions, particularly when they can do so. This includes a failure to support the child and adolescent's development and overall well-being [7]. There are significant differences in how caregivers approach upbringing, including the decisions they make regarding children's health care. One approach to resolving diagnostic uncertainties is to compare the specific circumstances of a child or adolescent suspected of neglect with those of other ones in similar family situations[53][54][55]. The National Institute for Health

and Care Excellence (NICE) regularly reviews the key indicators of suspected neglect[56].

Table 2. Indicators of neglect with stronger evidence. Adapted from[53][54] [55] [56].

INDICATORS	Description
Physical indicators in children and adolescents	▪ Poor hygiene. Clothing unsuitable for the climatic conditions. ▪ Stunting. Malnutrition due to lack of adequate intake for age and needs once other causes have been ruled out. ▪ Repeated accidents due to lack of supervision. ▪ Lack of vaccinations and medical care. ▪ Delay in any area of development due to lack of stimulation. ▪ Inadequate dietary and/or scheduling habits. ▪ Wounds, injuries, or marks. Symptoms of diseases caused by maltreatment.
Behavioural indicators in children and adolescents	▪ Somnolence, apathy, depression, aggression, sadness, antisocial behaviour. ▪ Behaviour and expressions inappropriate to their age. ▪ Involved in criminal activities. ▪ School failure and/or absenteeism, language delay. ▪ He/she says there is no one to look after him/her. ▪ Emotional immaturity; global maturational delay.
Indicators of the person suspected of violence[10]	▪ Failure to provide schooling for the children and adolescents in their care in relation to their age. ▪ Intake of toxic substances during gestation and/or afterwards. ▪ Lack of parental supervision. ▪ They tolerate all the child's behaviour without setting any limits. ▪ Absent fathers and mothers in their parental role. ▪ Frequent visits to emergency services due to lack of medical follow-up. ▪ Chronic, conspicuous disease that does not lead to medical consultation. ▪ Absence of routine medical care. ▪ Lack of or inadequate care and attention to special needs due to chronic illness. ▪ Conflictual separations of parents (use of children in allegations and accusations).

8.2. Emotional or psychological violence

Emotional or psychological violence includes isolated situations or patterns of behaviour in which the provision of appropriate and supportive care or environment fails, or other behaviours such as rejecting, marginalising, isolating, exploiting, verbally assaulting, belittling or acting with emotional neglect[57]. It may also include the involvement of the child or adolescent in conflicts

[10] It is important to note that, in many cases, the aggressor does not exhibit any noticeable behavioural traits.

between parental figures, or between parental figures and other significant family members in the living environment, such as exposure to gender-based violence [54][57].

Table 3. Indicators of emotional or psychological maltreatment in childhood and adolescence with more evidence. Adapted from [57] [58]

INDICATORS	Description
Physical indicators in the child and adolescent	▪ Sadness, without the presence of other probable causes. ▪ Malnutrition, failure to thrive and stunting. ▪ Psychomotor and maturational delay. May be due to lack of stimulus. ▪ Hair thinning, alopecia. ▪ Psychosomatic illnesses and symptoms (headache, abdominal pain, etc.).
Behavioural indicators in children and adolescent	▪ Mistrust and apathy towards the adult. ▪ Seeks inappropriate physical contact. ▪ Inhibition in playing with other children or adolescent. ▪ Socio-emotional immaturity. ▪ Low self-esteem, depressed mood. ▪ Scared, shy, passive character. ▪ Decreased attention span. ▪ Language delay and/or school failure. ▪ Disorders of eating behaviour, sleep, or sphincter control (enuresis, encopresis). ▪ Disorders related to obsessive thought structures, phobias, anxiety, regression, impulsivity, lack of control of their behaviour and lack of empathy and mentalisation of themselves and other people's emotions. ▪ Self-injurious behaviour, suicidal ideation, or attempts. ▪ Anti-social behaviour, involvement in criminal activities and/or engaging in health risk behaviours (use and/or abuse of tobacco, other drugs, alcohol); early sexual activity without contraception, sexual promiscuity, prostitution.
Indicators of the person suspected of violence[11]	▪ Exhibits coldness and lack of affection in his/her treatment of the child. ▪ Verbal rejection, insults to the child or adolescent. Disproportionate discipline. ▪ It forces the practice of extreme convictions and beliefs (nutritional, religious, cultural). ▪ Denies medical care, treatment or preventive measures based on their own beliefs. ▪ It seems not to care about the problems of the child or adolescent. ▪ Tolerates all behaviour without setting any limits. ▪ Does not accept the initiative of the child or adolescent; prevents greater autonomy. ▪ Isolates the child from social interactions. ▪ Excessive social or work life, absent caregiver. ▪ Encourages criminal behaviour; exposes the child or adolescent to pornography; rewards aggressive behaviour. ▪ Gender-based violence.

[11] See footnote 10 on page 27.

8.3. Physical violence

Physical violence involves the non-accidental infliction of injury, harm or illness to a child or adolescent or exposing them to the risk of such injury, harm or illness, [7,57].

There are aspects that can help us to differentiate the non-accidental, physiological, or caused by other mechanisms nature of injuries such as:

- Contradictory and/or changing explanation provided by persons accompanying the child or adolescent.
- Described mechanism not consistent with the capacities and abilities of the child or adolescent or with clinical findings.
- Delay in seeking help or health care.
- History of multiple accidents or trauma.
- Presence of "*sentinel lesions*": These are those injuries that occur in children under 2 years of age, and which are recorded in the medical records (MR), with implausible attempts at explanation by the person responsible or which are impossible to justify due to the infant's maturity development. Their presence raises suspicions of possible situations of abuse[59].

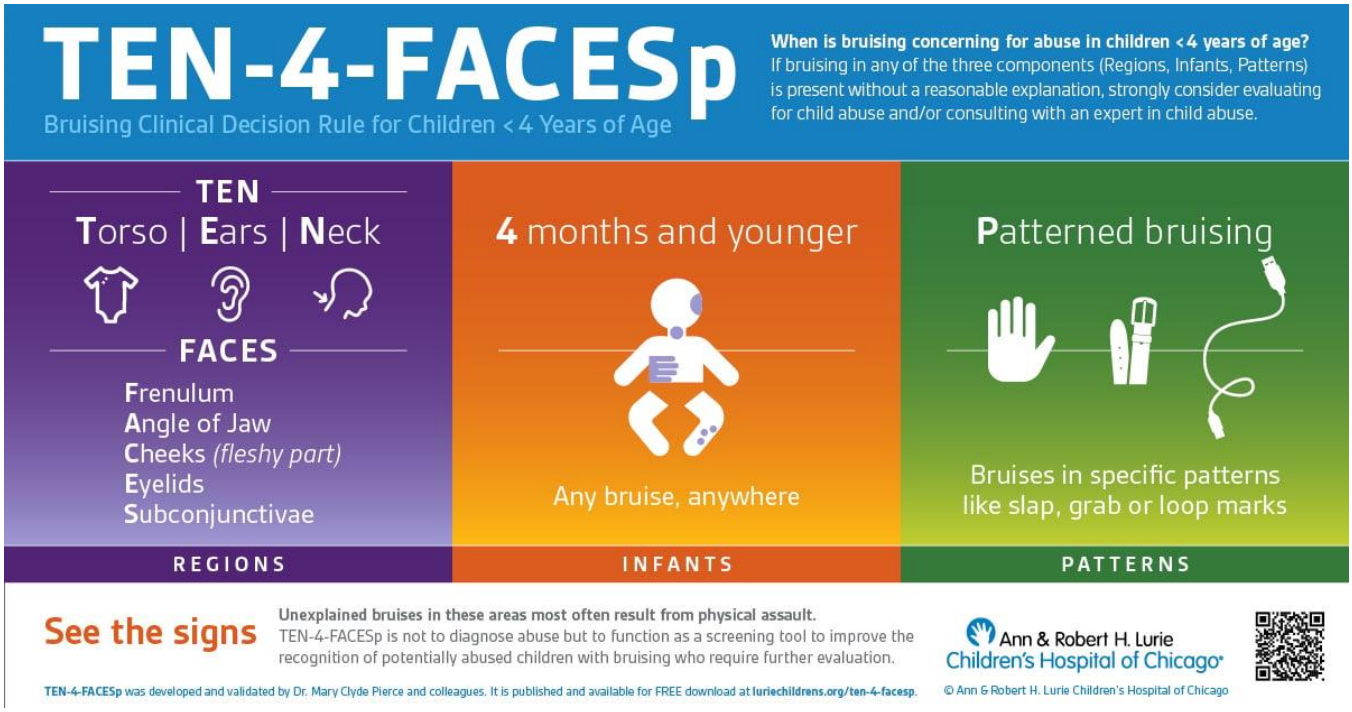
Table 4. Indicators of physical abuse with more evidence. Adapted from [60][61][57]

