

## Meeting report

# Consultation in south-eastern Europe on WHO guidelines for the health sector response to child maltreatment

Budva, Montenegro  
29–30 January 2019





## **Meeting report**

# **Consultation in south-eastern Europe on WHO guidelines for the health sector response to child maltreatment**

**Budva, Montenegro**

**29–30 January 2019**

## Abstract

A lack of safe and nurturing relationships in childhood is thought to adversely affect neurodevelopmental change, and in turn, the emotional, cognitive and behavioural development of a child. Adverse childhood experiences are linked both with a propensity for increased violence later in life and with health-harming behaviours, such as alcohol and drug misuse, physical inactivity, depression and self-harm. In the WHO European Region, the prevalence of child maltreatment ranges from 9.6% for sexual abuse to 22.9% for physical abuse and 29.1% for mental abuse. A consultation on the forthcoming WHO guidelines for the health sector response to child maltreatment, held in Budva, Montenegro on 29 and 30 January 2019, brought together national experts from the health and welfare sectors of selected Member States of the WHO European, including the south-eastern sub region, and representatives of WHO headquarters, the WHO Regional Office for Europe, the United Nations Children's Fund (UNICEF) and other stakeholders. Participants commented on the INSPIRE package and the guidance currently in preparation by WHO, namely the WHO guidelines for the health sector response to child maltreatment and the WHO pocketbook of primary care for children, and shared details of their current child protection systems, legislation and policy for the identification, treatment and reporting of suspected child maltreatment and examples of effective intersectoral working.

## Keywords

CHILD ABUSE – PREVENTION AND CONTROL  
VIOLENCE – PREVENTION AND CONTROL  
CHILD WELFARE  
COOPERATIVE BEHAVIOUR  
HEALTH SECTOR RESPONSE  
CLINICAL GUIDELINES

Address requests about publications of the WHO Regional Office for Europe to:  
Publications

WHO Regional Office for Europe  
UN City, Marmorvej 51  
DK-2100 Copenhagen Ø, Denmark

Alternatively, complete an online request form for documentation, health information, or for permission to quote or translate, on the Regional Office website ( <http://www.euro.who.int/pubrequest> )

© World Health Organization 2019

All rights reserved. The Regional Office for Europe of the World Health Organization welcomes requests for permission to reproduce or translate its publications, in part or in full.

The designations employed and the presentation of the material in this publication do not imply the expression of any opinion whatsoever on the part of the World Health Organization concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Dotted lines on maps represent approximate border lines for which there may not yet be full agreement.

The mention of specific companies or of certain manufacturers' products does not imply that they are endorsed or recommended by the World Health Organization in preference to others of a similar nature that are not mentioned. Errors and omissions excepted, the names of proprietary products are distinguished by initial capital letters.

All reasonable precautions have been taken by the World Health Organization to verify the information contained in this publication. However, the published material is being distributed without warranty of any kind, either express or implied.

The responsibility for the interpretation and use of the material lies with the reader. In no event shall the World Health Organization be liable for damages arising from its use. The views expressed by authors, editors, or expert groups do not necessarily represent the decisions or the stated policy of the World Health Organization.

## Contents

Acknowledgements.....	ii
Scope and purpose.....	1
Introduction .....	3
The cost and consequences of adverse childhood experiences and how they can be avoided .....	3
The importance of prevention and the INSPIRE package .....	4
Introduction of the draft WHO Guidelines for the health sector response to child maltreatment .....	5
Safeguarding child rights – intersections between child protection and health sector response .....	7
Country examples of effective intersectoral working for responding to child maltreatment .....	8
Montenegro .....	8
North Macedonia .....	9
Republic of Moldova .....	10
Serbia .....	11
Presentation of examples of health sector response guidelines: challenges of development and implementation .....	12
Czechia .....	13
Latvia.....	14
Montenegro .....	14
Market place: European country profiles with examples of the health sector’s role in responding to child maltreatment .....	15
Reflections: panel on key issues raised, reflection on the scope of and process for the development of national guidelines.....	16
WHO Pocketbook of Primary Care for Children: responding to child maltreatment .....	17
Role of the health sector and primary health care providers in responding to child maltreatment ...	17
Group work: discussion of the process to develop and implement national guidelines for the health sector response to child maltreatment .....	20
Panel: how WHO and UNICEF could help to implement recommendations – implications for capacity development.....	22
Next steps .....	24
Closure of the consultation.....	24
References .....	25
Annex 1. Programme of work .....	26

## Acknowledgements

The consultation was held in Budva, Montenegro, in collaboration with the Ministry of Health of Montenegro and with the generous support of the Government of Germany.

## Scope and purpose

Child maltreatment is one of the hidden forms of violence, and evidence shows that the prevalence is unacceptably high in the 53 countries of the WHO European Region. The *World Report on Violence and Health* defines child maltreatment as physical, sexual or emotional abuse and/or deprivation and neglect. Child abuse, if severe, can lead to homicide, and although the numbers appear relatively low at about 629 deaths each year in children under 15 years of age, deaths are only the tip of the iceberg. Reports suggest that the prevalence of child maltreatment is much higher. In the WHO European Region the prevalence ranges from 9.6% for sexual abuse, 22.9% for physical abuse to 29.1% for mental abuse, suggesting that tens of millions of children are abused before the age of 18 years. Child maltreatment is one of the more serious forms of adverse childhood experiences (ACE),<sup>1</sup> though other adversity may also present itself.

A lack of safe and nurturing relationships in childhood is thought to adversely affect neurodevelopmental change, and in turn, the emotional, cognitive and behavioural development of a child. Adverse childhood experiences are linked both with a propensity for increased violence later in life and health-harming behaviours, such as alcohol and drug misuse, physical inactivity, depression, self-harm, leading to poor health outcomes, including those due to increased noncommunicable diseases and psychiatric disorders. The scale, risks, consequences and evidence base for preventive action and policy options are summarized in the European report on preventing child maltreatment. In view of concern about the scale and consequences of child maltreatment, all 53 Member States of the WHO Regional Committee for Europe gave their unanimous support to resolution EUR/RC64/13 on investing in children: the European child and adolescent health strategy 2015–2020 and the European child maltreatment prevention action plan 2015–2020. This calls for leadership by the health sector in coordinating an intersectoral prevention response focusing on improved surveillance, developing a comprehensive national action plan for prevention, and more widespread implementation of prevention programmes. A progress report, country profiles and the European status report on preventing child maltreatment were presented to Member States at the WHO Regional Committee for Europe in September 2018. These show that the prevention and response to child maltreatment programmes needs to be stepped up.

The United Nations Convention on the Rights of the Child requires all Member States to offer effective child protection, giving paramount importance to the rights and best interests of children under the age of 18 years. The United Nations Sustainable Development Goal target 16.2 calls for ending abuse, exploitation, trafficking and all forms of violence against and torture of children. In response, international agencies such as WHO and UNICEF and governments have come together to form the Global Partnership to End Violence Against Children. In addition, in 2016 the World Health Assembly adopted the Global plan of action to strengthen the role of the health sector within a multisectoral response to address interpersonal violence, in particular against women and girls, and against children. The Minsk Declaration on the Life-course Approach in the Context of Health 2020 highlights the importance of investing in early childhood development and

---

<sup>1</sup> Adverse childhood experiences (ACE) may be one or more of emotional, physical and or sexual abuse, physical and or emotional neglect, substance misuse and or mental illness amongst family members, violent treatment of mother, separation or divorce of parents, imprisonment of family member.

promoting safe, stable and nurturing relationships to prevent adverse childhood experiences and maximize developmental potential to ensure better health and social outcomes as adults.

There is a large evidence base that prevention of child maltreatment and violence is more cost-effective than dealing with serious and far-reaching health and social consequences. This evidence has been captured in *Implementing child maltreatment prevention programmes: what the experts say* and *INSPIRE: Seven strategies to end violence against children*, produced by WHO and the Global Partnership to End Violence Against Children. One of the seven strategies is improving the response to child maltreatment. In response to this, WHO is developing guidelines on the health sector response to child maltreatment. In line with Health 2020, the European health policy framework, the United Nations 2030 Agenda for Sustainable Development, and the aforementioned global and European action plans, the WHO Regional Office for Europe organized a consultation in south-eastern Europe to build capacity in responding to child maltreatment. The consultation engaged European participants from sectors such as health and welfare and civil society to focus on to the gold standard of such a response by presenting the contents and recommendations from the WHO guidelines on the response to child maltreatment. Participants were from selected European countries, including those from south-eastern Europe. The development process of the guidelines commenced in 2016 and evidence-based recommendations have been formulated. The guidelines aim to help practitioners to identify children who are victims of physical, sexual and emotional abuse and neglect and to provide first-line support. They focus on (a) identification of children who suffer abuse or neglect; (b) assessing the safety of the child; (c) interacting with caregivers in suspected cases of child maltreatment; (d) providing first-line support for children exposed to child maltreatment; (e) providing basic psychosocial support to victims of child maltreatment and helping with more severe mental health problems; (f) responding to child sexual abuse; and (g) collecting medical history, conducting physical examinations and appropriate documentation of findings.

The aim of the meeting is to build institutional capacity in promoting the health sector response to child maltreatment and to consult with European practitioners on the recommendations of the guidelines and debate the support needed for their implementation.

The specific objectives of the consultation are to:

- (a) provide an overview of the current situation in selected European countries on child maltreatment;
- (b) obtain country examples on the health sector's role in responding to child maltreatment;
- (c) provide an overview of available relevant global guidelines;
- (d) discuss the scope of and process for the development of national guidelines for the health sector response to child maltreatment;
- (e) consider mechanisms for multisectoral collaboration and implementation of the guidelines;
- (f) debate how to develop or update existing protocols and/or training curricula and how best to train health-care providers and health managers.

## Introduction

The WHO Regional Office for Europe organized a consultation on the health sector response to child maltreatment in Budva, Montenegro, on 29 and 30 January 2019, at the invitation of the Ministry of Health of Montenegro. A total of 52 participants attended from 22 countries. For the programme of work, see Annex 1. For the list of participants, see Annex 2.

