RECOMMENDATION

Recommendations on Recognition and Response to Child Abuse and Neglect in the Indian Setting

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Justification: Pediatricians are usually the first point of contact of children with the health system. Studies worldwide have shown that there is insufficient knowledge about child abuse recognition and management among health workers. Presently no uniform guidelines exist in India for pediatricians regarding the appropriate response to child abuse.

Process: As part of the Child Rights and Protection Programme (CRPP) under IAP VISION 2007 of Indian Academy of Pediatrics, a 'Training of Trainers (TOT) Workshop on Child Rights and Protection' was held in Mumbai in January 2007. It was attended by participants from all over the country. The workshop recommended 'developing country-specific teaching and training material'. A Task force of IAP CRPP was formed and it developed a module for 'Training of Trainers Workshops for Pediatricians'. A National Consultative Meet was held in October, 2007 at New Delhi, where the program was discussed and ratified.

Objectives: To train pediatricians to: recognize and respond to child abuse; engage in a multi-disciplinary networking mode to deal with child abuse; and, document, record and report instances of child abuse.

Recommendations: Guidelines for recognition and management of child abuse are presented. All pediatricians should assess suspected harm with the same thoroughness and attention as they would do with a life threatening condition. Poor management after disclosure can increase psychological damage. Pediatrician should believe, support, reassure, treat and ensure rehabilitation of victims of child abuse, keeping the best interest of the child as the primary goal.

Keywords: *Child abuse and neglect (CAN), Child protection, Child rights, India, Maltreatment.*

According to World Health Organization, an estimated 40 million children between 0-14 yrs of age suffer from abuse or neglect and require health or social care(1). Definitions of various forms of child abuse were suggested in 2009 (***Box* 1**). Statistics reveal that child abuse, in all its forms- physical, sexual, emotional and neglect- is common in India, across all strata of society. Results from the National Study on Child Abuse (NSCA)(2), undertaken by the Ministry of Women and Child Development, suggest that two out of every three children suffer physical abuse (88.6% by their parents), 53.2% children face one or more forms of sexual abuse, and every second child reported facing emotional abuse. Most children do not report the matter to anyone(2).

Pediatricians are the professionals most concerned about the well-being of the child, in addition to being a respected group in the society. They are often the first contact of a child who has suffered abuse. In the outpatient or casualty, whenever one comes across a case of child abuse, chances are that the severity may often determine whether we do suspect it or fail to recognize the subtle varieties. The pediatrician can only recognize all such cases, when he/she considers every child seen by him/her potentially at risk of either abuse or

BOX 1 DEFINITIONS OF VARIOUS TERMS RELATED TO CHILD ABUSE

• **Child abuse or maltreatment** constitutes all forms of physical and/or emotional ill-treatment, sexual abuse, neglect or negligent treatment or commercial or other exploitation, resulting in actual or potential harm to the child's health, survival, development or dignity, in the context of a relationship of responsibility, trust or power.

• **Physical abuse** of a child is that which results in actual or potential physical harm from an interaction or lack of interaction, which is reasonably within the control of a parent or person in a position of responsibility, power, or trust. There may be single or repeated incidents.

• **Child sexual abuse** is the involvement of a child in sexual activity that s/he does not fully comprehend, is unable to give informed consent to, or for which the child is not developmentally prepared and cannot give consent, or that violate the laws or social taboos of society. Child sexual abuse is evidenced by an activity between a child and an adult or another child who by age or development is in a relationship of responsibility, trust or power; the activity being intended to gratify or satisfy the needs of other person. This may include but is not limited to: the inducement or coercion of a child to engage in any unlawful sexual activity; the exploitative use of a child in prostitution or other unlawful sexual practices; and, the exploitative use of children in pornographic performances and materials.

• **Emotional abuse** includes the failure to provide a developmentally appropriate, supportive environment, including the availability of a primary attachment figure, so that the child can develop a stable and full range of emotional and social competencies commensurate with his/her personal potential, and in the context of the society in which the child dwells. There may also be acts toward the child that cause or have a high probability of causing harm to the child's health or physical, mental, spiritual, moral or social development. These acts must be reasonably within the control of the parent or person in a relationship of responsibility, trust or power. Acts include restriction of movement, patterns of belittling, denigrating, scapegoating, threatening, scaring, discriminating and ridiculing.

• **Neglect** is the inattention or omission on the part of the caregiver to provide for the development of the child in all spheres: health, education, emotional development, nutrition, shelter and safe living conditions, in the context of resources reasonably available to the family or caretakers and causes, or has a high probability of causing harm to the child's health or physical, mental, spiritual, moral or social development. This includes the failure to properly supervise and protect children from harm as much as is feasible.

