Short Communication

Child Protection in Context of COVID-19 Pandemic: Practice Guidelines for Pediatricians

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Received on: 01-Oct-2021 Accepted for Publication: 11-Dec-2021

ABSTRACT

Background: Pediatricians are likely to encounter children who have suffered instances of abuse and neglect on account of societal changes due to the COVID-19pandemic. There is an urgent need to up skill paediatricians on recognising and responding to cases of child abuse and neglect (CAN) in the Indian context. In this document, the term "abuse" refers to physical, emotional, sexual abuse and neglect and a child refers to an individual below the age of 18years.

Aims: To assist and provide resources to pediatricians and allied medical professionals to help recognize and respond to suspected cases of CAN during the COVID-19 pandemic.

Methods: The executive board of the Indian Child Abuse Neglect and Child Labour (ICANCL) group of Indian Academy of Pediatrics (IAP) approved a series of meetings with a working group of multidisciplinary medical professionals to address the impact of the pandemic on children. The group framed guidelines after extensive testing in clinical setups, discussions, and iterations.

Results: COVID-19 specific guidelines on recognition and response to CAN were formatted into flowcharts for ease in comprehension and execution.

Conclusions: The pandemic has dramatically increased the potential for violence, abuse and neglect in vulnerable children's lives in India. The pandemic also has impacted the lives of parents, many of whom have lost livelihoods or been challenged by physical and mental health issues that adversely affect the lives of their children at home. Screening and assessment of CAN by paediatricians is therefore essential in prevention and early intervention to protect children's safety.

Keywords: Child abuse and neglect (CAN), guidelines, pediatrician, pandemic

INTRODUCTION

Child abuse and neglect is a serious, widely prevalent, yet under-reported public health problem in India [1]. In this document, the term "*abuse*" refers to physical, emotional, sexual abuse and neglect and a child refers to an individual below the age of 18 years [2]. Estimates of the prevalence of child sexual abuse (CSA) range from 4-41%, depending on the sample population, definition of CSA and method of measurement considered [3]. In a study of adolescent students in Kerala, lifetime prevalence of abuse was high, with 73.9% of youth reporting physical abuse, 73.4% endorsing emotional abuse; 66.9% reporting neglect and 19.9% reporting sexual abuse [4]. Child abuse exerts a multitude of short- and long-term health effects on children, which may include serious and often lifelong adverse consequences to their mental, physical, and reproductive health, academic performance, and social functioning.

Pediatricians and other health professionals are often the first point of contact for abused and neglected children [5,6]. They play a key role in detecting child abuse and providing immediate and long-term care and support to

children [7,8]. Adverse health effects of various forms of child abuse may range from mild bruising to fatal head injury, inflicted burns, sexually transmitted infections, HIV/AIDS, unwanted pregnancy, post-traumatic stress disorder, major depression and suicide, anxiety disorders and substance misuse [9,10,11].

India has been affected by the second highest burden of Coronavirus (COVID-19) infections in the world [12]. The lockdown measures mandated by the Indian Government to contain the pandemic have led to losses of livelihood and income for millions of informal labourers, migrants, and daily wage workers [13]. Due to closure of schools, limited movements outside their homes and anticipated COVID-19preventive measures, children and young people are experiencing heightened adversities [13, 14]. Children in marginalized communities are made more vulnerable due to food insecurity, malnutrition, and limited access to health services, and routine immunizations [13,15].

CHILDLINE, an Indian national hotline (Telephone 1098) for children and families in distress, received 4,392, 772 calls during the initial period of the COVID-19lockdown in India (April to September 2020)[16]. Of these calls, 290,766 required interventions; 60% were related to concerns accessing food or medical assistance. In addition, 74,400 calls were made for Child Abuse and violence. CHILDLINE responded to calls to prevent and stop child marriage (12413), child labour (9727), beggary (3855) hazardous work (2269), child physical abuse (8058), child emotional abuse (3895), child sexual abuse (penetrative sexual intercourse; 1952), child molestation (1045) and child trafficking (1585) for marriage and labour. While these rates do not represent a significant increase relative to pre-COVID-19numbers, a real increase may be obscured by constraints in the ability of children and families to reach out to CHILDLINE, for instance, lack of privacy to make a call. These protection and safety concerns are echoed by the World Health Organization (WHO) [17].The World Health Organization has expressed concern about the psycho-social and mental health consequences of theCOVID-19pandemic control measures [17]. Self-isolation and quarantine may lead to increased child and caregiver anxiety, depression, and self-harm, as well as harmful alcohol and drug use by caregivers, and the potential for greater incidences of domestic violence [17]. These factors may increase the risk for child abuse, exploitation, and neglect in several ways. Increased exposure of anxious children to stressed and potentially violent caregivers may lead to increased rates of physical abuse [18]. Sexual abuse and exploitation may increase due to exposure to sex offenders within homes. Desperate financial conditions may drive adolescents to consider producing and selling online child sexual abuse materials (OCSAM) (formerly called, 'child pornography') or engaging in live stream sex acts for payment. For children who engage in high-risk online behaviours, increased time on the internet may increase their risk for online sexual solicitation and exploitation by others [19,20]. Parents in severe financial distress may allow their children to be commercially sexually exploited or to accept jobs involving hazardous labour or get them married.