Dr Miro Knežević, Director-General, Directorate for Public Health and Public Health Care Programme, Ministry of Health, Montenegro, opened the meeting and welcomed participants. Child maltreatment<sup>1</sup> in its myriad forms is a long-standing and persistent problem. In Montenegro, following the Strategy for Protection against Family Violence 2012–2015, new draft national guidelines on action by the health sector to protect children from violence, abuse and neglect is in preparation, prohibiting all forms of violence and discrimination and designed to be fully applicable in practice. A wide range of sectors, including health, social protection, education, law enforcement, the judiciary and civil society, are involved in child protection, so a multisectoral approach and integrated interventions are essential.

Ms Mina Brajovic, Head of the WHO Country Office in Montenegro, addressing the meeting in a pre-recorded video message, commended the Montenegrin Government on its commitment to combating violence against children. Adverse childhood experiences have been shown to have an adverse effect on children's health, educational attainment and subsequent work opportunities and economic prosperity. Violence is often perpetuated from one generation to the next and contributes to persistent social injustice. However, it can be prevented by appropriate interventions in a whole-of-government and whole-of-society approach. In 2014, the Member States of the WHO European Region adopted the European child maltreatment prevention action plan 2015–2020, intended to strengthen the capacity of the health system to identify, treat and prevent violence against children, improve monitoring and data quality and promote collaboration with other relevant sectors.

Mr Jonathon Passmore, Programme Manager, Violence and Injury Prevention, WHO Regional Office for Europe, welcomed the great interest shown in the consultation. As part of its work on enacting the Action plan, the Regional Office is working with Member States to implement the INSPIRE package of seven recommended strategies for ending violence against children, in collaboration with the United Nations Children's Fund (UNICEF) and other national and international agencies.

## The cost and consequences of adverse childhood experiences and how they can be avoided

**Dr Dinesh Sethi, Consultant, Violence and Injury Prevention, WHO Regional Office for Europe**

Approximately 629 children die every year in the WHO European Region as a result of interpersonal violence; a peak in deaths in eastern Europe between the mid-1990s and the mid-2000s corresponded with a period of economic and political transition in that part of

---

<sup>1</sup> The term "child maltreatment" encompasses all forms of child abuse (physical, sexual, mental, emotional, etc.), as well as child neglect.



the Region. However, the death rate is merely the tip of the iceberg: a study by Hillis et al. (1) showed that at least 1 billion children worldwide, and 55 million in the European Region, were subjected to some type of abuse in 2014. The most common types of maltreatment in Europe are emotional and physical abuse, and neglect; only 10% of cases come to the attention of child protection agencies.

Adverse childhood events have serious and lifelong effects on brain, cognitive and behavioural development, leading to problems of physical and mental health in later life, including increased rates of harmful behaviours such as smoking, alcohol drinking and drug-taking and increased rates of attempted suicide. A study by Bellis et al. (2014) (2) concludes that subjects who experienced four or more adverse childhood events are 10 times more likely to be problem drinkers and 49 times more likely to have ever attempted suicide. If they had experienced no such events, their risk of problem drinking would have been reduced by 51% and their risk of (attempted) suicide by 83%. Children subjected to adverse childhood events are more likely to suffer violence and/or become perpetrators of violence themselves in adulthood.

The economic cost of violence against children includes both short-term costs (e.g. health care) and long-term costs (health care, lost productivity, costs to the justice, education and child welfare systems, etc.). These costs have been estimated at as high as 3% of gross domestic product in North America and Europe. Preventive measures such as detection and support of at-risk families, home visits by nurses, parenting programmes and preschool enrichment programmes are cost-effective, with benefits accruing over time. The current consultation is intended to identify and share best practices for health-care professionals to identify and respond appropriately to child maltreatment, but also to contribute to its prevention in collaboration with child protection agencies, the justice system, education and other relevant sectors.

## **The importance of prevention and the INSPIRE package**

**Mr Jonathon Passmore, Programme Manager, Violence and Injury Prevention, WHO Regional Office for Europe**

The international community is increasingly adopting a public health approach to violence against children. United Nations Sustainable Development Goal target 16.2 sets the ambitious target of ending abuse, exploitation, trafficking and all forms of violence against children by 2030. Target 14 of the Thirteenth General Programme of Work of WHO is to “decrease the number of children subjected to violence in the past 12 months, including physical and psychological violence by caregivers in the past month, by 20%”.

Many Member States of the WHO European Region are “pathfinder countries” in the Global Partnership to End Violence against Children, hosted jointly by WHO and UNICEF. Resources such as the INSPIRE technical package provide practical guidance to help Member States to respond to the problem of violence against children, taking a life-course approach and focusing on prevention. The technical package includes a core document, an implementation handbook, a results framework and a set of core indicators.<sup>1</sup>

The seven basic strategies of INSPIRE are as follows:

---

<sup>1</sup> See [https://www.who.int/violence\\_injury\\_prevention/violence/inspire-package/en/](https://www.who.int/violence_injury_prevention/violence/inspire-package/en/).

- implementation and enforcement of laws (e.g. laws banning corporal punishment in homes and schools or the criminalization of sexual abuse);
- norms and values (e.g. action to counter harmful social and gender norms);
- safe environments (e.g. the role of environmental factors in the perpetuation of violence);
- parent and caregiver support (e.g. helping parents to learn positive parenting strategies and methods of discipline);
- income and economic strengthening (e.g. conditional cash transfers, micro-finance programmes);
- response and support services (e.g. in the health-care and child protection services);
- education and life skills (e.g. school-based programmes to help children to recognize and avoid violence).

Many activities consistent with the strategies are already being undertaken in Member States, and further technical support and guidance are available from the Regional Office. It is hoped that, by 2030, over 80 Member States globally will have fully implemented the strategy on laws and over 30 will have implemented the strategy on safe environments.

## **Introduction of the draft WHO Guidelines for the health sector response to child maltreatment**

**Ms Berit Kieselbach, Technical Officer, Prevention of Violence Programme, WHO headquarters**

The draft WHO guidelines for the health sector response to child maltreatment are intended to provide evidence-based recommendations for front-line health-care providers in both low-and high-resource settings for the provision of immediate and medium-term, high-quality care for children and adolescents<sup>1</sup> (from birth to 18 years) exposed to physical, emotional and sexual abuse and neglect.

The guidelines were prepared following a systematic literature review. The selected articles were assessed for quality by an international expert group and subjected to two peer reviews by experts and practitioners. They are aligned with the WHO clinical guidelines on responding to children and adolescents who have been sexually abused (3) and the mhGAP intervention guide for mental, neurological and substance use disorders in non-specialized health settings (4).

The guidelines are based on the following principles:

- child- and adolescent-centred support
- all action taken in the best interest of the child
- consideration of the evolving capacities of the child or adolescent
- non-discrimination
- full participation

---

<sup>1</sup> Throughout this section, the term "child" should be taken to mean "child or adolescent".

- safety, confidentiality and privacy
- informed consent.

Initial identification of suspected child maltreatment may occur through direct disclosure by the child, parents or the school, although such disclosure is relatively rare. Universal screening of all children is not recommended because the appropriate response services may not be available and because of the likelihood of false positives (and the consequences) and the fact that, to date, there is no evidence to show that it will result in overall improved outcomes. The recommended procedure for identifying possible child maltreatment is clinical enquiry during routine health-care provision, if there are grounds for suspicion, using guidance such as that in the (forthcoming) accompanying WHO clinical handbook on child maltreatment. An example is provided in the guideline on child abuse and neglect issued by the National Institute for Health and Care Excellence (NICE) in the United Kingdom of Great Britain and Northern Ireland (5), marking suspected physical injuries on a standardized diagram, etc.

When taking the child's medical history, health-care professionals should inform the child of any mandatory reporting obligations and record the information in a form that will be available for any subsequent interviews, so that the child does not have to repeat the story multiple times. The health-care professional should ask clear, open-ended questions, using non-stigmatizing, age-appropriate language, and allow the child to respond in any way he or she wishes (e.g. using dolls, drawing pictures).

During medical procedures or examinations, the health-care professional should ensure that the examination space is safe and private, obtain the child's consent and assent for each intervention, ensure that the collection of forensic evidence is based on the child's account of the abuse and refrain from interventions that are medically unnecessary or harmful, e.g. virginity testing. The aim is to assess both physical and emotional health.

The health-care professional should seek to reduce the risk of reoccurrence of the same, or a different type of, violence. The child and caregiver should be involved in safety planning when appropriate. The health-care professional should refer the child to other agencies as appropriate, making sure to follow up all referrals and plan for the action to be taken if contact is lost with the child.

Mental health care should be offered only if the child presents with a mental health problem. Parents should be involved in this care when it is safe to do so. Cognitive behavioural therapy with a trauma focus appears to be effective for various diagnoses and types of maltreatment: in some cases, such therapy can be delivered by non-health-professionals. Pharmacological interventions are not recommended for anxiety disorders or depressive episodes in non-specialist settings.

Children who have been sexually abused should be treated in accordance with the *WHO clinical guidelines on responding to children and adolescents who have been sexually abused*. Children who have been raped and who present within 72 hours should be offered HIV post-exposure prophylaxis and adherence support. Girls who present within 120 hours (five days) should be offered emergency contraception. Vaccination against hepatitis B and human papillomavirus should be offered in accordance with national guidance.

Caregivers can be a valuable source of support for the child, and may be required to give consent for any treatment. However, they may also be perpetrators or enablers of violence,

or victims themselves. There is currently insufficient evidence to recommend any specific interventions for perpetrators, although there is some evidence that primary prevention measures such as home visits and parenting programmes are effective.

The procedures for reporting suspected child maltreatment will vary from country to country. There may be mandatory requirements for reporting to child protection agencies or the police, of which the child should be made aware. Reporting, which is a legal requirement incurring legal responsibility, should not be confused with referral to another agency. Health-care professionals should bear in mind the implications of reporting for the health, safety and well-being of the child (e.g. possible removal from the family or reprisals by the perpetrator or others) and make their first priority the child's immediate medical needs and the provision of first-line support. Other ethical issues where some current practices may not be consistent with international human rights standards are the reporting of consensual sex between adolescents and the informing of parents or caregivers without an adolescent's consent.

The safety and well-being of health-care providers themselves must not be forgotten. They may be at high risk of violence. Health systems can provide additional support to prevent carer burnout and mitigate the stress of giving evidence in court, for instance through mentoring and continuing professional development.

The guidelines will be supplemented by a technical report on the development of policies and national guidelines, a clinical handbook providing practical information for health-care providers and a training curriculum, all scheduled to be issued in 2019.