Source: *Report of the Consultation on Child Abuse Prevention, 29–31 March 1999, WHO, Geneva. Geneva, World Health Organization, 1999(1).*

neglect. Multiple studies worldwide have demonstrated that health workers have insufficient knowledge and/or training in addressing child abuse. The NSCA(2) also recommends that 'good practices in protection need to be documented/ shared for qualitative improvement at all levels'.

The Child Rights and Protection Program (CRPP), taken up under VISION 2007 program of Indian Academy of Pediatrics, stems from the United Nations Convention on the Rights of the Child (UNCRC)(3), and is a major step in the history of Child Rights in India. It aims to provide an impetus to the involvement of pediatricians in child protection activities. As part of the CRPP, a 'Training of Trainers (TOT) Workshop on Child Rights and Protection' was held on 10th and 11th January, 2007 in Mumbai (under the *aegis* of Pedicon 2007, Department of Pediatrics, LTMG Hospital, Sion, Mumbai; The Royal College of Pediatrics and Child Health; and, Northumbria Healthcare Trust, UK). The recommendations at the end of the workshop included: developing country-specific teaching and training manual, to organize methodology workshop for TOT, and, formation of Task force of IAP CRPP Programme. This task force developed a module for 'Training of Trainers Workshops for Pediatricians'. RCPCH shared their protocol on 'Response to child abuse'(4,5) and gave permission to modify it in the Indian context. A National Consultative Meet was held on 10th and 11th October, 2007 at New Delhi to discuss and approve the abovementioned teaching program. Participants included pediatricians from all parts of the country, as well as, all members of the

'task force' [***Annexure* 1**]. The program was discussed and ratified at the meet.

RECOMMENDATIONS

Who is a child?

Most of the Government programs on children are still targeted for the age group below 14 years. The UNCRC, 1989(3) defined the child as "every human being below the age of eighteen years unless, under the law applicable to the child, majority is attained earlier. After the introduction of the Juvenile Justice (Care and Protection) Act, 2000 (amended 2006), for all practical purposes, a child is considered as a person below 18 years.

Recognizing child abuse

Interviewing the child with abuse

A large proportion of children encounter abuse in their homes itself(3). Most cases of child abuse are committed by people known to the child and most children do not report the matter to anybody. When abuse is suspected, the concerned doctor must try to gather a detailed medical history from the child, if possible, and the caretakers. During the interview process, the following points need to be considered:

- If possible, interview the child alone (separately from the attendants).
- The interviewer must be sensitive to the child's possible fears and apprehension when discussing the home situation and should tailor the interview to the child's developmental level.
- Repetitive interviews can be problematic to the child. The doctor concerned must gather the basic information necessary to help make the decisions that are in best interest of the child.
- In cases of severe abuse, parents may flee with the child, and thus it is advisable to report the case to the authorities, prior to informing the parents of the suspected diagnosis.
- Documentation of the interview results is essential.
- Above all, everything is to be done in the best interest of the child.

Maintaining a professional approach with the family, although not always easy, can facilitate the interviewing process. Explaining the reporting process and what the parents can expect to happen is often helpful. Non-accusatory statements should be used. The various techniques and stages on interviewing a child with abuse are available elsewhere(4-8).

Response of the pediatrician to child abuse

A pediatrician's response to a case of child abuse, either in the outpatient or inpatient settings should follow three cardinal principles. It should be:

1. *Child centered and child friendly*: It should keep the best interest of child in mind. Safety of the child is to be considered paramount.
2. *Family supportive*: Response should provide adequate support to the family as generally family forms the backbone of the child protection system. Keeping the child permanently in an institution is the last option in child protection.
3. *According to the law of the land and safe for the pediatrician*: The management and documentation of the case should be impeccable to avoid professional litigation later.

When a pediatrician is confronted with a suspected case of child abuse, it is important not to jump to the diagnosis of abuse. The basic rules to be followed include:

- To consult widely with people who know the child well, like relatives, teachers etc., apart from parents.
- To gather information from other professionals like the child's regular pediatrician, the parents' physician, especially if the parent is suffering from mental disease, drug abuse, or other chronic diseases.
- To check past medical records for any hospital admissions (for child safety concerns) and developmental history.
- To document child safety concerns after a comprehensive medical assessment.

- To make a final conclusion after discussing the case with seniors, peers, psychologists and probably even NGOs and social worker.