Given major concerns regarding child violence and exploitation within the context of the COVID-19and future pandemics, the executive board of the Indian Child Abuse and Neglect and Child Labour (ICANCL) Group of the Indian Academy of Pediatrics (IAP) convened a series of meetings with experts to create recommendations for pediatricians that will assist them in preventing, recognizing, and responding to child abuse and neglect during and after the period ofCOVID-19pandemiclockdown [21]. The meetings occurred from July 2020 to March2021 and were attended by academic and practicing pediatricians, child abuse specialists, child development, adolescent and forensic medicine specialists, child psychiatry, psychologist, and medical administrators. Due to the COVID restrictions and the need for a quick screening, the expert consensus was to frame simple and brief guidelines that could be easily implemented in clinical practice.

AIMS AND OBJECTIVES

The present ICANCL group, IAP guidelines that follow are intended to assist pediatricians and allied medical professionals in

- screening for family and child stressors related to COVID-19 and other pandemics,
- providing anticipatory guidance to address vulnerabilities and prevent child abuse and neglect.
- recognizing and providing prompt (immediate/early) healthcare response to suspected cases of CAN.

In the context of this document the term "*abuse"* refers to physical, emotional, sexual abuse and neglect and a child refers to an individual up to and including18 years of age.

METHODS

Development of Guideline for Screening

A series of 15 consultative expert group meetings were conducted during the pandemic keeping in mind the impact of the pandemic on the lives of children. The meetings occurred from July 2020 to March 2021 and included executive board members of ICANCL group.The guidelines were formulated with a variant of the focus group discussion in addition to the Delphi method. The discussions involved a range of medical professionals who framed guidelines after extensively reviewing their scope of implementation in a variety of setups including but not limited to private practice clinics, private hospitals, medical colleges,and governmental hospitals. Pediatricians across the country working in these set ups were consulted regarding the practical feasibility of the guidelines. Feedback received from the field was incorporated to refine and simplify the guidelines to suit a range of settings.

RESULTS

Approach to screening for COVID-19 related Stress and Child Protection Risks

It is essential to build rapport with the child and caregiver before initiating conversations of sensitive topics. The healthcare provider should:

- ensure a quiet, private, and child-friendly environment, and begin with a conversation that is non-threatening in nature,
- obtain consent from the caregiver (assent from the child) to ask a few additional questions regarding their subjective experiences during the pandemic.
- ask open-ended questions with a non-judgmental and reflective listening attitude that encourages bidirectional communication. Maintain confidentiality to the extent allowed by laws and policies, and explain the limits of confidentiality to the caregiver and child (as developmentally appropriate).

The screening process is summarized in Figure 1. It is recommended that all children and/or their caregivers who attend a health facility be screened for CAN by asking probe and qualifier questions. When screening a child, adolescent, or adult caregiver, the pediatrician should ask open-ended, non-leading questions to explore any concerns that are voiced. ("Can you tell me more about that? Help me understand….") Direct questions may be used to address specific details that are not forthcoming in the patient/caregiver narrative but should be followed by a return to open-ended questions ("You mentioned the child's father has become violent. When was the last time this happened? (direct question) …." "I see"). "Tell me more about that episode." (open ended question).

The algorithm/flowchart in Figure 2 outlines the brief screening and immediate management process for caregivers of young children (<10 years) or those with disabilities. Figure 3 describes the process for screening older children (≥10 years) and younger children with concerns of CAN (5-10 years). The screen should be done outside the presence of the caregiver in order to allow the child/adolescent to feel comfortable sharing concerns.

The clinician should maintain a non-judgmental, calm demeanour and engage in active listening (maintain eye contact, nod, occasionally repeat back a few words that have been said to demonstrate listening). They should acknowledge and appreciate child/caregiver insight and positive coping skills and reassure that they are available to help. The provider may then engage the individual in problem-solving to address concerns. It is helpful to begin by asking the child or caregiver for their opinion about what they think may be helpful before offering additional ideas and resources. The clinician may provide directed anticipatory guidance on positive parenting, internet safety, or strategies for stress reduction and emotional regulation; for example, local and national resources may be offered in the form of online information and brochures. Specific resources may be found in this document. Health professionals throughout India should offer caregivers and children the hotline number for CHILDLINE (1098) and provide information about this comprehensive resource [16]. CHILDLINE provides emergency assistance for children facing violence, sexual abuse, exploitation, or neglect, as well as families in need of basic assistance during the COVID-19pandemic (e.g., food, shelter, access to health care). Clinicians need to be familiar with CHILDLINE and all it has to offer. Posters and brochures may be helpful in providing this information to families.