## **Safeguarding child rights – intersections between child protection and health sector response**

**Mr Aaron Greenberg, Senior Regional Adviser for Europe and Central Asia, Child Protection, UNICEF**

The health sector is a crucial partner in child protection: children and their parents or caregivers often have contact with health-care professionals more frequently than with other workers involved in child protection, and are more likely to trust them. However, the role of the health sector in child protection is not always clear: health-care professionals may notice signs indicative of child maltreatment, but it may not be clear to whom they should be reported, and they are not authorized to carry out actual child protection measures (e.g. removal from the family). It is not always clear where health-care professionals should report their concerns. Both health-care and child welfare professionals are in short supply and frequently overburdened with work.

One effective approach to the issue has been developed in Scotland, United Kingdom. At municipality or district level, a senior paediatrician and a senior nurse (the "coordination leads" – called "named doctors" or "named nurses" in other systems) are appointed to liaise with the social welfare system and the justice authorities. At hospital level, a senior paediatrician and a nurse/health visitor promote training in the health aspects of child protection and coordinate the health component of case reviews. Family doctors, nurses, midwives and health visitors identify parents or caregivers who need support, refer them to the appropriate professionals and provide support for case conferences. The child and adolescent health mental health services provide advice on therapeutic interventions for children who have been abused. All visits by children to accident and emergency

departments are recorded and the health visitor or school nurse is informed where applicable.

In many cases, there is suspicion, but no clear evidence, of child maltreatment. In such cases, a “case conference” will be convened, which in the Scottish example above will bring together a senior social worker and representatives of the health sector, e.g. midwives or nurses, and other sectors, e.g. the school or kindergarten, to find the solution that best meets the child’s interests. The child and parents or other family members will be involved wherever possible, since the best solution usually lies in keeping the child in the family and providing support through the extended family (e.g. grandparents) or child protection agencies. In such a situation, the family may feel anxious and threatened, and health-care professionals can be a welcome and trusted source of support.

Participants shared their experiences of liaison between the health-care sector and child protection sector, noting the lack of effective tools for the collection of data relating to multiple sectors. They stressed the importance of concerted action, especially with the education sector, to counter the widespread tolerance of low-level intergenerational violence (smacking, shaming) in many societies. In Albania, every local authority has a child protection department staffed by social workers, who collaborate closely with health-care professionals. In Bosnia and Herzegovina, there is a common system for child immunization, early-years development and identification and intervention in cases of child maltreatment. The country also has a network of community mental health centres, staffed by psychologists and occupational therapists, intended to help adults to recover from the traumatic events of the break-up of the former Yugoslavia and, inter alia, reduce intergenerational violence. In Montenegro, psychologists (assistants to the medical workers) are employed in the primary health care centres and provide services in health institutions. In an example from the WHO Western Pacific Region, the hospital network in Mongolia has set up “one-stop shops” for children suspected to have suffered maltreatment, where the family is automatically referred to welfare and counselling services and, if necessary, to the justice system following initial presentation at the emergency department.

## **Country examples of effective intersectoral working for responding to child maltreatment**

### **Montenegro**

**Dr Nela Krnić, Child Protection Officer, UNICEF Montenegro; Ms Svetlana Stojanović, VIP Focal Point, Ministry of Health of Montenegro**

The reforms of the health system of Montenegro, which started in 2003, had the main goal of providing health-care services on the principle “the patient comes first”. Medical services for victims of violence are mainly provided first in emergency care, while rehabilitation for persons who have suffered violence involves health facilities at all three levels of health care, depending on the type of service required. The reform has contributed to policy development and actions, which promote research, evaluation, surveillance and data collection. A large body of legislation, policy documents and guidance is in place, based on a public health approach. A strategy for child violence prevention and protection and an accompanying action plan have been adopted for the period 2017–2021: a multisectoral commission has been established to monitor, implement and evaluate them, with several targets, including a reduction of 20% by 2021 in the number of children exposed to violence

within the family; other targets cover improved reporting of child neglect and sexual violence and an increased perception among the public that corporal punishment of children is unacceptable. Collaboration between the ministries and agencies involved in the strategy is managed by a working group of practitioners at grass-roots level through implementation of the activities, service delivery and collection of the data on the principle that each institution submits data from its own area of competence to other relevant institutions.

Most recently, the Government has adopted the Protocol on treatment, prevention and protection of violence against women and domestic violence (2018), based on an earlier protocol dating from 2011. It is now working on draft national guidelines on treatment by the health sector to protect children from violence, abuse and neglect, due to be adopted in 2019. The draft guidelines stress multisectoral and multidisciplinary cooperation, which is recognized as the key to success in violence and injury prevention.

Challenges include the improvement of collaboration between the Ministry of Health and the Ministry of Labour and Social Welfare, especially in the areas of home visits and parenting programmes, and increasing accountability among professionals.

### **North Macedonia**

Dr Sanela Skhrijelji, Ministry of Labour and Social Policy; Professor Fimka Tozija, Institute of Public Health of North Macedonia, Faculty of Medicine, Sts Cyril and Methodius University, Skopje, North Macedonia; Dr Marija Raleva, Department of Child and Adolescent Psychiatry, Faculty of Medicine, University of Skopje.

Violence against children incurs enormous financial costs in addition to its human and social impact. In North Macedonia, violence against children is seen as a public health issue that requires an epidemiological response. In a 2017 study conducted in collaboration with UNICEF, 79% of parents said that they had used at least one violent method (psychological or physical) to discipline their children (6).

In view of the enduring effect of adverse childhood experiences on the stress-sensitive biological systems of the child and the associated increase in risk of age-related diseases, the country now places increased emphasis on early-years prevention and support programmes, which have the greatest impact and are the most cost-effective. The health sector focuses on capacity-building, mechanisms for the prevention and treatment of child abuse and neglect, documentation and implementation and scale-up of prevention programmes, parenting education and home visits by nurses.

A multisectoral response is essential – for instance, social workers focus on prevention and response, the justice system provides access to child-friendly justice, the education system strengthens social and emotional skills and works to prevent peer violence. A set of 43 indicators covering all sectors has been defined. However, data to monitor the situation of violence against children are scarce and show many gaps; such data are not systematically collected, disaggregated or correlated. Child protection professionals are not sufficiently familiar with the protocols and guidelines relating to violence against children and do not always recognize neglect as a form of violence.

A national coordination body has been established for the protection of children from abuse and neglect. Its tasks are to collect and process data, monitor and analyse abuse and neglect of children at the national level and draft proposals and legal opinions for new legislation.

The first national focal point for violence and injury prevention was appointed in 2003, and a national task force for violence and health in 2005.

There is a large body of national policies and strategies, and ample legislation that provides for surveillance, monitoring and data collection. A multisectoral group has drawn up a set of indicators for surveillance of violence against children, with the support of UNICEF. However, reporting of suspected cases of child maltreatment, although mandatory, is still inadequate; data quality is poor, and there is little exchange of primary information between sectors.

## **Republic of Moldova**

### **Dr Nelea Revenco, Institute of Mother and Child**

Child maltreatment is a serious problem in the Republic of Moldova. According to the UNICEF Multiple Indicator Cluster Survey in 2012 one third of deaths in children aged under five years are due to physical injury, and 76% of children aged between 2 and 14 years have suffered physical or psychological violence. Boys are subjected to corporal punishment more frequently than girls. The high prevalence of child maltreatment may be due to the general tolerance of domestic violence by both men and women or a lack of knowledge of alternative disciplinary methods among parents. The serious economic situation in the country is also likely to be a contributory factor.

Relevant policy documents include a strategy on child protection for the period 2014–2020, its accompanying action plan for the period 2016–2020 and a 2013 law on special protection for children in high-risk groups and children separated from their parents. An intersectoral collaboration mechanism for the detection, assessment, management, treatment and monitoring of children who have been, or may be, subjected to violence, neglect, exploitation or trafficking was set up in 2014. An intersectoral mechanism for primary prevention of threats to the well-being of all children was set up in 2018. A family law and justice centre will shortly be created, but there are challenges in the training of social workers.

Any suspicions must be reported to local social welfare services within 24 hours. Over 4000 cases per year were reported to the Ministry of Health and Social Protection in 2017, mainly in relation to children aged between 1 and 15 years and suspected neglect or physical abuse. Most cases were reported by family doctors or relatives of the child, while very few suspicions were reported by members of the child's local community.

The Moldovan paediatrics association, with the Institute of Mother and Child and the National Centre for the Prevention of Violence against Children, have produced two sets of guidance materials for health-care professionals: the first on the identification, management, treatment and monitoring in health-care institutions of children who have been, or may be, subjected to violence, and the second on differential diagnosis in cases of violence against children, neglect, exploitation and trafficking. Other positive developments include the training of specialists in the prevention of and intervention in suspected cases of violence against children and the development of a specialized form for the reporting of suspected cases.

In order to meet the challenges facing it, the Government plans to set up specialized regional services for children who have been, or may be, subjected to violence, with a sustainable financing mechanism, and develop operating procedures and quality standards

for them. Health-care professionals will use the coding system of the International Classification of Diseases, 10th edition, to document suspected cases of violence against children. Those undertaking home visits should focus on improving parenting skills. Social media campaigns should work to strengthen families and raise awareness of inappropriate behaviour towards children.

## **Serbia**

### **Dr Marija Markovic, City Institute of Public Health, Belgrade**

In 2017, there were six child deaths as a result of violence in Serbia. There is no single database to record non-fatal cases of violence against children. An extensive legal framework is in place to protect children against violence. It includes a 2013 law on special measures to prevent the commission of crimes against the sexual freedom of minors (“Maria’s Law”); a 2015 law on health documentation and evidence in health care; and a 2016 law on prevention of domestic violence.

The general protocol on child abuse and neglect, adopted in 2005, has been supplemented by special protocols on the protection of children in child welfare institutions and the health-care system (the latter reissued in revised form in 2018), guidelines for the judicial authorities and police, etc. A central database for reporting in the health-care system on child abuse and neglect recorded 980 reports of child abuse and neglect in 2017: 14% of the children involved were hospitalized because of their injuries. The special protocol on the protection of children in the health-care system includes a protocol for action in suspected cases of child abuse and neglect. Child protection teams are set up at primary, secondary and tertiary level and collaborate with social services, police, local government and other agencies.