The responses of a pediatrician to a child abuse case can be broadly classified into:

1. *Urgent response* is needed if the child is brought dead or with a life threatening injury or with acute sexual assault (reports within 24-72 hours of the abuse). The child will need emergency care and the police would require immediate forensic samples to book a strong case against the abuser. Such cases are best managed in a government hospital setting.

2. *Admission to the hospital* is needed in all cases of serious injuries. A child may be admitted incase it is felt that there is an immediate threat to his safety at home.

3. *Social Services* like Child Welfare Committee (CWC) and Child Helpline (Phone No.1098) or local NGOs may be contacted if the parents refuse to follow the treatment plan or if there is an immediate threat to safety of other sibs. CWC and Child Helpline can also be contacted in any case where child rights are violated like neglect, child labor, corporal punishment at school, child marriage etc.

4. *Planned response* is the best. Here a planned interview and examination are performed in a child-friendly atmosphere with the appropriate equipment and health personnel (social worker, psychologist, gynecologist if needed). A child friendly atmosphere is one that is sensitive to the needs of the child, where he feels comfortable, relaxed and at ease to confide his problems.

Reporting Child Abuse

The following background information is important before the pediatrician decides to handle a case of child abuse or neglect:

Childline. This service, launched by the Government of India, is a 24-hours free phone service, which can be accessed by a child in distress or an adult on his behalf by dialing the number 1098 on telephone. *Childline* provides emergency assistance to a child and subsequently based upon the child's need, the child is referred to an appropriate organization for long-term follow up and care. It responds to calls for medical assistance, shelter, repatriation, missing children, protection from abuse, emotional support and guidance, information and referral to services, death related calls etc.

Child Welfare Committee. Under the JJ Act, it is possible for the Child Welfare Committee to declare any parent or guardian; who grossly abuses a child, or fails to protect a child from being abused, as unfit persons and order for the removal of the child from the custody of such persons. The offences under this Act are cognizable and the special police officer or any of his subordinate may arrest a person without warrant and search the premises without warrant.

Mandatory reporting. Mandatory reporting mandates certain professionals to report to appropriate authorities suspected cases of child physical and sexual abuse. Designated professionals (including pediatricians) are required by law to report all suspected cases of child abuse and neglect. They are protected by law in case of an erroneous reporting, as long as it was in good faith. They are legally penalized in case they fail to report. Under this law, proof is not required to report, and the only requirement is to report suspected abuse. In India, such provisions have not yet been introduced.

Whom to Report. In the absence of 'mandatory reporting' provisions and child protection services in India, this constitutes an important decision. Usually the reporting can be done to the Police, the local Child Welfare Committee, and even to the *Childline*. However, even after reporting, networking among various professionals is usually required to follow-up the case to its just conclusion.

The team developed the following flow charts, based on our discussions and on previously published material(4,5,15), which provide suggested protocols for pediatricians to respond to physical (***Fig.* 1**), sexual (***Fig.* 2**), and emotional abuse (***Fig.* 3**). Following are the important goals of a pediatrician's response:

1. Immediate goal is to ensure safety and provide emergency care if needed.

2. Comprehensive medical assessment including history, examination and investigations, and documentation.

3. Short term goals include providing immediate emotional (counseling) and social support to the child and family and treating physical problems like injuries, providing immunization, STD prophylaxis and emergency contraception.

4. Long term goals include complete physical and psychosocial well being of the child. They also ensure his reintegration into the family and social system.

Comprehensive Medical management

History

1. A detailed account of the incident(s) should be sought from both the caregiver and the child, separately. History should be recorded verbatim. The rapport building and interviewing skills of the examiner are of utmost importance. The examiner should observe the behavior of the child during history-taking.

2. Presenting symptoms of the child are noted. Physical, mental and personality development should be noted.

3. Family and Social history should be taken with details about the marital status of parents, whether the family is a broken or dysfunctional one, total number of members in the family, interpersonal conflicts and social interaction among various family members, etc.

4. Social history includes employment details of parents, their age, education and physical and mental maturity, nature of parent-child relationship, any concerns about profession, health, education, etc.

5. Sexual history of victim about exploitation or abuse should be obtained. Presence of addictions such as alcohol, drugs and tobacco should be noted. The recorded information should include the relation of the victim with the accused and exploiter, age difference of accused and victim and other relevant information.

The presence of a chaperone, preferably a nurse is a must during the assessment. The assessment should be recorded in a special proforma. History-taking from the parent or caretaker should be documented separately from that of the child. Repeated interviews are to be avoided.