The limits of confidentiality should be explained before beginning a discussion of sensitive issues which may lead to mandatory reporting (for instance in case of suspected sexual abuse). Using a developmentally appropriate approach, the clinician may inform the child that authorities must be notified if information is revealed that indicates harm has been done to the child or to others (or may be done in future) or laws have been violated. The child should also understand that the information would then be shared with an adult whom the child trusts. Confidentiality cannot be maintained when the child reveals sexual abuse, criminal behaviour, suicidal behaviour or when hospitalisation is indicated. According to the Protection of Children from Sexual Offences Act (POCSO) it is mandatory to report all cases of CSA to the police [22].

In some cases, a child may be experiencing significant mental health issues that require additional counselling. If the clinician is experienced in providing this counselling an appointment can be made to engage in further discussion. Alternatively, the provider may wish to refer the child to a mental health professional. A toll-free hotline to the National Institute of Mental Health and Neurosciences (NIMHANS) may be useful (0804611007) [23].

When screening adolescents, the clinician may refer to some or all the questions included in the HEEADSSS psychosocial assessment (see Table 1)[24]. It is helpful to inquire about problems during the pandemic related to home, nutrition, schooling, media, mental well-being, and safety. A physical, systemic, and mental status examination should be conducted. Possible indicators of CAN on physical examination are given in Table 2. If there are red flag signs of psychoses, suicidal behaviour or severe mental disorder, the child should be immediately referred to a mental health professional.

If abuse is suspected and the safety of the child may be compromised, a detailed safety plan should be discussed with the non-abusing caregiver to ensure physical and psychosocial well-being. Concerns of sexual abuse should be referred to authorities per the POCSO Act [22]. The caregiver and child should be made aware of the requirements of mandatory reporting. If patient or caregiver voice concerns about reporting, these should be acknowledged and explored by the clinician, and the provider should reiterate the reasons for reporting (e.g., the safety of the child and other potential victims). The clinician should also explain that while a report must be made to law enforcement, the child/caregiver is not required to pursue an investigation.

Figure 1: Summary of the screening process

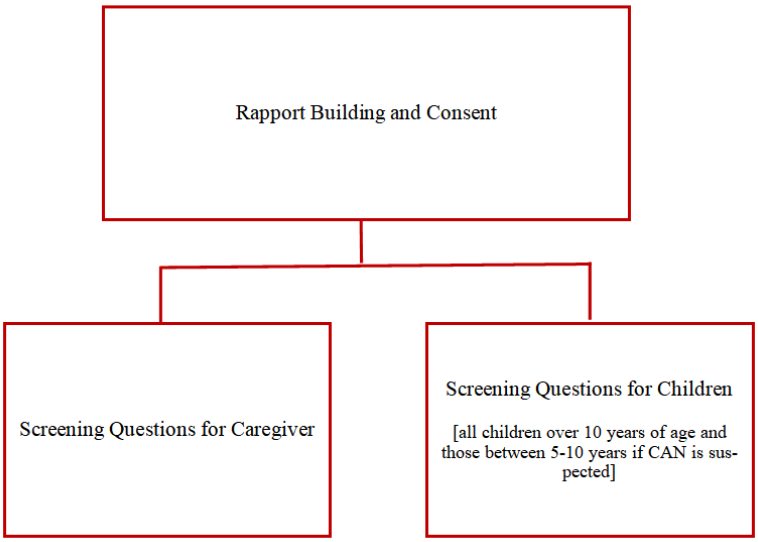


Figure 2: Algorithm of Brief Screening and Assistance for Caregivers)