INDICATORS	**Description**
Physical indicators in the child and adolescent	▪ Erosions, ecchymosis, or bruises are the most frequent injuries of physical abuse, followed by fractures. Bruises or bruises should be suspected when: - Multiple or frequent and repeated presence of lesions (important in <3 years). - They are at various stages of development. - They are in unusual or clothing-protected areas (e.g. buttocks, inner thighs, back, trunk, genitals, and ears). - They have geometric shapes or forms that give away the object from which they were made. - There is ecchymosis on the forearms or iliac crests as a restraining mechanism. - They are found on the scalp associated with intracranial lesions. - Whenever they occur in children under 4 months of age. - Sentinel lesions: ○ 0-6 months: scratches, burns, oropharyngeal lesions (torn frenulum,

	both labial and lingual). o 6-12 months: fractures of long bones or cranial bones, intracranial haemorrhages. o Under 24 months: rib fractures, abdominal trauma, subconjunctival haemorrhages, and genital injuries. - The acronym TEN- 4 FACES in children under 4 years of age helps us to remember the locations of haematomas most suggestive of a non-accidental cause (see Figure 3). ▪ Human bite: the footprint of an adult person has a separation of more than 3 cm between canines. ▪ Traumatic alopecia due to intentional plucking located in the occipital or parieto-occipital area in various stages of evolution. ▪ Burns: o Clearly defined signs of the object that has produced the contact burn (cigarettes, iron, etc.) are recognised. o The edges of the wound, whether caused by scalding or contact, are sharp and precise, almost geometrical with no splash injuries. o Burns indicative of immersion in hot water, covering the entire surface of the hand (like a glove) or feet (like a sock) or fritter-shaped burns on the buttocks or genitals. o Presence of different burnt areas and in various stages of healing. ▪ Fractures. o Any fracture in a child who is not walking. o Multiple fractures or fractures at various stages of healing. o Metaphyseal fracture in a child under 1 year of age. o Diaphyseal spiral or oblique fracture of the long bones, especially in children under 3 years of age. o Posteromedial rib fractures in infants. o Cranial fractures: especially if they are bilateral, complex, and anfractuous, depressed, or crossing sutures. If the impact energy is extremely high, they are associated with subdural haematomas. ▪ Wounds or scrapes: on the mouth, lips, gums, and eyes; on the external genitalia; on the back of the arms, legs, or torso. ▪ Carer-induced factitious disorder[62]. ▪ Internal injuries such as subdural or dural haematoma, subarachnoid haemorrhages, retinal haemorrhages, retinal detachment, pulmonary or spleen haematoma, haemothorax, pneumothorax or chylothorax, among others.
Behavioural indicators in children and adolescents	▪ Shows caution about physical contact with adults. ▪ Seems to be afraid of parents or caregivers, to go home, or cries when school is over, and he/she must leave school or nursery school. ▪ They say that the person responsible for their care or colleagues have ever caused them harm. ▪ He/she is overdressed and refuses to undress in front of others. ▪ Feels inordinate concern about other children's crying. ▪ Displays extreme behaviours (e.g. extreme aggression or rejection). ▪ Tendency to loneliness and isolation.
Indicators of the person suspected	▪ Abused as a child. ▪ Uses harsh discipline, inappropriate to the age, the offence committed and the condition of the minor.

of violence[12]	▪ No, illogical, unconvincing, or contradictory explanations are given for the child's injury. ▪ It seems not to care about the child. ▪ Perceives the child in a significantly negative way, e.g. sees him/her as evil, perverse, a monster, etc. ▪ Abuse of alcohol or other drugs. ▪ Attempts to conceal the injury or protect the identity of the person responsible for the injury.

Illustration 3 Acronym TEN-4-FACES-p.



Source: with permission for its translation and adaptation in the spanish version[63] [64]

8.4. Sexual violence

According to legislation, sexual violence is considered to be acts of a sexual nature that are not consented[13] or that condition the free development of sexual life in any public or private sphere, including sexual aggression, sexual harassment and the exploitation of the prostitution of others,

[12] See footnote 10 on page 27.
[13] It should be noted that minors under the age of 16 cannot give consent, except in relationships between equals without any age or maturity imbalance. Furthermore, enhanced protection applies when the victim is between 16 and 18 years old, if there is an abuse of superiority or vulnerability of the victim. [65].

as well as all other crimes which, at the time of writing this protocol, are regulated in Title VIII of Book II of Organic Law 10/1995, of 23 November, of the Penal Code, specifically aimed at protecting minors. Also, sexual violence committed in the digital environment, which includes the dissemination of sexual violence through technological means, non-consensual pornography, and sexual extortion. Likewise, among the behaviours with an impact on sexual life, FGM, forced marriage, harassment with sexual connotations and trafficking for the purpose of sexual exploitation are considered sexual violence. This includes the homicide of women linked to sexual violence, or sexual femicide[34][65] .

It is important to note that children and adolescents who have been victims of CSV may initially appear to be asymptomatic, which does not mean that the events could not have occurred. In addition, they may not show rejection towards the person who has caused the abuse, especially if he or she comes from their immediate family environment. It is necessary to consider that, in sexual violence, the aggressor gradually establishes a strong bond with the victim to isolate her/him so that she/he does not ask for help or talk about the violent situation.

To support the assessment of sexual violence, there is the "*Guide of Common Basic Guidelines of the NHS for Health Care Action in the Face of Sexual Violence*"[66], the "*Common Protocol of the NHS for Health Care Action in the Face of Sexual Violence 2023*" [67], as well as the "Guide for Action in the Care of Minor Victims in the Institutes of Legal Medicine and Forensic Sciences (2018) "[68] and the "*Protocol for Forensic Medical Action in the Face of Sexual Violence in the Institutes of Legal Medicine and Forensic Sciences (2021)* "14[69].

Table 5. Indicators of sexual violence with more evidence. Adapted from [70,71]

INDICATORS	DESCRIPTION
Disclosure by the	The fact that a child or adolescent tells us that he or she has been a victim of CSV is one of the most powerful and specific indicators. Even if the explanations are

[14] At the time of writing this protocol, the *"Guide of Recommendations for Action by the Institutes of Legal Medicine and Forensic Sciences with Biological Samples and Evidence Collected and Sent by Health Centres in the Context of Organic Law 10/2022, of 6 September, on the Comprehensive Guarantee of Sexual Freedom"* is in the process of being approved. This guide will be of significant support in the event that the collection of samples and evidence by the healthcare centre becomes necessary.

victim.	inconsistent, contradictory or retract previous accounts.
Physical indicators in the child and adolescent	▪ Pain, itching, bleeding, or discharge from the external genitalia, vaginal or anal area, excoriations on the inner thigh. ▪ Erosions, bruises, and haematomas in the genital, anal or breast area. ▪ Neck or breast suggillation. ▪ Traces of semen, pubic hair, or specific antigens (e.g. acid phosphatase), in the mouth, anus, genitalia or on clothing. ▪ Sexually transmitted infections (STIs). ▪ Recurrent urinary tract infections. Vulvovaginitis. ▪ Foreign bodies in the bladder, vagina, or anus. ▪ Swollen or red cervix or vulva. ▪ Hymen ruptures. ▪ Ruptured anal sphincter. ▪ Thickening of perianal folds. ▪ Perianitis. ▪ Perianal warts. ▪ Single or recurrent multiple anal fissures, not secondary to constipation. ▪ Pregnancy (especially in early adolescence). ▪ Difficulty in walking and sitting of unknown cause. ▪ Torn, stained or bloody underwear.
Behavioural indicators in children and adolescents	We need to know about normal sexual development to be able to accurately assess inappropriate behaviours that may be related to CSV. Children's sexual play involves consensual and appropriate activities, serves the functions of satisfying curiosity and learning about sexual differences, and involves children at the same level of cognitive development. Inappropriate sexual behaviour cannot always be attributed to CSV. However, when present, they justify assessment. We must also consider other stressors (emotional abuse, physical abuse, family dysfunction, etc.) or inappropriate exposure to sexualised material. ▪ Strong resistance to genital exploration. ▪ She/he claims to have been subjected to conduct consistent with any form of sexual violence. ▪ Displays strange, sophisticated, unusual, or age-inappropriate sexual behaviour or knowledge (compulsive masturbation with objects, oral-genital fondling, asking to be touched in the genital area, sexually seductive behaviour, etc.). ▪ Early and age-inappropriate sexual knowledge. ▪ Sexualised behaviour or sexual assaults on other children. ▪ He or she may appear reserved, rejectionist or has childlike fantasies or behaviours, and may even appear to have maturational delay or regressive behaviours. ▪ Poor relationships with peers. ▪ Sleep and eating disorders. ▪ Post-traumatic stress syndrome. ▪ Psychosomatic symptomatology. Enuresis, encopresis. ▪ Low self-esteem. Night terrors. ▪ Anxiety, depression, dissociation, self-harm, ideation of self-harm attempts. ▪ Behavioural problems, criminality, and violence.

