



MINISTRY OF HEALTH  
REPUBLIC OF GHANA



# CHILD PROTECTION GUIDELINES

For Health Workers 2018



for every child





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For Health Workers

FIRST EDITION, 2018



**MINISTRY OF HEALTH**  
REPUBLIC OF GHANA





# Child Protection Guidelines for Health Workers

@2018

First Edition 2018

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## LIST OF ABBREVIATIONS

|               |  |
|---------------|--|
| <b>CRC</b>    | Convention on the Rights of the Child              |
| <b>DOVVSU</b> | Domestic Violence and Victim Support Unit          |
| <b>GOG</b>    | Government of Ghana                                |
| <b>GPS</b>    | Ghana Police Service                               |
| <b>HIV</b>    | Human Immunodeficiency Virus                       |
| <b>ILO</b>    | International Labour Organisation                  |
| <b>MoE</b>    | Ministry of Education                              |
| <b>MoGCSP</b> | Ministry of Gender, Children and Social Protection |
| <b>NGO</b>    | Non-Governmental Organisation                      |
| <b>PEP</b>    | Post-Exposure Prophylaxis                          |
| <b>STI</b>    | Sexually Transmitted Infection                     |
| <b>UNICEF</b> | United Nations Children's Fund                     |
| <b>WHO</b>    | World Health Organisation                          |

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The Child Protection Guidelines for Health Workers have benefited from the input of several organizations, institutions, and individuals.

These Guidelines build on earlier efforts by stakeholders in child protection in Ghana to come up with a common document to guide various professionals in handling child abuse. The Guidelines have greatly benefited from the capacity and gaps analysis of Ghana's health sector that was carried out between February and August 2016 in six regions of Ghana.

The input of health workers and other professionals consulted through focus group discussions, in-depth interviews and the provision of technical and financial support from United Nations Children's Fund (UNICEF) Ghana is also acknowledged.

The Guidelines were reviewed by a team of health professionals including Professor Ebenezer Badoe Department of Child Health, School of Medicine and Dentistry, University of Ghana, Dr. Gyikua Tejumade Plange-Rhule of the Kwame Nkrumah University of Science and Technology, and Dr. JD Clayman of Ghana Health Services. Other members of the review team were Dr. Justice Yankson of the University of Ghana, Dr. Cynthia Bannerman of Ghana Health Service, and Dr. Isabella Sagoe-Moses of Ghana Health Services. The process of guideline development was facilitated by George W Kivumbi, PhD, an International Consultant to whom we are most grateful.

Four major documents have been consulted while preparing these Guidelines; World Health Organization Guidelines for Medico-Legal Care for Victims of Sexual Violence; draft working document developed by several stakeholders in child protection and used on a limited scale in the Department of Child Health of Korle Bu Teaching Hospital of the University of Ghana, the Child Protections Guidelines for health workers in Fiji, and National Guidelines on the Management of Sexual Abuse in Kenya. Reference has also been made to several documents and resources including other Guidelines from the World Health Organisation.

The document was developed with funding provided by the Government of Canada through the Child Protection Unit of UNICEF Ghana. The Ministry of Health gratefully acknowledges the government and people of Canada for this financial support.

The Ministry of Health will review the Guidelines on a regular basis, as required.

**\* This manual contains graphic images that may be disturbing**

# PREFACE

In February 2015, the Government of Ghana approved its new Child and Family Welfare Policy. The Policy expects the Ministry of Health (MoH) and Ghana Health Service (GHS) to play the following roles:

- i) Provide preventative and responsive medical and forensic services in cases of child abuse
- ii) Ensure that internal policies and standards are adapted and aligned with the Policy
- iii) Ensure regular collection and analysis of data and trends relating to cases of child abuse handled by health workers.
- iv) Support victims of violence and link with other relevant service providers
- v) Ensure free medical care and services for victims of child abuse, neglect and exploitation.

This document is designed because there are currently no Guidelines within Ghana's health sector on how to provide immediate and continuing medical response to child victims of abuse. Similarly, many health workers have limited knowledge and skills in child protection. Hence the Guidelines will support health workers in preventing child abuse and managing child abuse. They will guide service providers to observe appropriate standards in the provision of child protection services and ensure holistic support for all children victims of abuse as well as follow up, irrespective of where they present.

The Guidelines will also assist care providers in minimizing the trauma child victims may experience, promoting healing, and maximizing the collection and preservation of evidence from victims, including documentation of findings, for potential use in the legal system. Likewise, the Guidelines will address both health and evidentiary needs of the victim following abuse and defilement of children. This is of paramount importance to successfully prosecuting sex offenders.