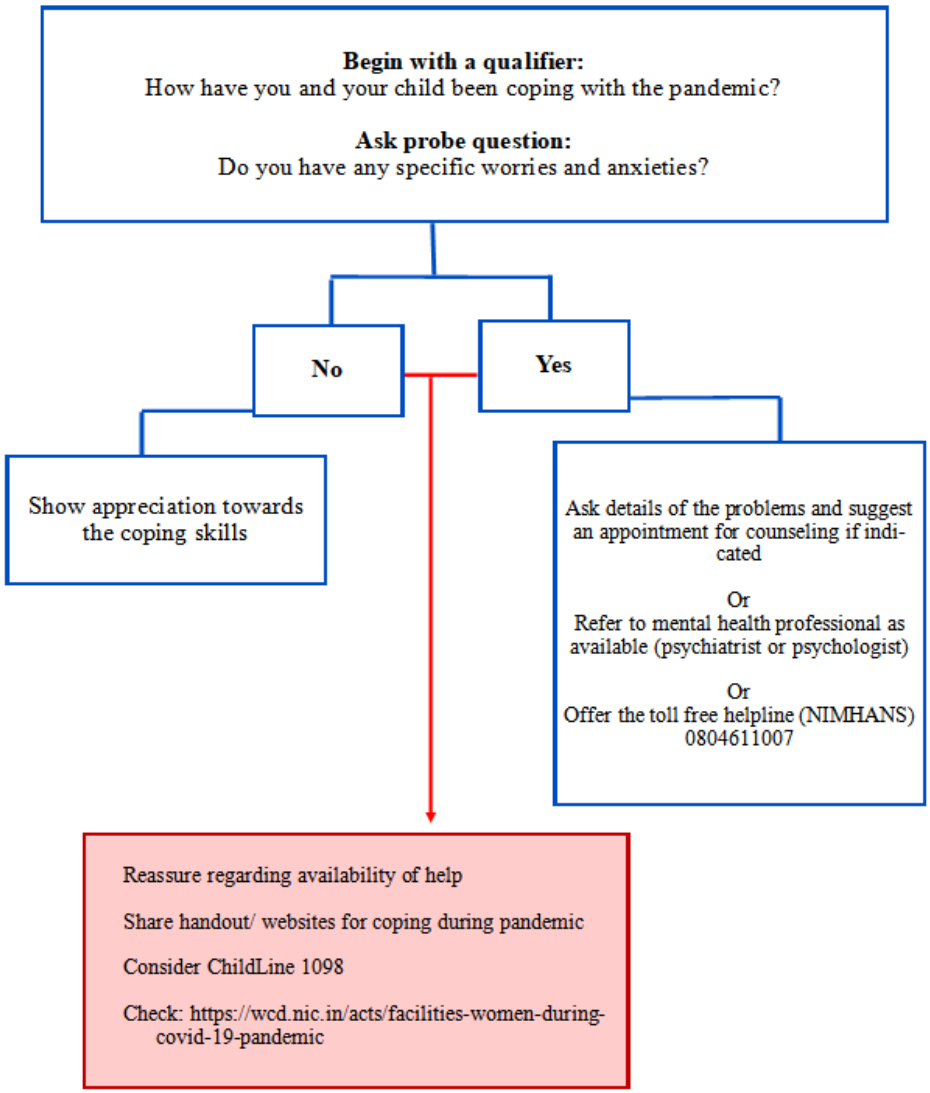
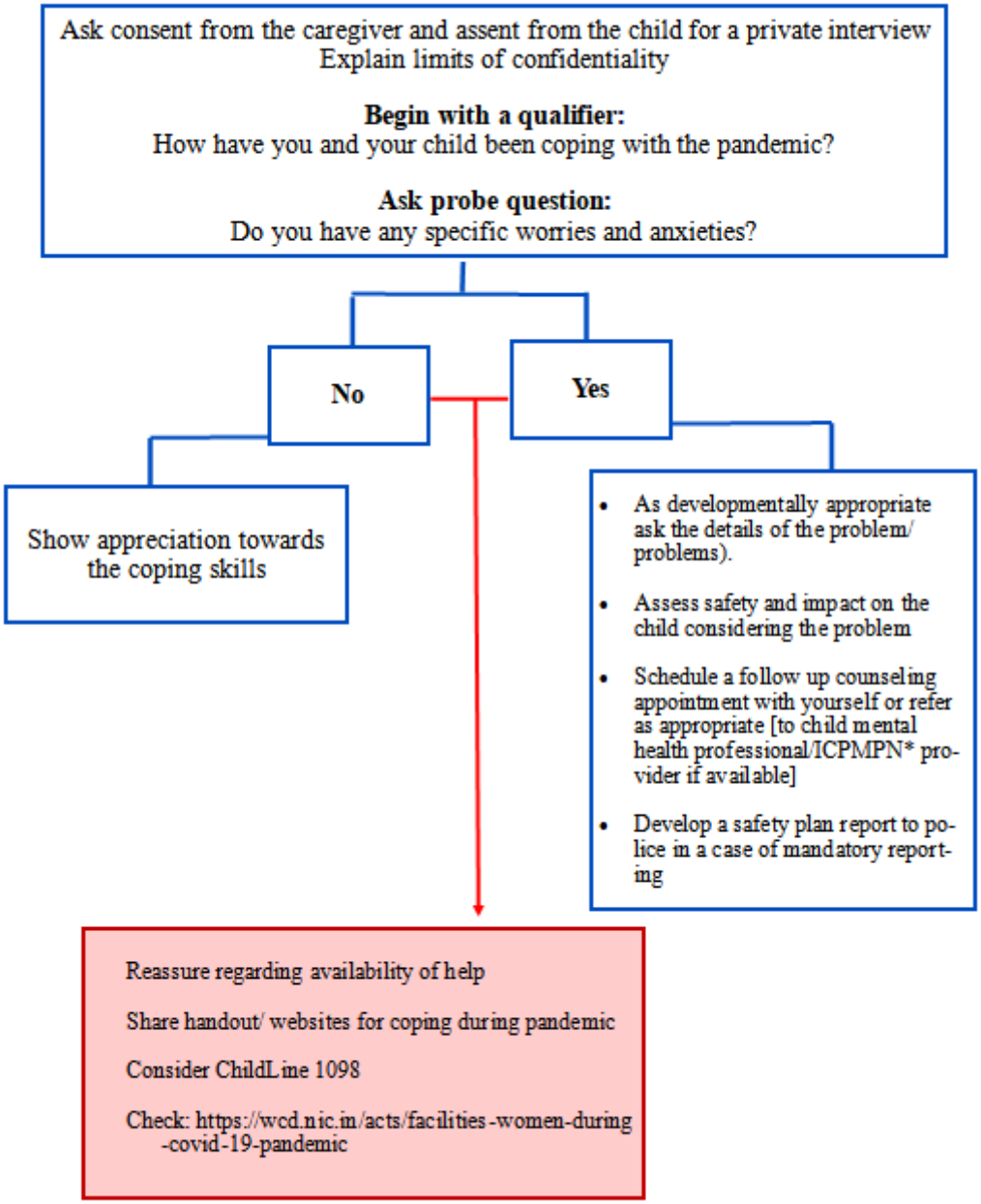