	▪ Sexual promiscuity, male or female prostitution. ▪ Sudden changes in behaviour. ▪ Symptoms, signs, behaviours or non-specific disturbances that may appear as reactions to stressful situations: crying, regressive behaviours, anxiety, isolation, lack of emotional self-control, repeated and varied phobias, extreme guilt or shame, functional disorders, aggression, runaways, excessive consumption of alcohol and/or other drugs, self-destructive behaviours or suicide attempts, criminality, decreased school performance, etc.
Indicators of the person suspected of violence[15]	▪ Extremely protective or jealous of the child or adolescent. ▪ Seemingly facilitating examinations, does not offer logical explanations for possible injuries; may have a good social image. ▪ Encourages the child or adolescent to engage in sexual acts or prostitution in the presence of the person suspected of violence. ▪ Exposes the child or adolescent to pornography. ▪ Difficulties in couple relationships. ▪ Childhood histories of physical, psychological, or sexual abuse. ▪ Abuse of alcohol and/or other drugs. ▪ Often absent from the home. ▪ Consumer of prostitution. ▪ Has been or is a perpetrator of gender-based violence.

8.5. Child trafficking and exploitation

Trafficking in human beings is the process of recruiting, transferring, harbouring, delivering or transferring control over a person by using violence, intimidation or deception, or by abusing a situation of superiority or of need or vulnerability of the victim, or by giving or receiving payments or benefits to achieve the consent of the person having control over the victim, with the purpose of subjecting the victim to exploitation [72][71][73], which can be applied to minors, on whom it can cause serious physical, psychological and developmental alterations in later stages. Even if none of the above-mentioned means of commission are used, any of the above-mentioned actions shall be considered as trafficking in human beings when carried out with respect to minors for the purpose of exploitation.

Exploitation is defined as "*the imposition of any work, service or activity, whether regulated or unregulated, lawful or unlawful, exacted from any person under domination or lack of freedom of*

[15] Refer to footnote 10 on page 27.

choice in the performance of that work, service or activity". This concept includes: slavery, servitude and forced labour or services; begging; engaging in criminal activities; the provision of sexual or reproductive services; the removal of organs or body parts or tissues; and the celebration of forced marriages or de facto unions, according to any rite [72][74]. The document on *Health Action against Trafficking for Sexual Exploitation* is annexed to the Common protocol for a healthcare response to gender violence in the National Health System *(NHS)*[75].

Table 6. Indicators of trafficking/sexual and labour exploitation of children in destination countries and cases of internal trafficking. Adapted from [70][76][77][78].

INDICATORS	Description
Indicators of control exercised by operators.	▪ Transfer to other cities or countries in a noticeably short space of time and without the child or adolescent being clear about where he or she is or how he or she arrived. ▪ Presence of an adult person watching and controlling a child or adolescent in the street. ▪ Mediation by an adult who has no family ties with the child or adolescent to avoid contact with social workers, police, or health personnel. ▪ Apparent voluntary escape from a reception centre. ▪ Lack of time for the child or adolescent to interact without a controlling adult with social service workers or health staff. ▪ Deep concern about lack of income and fear of being punished for it. ▪ A third person holds the child or adolescent's identity documents. ▪ The person claiming to be a responsible relative does not share genetic compatibility (DNA). ▪ Claiming to have incurred an elevated level of debt. ▪ The child or adolescent engages in physical activities or is on the street for prolonged periods of time in very severe physical or climatic conditions. ▪ The child or adolescent shows fear or anxiety, especially in the presence of the supervisor or accompanying person(s). ▪ Statements that are inconsistent or indicate indoctrination. ▪ People accompanying the child or adolescent show aggression towards the child. ▪ The child or adolescent has visible injuries.
Indicators of a child and adolescent's isolation due to the presence of exploiters	▪ Lack of knowledge on how to lead a normal life on their own. ▪ Poor knowledge of the local language. Extremely limited social life: lack of a network of friends other than "family". ▪ Social isolation and marginalisation. ▪ The child or adolescent does not know where he/she is and does not know his/her address. ▪ The child or adolescent has no or limited access to communication.

Indicators of violence, abuse, or neglect	▪ Physical signs of violence. Aspects related to the behaviour of the child or adolescent: - Habitual abuse of narcotic substances, particularly cocaine or similar. - Tendency to interact with others as if he/she constantly needs to outdo them or show them who is boss. - Changes in behaviour and different attitudes towards different people with whom he/she interacts. - Complete refusal to engage in dialogue (silence, keeping a distance, etc.). - Extremely hostile and defiant behaviour, both in body language and speech, like that found in an adult offending environment. ▪ CSV indicators. See previous section. ▪ State of denial and neglect of self-care or one's own needs. ▪ The child or adolescent shows signs of fear and anxiety. ▪ The child or adolescent makes statements that are inconsistent. ▪ People accompanying the child or adolescent show aggression towards him/her. ▪ The child or adolescent has visible injuries. ▪ The child or adolescent frequently goes to the emergency room for injuries, STIs, abortion, etc.

Source: Sexual violence against children. Child sexual abuse and exploitation. A guide to basic material for training professionals. Save the children. 2012[70]

8.6. Other types of violence

In addition to the types of violence listed above, attention should be paid to signs of other types of violence:

a) Gender-based violence. The legislative framework recognises the condition of direct victims of gender-based violence to children and adolescents, by the mere fact of living in an environment with such violence, since this circumstance implies psychological abuse in all cases, to which can be added physical, psychological and sexual abuse of the minor by the abuser [4] [79] [80].

In addition, gender-based violence can also occur between teenage partners or ex-partners, as well as in young girls by men other than their partners. The approach to gender-based violence in women over 14 years of age is included in the protocols for action on gender-based violence, both in the "Common protocol for a healthcare response to gender violence" and in the regional protocols developed subsequently [42]as well as in the regional protocols

developed subsequently. However, the detection of this type of violence in the adolescent population may go unnoticed by healthcare system staff, as this is an age group that transits less frequently through the healthcare system after the end of the paediatric follow-up period. It is important to guarantee in all cases the necessary protection and health care, especially specialised and quality mental health care, and the necessary measures for the recovery of the victims' life project (academic, family, and social).

b) Genital mutilation. There is a common protocol for health action on Female Genital Mutilation [81].

c) Prenatal and perinatal abuse. Risk factors or vulnerability indicators[82] [83]**.**

Prenatal and perinatal risk factors or indicators of vulnerability may include aspects such as:

- Unwanted or overestimated pregnancy.
- Maternal age and age of upbringing figures (adolescents, late pregnancies).
- Short pregnancy interval (less than 18 months).
- Very unfavourable socio-economic situation.
- Foetal abnormalities or malformations.
- Disability and special needs without support or resources.
- Perinatal mood and anxiety disorders [84].
- Lack of follow-up/care during pregnancy and puerperium.
- History of voluntary or non-spontaneous abortions.
- High-risk use of alcohol, tobacco or other drugs or psychoactive substances[16].
- History of violence or abuse. Gender-based violence can occur or increase during pregnancy [85] and is associated with an increased likelihood of miscarriages, stillbirths, premature births and low birth weight babies, as well as behavioural and emotional disorders, and higher rates of mortality and morbidity in infants and children.

[16] The consumption of any of these substances during pregnancy is considered risky, and therefore, the recommendation is to avoid their use.

The objective of the assessment and intervention is to establish a supportive relationship with the pregnant individual[17] and her environment, which prevents or stops the abuse, reducing or eliminating the risk factors to avoid reaching alarm indicators [86].

Prenatal and perinatal abuse is those actions or omissions of the pregnant individual or her environment that negatively or pathologically influence the pregnancy and perinatal period, endanger the health of the foetus, or cause it, directly or indirectly, harm. Prenatal and perinatal abuse is also considered to be any abuse of a woman, with a special focus on gender-based violence, or of other pregnant women, as there is a high prevalence during pregnancy [82][85,87,88] . Prenatal and perinatal abuse can sometimes be identified by the involvement of the foetus or detected or manifested after birth.