The national policy framework also includes the strategy on prevention and protection from violence against children (2008–2015), with its accompanying action plan (2010–2012), and strategies on youth, gender equality, trafficking in human beings and social inclusion of the Roma population. A number of institutional mechanisms are in place, including the Protector of Human Rights and Freedoms (Ombudsman) of Serbia, a council for combating domestic violence and an interministerial team for the prevention of peer violence.

Challenges include the lack of a functional, effective central body for coordination, evaluation and monitoring and the lack of a standardized methodology to monitor the implementation of existing protocols. There are no centralized administrative records. Recommendations from UNICEF include strengthening of key institutional mechanisms and the local level of the protection system and awareness-raising to change social norms, values and attitudes. Following an adverse childhood experience survey in 2015, WHO recommendations include the development of a national policy for prevention, evidence-based prevention programmes and a strengthening of system response and data collection.

In response to those recommendations, a Council for the Rights of the Child was set up in 2017, and a new action plan for children covering the period 2018–2020, a law on child rights and a national strategy on prevention and protection against violence against children for the period 2018–2022 are in preparation. The national strategy is funded from the regular Government budget and will be evaluated by the Council on the Rights of the Child. A new survey on adverse childhood events is under way. Currently available survey findings show that 70% of children have been subjected to physical or emotional violence and that



39% have witnessed domestic violence, particularly in the Roma community. Other planned measures include the creation of a sustainable reporting system covering all levels of health-care institution, a single database for all incidents of violence and comprehensive education for health-care workers and associated personnel.

## **Presentation of examples of health sector response guidelines: challenges of development and implementation**

**Dr Danya Glaser, University College London, United Kingdom**

The National Institute for Health and Care Excellence (NICE) in the United Kingdom has adopted Clinical Guideline No. 89 (CG89, most recently updated in October 2017), entitled “Child maltreatment: when to suspect maltreatment in under 18s”. NICE Guideline No. 76 (NG76), also published in October 2017, covers the recognition of and response to physical, sexual and emotional abuse and neglect in children and young people under the age of 18 years. The recommendations include principles for working with children and carers and advice on vulnerability, multiagency cooperation in service plans and delivery, early intervention before maltreatment occurs and therapeutic interventions following maltreatment. They define indicators for suspected physical and sexual abuse and neglect; emotional, behavioural, interpersonal and social functioning; fabricated or induced illness; and interaction between the child and parent or caregiver. They do not cover risk factors for maltreatment, child sexual exploitation or female genital mutilation. Nor do they deal with the situation of children with disabilities, although this will be covered in the forthcoming WHO guidelines.

If health-care professionals suspect maltreatment, they should write down what they see and hear, look for other indicators of child maltreatment, gather information from other relevant agencies, discuss the case with colleagues designated as child protection leads and review the child’s case in due course. They should document and report on these actions, which should trigger further action by relevant agencies, including support for the family.

Clinical Guideline CG89 has been widely disseminated in health-care services in England and Wales; it is included in mandatory training for health-care professionals, including support staff such as hospital receptionists, and in clinical audits. The new NICE quality standard on child abuse and neglect (QS179)<sup>1</sup> will yield evidence on its impact in due course. Favourable factors for its implementation include strong child protection legislation, the statutory guidance on intersectoral working, multiagency safeguarding arrangements at local level and the presence of named safeguarding doctors and nurses in all health-care settings.

A number of principles from the United Kingdom situation could also be applied in other countries:

- child protection should be a matter of civil law – the child’s best interests are paramount and the family unit should be maintained wherever possible, with clear thresholds for intervention;
- possible criminal proceedings should be considered separately from child protection issues – the burden of proof for criminal prosecution is much higher;

---

<sup>1</sup> QS179 was formally issued shortly after the consultation, in February 2019. See [www.nice.org.uk/guidance/qs179](http://www.nice.org.uk/guidance/qs179).

- the procedure for reporting concerns must be very clear;
- multiagency cooperation should be statutory, with clear roles governing investigation and intervention;
- awareness-raising is essential to increase knowledge about the prevalence of and harm done by child maltreatment, how to recognize it and effective interventions – particular attention should be paid to neglect, which is more common than violence;
- effective methods of awareness-raising include publications, e-learning, mandatory training, targeting of specific audiences and conferences;
- change is much easier to include in initial professional training – it is much harder to change existing practice;
- change requires baseline information about the existing situation, in order to understand the current context and evaluate the effectiveness of the change;
- to change the beliefs of individual health-care professionals, they need information about the prevalence of and harm done by child maltreatment and they must take individual professional responsibility for any suspicions they have.

Effective behavioural change requires the provision of information (frequent repetition, delivery in small groups, endorsement by respected opinion leaders). Innovative ideas should be integrated into current practice. The skills of health-care professionals can be improved through supervision by named professionals and the development of specific protocols for evaluating possible neglect, injury or sexual abuse. A facilitating environment is essential, with strong leadership and the allocation of adequate time to learn the new skills. Incentives are not necessarily purely financial: “carrots” (completion of appropriate training as an obligation in employment contracts, proof of training for a clinical audit) are likely to be more effective than “sticks” (inspections and penalties).

Child protection should be distinguished from safeguarding: the former refers to immediate measures to avoid further harm to children due to sexual abuse, physical injury, induced illnesses, etc., while the latter refers to broader measures to protect children from physical violence, neglect or emotional abuse. The aim is to determine whether the child’s current situation is harmful and, if so, to take action. In the United Kingdom, child protection is the responsibility of the social welfare department rather than the health sector. The child’s best interests are the main consideration, even if this involves removing the child from the family as a last resort: in other countries, more emphasis may be placed on keeping the family together at all costs. There are currently no guidelines in the United Kingdom for the treatment of perpetrators.

## **Czechia**

### **Dr Jana Procházková, Charles University, Prague**

In Czechia, child sexual abuse is covered in basic medical training and in continuing professional development. Every child undergoes regular medical examinations. There are no home visits. Psychological consultations are available, but only at the request of the parent or caregiver. The public are legally obliged to report suspected child maltreatment, but the actual rate of reporting is very low. Many earlier prevention programmes are no longer in operation, but a programme on prevention of violence is planned for 2020.

Challenges include problems in intersectoral collaboration and work with families, shortages of health-care workers, and a lack of safe places for children who have suffered abuse, although all police stations now have private interview rooms. Work is under way to develop guidance for the health sector response to child abuse.

## **Latvia**

### **Mrs Inga Liepina, Public Health Department, Ministry of Health**

In Latvia, concerns have been raised about the low level of reporting suspected child abuse, despite a legal requirement for the police to be informed of any suspicions within 12 hours. In response, concise guidelines have been prepared for all health-care professionals, particularly family doctors, paediatricians, gynaecologists and nurses, detailing the signs of the main types of child maltreatment (neglect and emotional, physical or sexual abuse). For instance, health-care professionals may look out for a child who is not vaccinated or who has poor oral hygiene; an absence of a close relationship between the child and the parent; injuries in infants; a child who complains of abdominal pain, painful urination or genital itching. The child should undergo a comprehensive physical examination. The health-care professional should ask indirect, open and non-intimidating questions; there is no need to repeat the same questions over and over again. The conversation should be documented, recording the child's own words, the parent or caregiver's attitude, any emotional or psychological symptoms observed and any physical signs of abuse, with details of the location of injuries, their size, the colour of any bruises, etc. The guidelines were drafted by the Ministry of Health, with input from the Centre for Disease Prevention and Control, WHO, the Ministry of Welfare, the State Inspectorate for Protection of Children's Rights, the police and other stakeholders. There is no training curriculum on child protection, although a growth and employment programme funded by the European Union provides for education about the recognition and prevention of violence.

It is important to involve respected opinion leaders, health professional associations and other relevant ministries and institutions, but also to acknowledge that front-line health-care workers may need to work alone and may need support for that role. WHO could usefully provide examples of best practices and organize workshops for health-care professionals, as well as disseminating guidance on child protection.

## **Montenegro**

### **Dr Vesna Mačić, Children's Dispensary, Primary Health Care Centre, Kotor**

Montenegro is a traditional patriarchal Balkan society undergoing rapid social change. Training for paediatricians in the identification of suspected violence against children began in 2016, at the national level, organized by the Ministry of Health, UNICEF, nongovernmental organizations, the Association for Preventive Pediatrics and the nongovernmental organization "SOS" Podgorica, on the topic "prevent violence – stop silence". This two-day seminar involved about 50 paediatricians from 2016 to 2018, together with a small number of psychologists and nurses. In Montenegro, there are about 150 paediatricians at all three levels of health care. All paediatricians need this basic seminar because timely and effective responses to violence against children are questioned in all further activities. The education of nurses, particularly patronage (outreach) nurses, is also imperative in further professional work. Accordingly, training has begun for the identification of violence against children; an initial group of 25 nurses has been trained to

conduct home visits. Specialized child protection teams, including nutritionists, psychiatrists, psychologists and nurses, will be appointed in all health-care institutions in due course. In the meantime, most cases are identified by family doctors: they need better training, and they frequently work in small communities, which means that members of the public may be concerned about reporting a prominent local figure. There is a need to increase public awareness about violence against children through parenting classes and online resources.

The empowerment, support and protection of doctors in reporting is properly recommended in the draft guidelines that are being developed. It is recommended to form an "expert team" of a minimum of three professional representatives from each involved institution, where their responsibility would be confirmed by signatures on a joint decision. This is very important in terms of the kind of environment and society we live and work for.

In particular, it is important to make sure that the guidelines are not a "textbook", but a short, clear, decisive book formula that will be on the table of every chosen doctor (i.e. a doctor chosen by the patient himself/herself). Talking with the parents in "parenting schools" is very important; here they can learn and get answers to their questions about raising a child today. Of course, since the health system interacts with the social services, the police and the prosecutor's office, it is essential to continue intersectoral education and cooperation; this has already begun.

Finally, in line with the trend of digitization and online communication, it is necessary to create sites for helping children and parents, invest in a campaign through radio, TV and social networks, and visit educational institutions and engage in conversations, such as those currently realized very well through the youth counselling centre in primary health care.

## **Market place: European country profiles with examples of the health sector's role in responding to child maltreatment**

Country profiles from the *European status report on preventing child maltreatment* were used to stimulate debate on the health sector's role in responding to child maltreatment.