## HOW TO USE THESE GUIDELINES

### ABOUT THE GUIDELINES

- The Guidelines are meant to help health workers ensure consistency and quality in delivery of services for abused children.
- They will assist health workers in ensuring children's safety and development.
- The Guidelines will also promote multi-agency working in child protection

### PRIMARY USERS OF THE GUIDELINES

- The Guidelines are for doctors, physician assistants, nurses and midwives, and community health nurses.
- The Guidelines are to be used at CHPS compounds, Polyclinics, Health Centres, District Hospitals, Regional Hospitals, and Tertiary Hospitals.

### APPLICATION OF THE GUIDELINES

- The Guidelines are meant to assist health workers in their daily practice in the health sector
- The Guidelines should be applied considering differences in experiences in resources and services offered across the regions, districts, and health facilities.
- In situations where there is no doctor at a health facility, the health worker authorized by the health facility or who manages the abused child will handle the entire process including taking the necessary actions needed.

## DEFINITION OF TERMS

**Child:** a person below the age of 18. A child is defined in the Ghanaian context in relation to the family and concept of childhood. Thus, a child is one who is still largely dependent on an adult for the necessities of life

**Child Abuse:** refers to any act of omission or neglect or treatment that may be injurious to the mental and physical wellbeing of a child. Manifestations include child dumping, child neglect, child labour, incest, and rape, ritual murder of children, indecent assault, sexual exploitation, child street vending, excessive corporal punishment, and ill treatment

**Child Protection:** seeks to guarantee the right of all children to a life free from violence, abuse, exploitation and neglect.

**Fit Person:** An adult who has high moral character and integrity and of sound mind capable of looking after a child and has been registered by a probation officer or Social Welfare as being able to provide a caring home for a child.

**Forensic:** means relating to the use or application of scientific knowledge or methods and techniques to the investigation and solving crimes for use in the courts of law.

**Loco Parentis:** Acting as parent/ guardian.

**Sexual abuse:** occurs when dependent, developmentally immature children and adolescents participate in sexual activities that they do not fully comprehend, to which they are unable to give informed consent, and that violate the social taboos of family roles



# MODULE ONE:

## INTRODUCTION AND CONTEXT OF THE GUIDELINES

### 1.1 INTRODUCTION

- Millions of children worldwide from all socio-economic backgrounds, across all ages, religions and cultures suffer violence, exploitation and abuse every day (UNICEF (2012).
- Children are exposed to different types of violence, exploitation and abuse, armed violence, trafficking, child labour, gender-based violence, bullying each with their own characteristics.
- Violence, exploitation and abuse occur in the homes, families, schools, care and justice systems, workplaces and communities across all contexts (UNICEF 2012).
- Child abuse is deeply rooted in cultural, economic and social practices (Krug EG et al., eds. 2002).
- The short and long term impact of child abuse include among others, failure to thrive as infants, physical injury, fearful, acute anxiety, psychosomatic disorders, behavioural problems and delayed development.

### 1.2 CHILD ABUSE IN GHANA

- Over 90% of children report having experienced physical violence, both at home and in the school environment (Ghana Statistical Service 2011).
- A 2009 study conducted in selected schools found that 14 per cent of school children surveyed had been sexually abused (Government of Ghana 2014).
- Neglect, physical, emotional and sexual abuse and exploitation of children are widespread problems (National Child Protection Study 2013)<sup>1</sup>.
- There were 1,198 cases of defilement reported to Domestic Violence and Victim Support Unit of Ghana Police (DOVVSU) in all regions in 2015.
- Non-maintenance or neglect was the most prevalent child abuse related offence reported to DOVVSU in all regions for the period of January to December 2015.
- Children in Ghana are abused in the home and within the domestic setting, in school, even at the Early Childhood Care and Development (ECCD) centres in the orphanage, in the community, and in the hospital.

<sup>1</sup> 2013 National Child Protection Study by Government of Ghana. This was a study that followed the 2010 Mapping and Analysis of Ghana's Child Protection System.

### 1.3 PROTECTING CHILDREN FROM ABUSE

- A child protection system is as a set of laws, policies, regulations and services needed across all social sectors to support prevention and response to child abuse.
- These systems are a set of usually government-run services designed to protect children and young people who are underage and to encourage family stability.
- At the level of prevention, their aim includes supporting and strengthening families to lower the risk of child abuse.
- When abuse occurs, the aim to provide competent and compassionate care to affected children.

### 1.4 SITUATION OF CHILD PROTECTION IN GHANA'S HEALTH SECTOR'S

Child protection efforts in the health sector are on a limited scale and are mainly carried out by development partners and the Ghana Health Service. An assessment of the capacity and gaps of the health sector in early 2016 established that most of the health facilities in the six regions lack facilities for adequate care for children who experience abuse. Professionals in the health sector have gaps in providing services for child abuse that need to be addressed while resources to adequately support the perceived 'few' reported cases are never enough.