- It is important to treat the child and the parents with respect and dignity without making accusations.

- Listen carefully and have a sensitive, empathic and nonjudgmental attitude.

- Ask open-ended and non-leading questions.

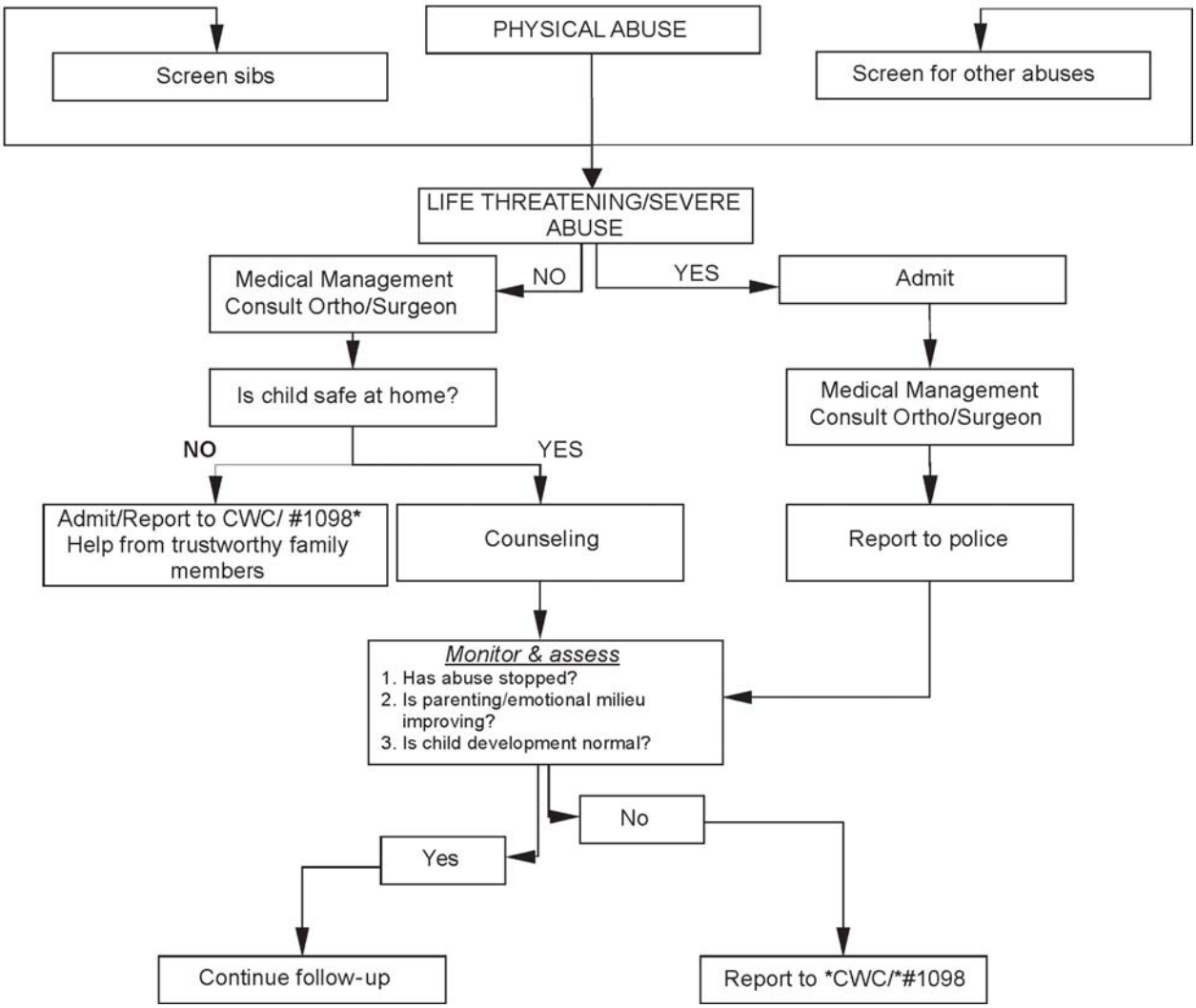
- Nonverbal cues as 'watchful frozenness', sad mood, avoidance of eye contact, etc. should be recorded. Exact question and answers need to be recorded verbatim.

- Points to be covered in history include place, time, witness, present and past history, noticeable behavior change, developmental and immunization history. Family history, pedigree chart and social history are extremely important. A psychosocial history known by the acronym HEEADDSS (details of home, education, eating behavior, activities and peers, drugs, depression, suicide, sexual history and sleep pattern) can be taken directly from an adolescent patient.