### **Albania**

The State Agency for Child Rights Protection has drawn up a protocol for reporting cases of child maltreatment by different sectors, although there is little systematic exchange of information. Guidelines on domestic violence have existed since 2012.

### **Armenia**

Information exchange and administrative cooperation between sectors are mandated by a Government decree, although no formal procedures have been adopted. In the health sector, there is a clinical protocol regulating the care of all persons, including children, who have suffered sexual violence, although it is in need of updating. Teachers and nurses are trained to promote positive parenting skills and to recognize signs of violence against children. Child protection centres provide medical, psychological and legal advice.

### **Bosnia and Herzegovina**

Services related to violence against children are well integrated between sectors and well resourced. The main priorities are support for parents and school-based life skills education. Guidelines and protocols have been adopted on child maltreatment, peer violence,

identification of children who have been subjected to abuse and the procedure for physical examination of children and documentation of the findings. The main challenges are defining the roles of the various sectors and involving schools in the prevention of violence against children.

### **Croatia**

Action by the health-care system, social welfare department and justice authorities is well coordinated. There are protocols on child maltreatment, which stipulate that family doctors must refer any suspicions to a hospital. Every health-care institution has a named focal point for child protection.

### **Georgia**

A Government decree stipulates that children who have suffered violence must receive medical and psychological support. There are specialized reporting forms on violence against children for health-care professionals, social workers, police officers, etc.

### **Turkey**

There is good collaboration between the Ministry of Health, the Ministry of Family and Social Policy and the Ministry of Justice, although there are no formal protocols. Child protection centres are being set up under the Ministry of Health, but bureaucracy is a major obstacle.

## **Reflections: panel on key issues raised, reflection on the scope of and process for the development of national guidelines**

**Dr Danya Glaser, University College London; Ms Berit Kieselbach, WHO headquarters; Dr Svetlana Shport, Federal Medical Center for Psychiatry and Narcology, Russian Federation**

Summing up the discussion, panel members highlighted the shortage of health-care workers and the need for training in intersectoral collaboration. There is particular confusion about the links between the health sector and social welfare services.

Mandatory reporting of suspected cases of child maltreatment, when essential, should not absolve professionals of the responsibility to ensure that action is subsequently taken: overworked health-care professionals may report their concerns to social workers and consider that their task is done, but the social workers may be just as overburdened. Guidelines for dealing with suspected cases of child maltreatment are not mandatory, but there is often a professional obligation to abide by them, for instance in the professional's terms of employment.

In the Russian Federation, the health sector has established effective collaboration with the police. A special protocol has been developed for children who have suffered sexual abuse. Practical support for children and adolescents who engage in self-harming or health-harming behaviour and those at risk of suicide is offered in collaboration with the Ministry of Education, although measures such as telephone helplines are more successful in large cities than in rural areas. There is no formal exchange of data between sectors, but reports on issues such as self-harming are shared with all relevant agencies.

## **WHO Pocketbook of Primary Care for Children: responding to child maltreatment**

**Dr Dinesh Sethi, WHO Regional Office for Europe**

The forthcoming pocketbook of primary care for children and adolescents aims to present updated primary care guidelines that address the needs of children and adolescents presenting to first-level health facilities in the WHO European Region. It is based on existing WHO guidelines and the recommendations of an editorial group of physicians and child and adolescent health experts. It will have six major sections, of which three are particularly relevant to child maltreatment: health promotion and prevention from birth through adolescence; the child presenting with a complaint (cough, fever, etc.); and the child (birth to 18 years) with specific disease. There will also be a separate chapter specifically dealing with child maltreatment. The section on maltreatment will be approximately 20 pages in length and will cover identification of maltreatment of children, diagnosis, interview methods, ways of interacting with children and caregivers, prevention and management of maltreatment of children, risk assessment and follow-up, particularly in respect of children's mental health needs.

### **Role of the health sector and primary health care providers in responding to child maltreatment**

**Mr Rustam Talishinskiy, Science Issues of Traumatology and Orthopedics Institute, Azerbaijan; Ms Rumiana Dinolova, National Center of Public Health and Analyses, Bulgaria; Ms Hanna Vseiov, Ministry of Social Affairs, Estonia; Ms Bermet Baryktabasova, Ministry of Health, Kyrgyzstan; Ms Audrone Astrauskiene, Ministry of Health, Lithuania; Dr Mevlida Gusinjac, Ministry of Health, Montenegro; Mr Tiberius Bradatan, Ministry of Health, Romania; Ms Irena Krotec, National Institute of Health, Slovenia; Mr Oleh Dudin, Ministry of Health, Ukraine**

#### **Azerbaijan**

At the primary health care level, cases of child maltreatment are identified and recorded by family doctors or community paediatricians, who receive specialized training. Many cases of child maltreatment are identified from video surveillance at schools and other public institutions and urban streets. Every region has a family violence commission, staffed by specialists from the ministries of health, education, labour and justice, which deals with cases of family violence.

#### **Bulgaria**

Child protection is assured by two Government agencies, the Agency for Social Assistance and the Agency for Child Protection. Every municipality has a multidisciplinary child protection team. However, data are not collected or exchanged systematically: the education system employs educational psychologists but does not collect any data about maltreatment or violence. Only 1% of reports of child maltreatment are made by family doctors. According to a survey by the National Center of Public Health and Analyses, 40% of respondents reported experiences of violence or neglect, and 28% reported physical violence. One in three respondents reported that they had been bullied at school.

## **Estonia**

The social welfare system in Estonia has created an effective child protection system, but cases of child maltreatment are much more likely to be initially detected by parents, neighbours, teachers or a family doctor. The health sector occupies a special role, as the first public agency with which most children come into contact. Children attend health-care facilities for routine check-ups, and doctors and nurses enjoy widespread public confidence. New health system guidelines are currently being finalized; these are aligned with WHO evidence-based tools.

## **Kyrgyzstan**

Kyrgyzstan is a patriarchal society with strong social expectations and persistent taboos. Family violence is a major problem. The child protection system includes home visits for children under 5 years and guidelines on psychological help for children who have witnessed violence. A simple standardized form has been developed for the reporting of all types of violence against both children and adults, and an e-reporting system is also in place. Further child protection measures are planned, including monitoring of children from the earliest age, guidance for emergency departments and family doctors and measures to deal with mental health problems.

## **Lithuania**

A strong, flexible health system plays an essential role in the prevention of child maltreatment. However, health-care professionals cannot always provide the best care because of a lack of specialized staff, support and training. The Ministry of Health is currently updating its guidance on the diagnosis of child maltreatment, and the subject is covered in medical school curricula. Unfortunately, child maltreatment and family violence are common and perceived as normal by the general public. Specialized support is provided by an intersectoral team of medical, legal, police and welfare professionals, and strict alcohol control measures have been introduced, since family violence is often associated with heavy drinking. Prevention programmes include parenting skills education and home visits by nurses. Specialized centres have been set up to help children who have been subjected to sexual abuse, providing medical, psychological, welfare and legal services. There is a total of 114 mental health centres at municipal level, staffed by psychiatrists, psychologists, nurses and social workers. There are many good practices at local level, but it is difficult to scale them up to the national level.

## **Montenegro**

In Montenegro health care is being developed as in most of the European countries. It is at the primary level in 18 Primary Health Care Centers, at a secondary level in 7 general hospitals and 3 special hospitals, at the tertiary level at the Clinical Center of Montenegro and the Institute of Public Health. There are also two institutes: Institute of Emergency Medicine and the Blood Transfusion Institute.

The model of primary health care organization is being realized through the Health Care Centers:

Selected Doctors: Chosen doctor for Adult, for Children-Pediatrician, chosen doctor for Women - Gynecologist and chosen doctor dentist.

Support Centers: Center for Lung Diseases and TBC, Center for Mental Health, Center for Diagnostics, Center for Children with Special Needs, Center for Prevention.

Support units: Patronage Unit, Physical Therapy Unit at Primary Level, Medical Transportation Unit.

The scope of work of the chosen doctor team is: Preventive work (preventive examinations, prevention of chronic non-communicable diseases, cancer prevention, vaccinations), Curative work: diagnostics, treatment, rehabilitation, home treatment) and public authorizations: drug prescribing, sick leave, processing for disability commission, referrals and travel orders.

### **Romania**

Romania was one of the first countries to ban corporal punishment in all settings. The country has adopted a national strategy for the protection and promotion of children's rights for the period 2014–2020, plus a national strategy for the Roma minority covering the period 2015–2020. Further revisions of the legislation relating to child maltreatment are under way. Fifty-two local intersectoral teams have been set up to deal with child maltreatment, family violence and child labour. Greater investment is required to prevent, identify and respond to child maltreatment: there is a system for referral of suspected cases to medical or mental health professionals, but it is not widely implemented. Home visits by nurses have been introduced, but their effectiveness has not been evaluated.

### **Slovenia**

Slovenia has a strong preventive medicine system, with approximately 10 antenatal check-ups for pregnant women, paid for by health insurance, and regular check-ups for children. Nurses employed on home visits are trained to support vulnerable new mothers and identify cases of child maltreatment. Programmes on parenting education, communication between parents and the psychological needs of children are currently being updated. The parenting programme "The Incredible Years" and the online counselling service for teenagers "This is Me" are operating successfully.

Training in the identification of and response to child maltreatment are mandatory for trainee paediatricians and family doctors, accounting for 16 hours of their two months of training in public health medicine. In 2016, the National Institute of Public Health introduced training on the prevention of sexual violence against children for teachers, kindergarten workers and school counsellors, although the training is optional. Expert guidelines have been drawn up for health-care workers on the response to family violence and child maltreatment. In 2018, training on screening for family violence in the perinatal period was introduced for all gynaecology teams. Challenges include the need for training for all health-care professionals and teachers, the lack of a unified database on child maltreatment for all sectors and the need to make court proceedings more child-friendly.

### **Ukraine**

In Ukraine, the old Soviet model of health financing is being replaced by a system where financing follows the patient. All doctors are trained to identify cases of child maltreatment. A law on domestic violence has been adopted, covering violence against children, sexual abuse and partner violence, with associated legislation including a law to protect health-care workers from violence. Ukraine has implemented NICE guidelines, including those



related to child abuse, and the Ministry of Health has issued guidance on the response by health-care professionals to suspected cases of child maltreatment.