Figure 3: Algorithm of Brief Screening and Immediate Assistance for Children and Adolescents



* Indian Child Protection Medical Professional Network (ICPMPN) Provider

Recognizing and Responding to Suspected Child Maltreatment

In partnership with UNICEF, the ICANCL group created a reference handbook "*Child Abuse: Recognition and Response*" for pediatricians and medical professionals [27]. The handbook provides basic knowledge, current guidelines, and a Standard Operating Protocol (SOP) for prompt recognition and management of survivors of child abuse. Additional comprehensive guidelines exist to assist clinicians to recognize and appropriately respond to child maltreatment [28,29,30].

The response to CSA is both nuanced and complicated due to the complex interplay of psychological and social processes involved in this form of abuse. Therefore, guidelines for CSA necessitate mental health and multidisciplinary professionals to work with many processes and systems to effectively assist the child. The Protection of Children from Sexual Offences (POCSO) Act (2012) is a comprehensive law which makes reporting of CSA mandatory and defines guidelines for child friendly police and court procedures [22,].

Table 1: Examples of Screening Questions based on HEEADSSS framework [24].

Home: - Who lives with you and how is your relationship with the people you live? - Have there been any recent changes in your relationships with family or friends related to Covid19? - Is there any violence in your home? - In whom do you confide your problems?
Education/ Employment: - Are you going to school or do you have online school classes? - How do you feel about online classes? - Are you facing any problems with your schoolwork? Who helps you with your schoolwork?
Eating: - Are you and your family able to get enough food to eat? - Have there been any changes in your eating habits/appetite/or weight? - How do you feel when you look at yourself in the mirror?
Activities: - How do you spend your day? How many hours do you spend online? - Do you feel any pain/body aches after using the internet? - What do you use the internet for? - Have you ever been upset by online images/comments? - Has anybody sent you, or asked you for inappropriate online images/ texts?
Drugs and Alcohol use: - Do any of your friends or family members use alcohol and drugs? Has this become more of a problem during the pandemic? - How do you feel about alcohol and drug use? - When friends/family use drugs or alcohol, do they act in ways thatdisturb you? If yes, how?
Sexuality: - When was your last menstrual period? - Do you have any vaginal/ urethral discharge or painful micturition? - Are you sexually active? If yes, what is the age of your partner? Is your partner a male or a female? - Has your partner ever been violent toward you or forced you do things that you didn't want to do? - Do you use contraception? If yes, share details. - Have you ever been touched in a way that made you feel uncomfortable? If yes, by whom? When? Were authorities involved?
Suicide/Depression: - Do you feel "stressed", "upset" or "irritable" more than usual (or more than you prefer to feel)? - Do you feel sad or a loss of interest in your daily life? - Are you having trouble getting to sleep? - Have you ever thought about hurting yourself or someone else? - Are you feeling like hurting or killing yourself now?
Safety: - Do you feel safe at home? - Have you ever been in a physical fight? If yes, with whom? - Has anybody bullied you? - Do you know the phone number of CHILDLINE?

Pediatricians and allied professionals should discuss with the child and caregiver as appropriate, to maintain transparency and trust. Exceptions to this may occur if the child is not able to understand due to developmental or medical issues, or if the caregiver is a suspected offender. In managing these circumstances, it is always best to make the child's best interest the highest priority. Emergency and therapeutic medical care must be provided in all case of CSA, even in absence of police or magisterial requisition.

In cases of suspected CSA, informed consent/assent must be obtained from caregiver and patient before conducting a medical evaluation of CSA, collecting samples for forensic examination, performing diagnostic testing, and offering treatment. If the child is over 12 years of age, consent should be sought from the child. For those below the age of 12 years, a parent or the guardian is required to provide it. The person obtaining the consent should clearly explain the purpose of each process, as well as potential risks, benefits, possible adverse effects, and approximate amount of time required [31]. Police personnel should not be present during any part of the examination. Where the victim is a girl, the medical examination should be conducted by a woman doctor in the presence of the non-offending parent of the child or any other person in whom the child reposes trust or

confidence (child should choose). If such a person cannot be present, the examination is conducted in the presence of a woman nominated by the head of the medical institution. Detailed, well-documented medical records must be kept. Treatment of sexually transmitted diseases (STIs), emotional support and referrals to multidisciplinary team should be made as indicated.