Examination

Examination of victims of abuse and neglect follows the same basic principles as examination for any other medical condition, but requires an expertise which accrues from training and regular updating. There are many standard works on the examination of the abused child(4,5,8-10), where a detailed discussion is available. Parental and (preferably) the child's consent are essential for a medical examination. The child may prefer to get examined by a doctor of the same sex. He may also choose to have a trustworthy adult along with him during the procedure. The pediatrician may seek the expertise of a forensic physician and a gynecologist (for a female child) while examining a case of sexual abuse. The following should be recorded:

- Resistance to examination, especially in a case of



** Child Welfare Committee; Childline (phone number 1098)*

FIG. 1 *Response to physical abuse.*

sexual abuse and/or, dissociation (going to sleep during examination)

- General demeanor (like unkempt appearance in neglect)
- Vitals and head-to-toe general physical examination, especially noting pallor, bruises, vitamin deficiencies (and malnutrition), sequelae of unexplained trauma, etc.
- Height, weight and head circumference to be plotted on growth chart
- Sexual Maturity Rating for adolescents
- All injuries are to be marked on anatomical diagrams. Special sites to look for injuries include ears, inside the mouth, soles, genitalia and anus.
- Systemic examination is done, especially to look for injuries.
- Examination of genitalia in girls should be done in supine (frog leg), prone (knee chest) and left lateral position. Details of hymen and injuries are