Prenatal and perinatal risk and abuse can cause harm or health problems after birth, which may condition development later in life and increase the risk of abuse. The upbringing and parenting are complex processes, marked by society and culture as well as one's own capacity and experience, so that care for the gestation process should seek to offer a healthy experience free of any kind of discrimination and violence of the pregnancy and birth process [85], including addressing the experiences of abortion, foetal and neonatal death [86].

d) **Caregiver-induced factitious disorder.**

Refers to clinical situations where a child or adolescent receives unnecessary and harmful or potentially harmful medical care due to the overt actions of a caregiver, including exaggerating symptoms, lying about the history or simulating physical findings (fabrication), or intentionally inducing illness in the child or adolescent [89]. The most significant difference with other forms of abuse is the involvement of health care professionals as unwitting but sometimes necessary instruments of abuse. Detection is difficult and depends on the recognition of warning signs that should arouse suspicion[90]. Over time it has received different names, also known as Munchausen syndrome by proxy, factitious disorder inflicted

[17] When we refer to pregnant women and/or pregnant people, we are addressing both women and individuals who are pregnant.

on another (DSM-5) or medical child abuse in the American literature, where the health care professional is understood as a tool to cause harm.

Diagnosis is particularly complicated because detailed anamnesis of the caregivers, which is an unbelievably valuable tool for diagnosis, becomes ineffective and even counterproductive. In clinical practice, when the findings do not coincide with those expected, it is necessary to assess whether the care that the minor is receiving may cause potential or actual harm[91], and it is important to collect information from other care centres to which he/she may have attended. Identifying and responding to this complex form of child maltreatment requires carefully coordinated multidisciplinary intervention[90].

e) **Violence in institutions**.

Dysfunctional institutions and administrations, as well as difficult access to victim services and bureaucratic obstacles hinder the exercise of children's rights. In the health sector, the failure to adapt facilities, procedures or professional actions to the rights, stage of development, disability, personal characteristics and emotional state of the child or adolescent victim of any form of violence, as well as the lack of training that can lead to difficulties in diagnosis (under-diagnosis) and in the rest of the actions (notification, intervention and follow-up), can lead to obstacles to access as well as contribute to secondary victimisation[18], which ultimately leads to the lack of protection for victims[10].

f) Other practices affecting the health, integrity, or rights of minors.

a. **Submission and/or chemical vulnerability (CS&V)**. It includes chemical submission (CS) when psychoactive substances are administered surreptitiously and chemical vulnerability (CV) when voluntary use of alcohol, other drugs, or medication results in diminished capacities. Good Practice Guidance for Forensic Action for the Victim of a Substance-Facilitated Crime: Intervention in Suspected Chemical Submission (2022) is available[93][93].

b. Assault on adolescents by sharp object ("prick"). There is a document available on the Common Basic Guidelines of the NHS for health action in cases of assaults on

[18] Secondary victimization refers to harm that arises not directly from the criminal offence itself, but from the response of public or private institutions and other individuals towards the victim. [92]

women by sharp objects ("prick") in leisure contexts [94][94], which is also applicable to children and adolescents.

c. **Bullying between minors, especially bullying in the school environment.**
d. **Cyber-bullying**[95][95]**.**
e. **Public dissemination of private or privacy-intrusive data or audiovisual material.**
f. **Forced and child marriage.**
g. **Hate violence.**[96][97]

It is important to bear in mind that different types of violence can co-exist.

This protocol provides a general approach to all types of violence against children and adolescents. In the future, specific materials will be developed for those types of violence with particularities with respect to this general procedure.

9. Differential diagnosis

Differential diagnosis should be made with other probable causes that could explain the symptoms or signs, to confirm or rule out the consideration of a possible indicator of violence.

See Annex 3.

10. Initial assessment of violence in children and adolescents

10.1. Recommendations for assessment

It is vital to take into account specific aspects and recommendations during the care of the child and adolescent to prevent secondary victimization, enhance their well-being, and facilitate a comprehensive and accurate assessment. [5] [7] [57]

- Attention should be focused on the best interests of the child or adolescent above all other considerations, as established by the Committee on the Rights of the Child (2013) in its General Comment No. 14 (2013)[98] , always respecting their dignity, privacy and right to participation, confidentiality and ensuring their protection through safety assessments. For children and adolescents with disabilities, it is essential to ensure that the entire process is

fully accessible. A formal assessment of this interest must be conducted, as it is unique to each child or adolescent.

- Place the child or adolescent in a quiet and appropriate space, accompanied by an adult of their choice, unless a reasoned decision excludes this person, or their presence is deemed to hinder communication between the child or adolescent and the healthcare professional. In such cases, it is recommended that the child or adolescent be accompanied by at least two staff members from the corresponding institution.

    - Whenever possible, ask the child/adolescent if they prefer to be attended by a woman or a man, or by someone younger or older. Whenever possible, the child/adolescent should be attended to by the most experienced healthcare professional, accompanied by another professional who will serve as an observer and witness to the interaction. It is recommended that these professionals remain consistent throughout the process.

    - Foster a climate of trust by maintaining an empathetic attitude and encouraging open communication. This involves establishing a collaborative, non-paternalistic relationship that allows the child/adolescent to express their feelings freely.

    - Isolate the child or adolescent from potential perpetrators by conducting a thorough safety assessment. Implement all necessary measures to safeguard the child or adolescent's best interests, which may include hospitalization if required.

    - It is crucial to coordinate the involvement of all professionals engaged in the assessment and care processes, ensuring a comprehensive evaluation and examination ideally conducted in one session and as promptly as possible. This must respect the child or adolescent's timelines and involve clear communication about each step of the procedure, both to the child or adolescent and their legal representatives or trusted person, with the child/adolescent's consent. This approach helps prevent secondary victimization and supports informed decision-making and follow-up care.

    - If translation, interpretation, or sign language support is needed, trained staff of the child or adolescent’s preferred gender should provide it to ensure universal access to comprehensive and quality care. Visual aids, hearing and communication aids and age-

and disability-appropriate terms, as well as instruments[19] and positions that minimise physical discomfort and/or psychological distress, explaining what to expect after the test and giving instructions for follow-up will be used.

- It is essential to train healthcare system professionals who work with children and adolescents to effectively assess cases of violence.

During the interview/anamnesis , children and adolescents are often wary of adults, reject physical contact and refuse to talk, so it is recommended that an appropriate atmosphere be established with general and neutral questions, as well as an assessment of their capacities, in order to adjust to the age, disability and degree of maturity of the child or adolescent, using accessible and non-stigmatising language and terminology and the necessary communication support. Additionally, the child or adolescent should be informed about the process, including aspects related to the confidentiality of the information shared during the interview. This includes the necessity of communicating certain information to relevant protection bodies and agencies. Depending on the assessment of the child/adolescent's capacity, their consent should be sought for this communication.

Listen attentively, demonstrating genuine interest in both verbal and non-verbal cues. Avoid interpreting or judging the child/adolescents' words. Express mutual understanding and validate their experience, praising their courage for sharing. Aim to counteract any feelings of guilt and reinforce the supportive role that social and healthcare professionals can play. It should be borne in mind that on many occasions the child/adolescent's feelings and thoughts about the experience can become fragmented and disorganised, finding it very difficult to make sense of or explain what is happening[99]. Ask clear and open-ended questions, avoiding closed or judgmental inquiries that could influence the child/adolescent's account. Record the child/adolescent's testimony using quotation marks. Encourage the child or adolescent to express themselves freely, using drawings or other resources if they wish. Conclude the

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Specula or anoscopes, as well as digital or bimanual examinations of the vagina or rectum of a prepubertal child, are not routinely required unless medically indicated. If a speculum examination is necessary, sedation or general anaesthesia should be considered, and the need for it should be explained to the child or adolescent [5].

conversation in a relaxed manner by discussing topics that interest the child or adolescent. It is crucial to remember that the purpose of the interview is health-focused, aimed at gathering the necessary information for clinical care and reporting. Avoid revisiting unrelated topics that could distort the testimony, as this may be the only evidence available. Such aspects should be reserved for the forensic interview. Coordination among various levels of care is essential.

After the interview, a **thorough and complete clinical examination** should be considered **, coordinated with the clinical and/or forensic specialists if appropriate,** which should be carried out in a calm atmosphere and as quickly as possible, although allowing time to coordinate it in the best conditions and always respecting the child/adolescent's time. The child or adolescent should not be compelled to undergo a physical examination. A dialogue should be conducted with the child/adolescent using language that is adapted to their developmental stage and capacities. The need for and characteristics of any examinations should be clearly explained, always prioritizing the child's well-being.

The actions of all specialists involved, including the forensic expert, should be closely coordinated to minimize the repetition of examinations. The number of examinations should be kept to an absolute minimum, ensuring they are strictly necessary to prevent any potential secondary victimization.