Table 2: Potential Indicators of Sexual and/or Physical Abuse* [25,26]

Nonspecific Signs/Symptoms of Traumatic Stress
• Sudden changes in behavior • Chronic pain without obvious source • Change in eating patterns. • Sleep problems • Interpersonal problems (e.g., withdrawal, aggression; avoidance) • Decrease in academic performance. • Anxiety, poor concentration • Dissociative symptoms • Problematic sexual behavior • Depression, self-harm behavior • Difficulty controlling emotions
Sexual Abuse
• Symptoms/signs of sexually transmitted infection • Anogenital trauma • Pregnancy (in specific contexts)
Physical Abuse

• Injuries in ordinarily protected areas of body (e.g., ears, neck, torso, upper arms, upper, medial, or posterior thighs, genitalia, buttocks, feet)
• Patterned injuries (reproduce shape of impacting object)
• Explanation of injury that is:
  ○ Inconsistent with child's developmental capabilities
  ○ Inconsistent with mechanism or appearance of injury
  ○ Changing over time or between caregivers

REPORTING PROCEDURES

The Ministry of Women and Child Development, Government of India is as the apex body for administration of the rules, regulations and laws relating to women and children [32,33]. The National Commission for the Protection of Child Rights (NCPCR) is an Indian statutory body established by an act of the Parliament, the Commission of Protection of Child Rights (2005) [34]. The NCPCR works under the aegis of the Ministry of WCD under the Government of India. Each Indian state/Union Territory has a State Commission for the Protection of Child Rights(SCPCR) to implement and monitor child rights and protection programs The NCPCR has recently introduced Protection of Children from Sexual Offences Act (**POCSO**) **E-box** on its **website** (www.ncpcr.gov.in) for anyone to anonymously report complaints of child abuse [22].The Juvenile Justice (Care and Protection of Children) Act (JJ Act 2015) is the primary legal framework for juvenile justice in India, that establishes a framework for both Children who are in conflict with law (CCL) and Children in need of care and protection (CNCP) [33]. The JJ Act ensures proper care, protection, development, treatment, and social re-integration of children in difficult circumstances by adopting a child - friendly approach keeping in view the best interest of the child. Each district has a District Child Protection Unit (DCPU), in which there are

juvenile justice boards (JJB), child welfare committees (CWC) and special juvenile police units (SJPU). Every block (city ward) and every village have a Child Protection Committee to monitor child protection services at the local level. Pediatricians should have easy access and maintain contact information of these services in their regions.

The ICANCL Group, IAP has collaborated with the International Centre for Missing and Exploited Children (ICMEC), USA, and developed an Indian Child Protection Medical Professional Network (ICPMPN) (2017-present) [35,36]. The ICPMPN is comprised of a network of pediatricians and allied medical doctors from across India, who are trained on the medical management of child sexual abuse and exploitation. The goal of the network is to increase accessibility to medical services for abused children and their families and improve the quality of medical evaluations for suspected victims of child sexual abuse. Community providers may contact network members to ask questions about CAN and register for trainings on abuse awareness and response [36].

Strategies for Prevention and Intervention in Suspected Child Maltreatment

Pediatricians play an important role in advocating for the health and well-being of children and their families. This role is especially important during the course of the pandemic. Primary prevention of child abuse and neglect is integral to keeping children safe and healthy. Practitioners may take one or more of the following steps to help prevent child abuse and neglect during the COVID-19pandemic:

1. Train staff to recognize potential indicators of abuse. All office/clinic/hospital personnel should be aware of risk factors for, and possible indicators of sexual abuse, sexual exploitation, physical abuse, emotional abuse, and neglect.

2. Develop and implement facility guidelines for how to recognize and respond to suspected abuse/exploitation/neglect. This may range from a single, simple flow diagram of steps involved in the recognition and response process (from triage to discharge, with reports/referrals), to a comprehensive document discussing risk factors, mandatory reporting laws, potential indicators, roles, and responsibilities of staff members when child maltreatment is suspected, screening questions, exam, diagnostic testing, and treatment guidelines. All staff members need to be trained on the guidelines so they can respond appropriately [27].

3. Post signage, and display brochures containing resources, such as CHILDLINE and other hotline numbers for patients and families, and information on organizations dedicated to the prevention of child abuse, intimate partner violence, or suspected exploitation/trafficking. Children and caregivers should contact CHILDLINE (1098) to report suspected maltreatment and exploitation and receive emergency assistance[16].

4. Talk to parents about common parenting stressors experienced during the pandemic and positive parenting practices to support and guide children [37]. The World Health Organization has published a series of brochures providing anticipatory guidance for parents during the COVID-19pandemic [38]. Talk to parents about safe internet use, and child sexual abuse prevention [39].

5. Screen for possible abuse and neglect during clinical visits [refer Figures 1,2 and 3].

6. Be familiar with the POCSO Act, as it pertains to the responsibilities of health professionals in response to suspected sexual abuse/assault.[22].