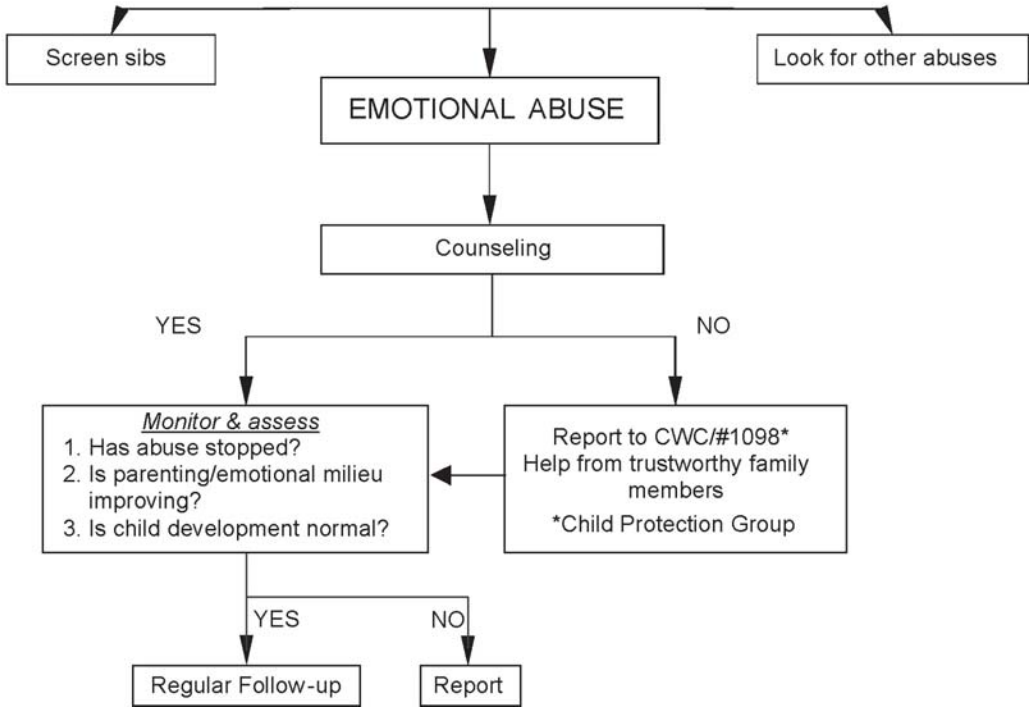


FIG. 2 *Response to emotional abuse.*

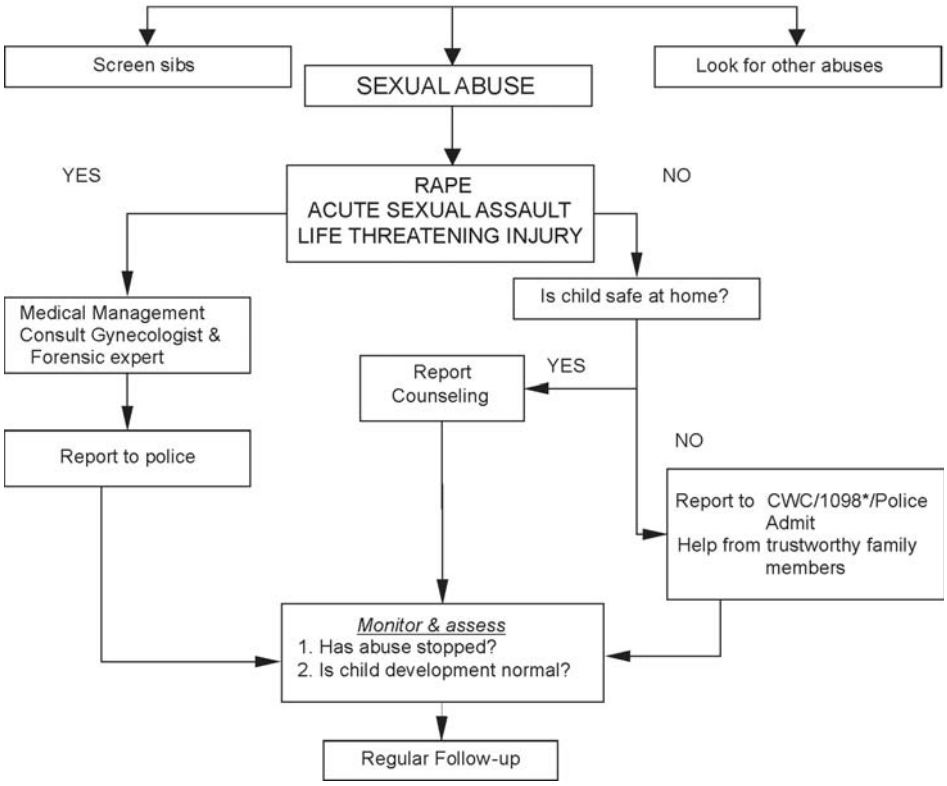


FIG. 3 *Response to sexual abuse.*

to be noted. Anal dilatation on per rectal examination may indicate sodomy, and must be documented. Presence of discharge, genital ulcers, warts and inguinal lymphadenopathy are to be noted and, samples preserved in appropriate manner for forensic evaluation.

It is important to know that in 70-85% of documented sexual abuse, the physical examination is normal.

Investigations

The correct age of the child should be established for any case that is going to be reported and is a must in case of a trafficked child. Other investigations which need to be done:

- Child sexual abuse: STD screening, including low and high vaginal (in post pubertal girls) swabs and urethral swabs in boys, and serology for HIV, hepatitis B and syphilis are done in cases of acute sexual assault, penetrative abuse, vaginal/ urethral discharge and, STD in abuser. Pregnancy test should be done in an adolescent girl. Forensic samples maintaining the chain of evidence include skin, hair, nail clippings, clothing, saliva, and, oral and genitourinary secretions in acute sexual assault(11).

- Physical abuse: Skeletal survey is done in a case of multiple injuries, and in all cases if a child is below 2 years. Multiple bruising entails a detailed hematological profile, including bleeding and coagulation profile. Neuroimaging and ultrasonography of abdomen are indicated in a case of head and abdominal injury, respectively.

Management

Management should be child friendly and should aim at achieving the short term and long term goals. The current and future plans of action should be discussed with the non-offending family members. The need for breaking immediate contact with the abuser, if he/she is a known person, should be emphasized.

The physical injuries should be treated. Hepatitis B vaccination should be considered if the sexually abused child is not vaccinated, and if the child presents within six weeks of the last assault (schedule 0, 1, 2, 12)(12). DPT/ DT vaccination should be given in unvaccinated children. Tetanus immunization status should be confirmed and updated, if necessary. Overall, the risk of acquiring a STD is low and varies according to many factors(13). STD prophylaxis and emergency contraception is to be given to an adolescent with acute sexual assault. STD prophylaxis should be offered in cases of oral-genital, genital-genital, or anal-genital contact by the abuser. HIV prophylaxis may be indicated in specific cases(12,13); it should be considered for every case that presents within 72 hours of the most recent abuse, if unprotected anogenital penetration has occurred, taking into consideration risk factors(12). All children of the family should be screened for abuse if the abuser is close to the family. Multiple types of abuses may coexist in the same patient and should be specifically looked for and managed. Injuries should be treated as needed. Lacerations extending into the vagina are not common and should be assessed by a gynecologist, as the full extent of the laceration must be determined. The vaginal wall is extremely thin in the prepubescent child and may be perforated more easily than in the older child(13).