Biological samples and evidence should be collected as a priority by forensic medicine. Those exceptionally collected at the health care facility shall be duly preserved for referral, ensuring the chain of custody and as immediately as possible, to the Institutes of Legal Medicine and Forensic Sciences Institute of Legal Medicine and Forensic Sciences (IMLCF). The duration and specific conditions for storage shall be established by scientific protocols set forth by the competent authorities[65,69,93].

Comprehensive documentation of visible injuries to the minor is recommended, utilizing audiovisual methods to facilitate review by other professionals and to serve as evidence in court. If necessary, this documentation may be admissible as evidence in criminal proceedings. Therefore, it is recommended that protocols be established for the production, management, and custody of these materials.

In addition, it is necessary to take care of the **interaction with the caregivers**. Those caring for or accompanying the child or adolescent can serve as crucial support; however, they may also be the individuals who perpetrated the abuse, allowed it to occur, or feel powerless to intervene. Additionally, it should be noted that they may also be victims of gender-based violence or other forms of abuse. There should be an opportunity for separate discussions with the child/adolescent and their accompanying individuals. It is essential to provide accompanying persons with relevant information, encourage their participation in the process, and offer support while treating them with respect. This approach should be non-confrontational, avoiding blame or stigmatization. Professionals should acknowledge the positive aspects of their involvement, explain the potential health consequences of abuse or neglect, clarify the importance and possible side effects of any interventions, and outline the options and rights regarding consent to or refusal of treatment for the child or adolescent. Additionally, it is crucial to communicate the limitations of confidentiality and the obligations for reporting. If violence is suspected, the concern for the child/adolescent's health and well-being should be explained and that it needs to be addressed, either as a matter of urgency or in regular procedures[7], considering what information can be shared and with whom [5].

If it is known or suspected that the accompanying individual is the aggressor, the safety of the child or adolescent must be the top priority. The individual should be prohibited from having any further access to or accompanying the victim to prevent any potential pressure or intimidation that could silence the victim. If necessary, judicial assistance will be sought for admission or precautionary measures, and the appropriate security and police forces and centre security will be notified.

For more information, it is recommended to consult the document Action in the care of child victims in IMLCFs [58].

10.2. Assessment procedure

In general, information will be collected regarding the type of violence (see Table 1), the context (family or extra family), the relationship with the aggressor, the timeframe of the aggression (recent or not), frequency (single or multiple incidents), number of aggressors (one or multiple), methods employed (such as seduction, threats, deception, coercion, isolation, etc.), and the

nature of interaction (face-to-face or remote). Furthermore, a psychosocial risk assessment should be conducted if it has not already been performed.

In the initial biopsychosocial assessment of cases of violence against children and adolescent in healthcare settings, the process should commence with a comprehensive evaluation. This initial assessment will inform critical decisions based on clinical severity, life risk, safety (including the level of protection needed), risk of recurrence, and the vulnerabilities associated with identified risk factors.

10.2.1. Assessment of vital risk and clinical severity.

It is considered life-threatening:

- When there is a risk of death—whether that risk has previously existed or could arise if the situation of violence recurs or continues to occur—it is imperative to take immediate and decisive action to ensure the child/adolescent's safety and well-being.
- When there is a serious impact on the child/adolescent's health, evidenced by injuries or illnesses that require hospitalization or may result in lasting effects, urgent intervention is necessary to address their medical needs and ensure their safety.
- When there is a mental health disorder.
- Suicide risk.

Clinical severity refers to the intensity or severity of the harm suffered, or estimated in the medium and long term, by the child or adolescent in a situation of violence. The following factors should be considered in their assessment:

- Types of harm can be categorized based on their impact on the physical or psychological integrity of the child or adolescent.
- Location and severity of injuries.
- Level of vulnerability of the child or adolescent: age, previous illness, disability, etc.
- Signs of negligence.
- Possibility of sample collection in cases of recent sexual violence.

The physical and psychological examination should include:

- An examination should focus on observing and documenting the child/adolescent's overall behaviour (cooperative, suspicious, etc.), emotional state (such as sadness, anxiety, or panic), body language, and interactions with both professionals and accompanying individuals. This includes noting whether the child or adolescent seeks support from these individuals or displays signs of suspicion or fear. It is also important to record hygiene, clothes worn, childcare supplies, etc.
- A somatometry (height, weight and head circumference) should be taken and reflected in a growth chart [100].
- Assess and document the child/adolescent's stage of sexual development using the Tanner scale.
- Assess the presence of sentinel lesions (table 4).
- Conduct organ and systems screening, and as needed, request necessary complementary tests and referrals to other specialties, seeking to minimise additional harms, including trauma, fear and distress, and respecting the autonomy and wishes of the child or adolescent[5].
- The Adams classification (Annex 2) [101] can be consulted to assess the diagnosis of CSV.
- The general or gynaecological examination may be conducted under general sedation if the victim exhibits significant agitation or an elevated level of spasticity due to a disability, as this approach may help minimize discomfort. Informed consent must be obtained prior to the procedure.
- The Healthcare System will facilitate a psychopathological examination conducted by professionals specialized in assessing child victims of sexual violence, either within the Mental Health Teams of the NHS or in designated Units or Concerted centres that are equipped to gather pre-constituted evidence[20].

10.2.2. Security assessment (risk of unprotectedness).

The assessment of security is essential to determine the guarantees of protection or threat to it of

[20] For more information on pre-constituted evidence, refer to the *"Guide of Good Practices for the Declaration in Criminal Proceedings of Minors and Persons with Disabilities in Need of Special Protection: Intervention from Forensic Psychology, in Particular in Pre-constituted Evidence"* [27][27].

the child/adolescent's protection. In addition to the assessment that can be carried out for this purpose on the person in charge and/or accompanying the child/adolescent and the child or adolescent, the HSW carries out a subsequent exhaustive assessment considering:

- Who has the responsibility for the care of the child or adolescent, and other minor in the family.
- What care is required (according to age, health situation and personal autonomy - disability, dependency, etc.).
- What are the characteristics of care provision (attitude and capacity of carers, organisation of care, etc.)?
- What protection guarantees can be ensured (effective support, protection capacity to prevent recurrence, etc.).

Always considering the coherence of the explanations given, whether there are doubts about the possible authorship of the persons responsible, etc.

10.2.3. Assessment of recurrence risk

Se valorará el riesgo de recurrencia, es decir, la probabilidad de que una situación de desprotección y/o daño pueda ocurrir o vuelva a ocurrir, pudiendo poner en peligro la integridad o el desarrollo integral de la persona menor de edad. This risk can be assessed based on:

- History, frequency, and/or chronicity of episodes of violence.
- Behavioural characteristics and parental capacities of the caregivers, non-family environment and/or the child or adolescent.
- Existence or not of protective/disprotective factors in the family environment (including suspicion of gender-based violence).
- Existence or non-existence of protective/unprotective factors in the extra-familial environment where the violence is taking place: school, peers, social networks, etc.

10.2.4. Procedure depending on the outcome of the evaluation.

According to the clinical and social circumstances, and the information obtained up to this point, the team[21] should decide whether to proceed with an ordinary procedure or an emergency procedure:

Emergency procedure:

This is initiated in cases where there is a life-threatening risk (whether physical or psychological/emotional) to the child or adolescent, or when sampling is necessary due to the potential loss of evidence:

- In cases of recent sexual violence, forensic sampling is indicated within 72 hours (including instances of anal penetration) and can be conducted up to 7-10 days following vaginal penetration. If there is any doubt regarding the time for collecting samples, it is advisable to consult the correspondent IMLCF, including reaching out to on-duty forensic experts for urgent cases.

- There is, has been, or may be a risk to life:
  - Risk of death.
  - There is a significant impact on health, both physical and psychological, due to the presence of injuries or illnesses.
  - Injuries or illnesses necessitate hospital treatment.
  - Injury or illness may leave physical or psychological sequelae.
  - There is great psychological distress or risk of suicide.

- She/he is at risk of being unprotected from violence:
  - There is no adequate protective family attitude or capacity to modify or prevent the situation of abuse or violence.
  - Repeated negligence with damage or risk to health.
  - They do not offer logical explanations as to the possible perpetrators or the mechanisms of injury production.

[21] See footnote 8 on page 19.

- The individual within the family environment is suspected of being the perpetrator of the injuries, sexual violence, or any form of abuse.