7. Be familiar with the Indian Guidelines on the Medico-Legal Response to Sexual Violence. These guidelines provide a comprehensive review of the forensic medical evaluation, from history-taking to exam procedures, from diagnostic testing to treatment options and documentation [28].

8. Reach out to a member of the Indian Child Protection Medical Professional Network (ICPMPN) or a local One Stop Centre for advice and guidance regarding child protection issues [35,36].

9. Investigate local and national resources that address child and family vulnerabilities (for example: domestic violence shelters, drug rehabilitation facilities, mental health clinics) and those that provide child protection services. These may include small local organizations, government agencies and regional/national/international non- governmental organizations such as "CHILDLINE. Take time to determine each organization's capacity to provide services during the COVID-19pandemic [16].

CONCLUSION

Pediatricians and allied health professionals have an important role to play in preventing, recognizing, and responding to suspected child abuse. During the extremely stressful times surrounding the COVID-19 pandemic, the risk for CAN is likely to be elevated, and health care providers have a duty to screen for family stressors and potential abuse. Simple qualifier and probe questions should be asked of caregivers and age-appropriate children, to open the door for discussions of concerns related to abuse. Using a supportive, non-judgmental approach, the provider can explore the concerns, offer anticipatory guidance and resources, and make necessary mandatory reports as appropriate.

CONFLICT OF INTERESTS: None

FUNDING SOURCE: None

Disclaimer: The recommendations are the opinion of the participating experts to guide pediatricians to screen for and assist in recognizing and responding to cases of child abuse and neglect (CAN) in Indian settings during the times of COVID-19 Pandemic. These are neither binding, nor the only possible actions; individual practice may deviate from these depending on the situation in an individual case or the existing laws.

REFERENCES

1. Seth, R., & Srivastava, R. N. (2017). Child Sexual Abuse: Management and Prevention, and Protection of Children from Sexual Offences (POCSO) Act. *Indian Pediatrics*, 949-953.
2. John, J. T. (1999). IAP policy on age of children for pediatric care. *Indian Pediatr*, 461-463.
3. Choudhry V, Dayal R, Pillai D, Kalokhe AS, Beier K, Patel V. Child sexual abuse in India: A systematic review. *PLoS One.* 2018;13(10): e0205086.
4. Kumar, M. T., Kar, N., & Kumar, S. (2019). Prevalence of child abuse in Kerala, India: An ICAST-CH based survey. *Child Abuse Negl*, 87-98.
5. Dhawan J, Gupta S, Kumar B. Sexually transmitted diseases in children in India. Indian J Dermatol VenereolLeprol. 2010; 76:489-493.
6. Dube SR, Anda RF, Whitfield CL, et al. Long-term consequences of childhood sexual abuse by gender of victim. Am J Prev Med. 2005;28(5):430-438.
7. Norman RE, Byambaa M, De R, Butchart A, Scott J, Vos T. The long-term health consequences of child physical abuse, emotional abuse, and neglect: a systematic review and meta-analysis. PLoS Med. 2012;9(11): e1001349.

8. Shannon K, Crago AL, Baral SD, et al. The global response and unmet actions for HIV and sex workers. The Lancet. 2018;392(10148):698-710.

9. Varma S, Gillespie S, McCracken C, Greenbaum VJ. Characteristics of child commercial sexual exploitation and sex trafficking victims presenting for medical care in the United States. Child Abuse Neglect. 2015; 44:98-105.

10. Flaherty EG, Perez-Rossello JM, Levine MA, Hennrikus WL. Evaluating children with fractures for child physical abuse. Pediatrics. 2014;133(2): e477-489.

11. Pierce MC, Kaczor K, Aldridge S, O'Flynn J, Lorenz DJ. Bruising characteristics discriminating physical child abuse from accidental trauma. Pediatrics. 2010;125(1):67-74.

12. Johns Hopkins University and Medicine. (2020, December 28). *Coronavirus Resource Center*. Retrieved from Johns Hopkins University and Medicine: https://coronavirus.jhu.edu/region/india

13. Napier-Raman S, Rattani A, Qaiyum Y, VijayLuxmi Bose, Rajeev Seth & ShantiRamam (2021). Impact of COVID-19 on the lives of vulnerable young people in New Delhi, India: a mixed method study. BMJ Paediatrics Open. 5:e001171.

14. Panda, P. K., Gupta, J., Chowdhury, S. R., Kumar, R., Meena, A. K., Madaan, P., . . . Gulati, S. (2021). Psychological and Behavioral Impact of Lockdown and Quarantine Measures for COVID-19 Pandemic on Children, Adolescents and Caregivers: A Systematic Review and Meta-Analysis. *J Trop Pediatr* 67(1):fmaa 122

15. Shet, A., Dhaliwal, B., Banerjee, P., Carr, K., DeLuca, A., Britto, C., . . . Shastri, D. (2021, March 30). *COVID-19-related disruptions to routine vaccination services in India: perspectives from pediatricians*. MedRxiv. Retrieved from https://www.medrxiv.org/content/10.1101/2021.01.25.21250040v1

16. CHILDLINE. (2021, March 1). *Newsroom 2020*. Retrieved from CHILDLINE: https://www.childlineindia.org/a/newsroom/2020

17. World Health Organization. (2020). *Mental health and psychosocial considerations during the COVID-19 outbreak*. WHO.