Counseling of the child and family forms the cornerstone of the management. The immediate counseling of the child that can be done by the pediatrician should focus on the following:

- Believe the child, reassure and absolve feelings of guilt/ blame

- Explain about the existence of a medical, family and social support system.

- Listen carefully to all fears and concerns associated with disclosure.

- Teach coping and assertive skills.

Referrals to appropriate specialties should be made according to the need of the child. These will include psychologist, psychiatrist, orthopedic surgeon, surgeon, social services and police. The family members may also need counseling and treatment from mental health professionals.

Follow up

Follow up after 2 weeks, or earlier if necessary, is essential to reassess the child and evaluate for development of sequelae. In acute sexual assault of an adolescent girl, a repeat pregnancy test is warranted. A repeat serology for syphilis at 4-6 weeks and for HIV at 3-6 months is required.

The long term after-effects of abuse on the physical and mental health are well known, but some children suffer no adverse consequences. The outcome is influenced by the following factors: nature, extent and type of abuse, age of child, temperament and resilience of the child, relationship of abuser to the child, and family's response to abuse and medical management. A single episode of non-contact sexual abuse by a stranger may just need reassurance and letting out feelings in one or two counseling sessions with a good outcome. But prolonged abuse by a close family member will require longer and multiple counseling sessions to heal completely.

Regular follow up of the abused children should include the following: To verify if abuse has stopped, to monitor physical and mental health, To monitor development and ensure that it is normal, and to refer for therapy (counseling, cognitive behavior therapy or medication) for delayed presentation of symptoms.

The key points to be kept in mind while making decisions in the existing framework of child protection services include:

1. Seriousness of abuse: Serious abuse requires urgent intervention and long term follow up

2. Safety of the child: If the child is not safe at home, help from non-offending family members for a change in residence is sought for. CWC, Child Helpline and local NGOs may also help in this situation. If the home continues to be unsafe, safer options like foster care and adoption of the child need to be considered.

3. Importance of counseling and follow up of the child are important issues. Counseling of the parents, if they are the abusers, is also necessary. All abuse, especially sexual abuse, needs to be reported to the police.

The pediatrician's response must always be in accordance with the existing law of the country, as highlighted in these guidelines.

Medico-legal aspects, Documentation and Reporting

Most victims of obvious child abuse are directly brought to hospitals (usually Government hospitals) for medical examination by the police. They may be accompanied by Social worker (NGO), but at times are brought by parents / guardians. At other times, there may be incidental recognition of child abuse during consultation for an unrelated medical problem, which can occur in any type of setting. Guidelines are available for documentation and may be used or adapted depending on local settings(11).

All consultations with the patient should be in hand written notes, with diagrams, body charts, and if possible, photographic documentation. It should be understood that both, age determination and complete examination requires multidisciplinary references. Their opinions either in person or telephonically, should be recorded. Time, date, signature, designation and additional comments, wherever appropriate, are a must for enabling the due process of law.

The examining doctor should make sure that important details are not omitted. All aspects of consultation should be documented and detailed notes must be made during the consultation, patient's records have to be kept strictly confidential and stored securely. The documentation should be confined to areas of health care expertise only; interpretation of the same has to be done by a trained person if the examining Medical Officer is not trained in examination of medicolegal cases. Consent should always be taken in writing, and preferably from both the guardian and the victim. All documents should be preserved for, as yet, an undetermined amount of time.

Steps of medical examination

- Documentation should be accurate, impartial,

objective and scientific.

- After obtaining written consent, the preliminary data should be noted including the FIR No., date and time and place of examination, witnesses present during examination and recording, details of informant and relation with the child.
- Demographic information, brief History and an account of Assault should be taken.
- Examination of clothes of victim for semen stains, struggle tears, trace material etc. should be done.
- Genitalia examination and photography (if needed) should be taken.
- Findings of general physical examination, systemic examination, exam for injuries, clinical/ forensic (STD, pregnancy, etc) should be recorded.
- Examination for age determination (if needed) is a must in a trafficking case. Age determination involves multidisciplinary approach. The age range provided should be as narrow as possible.

The examining doctor must express opinion about physical/sexual abuse/age determination. Treatment should be administered, as per need. The examining doctor should be liberal in taking second opinion, and taking references from specialists in other faculties, as required.

Reporting by medical officer

The medical officer should not try to be an investigator. His duty is to the court and not to either party.