### **Group work: discussion of the process to develop and implement national guidelines for the health sector response to child maltreatment**

Three groups met separately to discuss the process of developing and implementing national guidelines for the health effects sector response to child maltreatment. A fourth group of Montenegrin stakeholders met at the same time to continue their work on the draft national guidelines on action by the health sector to protect children from violence, abuse and neglect.

#### **Group 1: Albania, Bosnia and Herzegovina/Republika Srpska, Croatia, Czechia, North Macedonia, Serbia**

All countries in this group have protocols on child maltreatment, some general and some referring specifically to child maltreatment or other types of violence. Most health-care workers use the protocols, but monitoring and data collection could be improved. The protocols used in different countries should be harmonized with one another and aligned with WHO guidance. The role of each sector should be clearly defined. Simplified, user-friendly guidelines should be provided for overworked primary care professionals. International agencies, including WHO, UNICEF and the United Nations Population Fund (UNFPA) should work together to support countries and use their influence with governments in action to combat child abuse and neglect.

Some countries provide training on child abuse and neglect at undergraduate level, and one (Albania) at postgraduate level. Adequate staffing levels, continuing professional development and annual refresher courses are essential if training is to be effective. Train-the-trainer or “snowball” techniques may be employed to disseminate expertise efficiently. The new skills learned during training should be reflected in working practices and workload standards (e.g. more time should be allowed for physical examination of children). Social workers trained in child protection should be appointed in every health-care institution.

All sectors involved in child protection (health, welfare, police, justice, education, etc.) should contribute to the response to child maltreatment, and training in intersectoral work should be provided.

Next steps: countries should develop or improve their action plans to combat child abuse and neglect; harmonize their guidelines to be in line with the forthcoming WHO guidelines; organize study visits by multisectoral teams within the subregion; and incorporate action against child abuse and neglect into the biennial collaborative agreements with WHO. Adequate staffing levels, the workload of health-care professionals and funding pose persistent challenges.

#### **Group 2: Bulgaria, Estonia, Latvia, Romania, Slovenia, Turkey, Ukraine**

In Bulgaria, the law on a child protection places an obligation on all members of the public to report cases of child maltreatment. The country has not yet acceded to the Council of Europe Convention on preventing and combating violence against women and domestic violence. In Estonia, family doctors are informed by hospitals when, for instance, a woman has given birth, and nurses will visit the family if necessary. More training for family doctors

is required, together with better evaluation of current practice. In Latvia, social workers are employed in hospitals.

In Romania, a programme funded until 2020 employs over 1500 nurses and 500 auxiliary health workers. A national database on child maltreatment has been established. In Slovenia, all schools employ health workers and social workers, to whom teachers may report any concerns. In Turkey, there are as yet no formal guidelines for intersectoral cooperation. A child suspected to have undergone abuse will be taken to a special centre, given a physical examination and interviewed by social workers, psychiatrists and forensic psychiatrists, with a subsequent report to a legal expert. In Ukraine, health-care workers must report all cases of suspected child maltreatment to the police and social welfare department; in addition, all hospitals have their own protocols on the response to child abuse. There is some political opposition to child protection legislation and associated data collection.

Overall, all countries have problems in collecting high-quality data, promoting intersectoral collaboration and managing cases where the child's parent or caregiver is unwilling to cooperate with the authorities. In some countries, patriarchal family structures persist and the preservation of traditional family values is a political issue. The response to suspected physical violence is obvious, but in cases of neglect or poverty it is much less clear-cut. Feedback on the eventual outcome of an investigation, perhaps using a harmonized computer system, would increase the motivation and job satisfaction of health-care professionals and social workers and help to avoid carer burnout.

### **Group 3: Armenia, Azerbaijan, Georgia, Kyrgyzstan, Lithuania, Republic of Moldova, Russian Federation**

In general, this group of countries does not have national guidelines or protocols: relevant WHO guidance could be adapted to the national situation by an intersectoral working group. The draft guidelines should be agreed with all stakeholders and approved by ministries of health, which should determine the human resources required for identification and confirmation of cases of child maltreatment and for documentation, monitoring, treatment and mental health care. Training should be provided at the preservice stage and as continuing professional development for nurses and other health-care professionals.

All governmental and nongovernmental workers are obliged to report cases of child maltreatment to the child protection services. A harmonized national protocol should be developed for intersectoral cooperation, detailing the procedures to be followed in each case. Relevant stakeholders are likely to include ministries of health, social welfare and internal affairs, crisis centres, etc. The partners will develop protocols, recommendations and training courses at each level for professionals from other sectors. The main roles of the health sector are to identify cases of child maltreatment, to respond by providing medical care, mental health care and support for action by other sectors, and to report suspicions as appropriate.

One programme in the Russian Federation is aimed at combating bullying by peers, parents and teachers in schools. School medical services and educational psychologists work together with the education department and specialist health services. Expert advice is available from specialist centres for adolescent medicine, including e-medicine services for doctors outside the capital, Moscow.

Dr Glaser noted that there is a major shortage of child and adolescent mental health professionals in the United Kingdom, and not every child will get specialist treatment. Simple non-medical measures can be very helpful, such as keeping children fully informed of what is happening with their case, assuring them that adults believe them and that what has happened to them is not their fault, helping them with basic problems of sleeping or eating and encouraging them to talk to a safe, trusted adult, e.g. the mother.

### **Panel: how WHO and UNICEF could help to implement recommendations – implications for capacity development**

**Dr Danya Glaser, University College London, United Kingdom; Mr Aaron Greenberg, UNICEF; Ms Berit Kieselbach, WHO headquarters; Ms Irena Krotec, National Institute of Public Health, Slovenia; Dr Marija Markovic, Belgrade City Institute of Public Health, Serbia; Dr Rustam Talishinskiy, Baku Traumatology and Orthopedics Institute, Azerbaijan**

The panel identified a number of positive aspects emerging from the consultation. All participants had acknowledged the vital role of the health sector in combating child maltreatment, since it is often the first point of contact for at-risk families. Most countries in the subregion already have legislation, protocols, guidelines and systems for reporting and referral of suspected cases of child maltreatment to the welfare and law enforcement authorities.

WHO guidelines and recommendations can make a valuable contribution to the development of national legislation and policy. They can be adopted as they are, or adapted and incorporated into existing instruments. Implementation of new measures is a long-term process, which must be constantly monitored and rewarded with incentives, training and support from named professionals. Evaluation of the new measures should use the criteria “are children’s lives more effectively protected by these measures?”, and “do the measures do less harm than the original situation?”. It should be borne in mind, however, that success or failure does not depend on the health sector alone.

The panel also identified a number of challenges. The shortage of financial and human resources is a problem for all Member States. Collaboration between the health sector and other relevant sectors (social welfare, education, justice, police, etc.) must be improved. New and/or updated protocols are required for the identification of and response to child maltreatment. In particular, child neglect often goes unrecognized: more awareness-raising campaigns should be conducted among both health-care professionals and the general public.

More emphasis should be placed on first-line support for children, in collaboration with other sectors, replacing the prevailing view that health-care professionals’ obligations come at an end as soon as they have reported any suspicions. Better reporting protocols are also required. The new and updated protocols and new interventions must be based on reliable evidence: this, in turn, will require improvements in data collection, using a system harmonized between the different sectors and giving busy staff the time to perform the task properly. Data should be disaggregated and measured against existing baseline data. Pending those improvements, however, a lack of data must not be used as an excuse for failure to take action against existing deficiencies.

It may not always be possible to give health-care professionals more money or more time, but training and task descriptions can be improved at relatively low cost. It is easier to train

health-care professionals in child protection issues at the preservice stage, rather than seeking to change entrenched attitudes and practices later. Clear, concise, easily actionable versions of guidelines and protocols should be issued, to make them more practical for busy health-care professionals to use. Better feedback on the outcome of reported cases will help to increase health-care professionals' motivation to report their suspicions.

It is not always clear which agency has the authority to decide on priorities and areas of responsibility for intersectoral action. In some cases, the health sector or other agencies may have a statutory obligation to take certain action, e.g. placing a child in juvenile detention. It is essential for each sector to know its respective responsibilities and obligations, which are assigned by a political decision.

The health sector should seek to improve communication with children and families and help them to make informed decisions. More attention should be paid to the particular risk of child maltreatment experienced by children with disabilities.

In the ensuing discussion, participants made the following points:

- it is important to analyse data as well as collecting it;
- there is no dispute about the importance of intersectoral collaboration but, in practice, the health sector can only propose and implement recommendations on its own behalf;
- WHO, UNICEF and other agencies are urged to harmonize their respective approaches and address the same problems in the same way;
- information flow should be a two-way process – not only from individuals and health-care professionals to ministries and welfare agencies, but also from these institutions to health-care professionals and the general public;
- support services for children who have suffered maltreatment and their families should be strengthened, particularly in respect of long-term support for children experiencing the effects of maltreatment over many years;
- the roles of the various agencies should be clearly defined – in Montenegro, for example, guidance on the psychosocial rehabilitation of sex offenders has been prepared, but it is not clear which ministry will arrange the relevant training in future; in Albania, child protection specialists from various sectors meet to decide which action each sector will take;
- improving the guidance on reporting given to health-care professionals will reduce the number of unnecessary referrals to overworked social welfare agencies;
- the care model for children who have to be removed from their families should be foster rather than institutional care wherever possible;

Ms Kieselbach said that the INSPIRE package lays out a joint response to child maltreatment by agencies from seven different sectors: in particular, it seeks to strengthen the role of the health sector in both prevention and response, which has been underrepresented in joint action in the past.

Dr Sethi noted that, while data from reporting and administrative procedures are valuable, they do not show the full extent of child maltreatment: adverse childhood experiences

surveys, such as those already conducted in Albania, Czechia, Montenegro, North Macedonia, Romania, the Russian Federation, Serbia, Turkey and other countries give a more accurate picture of the problem.

### **Next steps**

- A way forward may be local implementation pilots that should be transformed into nationwide programmes with an evaluative framework.
- WHO, UNICEF and UNFPA should advocate for joint action by multiple sectors, using their influence both with national governments and at local level.
- The normative support available from WHO can help to strengthen national guidelines and capacity for front-line work, as well as specialist services such as children's mental health services.

### **Closure of the consultation**

Ms Svetlana Stojanović, Ministry of Health, Montenegro, thanked all present for their active participation in a successful meeting, especially the organizers, representatives of WHO headquarters and the Regional Office and the WHO country office in Montenegro. She also thanked Dr Sethi for his contribution to the realization of the high-level consultations.