Similarly, if the case is identified in a non-hospital setting (such as primary healthcare center, out-of-hospital emergencies, or mental health services), an assessment will be conducted to determine whether it is necessary to transfer the child/adolescent to a hospital. If necessary, it is recommended to contact the professional on duty at the hospital by telephone and to ensure safe transfer, especially in the case of suspected domestic abuse, including contacting the SPF if necessary. In these cases, the assessment should be brief if the clinical situation of the child allows it, so as not to hinder the questioning, examination and taking of appropriate samples to be carried out in the hospital setting. If involuntary admission is necessary due to the circumstances of the violent event or to protect the victim, the court will be contacted, following the legally established procedure. The indications for hospital admission are:

- Need for specialised assessment, clinical tests or studies or treatment in a hospital service.
- Need for immediate protection of the minor. If the Court or the competent Social Services decree a situation of helplessness, and it is necessary for them to remain in the health centre.

Ordinary procedure: This process is initiated when there is no immediate physical or emotional risk, or lack of protection, and when there are diagnostic uncertainties that necessitate a more detailed assessment and interdisciplinary collaboration to establish a diagnosis and notify the appropriate authorities. If the HSW or specialized units are not informed, the medical and/or nursing professional caregivers of child or adolescent should reach out to these departments to coordinate actions with the family and the child/adolescent's environment, including school, peers, and neighbourhood, as necessary. This collaboration should also involve other professionals who need to be consulted to achieve a diagnosis once all relevant circumstances have been clarified.

11. Notification.

The LOPIVI establishes "*the duty of qualified communication*" as the special responsibility in the duty to notify, due to their qualifications, of those persons who, by reason of their position, profession, trade or activity, are entrusted with the assistance, care, teaching or protection of children and, in the exercise of these duties, have become aware of a situation of violence exercised against them.

This definition encompasses the health sector and establishes the obligation for immediate communication with the relevant social services. Furthermore, when such violence poses a risk to the health or safety of the child or adolescent, it must be reported immediately to the appropriate: security and police forces and/or the duty court or public prosecutor's office.

The child, adolescent and caregivers should be informed about the notification and its purpose, which is to clarify whether or not there is a possible situation of violence and to establish measures to prevent and reverse this situation and its adverse effects.

Notification procedure:

- who makes the notification?

  The healthcare professional caregivers of the child/adolescent's care. In cases where a referral from primary healthcare (PHC) to hospital care (HC) is necessary, the notification will be processed in the appropriate area, recognizing that notifications can originate from multiple sources.

- when to notify?

  According to LOPIVI, professionals must notify when they become aware of or become aware of indications of the existence of a possible situation of violence that deprives minors of their rights and well-being, which threatens or interferes with their orderly physical, psychological, or social development.

  The healthcare centre team will consider two approaches for this process: ordinary and urgent, as outlined in Section 10 on assessment of this protocol.

  In urgent cases, as previously described, communication should be made immediately, preferably via telephone.

- who to notify?

    - In all cases of suspicion or evidence of violence, it is essential to notify the appropriate social services.

        - As a general rule, if the risk of unprotectedness is mild or moderate, it will be reported to the MSS, and if it is severe, to the PEPC.

    - In addition, other authorities such as the court (through the injury report), the public prosecutor's office or the SPF must be notified.

        - The duty court, after receiving notification from the health care centre, may request the intervention of the IMLCF if the circumstances so require.

        - The healthcare professional responsible for their care may also consult with the Public Prosecutor's Office.

        - Consider notifying the SPF in urgent cases, with injuries or where the health or safety of the child or adolescent is threatened.

- how to notify?

  By sending, preferably electronically, the notification documents already available in the different settings:

    - Notification document for Social Services/Public Child Protection Agency.
    - Injury report for communication with the court[22].

  In case of emergency, also contact them by telephone.

- An anonymous reporting mechanism should be in place, preferably 24 hours a day, 365 days a year, adapted to the evolving capacity of children and adolescents, for any cases of violence or secondary victimisation in the healthcare system.

[22] If the examination is conducted jointly with forensic medicine, the forensic medicine team will complete the injury report. In any case, the health professional must document the assessment in the discharge report.

12. Intervention and follow-up

The healthcare system plays a crucial role not only in providing care but also in the secondary prevention (early detection) and tertiary prevention (management and recovery) of violence against children and adolescents.

All children and adolescents who have experienced violence should receive comprehensive, specialized, and multidisciplinary therapeutic care in welcoming and fully accessible environments. This care is essential regardless of whether protective measures are needed or the nature of any judicial proceedings that may arise. This care should be provided publicly, free of charge, and universally across the entire country, within the shortest possible time and in accordance with correspondent legislation. The principle of the best interests of the child or adolescent must guide it, as it is a fundamental part of their rights to health, life, and holistic development, as well as their right to be free from any form of violence or abuse.

A child or adolescent who perpetrates violence is also an individual in need of specialized care. Therefore, when a child or adolescent is identified as experiencing violence, an investigation into the potential causes will be conducted. This is crucial given the high likelihood that the child/adolescent is either a victim of or a witness to some form of violence. It is essential to ensure that the child or adolescent receives protection and specialized therapeutic support, along with ongoing follow-up and coordination.

Similarly, children or adolescent who witness violence between others, particularly when they have an emotional connection to those involved, should not merely be regarded as witnesses; they must also be recognized as victims of violence. In the case of children of women who are victims of gender-based violence, this situation is explicitly addressed in current legislation[80].

This specialized and multidisciplinary care should encompass emotional support and, if necessary, therapeutic guidance for the families of children or adolescents who have experienced or perpetrated violence. These families play a crucial role as guarantors of the children/adolescent's well-being and emotional stability throughout the process[102] [103] [104].

The assistance provided to children and adolescents should include the following elements:

- Coordinated anamnesis and examination.
- Attention to injuries or physical alterations resulting from the situation of violence, as well as any other observed health issues (vaccinations, psychomotor growth, and development, etc.).
- Sampling.
- Assessment of infectious disease prophylaxis (tetanus, etc.)
- In cases of sexual violence, the need for STIs prophylaxis, as well as the indication for emergency contraception or voluntary termination of pregnancy, should be assessed.
- Address the basic needs, wishes, and concerns of the child or adolescent while remedying deficiencies in stimulation, emotional support, education, and nutrition. Provide caregivers with resources and training to develop skills in stimulation and care, along with psycho-educational guidelines to address identified needs, emphasizing positive and non-punitive upbringing methods[105].
- Evaluate and address the psychological consequences of maltreatment that the child or adolescent may experience, both during the initial assessment and throughout the follow-up process. If psychiatric and/or psychological treatment is deemed necessary, a referral to specialized child and adolescent mental health teams should be prioritized, particularly in urgent cases[104].
- Facilitate access to specialized resources that support the recovery of the child/adolescent's life project and promote social inclusion, such as educational reinforcement programs and opportunities for youth employment, etc.

Additionally, it is a priority to ensure protection in cases where maltreatment is suspected to be occurring within the family or foster care environment, particularly when this poses an imminent risk to the child/adolescent's life or physical and psychological integrity. Coordination with the Integrated Public Family Protection (IPPF) or Municipal Social Services (MSS) can provide valuable information regarding past and current interventions involving the child or adolescent.

The team[23] will draw up an **intervention plan**, coordinated and agreed by the professionals involved, establishing a follow-up schedule for each case, as well as the necessary referrals to other bodies after the assessment and indicating the support resources required, in the case of children or adolescent with disabilities. Within the framework of this intervention plan, the HSW will provide necessary support and accompaniment measures for the child or adolescent and their family. They will also coordinate interventions to ensure continuity of care across various levels of healthcare and between care settings, facilitating referrals when appropriate.

While it is essential for all professionals in the healthcare system who interact with children and adolescents to receive basic training in the prevention and response to violence, some AACC are developing specialized units for addressing these issues. These include social paediatrics units, Barnahus projects, specialized courts, and other initiatives. Coordinating these specialized units with primary healthcare and interprofessional, inter-institutional mechanisms is crucial for effectively supporting victims and combating violence against minors. It is crucial to identify these units in each territory and establish coordination mechanisms, as outlined below.

It is important to emphasize that interventions involving children and adolescents with severe neurodevelopmental issues, disabilities, mental health challenges, or any other situation of special vulnerability and social risk—such as contexts of gender violence—must address their specific needs. Strengthening coordination with specialized entities, such as those focused on the care of individuals with disabilities, is recommended to ensure comprehensive support.

If the child, adolescent and/or accompanying person show difficulties in contacting other resources, the necessary support should be provided[7].

In cases of intra-familial violence where family intervention is necessary, such intervention should be conducted outside the sphere of the aggressor(s), particularly in situations involving sexual violence or gender-based violence. This approach should be coordinated with the appropriate specialized teams.

[23] See footnote 8 (page 19).