18. Roberton, T., Carter, E. D., Chou, V. B., Stegmuller, A. R., Jackson, B. D., Tam, Y., . . . Walker, N. (2020). Early estimates of the indirect effects of the COVID-19 pandemic on maternal and child mortality in low-income and middle-income countries: a modelling study. *Lancet Glob Health* 8: e901–08

19. Ybarra, M., Mitchell, K. J., Finkelhor, D., & Wolak, J. (2007). Internet Prevention Messages: Targeting the Right Online Behaviors. *Pediatrics and Adolescent Medicine*, 138-145.

20. UNICEF. (2021, March 31). *The WePROTECT global alliance*. Retrieved from UNICEF: https://www.unicef.org/documents/weprotect-global-alliance

21. ICANCL. (2020, August 31). *ICANCL Group*. Retrieved from Indian Child Abuse Neglect and Child Labour (ICANCL) Group: http://icancl.org/

22. Ministry of Women and Child Development. (2021, March 21). *Model Guidelines under Section 39 of The Protection of Children from Sexual Offenses Act, 2012*. Retrieved from Guidelines for the Use of Professionals and Experts under the POCSO Act, 2012: https://wcd.nic.in/sites/default/files/POCSO-ModelGuidelines.pdf

23. NIMHANS. (2021, January 2). *COVID-19 Information Resources*. Retrieved from National Institute of Mental Health and Neurosciences: https://nimhans.ac.in/health-information-nimhans/covid19-information/

24. 30) Contemporary Pediatrics. (2014, January 1). *HEEADSSS 3.0: The psychosocial interview for adolescents updated for a new century fueled by media*. Retrieved from Contemporary Pediatrics:

https://www.contemporarypediatrics.com/view/heeadsss-30-psychosocial-interview-adolescents-updated-new-century-fueled-media

25. Kellogg ND, Committee on Child Abuse and Neglect. Clinical report: The evaluation of sexual behaviors in children. *Pediatrics.* 2009;124(3):992-998.
26. Kellogg ND, Committee on Child Abuse and Neglect American Academy of Pediatrics. Clinical Report: Evaluation of suspected child physical abuse. *Pediatrics.* 2007;119.
27. Seth, R., Saldanha, S., N, J., Sagar, R., & Srivastava, R. N. (2020). *Child Abuse: Recognition and Response (A handbook for pediatricians and allied medical professionals).* New Delhi: Jaypee Brothers Medical Publishers.
28. Ministry of Health & Family Welfare, Government of India. Guidelines & protocols: Medico-legal care for survivors/victims of sexual violence. 2014;Available at https://main.mohfw.gov.in/sites/default/files/953522324.pdf; accessed on Nov 9, 2020.
29. Seshadri S, Ramaswamy S. Clinical Practice Guidelines for Child Sexual Abuse. *Indian journal of psychiatry.* 2019;61(Suppl 2):317-332.
30. Adams JA, Kellogg ND, Farst KH, Harper NS, Palusci VJ, et al. Updated guidelines for the medical assessment and care of children who may have been sexually abused. *J pediatrAdolesc Gynecol.* 2016;29:81-87.
31. Seth, R. (2018). Child sexual abuse & the development of a national child protection medical professional network. *Current Medicine Research and Practice*, 138-141.
32. Ministry of Women and Child Development. (2020, October 12). *Integrated Child Protection Scheme (ICPS).* Retrieved from MWCD: https://wcd.nic.in/integrated-child-protection-scheme-ICPS
33. Ministry of Law and Justice. (2015, January 1). *The Juvenile Justice (Care and Protection of Children) Act.* Retrieved from The Gazette of India: http://cara.nic.in/PDF/JJ%20act%202015.pdf
34. NCPCR. (2020, November 11). *National Commission for Protection of Child Rights*. Retrieved from NCPCR: https://www.ncpcr.gov.in/
35. ICMEC. (2020, September 22). Retrieved from International Centre for Missing & Exploited Children: https://www.icmec.org/
36. ICPMPN. (2020, October 2). Retrieved from Indian Child Protection Medical Professional Network: http://icancl.org/pdf/ICPMPN%20Provider%20List.pdf
37. Dandona, R., & Sagar, R. (2021). COVID-19 offers an opportunity to reform mental health in India. *The Lancet Psychiatry: Supplementary appendix*, 9-11.
38. World Health Organization. (2020, May 1). *#HealthyAtHome- Healthy Parenting*. Retrieved from World Health Organization: https://www.who.int/campaigns/connecting-the-world-to-combat-coronavirus/healthyathome/healthyathome---healthy-parenting
39. NIMHANS. (2020, August 31). *Community Child and Adolescent Mental Health Service*. Retrieved from NIMHANS: https://www.nimhanschildproject.in/resources/