Dr Yon likewise thanked participants for their insights into the important role of the health sector, both in response to child maltreatment and in primary prevention, and their recommendations on the role of WHO in normative work and the dissemination of best practices.

Following a short video showing highlights of the past two days, Dr Yon declared the meeting closed.

## References

- <sup>1</sup> Hillis S, Mercy JA, Amobi A, Kress H. Global prevalence of past-year violence against children: A systematic review and minimum estimates. *Pediatrics*. 2016;137(3):e20154079.
- <sup>2</sup> Bellis MA, Hughes K, Leckenby N, Jones L, Baban A, Kachaeva M et al. Adverse childhood experiences and associations with health-harming behaviours in young adults: surveys in eight eastern European countries. *Bull World Health Organ*. 2014;92:641-55. doi: <http://dx.doi.org/10.2471/BLT.13.129247>, accessed 6 February 2019.
- <sup>3</sup> Responding to children and adolescents who have been sexually abused: WHO clinical guidelines. Geneva: World Health Organization; 2017 (<https://www.who.int/reproductivehealth/publications/violence/clinical-response-csa/en/>, accessed 6 February 2019).
- <sup>4</sup> mhGAP intervention guide for mental, neurological and substance use disorders in non-specialized health settings. Geneva: World Health Organization; 2010 ([https://www.who.int/mental\\_health/publications/mhGAP\\_intervention\\_guide/en/](https://www.who.int/mental_health/publications/mhGAP_intervention_guide/en/), accessed 6 February 2019).
- <sup>5</sup> Child abuse and neglect [NICE guideline NG76]. London: National Institute for Health and Care Excellence; 2017 (<https://www.nice.org.uk/guidance/ng76/chapter/recommendations#recognising-child-abuse-and-neglect>, accessed 6 February 2019).
- <sup>6</sup> Survey on parents' and caregivers' knowledge, attitudes, practices and social norms associated with violence against children. UNICEF: Skopje; 2017:34.

## Annex 1. Programme of work

DAY ONE: TUESDAY, 29 JANUARY 2019		
08:00 - 09:00	Registration with coffee	
09:00 – 09:40 <b>Chair: Dr Miro Knežević,</b> Director General for Public Health and Public Health Programs, Ministry of Health of Montenegro	Official welcome	<b>Dr Kenan Hrapovic</b> , Minister of Health of Montenegro – (10 mins)  <b>Ms Mina Brajovic</b> , WHO Head of Country Office (Montenegro) – (5 mins)  <b>Mr Jonathon Passmore</b> , Programme Manager of Violence and Injury Programme, WHO Regional Office for Europe – (5 mins)
	Introduction of participants	(20 mins)
09:40 – 10:00	The cost and consequences of Adverse Childhood Experiences (ACEs) and how they can be avoided	<b>Dr Dinesh Sethi</b> , WHO Consultant – (15 mins presentation; 5 mins questions)
10:00 – 10:20	The importance of prevention and the INSPIRE package	<b>Mr Jonathon Passmore</b> , Violence and Injury Prevention Programme Manager (WHO Regional Office for Europe) – (15 mins presentation; 5 mins questions)
10:20 – 10:50	Introduction to WHO Guidelines for the Health Sector response to child maltreatment and recommendations proposed	<b>Ms Berit Kieselbach</b> , Technical Officer, WHO Headquarters, – (20 mins presentation; 10 mins questions)
10:50 – 11:10	Tea/Coffee	
11:10 – 11:30 <b>Chair: Dr Goran Cerkez,</b> Assistant Minister of Health of the Federation of Bosnia and Herzegovina	Safeguarding child rights- Intersections between child protection and health sector response	<b>Dr Aaron Greenberg</b> , UNICEF, Child Protection Lead, UNICEF CEA Regional Office – (15 mins presentation; 5 mins questions)
11:30-12:30	Country examples of effective intersectoral working for responding to child maltreatment and facilitated discussion	<b>Successes and challenges of the intersectoral response to child maltreatment:</b>  - <b>Ms Svetlana Stojanović</b> , Ministry of Health, Montenegro – (15 mins)  - <b>TBC</b> , North Macedonia – (15 mins)  - <b>TBC</b> , Serbia – (15 mins)  - <b>Dr Nelea Revenco</b> , Republic of Moldova – (15 mins)
12:30 – 13:30	Lunch	

<b>13:30 – 14:15</b> <b>Chair: Ms Berit Kieselbach,</b> WHO Headquarters	Development and implementation of Guidelines in the United Kingdom and lessons for other countries who want to develop or adapt WHO guidelines	<b>Dr Danya Glaser</b> , Institute of Child Health and University College London – (30 mins presentation; 15 mins questions)
<b>14:15 – 15:00</b>	Presentation of examples of Health Sector Response Guidelines from other countries: Challenges of development and implementation	<b>Dr Vesna Mačić</b> , Primary Health Care Center Kotor, Montenegro – (15 mins) <b>Mrs Inga Liepina</b> , Ministry of Health of Latvia – (15 mins) <b>Dr Jana Procházková</b> , Hussite Theological Faculty, Charles University, Czechia – (15 mins)
<b>15:00 – 15:30</b>	<b>Tea/Coffee</b>	
<b>15:30– 16:30</b> <b>Chair: Dr Dinesh Sethi,</b> WHO Consultant	<b>MARKET PLACE:</b> European country profiles with examples on the health sector’s role in responding to child maltreatment	- <b>Dr Karine Gabrielyan and Dr Nune Pashayan</b> , Armenia - <b>Dr Ilsa Dede and Dr Gentiana Qirjako</b> , Albania - <b>Dr Dalibor Pejovic</b> , Bosnia and Herzegovina - <b>Ivana Brkić Biloš</b> , Croatia - <b>Nana Kalmakhelidze</b> , Georgia - <b>TBC</b> , Turkey
<b>16:30 – 17:15</b>	<b>REFLECTIONS:</b> Panel on key issues raised, reflection on the scope of and process for the development of national guidelines- lessons learnt, constraints and opportunities	<b>Panellists:</b> - <b>Ms Berit Kieselbach</b> , Technical Officer, WHO Headquarters – (3 mins) - <b>Dr Danya Glaser</b> , Institute of Child Health and University College London – (3 mins) - <b>Dr Svetlana Shport</b> , Scientific Secretary of the National Medical Center for Psychiatry and Narcology named after V.P. Serbsky, Russian Federation – (3 mins) <b>Moderated Discussion</b> – (15 mins)
<b>19:00</b>	<b>Social event</b>	
<b>DAY TWO: WEDNESDAY, 30 JANUARY 2019</b>		
<b>09:00 – 09:10</b> <b>Chair: Dr Mevlida Gusinjac,</b> Director General for Health Care Protection Ministry of Health of Montenegro	Recap/debrief	<b>Dr Gentiana Qirjako</b> , Faculty of Medicine, Public Health Institution, Albania



<p><b>09:10 – 10:30</b></p>	<p>Towards effective Primary Health Care and Health Systems engagement in providing response to child maltreatment</p>	<p>WHO Pocketbook of Primary Care for Children: Responding to Child Maltreatment</p> <ul style="list-style-type: none"> <li>- <b>Dr Dinesh Sethi</b>, WHO Consultant (15 mins presentation 5 mins questions)</li> </ul> <p>Discussants to reflect on the Role of the Health Sector and Primary Health Care providers to respond to child maltreatment:</p> <ul style="list-style-type: none"> <li>- <b>Dr Mevlida Gusinjac</b>, Director General for Health Care Protection, Ministry of Health, Montenegro – (5 mins)</li> <li>- <b>Dr Rustam Talishinskiy</b>, Science Issues of Traumatology and Orthopedics Institute, Azerbaijan – (5 mins)</li> <li>- <b>Dr Rumiana Dinolova</b>, National Center of Public Health and Analyses, Bulgaria – (5 mins)</li> <li>- <b>Dr Hanna Vsevirov</b>, Ministry of Social Affairs, Estonia – (5 mins)</li> <li>- <b>Dr Bermet Baryktabasova</b>, Ministry of Health, Kyrgyzstan – (5 mins)</li> <li>- <b>Dr Audrone Astrauskiene</b>, Ministry of Health, Lithuania – (5 mins)</li> <li>- <b>Dr Tiberius Bradatan</b>, Ministry of Health, Romania – (5 mins)</li> <li>- <b>Dr Irena Krotec</b>, National Institute of Health, Slovenia – (5 mins)</li> <li>- <b>Dr Oleh Dudin</b>, Ministry of Health, Ukraine – (5 mins)</li> </ul>
<p><b>10:30 – 11:00</b></p>	<p><b>Tea/Coffee</b></p>	
<p><b>11:00 – 11:10</b> <b>Chair: Yongjie Yon</b>, WHO Regional Office for Europe</p>	<p>Introduction to Group work</p>	<p><b>Dr Yongjie Yon</b>, Technical Officer, WHO Regional Office for Europe</p>

<b>11:10 – 12:30</b>	<b>GROUPWORK:</b> Discussion on process to develop and implement national guidelines for the health sector response to child maltreatment, including integration into primary health care, processes, roles, responsibilities and mechanisms for implementation of guidelines and working with other sectors	<b>All</b>
<b>12:30 – 13:30</b>	<b>Lunch</b>	
<b>13:30 – 14:30</b> <b>Chair:</b> <b>Dr Dinesh Sethi, WHO</b> Consultant	Feedback from the breakout session groups	<b>Rapporteur – (10 mins each)</b>
<b>14:30 – 14:40</b>	<b>Mobility break</b>	
<b>14:40 – 15:30</b>	Feedback from the breakout session groups	<b>Rapporteur – (10 mins each)</b>
<b>15:30 – 16:00</b>	<b>Coffee</b>	
<b>16:00 – 16:40</b>	<b>PANEL:</b> How WHO and UNICEF could help to implement recommendations: implications for capacity development	<b>Panellists:</b> <ul style="list-style-type: none"> <li>- <b>Ms Berit Kieselbach</b>, Technical Officer, WHO Headquarters</li> <li>- <b>Dr Aaron Greenberg</b>, UNICEF, Child Protection Lead, UNICEF CEA Regional Office</li> <li>- <b>Rapporteurs</b>, from the group feedback</li> <li>- <b>Dr Marija Markovic</b>, City Institute of Public Health, Serbia</li> </ul>
<b>16:40 – 17:00</b>	Closing and reflections	<b>Ms Svetlana Stojanović</b> , VIP Focal Point, Ministry of Health of Montenegro – (3 mins intervention)  <b>Dr Yongjie Yon</b> , WHO Regional Office for Europe – (3 mins intervention)  Workshop Evaluation form
<b>17:00</b>	<b>CLOSE</b>	