There must be ongoing monitoring and support for the victim until full recovery is achieved, recognizing that the effects of violence can develop over the medium and long term. This follow-up should extend for as long as necessary and should also involve interventions with the family unit to create the most supportive environment possible for the recovery of the child or adolescent.

13. Recording in medical records and reports.

When violence is suspected or confirmed, it is very important to observe and record in the MR all the information gathered in the anamnesis (what is said and how it is said) and the clinical examination (type of injury, location, date of injury, how it occurred, adequate correlation of the explanation with age, severity, pattern and distribution of the injuries and the probability of non-accidental causes of the injuries , etc.), diagnostic and therapeutic guidance, support and communication measures and resources required in the case of the child or adolescent with a disability, as well as coordination between the professionals involved. The child/adolescent's behaviour, including non-verbal language, along with the behaviour of the caregiver or accompanying persons and their interactions with the child or adolescent, should be carefully documented. Finally, it is advisable to document in the MR any civil or criminal measures taken, such as custody arrangements, parental authority decisions, or restraining orders, as necessary for the information of those caregivers of the child/adolescent's care.

The episode of violence will be documented using the coding system established in each AACC until standardized criteria are developed at the national level, as outlined in the section on recording in the MR. This process will ensure confidentiality in accordance with current legislation.

The clinical, social, and forensic reports will be prepared, as necessary. Special reports may be generated as needed, such as in cases of female genital mutilation (FGM), prenatal abuse, and other specific circumstances.

14. Interdisciplinary coordination and referral to other professionals.

It is crucial to establish procedures that ensure coordination among professionals in public administrations responsible for addressing violence against children and adolescents. This collaboration will enhance assistance and provide effective protection in situations of risk and lack of protection, while also minimizing the risk of secondary victimization for the affected children and adolescents.

This coordination must occur both within and between health institutions, as well as with other entities involved in the process, such as:

- Municipal social services / Public child protection agency.
- Court (including IMLCFs) and prosecutor's office, facilitating protocolised procedures for notification and consultation.
    - It is advisable for the IMLCFs to have access to the electronic health record (EHR) through appropriate collaboration agreements, like those already established in some regions.
- SPF
    - Sometimes it is necessary to rely on the SPF for transport to the health care centre or for the custody of samples, for example. Depending on the circumstances, it may also be necessary to activate the security service of the health care facility.
    - There are specialised units dealing with violence against children and adolescents:
        - GRUME: from the Spanish Judicial Police Group specialising in minors, integrated into the Provincial Judicial Police Brigades.
        - UFAM: from the Spanish Family and Women's Care Units. National Police units specialised in the prevention and investigation of criminal offences of gender, domestic and sexual violence.
        - EMUME: from the Spanish Women and Minors Team of the Guardia Civil, Spain's national security and police forces, especially in rural areas.
- OAVD: from the Spanish Office for assistance to victims of a violent crime or a crime against sexual freedom. These offices support and accompany victims of crime, comprising a multidisciplinary team that typically operates under the department of justice. According to the LOPIVI, they serve as a coordination mechanism for various resources and services dedicated to the protection of minors.
- The educational settings. It is crucial to engage in prevention, detection, and recovery efforts

through programs that focus on educational reinforcement, curricular adaptation, social inclusion, promotion of fair treatment, and violence prevention, as well as facilitating their involvement in monitoring the progress of victims.

- Third sector entities.

To ensure effective coordination, it is recommended to establish an organizational structure within each care centre, integrated into the portfolio of services and aligned with the centre's objectives. Regional health structures[24] can also be considered that provide services to several centres, with professionals and units with a higher degree of specialisation that act as a reference, distributed throughout the territory to guarantee accessibility and quality of care. In some AACC, these integral units or referral care units already exist.

It is advisable to establish or utilize existing coordination structures within the territory that encompass various sectors related to health. These structures should facilitate the prevention and management of cases of violence against children and adolescents. An example of this could be the interdisciplinary area units or initiatives such as the Barnahus model for assessment and care of sexual violence against children[106], where all the agents involved are brought together in one place and direct actions with children and adolescents are carried out, such as counselling, initial assistance, pre-constituted evidence, therapeutic intervention and social and judicial counselling.

The development of intersectoral coordination protocols will be promoted at regional and municipal level, including at health centre level, where communication and coordination between the professionals of each institution is defined and facilitated and identified in the territory [107]the development of a map of health assets, as well as a directory that identifies the resources to be notified, and those that can provide support, could be useful [7].

[24] Evaluate the establishment or expansion of interdisciplinary committees at the health area level to coordinate the most complex cases, like the gender violence committees already present in some regions, which could serve as a model. These committees would include trained professionals from both hospital and primary health care settings, such as paediatrics, emergency care, gynaecology, general and community medicine, mental health, social work, and legal services. When necessary, representatives from education, social services, and other relevant entities could also be incorporated.

Lastly, coordination between AACC is crucial, particularly when a child or adolescent victim of violence relocates to another region. It is essential to guarantee continuity of healthcare and, whenever possible, to ensure effective communication with the child/adolescent's new healthcare team. Access to the health records (HR) and clinical and social reports should be facilitated nationwide to ensure effective follow-up for child and adolescent's victims of violence.

15. Monitoring and evaluation of the protocol.

Both the implementation and the outcomes of this protocol regarding the quality of care, protection, and recovery of vital projects must be evaluated using indicators that allow for the assessment of its impact and compliance. This will help identify areas for improvement and establish corrective measures as needed. A proposal for process and outcome indicators will be developed in a later phase, and these indicators will be reviewed and defined for periodic reporting.

For the purposes of this protocol, a case of violence is defined as any instance involving a child or adolescent victim of violence that is identified and recorded by healthcare professionals within the National Healthcare System (NHS). An in-depth study is necessary to establish indicators and, in parallel to the efforts made within the Healthcare System's approach to gender-based violence, to achieve a consensus on best practices and metrics.

- Common criteria for the entire NHS should be established concerning the specific codes within health information systems. These criteria will enable the cataloguing of cases of violence against children and adolescents and facilitate the development of standardized epidemiological indicators related to violence within the NHS.

- A standardized computation method should be implemented to extract a comprehensive overview of all detected and registered cases within the NHS.

- Indicators of magnitude, characteristics of violence, and of the children and adolescents.

- Disaggregation variables (geographical location, age groups, sex, type of disability, country of birth, etc.).

It is important to note that this protocol only identifies cases that come to the attention of the healthcare system. Determining the dimensions and characteristics of the issue necessitates effective

coordination among all parties involved, along with prevalence studies.

It is also important to evaluate the participation of victims and their families, as well as their level of satisfaction throughout the care process, using satisfaction surveys or similar tools.

16. Annex

Annex 1. Adverse Childhood Experiences and Beneficial Childhood Experiences.

Adverse Childhood Experiences (ACEs) [108][109][110][111][112] are defined as disruptive, chronic, or recurrent distressing events that have cumulative effects of varying severity and consequences for an individual's physical, mental, and social health throughout their life. The accumulation of ACEs in a child or adolescent increases the risk of significant physical and mental health problems, both in the present and future. It may also lead to criminal behaviour, heightened violence, substance abuse, and emotional, occupational, and relational difficulties throughout their entire life cycle [112] [113] [114].

Table 7: Adverse Childhood Experiences (ACEs)

Category.	Items
Violence and Neglect	- Psychological Abuse - Emotional neglect - Physical abandonment - Physical Abuse - Sexual violence
Family dysfunction	- Gender-based violence - Other domestic violence - Substance abuse - Mental illness in carers - Complex divorces - Imprisonment of the father and/or mother - Inter-parental conflict - Death of father and/or mother
Adversity in the social environment	- Witness to violence in the community - Loss of trust or relationships in the neighbourhood - Discrimination: race, religion, culture, etc.
Other	- Peer harassment - Institutionalisation in the protection system - Chronic illness - Poverty/Low socio-economic status

Source: Modified from Finkel or [115].

In this regard, it is noteworthy that Beneficial Childhood Experiences [110] have a cumulative effect on lifetime mental health outcomes, and buffer the negative health effects caused by exposure to ACEs.

Table 8. Beneficial childhood experiences [110]

- Feeling able to talk to your family about your feelings. - To have felt that your family supported you in tough times. - Feel safe and protected by an adult in their home. - Enjoy participating in the traditions of the community. - Have a sense of belonging to the school they attend. - Feeling the support of friends. - Have at least two adults (other than parents), who take a sincere interest in the child or adolescent

Annex 2. *Adams Classification*

Table 9. Physical signs related to the diagnosis of child sexual abuse. Adams classification[116] .