1. The report should be written clearly and precisely and should state clearly fact and medical opinion. The Court relies on objectivity, competence and integrity. Hence the medical officer should be balanced and accurate, report without exaggerations, and limit the report to facts.
2. The opinion must have components of injury, sexual activity and age estimation if required, and must consider whether there is sexual abuse or not, acute and chronic effect on victims body and mind, and whether proper samples have been collected for identification.
3. Positives and negatives should be included in the report. The medical officer should not mislead by omission and should avoid making generalizations.
4. Age determination is a must in trafficking cases.
5. The report should be reviewed and, if necessary, a peer review should be obtained before handing it over. Premature opinion should not be given.

Media and Child Abuse

The fundamental guideline for the media with regard to reporting on child abuse is to protect the identity of the child. The JJ Act, 2000; the Immoral Traffic Prevention Act, 1956; and, the Criminal Procedure Code prohibit the disclosing of the identity of victims. Press Council Act has also laid down the norms to be followed by the media, keeping in mind the rights of children.

Advise to Caregivers of an Abused Child

If a child discloses that he/she has been sexually abused or exploited:

- Support the child and explain that he/she is not responsible for what happened.
- Believe the child and don't make her/him feel guilty about the abuse.
- Be empathetic, understanding and supportive.
- Consult a doctor and consider the need for counseling or therapy for the child.
- Don't criticize the child or get angry with her/ him.
- Don't panic or overreact, with your help and support, the child can make it through this difficult time.
- Don't ignore the abuse. Voice your fears to responsible NGOs or individuals.
- Lodge a complaint with the police and ensure that the abuse stops immediately.

KEY POINTS

- Pediatricians should assess suspected harm with the same thoroughness and attention as they would do with a life threatening condition.
- Suspected cases to be informed to the Police or Child Welfare Committee or even *Childline*, depending on the merits of the individual case.
- Poor management after disclosure can increase psychological damage.
- Pediatrician should believe, support, reassure, treat and ensure rehabilitation of victims of child abuse, keeping the best interest of the child as the primary goal.
- Response to a case should be according to the law of the land and 'safe' for the pediatrician.

Guardians should be made to understand that their first responsibility is to the child – to protect him/her and to ensure that there is no breach of privacy or confidentiality.

CONCLUSIONS

These guidelines detail suggested actions to be taken after suspecting child abuse and neglect. Many of the details of examination and interviewing are already available in standard texts and have not been detailed here. We plan to review the guidelines as and when further changes in the laws dealing with age of child and, child abuse and neglect occur.

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Annexure I: LIST OF INVITEES TO THE NATIONAL CONSULTATIVE MEET

Chairperson: Dr Naveen Thacker, President IAP, 2007

Conveners: Dr Kiran Aggarwal (Former Member, Child Welfare Committee), Delhi; Dr Samir Dalwai (Member, Juvenile Justice Reforms, National Commission for Protection of Child Rights), Mumbai; Dr Rajiv Seth (Honorary Secretary, IAP-CANCL Group), Delhi.

Advisors: Prof RN Srivastava (Past President IAP and Advisor IAP CANCL Group), Delhi; *Loveleen Kacker (Joint Secretary, Child Welfare, MWCD), Delhi; *Dr Neela Shabde (Lead for RCPCH/NSPCC/ALSG CP Training Development Project, RCPCH), UK.

Members: Dr RK Agarwal (President-elect IAP 2007), Udaipur; Dr Atul Agarwal (EB member IAP, 2007), Bareilly; Dr Swati Bhave (Past-President IAP), Delhi; Dr Preeti Galagali, Bangalore; Dr Ajay Gambhir (Vice-President IAP, 2007), Delhi; Dr Piyush Gupta (Editor-in-Chief, Indian Pediatrics), Delhi; Dr Sujata Jali, Belgaum; Dr Devendra Mishra, Maulana Azad Medical College, Delhi; Dr Arbind Mohanty, Bhubhaneshwar; Dr Harish Pemde, Delhi; Dr Chhaya Prasad, Chandigarh; Dr Chandrika Rao, Bangalore; Victoria Rialp (Chief, Child Protection, UNICEF), Delhi; Dr Harmesh Singh, Ludhiana; Dr Anjana Thadhani, Mumbai.

**Could not attend the meeting*.

Disclaimer: The recommendations are the opinion of the participating experts regarding action to be taken in case of suspected CAN, in the light of current evidence. These are neither binding, nor the only possible actions; individual practice may deviate from these depending on the situation in an individual case or the existing laws.