## Annex 2. List of participants

### Albania

Ms Ilsa Dede  
Specialist at Children Section  
Ministry of Health and Social Protection  
Tirana

Dr Gentiana Qirjako  
Head of Department  
Institute of Public Health  
Tirana

### Armenia

Ms Karine Gabrielyan  
Chief Specialist  
Ministry of Health  
Yerevan

Dr Nune Pashayan  
Head of Children health care unit in Mother  
and child health care Department  
Ministry of Health  
Yerevan

### Azerbaijan

Dr Rustam Talishinskiy  
Associate Professor, PhD  
Deputy Director on Science Issues of  
Traumatology and Orthopedics Institute  
Baku

### Bosnia and Herzegovina

Dr Goran Cerkez  
Assistant Minister of Health  
Ministry of Health of the Federation of Bosnia  
and Herzegovina  
Sarajevo

Mr Dalibor Pejovic  
Head, Unit for Planning, Human Resources  
and Information  
Ministry of Civil Affairs of Bosnia and  
Herzegovina  
Sarajevo

Ms Sanja Skenderija  
Senior Technical Officer for Family and Child  
Protection  
Ministry of Health and Social Welfare of the  
Republika Srpska  
Banja Luka

### Bulgaria

Dr Romyana Dinolova  
MD, PhD, Chief Expert  
National Centre of Public Health and Analyses,  
Department of Mental Health  
Ministry of Health  
Sofia

### Croatia

Ms Ivana Brkić Biloš  
Head of Division for Epidemiology and  
Prevention of Noncommunicable Diseases  
Croatian Institute of Public Health  
Zagreb

### Czechia

Dr Jana Procházková  
Expert  
Clinical Psychologist, Psychotherapist, Court-  
appointed Expert-specialized at Violence  
and CAN syndrome  
Hussite Theological Faculty, Charles University  
Prague

### Estonia

Ms Ingrid Ots-Vaik  
Adviser  
Health System Development Department  
Ministry of Social Affairs  
Tallinn

Ms Hanna Vseviov  
Head of Department of Children and Families  
Ministry of Social Affairs  
Tallinn

## **Georgia**

Mrs Nana Kalmakhelidze  
Senior Specialist of Regulations  
Division at Health Care Department  
Tbilisi

Mrs Mari Tsereteli  
Head of Guardian-Custody and Social  
Programs Department  
LEPL Social Service Agency  
Tbilisi

## **Kyrgyzstan**

Dr Bermet Baryktabasova  
Consultant on evidence-based medicine and  
development of clinical protocols  
Ministry of Health  
Bishkek

Dr Nazgul Turdubekova  
Director  
Child's Rights Defenders' League  
Public Foundation (CRDLPF)  
Bishkek

## **Latvia**

Mrs Inga Liepina  
Senior expert in the field of epidemiological  
safety issues  
Environmental Health Division  
Public Health Department  
Ministry of Health  
Riga

Ms Sabine Zemite  
Public Health Analyst  
The Center for Disease Prevention and  
Control, Unit of Disease Prevention  
Riga

## **Lithuania**

Ms Audrone Astrauskiene  
Adviser  
Health Promotion Division  
Public Health Department

Ministry of Health  
Vilnius

Ms Inga Cechanovičienė  
Head of Specialized Health Care Division  
Personal Health Department  
Ministry of Health  
Lithuania

## **Montenegro**

Dr Miro Knežević,  
Director General  
Directorate for Public Health  
and Public Health Programs  
Ministry of Health  
Podgorica

Dr Mevlida Gusinjac,  
Director General  
Directorate for Health Care Protection  
Ministry of Health  
Podgorica

Ms Milica Dukic  
Nurse, Independent Adviser  
Ministry of Health  
Podgorica

Dr Vesna Mačić  
Chosen paediatrician, Children's Dispensary  
Primary Health Care Centre  
Kotor

Ms Svetlana Stojanović  
Independent Adviser  
VIP Focal Point  
Ministry of Health  
Podgorica

Professor Agima Ljaljević  
Professor at Medical School University of  
Montenegro,  
Institute for Public Health  
Podgorica

Dr Nenad Kavarić  
Chosen paediatrician  
Director of the Primary Health  
Care Center Podgorica  
Podgorica

Dr Paša Divanović  
Chosen paediatrician  
Primary Health Care Center Podgorica  
Podgorica

Ms Biljana Zeković  
NVO SOS Podgorica  
Podgorica

#### **North Macedonia**

Dr Sanela Skhrijelji  
Chief of Cabinet  
Minister of Labour and Social Policy  
Skopje

Professor Fimka Tozija MD PhD  
Institute of Public Health of the Republic of  
North Macedonia  
Faculty of Medicine, SS Cyril and Methodius  
University  
Skopje

Dr Marija Raleva  
Head of Department of Child and Adolescent  
Psychiatry  
Faculty of Medicine  
Skopje

#### **Republic of Moldova**

Mrs Lilia Oleinic  
Senior consultant  
Division for policies on hospital medical  
assistance  
Ministry of Health, Labour and Social  
Protection  
Chisinau

Dr Nelea Revenco  
Deputy Director for Science  
IMSP Institute of Mother and Child  
Head of the Paediatrics Department of the  
State University of Medicine and Pharmacy

“N. Testemitanu”  
Chair of the Specialized Commission of the  
MHLSP On Pediatrics  
Chisinau

#### **Romania**

Dr Tiberius Bradatan  
State Secretary  
Ministry of Health  
Bucharest

#### **Russian Federation**

Dr Svetlana Shport  
PhD in psychiatry, scientific researcher,  
Scientific Secretary of the Federal Medical  
Center for Psychiatry and Narcology  
Moscow

#### **Serbia**

Dr Marija Markovic  
City Institute of Public Health  
Belgrade

Dr Snezana Pantic Aksenrujevic  
Head of the Group  
Department for Public Health, Ministry of  
Health  
Belgrade

Dr Oliver Vidojevic  
Psychiatrist  
Institute for Mental Health  
Belgrade

#### **Slovenia**

Ms Irena Krotec  
Centre for Analysis and development of  
Health  
National Institute of Public Health  
Ljubljana

## **Turkey**

Dr Uğur Ortaç  
Health Specialist  
Ministry of Health  
Ankara

Dr Betül Ulukol  
Professor  
Ace PI Ankara University School of Medicine  
Ankara

Dr Aylin Yüksel  
Midwife  
Ministry of Health  
Ankara

## **Ukraine**

Dr Oleh Dudin  
Adviser to the Minister of Health  
Ministry of Health  
Kyiv

Mrs Olena Kolomiichuk  
Adviser to the Minister of Health  
Ministry of Health  
Kyiv

## **Partner organizations**

### **University College London, United Kingdom of Great Britain and Northern Ireland**

Dr Danya Glaser  
Honorary Consultant Child & Adolescent  
Psychiatrist  
Great Ormond Street Hospital for Children,  
Visiting Professor UCL  
London, United Kingdom

## **United Nations Children's Fund**

Mr Aaron Greenberg  
Senior Regional Adviser for Europe and  
Central Asia, Child Protection, UNICEF

Ms Aleksandra Ivanovska  
Child Protection Officer  
UNICEF Office Skopje

Dr Nela Krnić  
Child Protection Officer  
UNICEF Montenegro

## **World Health Organization**

### **WHO headquarters**

Ms Berit Kieselbach  
Technical Officer  
Prevention of Violence Programme

### **WHO Regional Office for Europe**

Ms Nina Blinkenberg  
Programme Assistant, Violence and Injury  
Prevention

Dr Lucia Hernandez Garcia  
Volunteer, Violence and Injury Prevention

Mr Jonathon Passmore  
Programme Manager, Violence and Injury  
Prevention

Dr Dinesh Sethi  
Consultant, Violence and Injury Prevention

Dr Yongjie Yon  
Technical Officer, Violence and Injury  
Prevention

### **WHO country office, Montenegro**

Ms Mina Brajovic  
Head

Mrs Darja Radovic  
Administrative Assistant

### **WHO country office, Republic of Moldova**

Dr Larisa Borderscova  
National Professional Officer

### **WHO country office, Bulgaria**

Dr Michael Alexandrov Okoliyski  
National Professional Officer

**Rapporteur**

Ms Teresa Lander

**Interpreters**

Ms Alla Pavetic

Ms Oksana Raicevic

Ms Sanja Rasovic

Mr Aleksandar Supeljak

## The WHO Regional Office for Europe

The World Health Organization (WHO) is a specialized agency of the United Nations created in 1948 with the primary responsibility for international health matters and public health. The WHO Regional Office for Europe is one of six regional offices throughout the world, each with its own programme geared to the particular health conditions of the countries it serves.

### Member States

Albania  
Andorra  
Armenia  
Austria  
Azerbaijan  
Belarus  
Belgium  
Bosnia and Herzegovina  
Bulgaria  
Croatia  
Cyprus  
Czechia  
Denmark  
Estonia  
Finland  
France  
Georgia  
Germany  
Greece  
Hungary  
Iceland  
Ireland  
Israel  
Italy  
Kazakhstan  
Kyrgyzstan  
Latvia  
Lithuania  
Luxembourg  
Malta  
Monaco  
Montenegro  
Netherlands  
North Macedonia  
Norway  
Poland  
Portugal  
Republic of Moldova  
Romania  
Russian Federation  
San Marino  
Serbia  
Slovakia  
Slovenia  
Spain  
Sweden  
Switzerland  
Tajikistan  
Turkey  
Turkmenistan  
Ukraine  
United Kingdom  
Uzbekistan

### World Health Organization Regional Office for Europe

UN City, Marmorvej 51, DK-2100 Copenhagen Ø, Denmark

Tel.: +45 45 33 70 00 Fax: +45 45 33 70 01

Email: [eurocontact@who.int](mailto:eurocontact@who.int)

Website: [www.euro.who.int](http://www.euro.who.int)