Indicator Type	**Physical signs**
A.1 Normal physical findings not related to sexual violence.	• Normal variations in the appearance of the hymen (annular, crescentic, imperforate, etc.). • Periurethral or vestibular band(s). • Intravaginal ridge(s) or spine(s). • Outer ridge at the hymen. • *Diastasis ani* (smooth area). • Perianal skin band(s) or tag(s). • Hyperpigmentation of the skin of the labia minora or perianal tissues in children of colour. • Dilatation of the urethral opening. • Normal midline variants: o Groove or ridge of the fossa, seen in early adolescence. o Midline fusion defect (perineal groove or stria). o Medial raphe (sometimes mistaken for a scar). o *Linea vestibularis* (medial avascular area). • Visualization of the pectinate line at the junction of the anoderm and rectal mucosa when the anus is fully dilated. • Partial dilation of the external anal sphincter, with the internal sphincter closed, allows visualization of part of the anal mucosa beyond the pectinate line, which may be mistaken for a laceration.
A.2 Findings commonly caused by medical causes other than trauma or sexual contact.	• Erythema of genital tissues. • Increased vascularisation of the vestibule and hymen. • Adherencia labial. • Rear fork friability. • Vaginal discharge that is not associated with a sexually transmitted disease. • Anal fissures. • Venous congestion or venous pooling in the perianal area. • Anal dilatation in children with predisposing conditions, such as current symptoms or history of constipation and/or encopresis, or children who are sedated, under anaesthesia or with altered neuromuscular tone due to other causes, such as post-mortem.
A.3 Findings due to other causes that may be mistaken for sexual abuse.	• Urethral prolapse. Lichen sclerosus and atrophic lichen. • Vulvar ulcer(s), such as aphthous ulcers and those seen in Behcet's disease. • Erythema, inflammation, and fissures of the perianal or vulvar tissues due to infection with bacteria, fungi, viruses, parasites, or other non-sexually transmitted infections. • Rectal prolapse.

	• Red/purple discolouration of genital structures (including hymen) due to post-mortem lividity, confirmed by histological analysis.
A.4 Findings with no consensus on their significance about possible sexual contact or trauma. (These physical and laboratory findings have been associated with a history of sexual abuse in some studies, but to date, there is no consensus among experts about the weight to be assigned to them in diagnosing child sexual abuse).	• Complete anal dilatation with relaxation of the internal and external sphincters, in the absence of other predisposing factors such as constipation, encopresis, sedation, anaesthesia and neuromuscular conditions. It should be confirmed using additional positions and/or examination techniques. • Notches or indentation at the edge of the hymen, at or below the 3rd or 9th hour positions, extending almost to the base of the hymen, but not a complete transection. These are rare findings and should be interpreted with great caution unless there is a history of an acute lesion at the same site. It should be confirmed using additional positions and/or examination techniques. • Complete cleft/suspected transection to the base of the hymen at 3 or 9 o'clock.
A.5 Injuries caused by genital trauma. (These findings are highly suggestive of sexual abuse or assault, even in the absence of an explicit reference from the victim, unless the child or caregivers provide an acceptable explanation of a traumatic history in a timely manner).	• Acute o Acute laceration(s) or bruising of the labia, penis, scrotum, or perineum. o Acute laceration of the posterior fork or vestibule, not affecting the hymen. o Acute hymenal laceration, any depth; partial or complete. o Bruising, petechiae or abrasions on the hymen. o Vaginal laceration. o Perianal laceration with exposure of the tissues below the dermis. • Healed lesions. o Perianal scar (an exceedingly rare finding that is difficult to diagnose unless an acute lesion is previously confirmed in the same location). o Fork or posterior fossa scar (another exceedingly rare finding that is difficult to diagnose unless an acute lesion is previously confirmed in the same location). o Transverse cleft scar/complete hymeneal transection. A defect in the hymen below 3 o'clock and 9 o'clock that extends to the base of the hymen, with no detectable hymenal tissue at that site. o Signs of female genital mutilation or cutting, such as a loss of part or all the foreskin (hood), clitoris, labia minora or labia majora, or linear vertical scar adjacent to the clitoris (female genital mutilation type 4).
B.1 Infections not related to sexual contact.	• Vaginitis caused by fungi such as Candida Albicans, or bacterial infections transmitted by non-sexual means, such as Streptococcus type A or type B, Staphylococcus, Eschericcia coli, Shighela or other Gram-negative micro-organisms. • Genital ulcers caused by viral infections such as Epstein-Barr virus or other respiratory viruses.
B.2 Infections that can come from either sexual or non-sexual contact.	• Molluscum contagiosum of the genital or anal area. (In young children, transmission is often non-sexual). • Condyloma acuminatum (human papillomavirus) in the genital or anal area. Warts that first appear after the age of 5 may be more likely to have been transmitted by sexual contact. • Herpes Simplex Virus types 1 or 2 infection in the oral, genital, or anal area.
B.3 Infections caused by sexual contact.	• Genital, rectal, or pharyngeal Neisseria gonorrheae infection. • Syphilis. • Genital or rectal Chlamydia trachomatis infection. • Trichomonas vaginalis infection. • HIV, if transmission by blood transfusion has been ruled out.
C Diagnostic findings of sexual contact.	• Pregnancy. • Semen identified in forensic samples taken directly from the body of a child.

Annex 3. Differential diagnosis

Table 10. Differential diagnosis[60,117–121]

Indicator Type	Most common differential diagnoses
Malnutrition	- Malnutrition resulting from neoplastic disease, infectious disease, or malabsorption. - Negligence.
Dehydration	- Dehydration resulting from accidental loss or illness. - Negligence.
Repeated poor hygiene	- Social vulnerability. - Negligence.
Bites	- Animal bite.
- Disorders of the level of consciousness. - Somnolence, hypotonia. - Irritability - Cranio-encephalic trauma. - Physical aggression with objects or against surfaces. - Shaking of the neck.	- Infectious or neurological disease. - Accidental poisoning (not repeated). - Accidental cerebral haemorrhage. - Administration of intoxicants or drugs. - Cerebral malaria. - Negligence. - Physical violence.
In the presence of any of the indicators in table 3, the presence of an origin other than emotional abuse must be ruled out.	- Neurodevelopmental diseases. - Organic diseases that cause alterations in the development of ponto-situational development. - Personality traits (shyness, rebelliousness, mistrust, aggressiveness, etc.). - Attachment disorders due to other causes. - Behavioural disorders of other origin. - ADHD and ASD. - Depression and anxiety of other origin. - Emotional violence.
Ecchymosis/Hematomas/ Retinal bleeding/haemorrhages.	- Haemorrhagic diseases: factor VIII and IX deficiencies, von Willebrand disease, immune thrombocytopenia (ITP), platelet function abnormalities and thrombocytopenia caused by leukaemia or other myelodysplasias. - Vitamin K deficiency. - Ingestion of salicylates. - Immunoglobulin A vasculitis (Schönlein-Henoch purpura) and other vasculitides. - Dermal melanosis (formerly Mongolian spots/blue spot). - Haemangiomas. - Unusual bruising and/or scarring that may be caused because of the application of alternative therapies (e.g. acupressure). - Delayed subaponeurotic fluid mass. - Cerebral malaria. - Sexual violence. - Physical violence. - Negligence.
Wounds (incised, contused, marks, scars) and fractures.	- Accidental trauma. - Osteogenesis imperfecta. - Pathological fractures. - Congenital insensitivity to pain. - Ehlers-Danlos syndrome. - Congenital syphilis. - Skeletal dysplasias leading to increased fractures such as osteoporosis, osteogenesis imperfecta, infantile cortical hyperostosis (Caffey's disease). - Onco-haematological diseases (leukaemia), bone or related

	tumours. - Rarer genetic syndromes: Hypophosphatasia, Menkes disease, homocystinuria, etc. - Sexual violence. - Physical violence. - Negligence.
Dermatological lesions.	- Mongolian or Batz spot. - Dystrophic ampullary epidermolysis. - Ampulliform impetigo. - Physical violence.
Alopecia. Peeling plate in infants.	- Alopecia areata. - Infections and parasitosis. - Mycosis. - Lack of hygiene. - Physical violence. - Negligence.
Burns	- Accidental injuries. - Phytophotodermatitis. - Complementary and alternative therapies: Moxibustion, etc. - Chemical burns. - Physical violence. - Negligence.

Annex 4 Guide to State and Autonomous Communities resources

It will be kept up to date on the website of the Ministry of Health[25].

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19. Erratum

On 1 April, CoViNNA approved the correction of the errata detected in the pages below. This document is the final approved version.

- The reference to revictimisation and secondary victimisation is removed as synonyms, leaving only secondary victimisation and its definition in the text on pages 8, 41, 43 and 57.
- Illustration 3 on page 32 is replaced by the original, translated with the author's permission.