The health sector assessment established that child abuse is not comprehensively covered in pre-service and in-service training of healthcare providers of various cadres in the country. The assessment however found that the health sector has the personnel, institutions, and resources that could be enhanced to boost child protection. This among others is by health workers integrating skills and information sharing on parenting, impact of trauma, injury prevention etc. in their roles at all levels.

### 1.5 GOAL AND OBJECTIVES OF THE GUIDELINES

#### GOAL

To provide guidance for comprehensive service delivery in the health sector for protection of children.

### 1.6 LEGAL CONTEXT IN DEVELOPING THE GUIDELINES

- 1) The legal framework that governs the Guidelines includes International and Regional Instruments as well as National legislation that exist to protect children from abuse.
- 2) Ghana was the first country to ratify the United Nations Convention on the Rights of the Child in 1990. Ghana has since then promulgated many laws and policies as well as establishing institutions and agencies to deal with the issue of child violence.
- 3) Ghana has Laws, Acts, Protocols, ratified Convention, Policies, and similar regulations that are supposed to protect children's rights and protect them from violence, abuse, and exploitation. (See the Box on the next page)

#### 1.6.1 EXISTING LEGISLATION FOR PROTECTION OF CHILDREN

##### International Instruments

- Convention on the Rights of the Child, and related protocols.
- The Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW)
- International Labour Organization (ILO) Convention 182,



### Regional Instruments

- African Charter on the Human and People's Rights,
- African Charter on the Rights and Welfare of the Child, (1990)

### National Instruments

- The 1992 Constitution of Ghana
- Domestic Violence Act 732 (2007)
- Persons with Disability Act 715 (2006)
- The Human Trafficking Act 694 (2005)
- Juvenile Justice Act 653 (2003)
- Labour Act 651 (2003)
- Children's Act 560 (1998)
- Criminal Code (Amendment) Act 554 (1998)

### Institutions and Agencies

- Ministry of Health and Ghana Health Service
- Ministry of Gender, Children and Social Protection (2013)
- Gender-based Violence Court
- The Girl Child Education Unit of the Ghana Education Service
- Domestic Violence and Victim Support Unit of the Ghana Police Service

### Policies and Interventions

- Justice for Children Policy (2015)
- Child and Family Welfare Policy (2015)
- National Gender and Children's Policy (2013)
- National HIV and AIDS, STI Policy (2013)
- National Plan of Action on the Elimination of the Worst Forms of Child Labour in Ghana (2011)
- Orphans and Vulnerable Children (OVC) Policy (2010)
- National Policy and Plan of Action on Domestic Violence (2009)
- Under Five Child Health Policy (2007)
- Adolescent Health and Development Strategy
- Livelihood empowerment against poverty (2007)
- National Social Protection Strategy (2007)
- National Policy Guidelines on Orphans and other Children made Vulnerable by HIV/AIDS (2005)
- Free Compulsory Basic Education (1996)
- Mental Health Policy and Programmes (1994 & 2000 revision)
- Substance Abuse Policy (formulated 1990)







# MODULE TWO:

## PUBLIC HEALTH AND MEDICAL APPROACHES TO CHILD ABUSE

An all-inclusive approach to dealing with child abuse is one that addresses multiple forms of abuse across the different settings in which it occurs. This includes components for prevention, protection, victim medical, psychological, legal and social assistance, victim rehabilitation and reintegration, and perpetrator interventions. There are two approaches, the public health approach that prevents abuse from occurring, and, the medical approach that provides care to children who experience abuse.

### 2.1 THE PUBLIC HEALTH APPROACH TO CHILD ABUSE

- The public health approach strives to prevent or reduce child abuse by identifying the risk factors of child abuse and addressing them before it occurs.
- The approach targets policies and interventions of known risk factors of child abuse by recognizing and responding to these risks early enough before abuse occurs.
- Primary or universal level interventions are those aimed at the entire population to provide support and education before child abuse occurs.
- An example of a primary intervention is a health worker who provides health education and information to the population in communities to prevent them from abusing children.
- Secondary level or targeted interventions are for families and children who have been identified as being in need or experiencing risk of abuse. Interventions are to alleviate the identified problems and to prevent escalation of problems which, should they escalate, may lead to abuse or neglect.
- An example of a secondary intervention is a health worker who makes home visits to homes that are known to abuse children and educate the guardians on child abuse and its consequences.
- Tertiary level interventions are for children who have experienced violence, abuse, neglect and exploitation. Interventions for these children should ensure their health and safety, increase their opportunity for their basic needs to be met and prevent continuation or repeat abuse.

- An example of a tertiary intervention is a health worker at a health facility handling the case of child abuse to ensure that the child receives prompt and appropriate treatment, investigations are carried out to make the perpetrator prosecuted for the offences, and ensuring that guardians of the child are supported through the process.

Figure 2.1 Public Health Child Protection Interventions – Triangle Diagram <sup>2</sup>

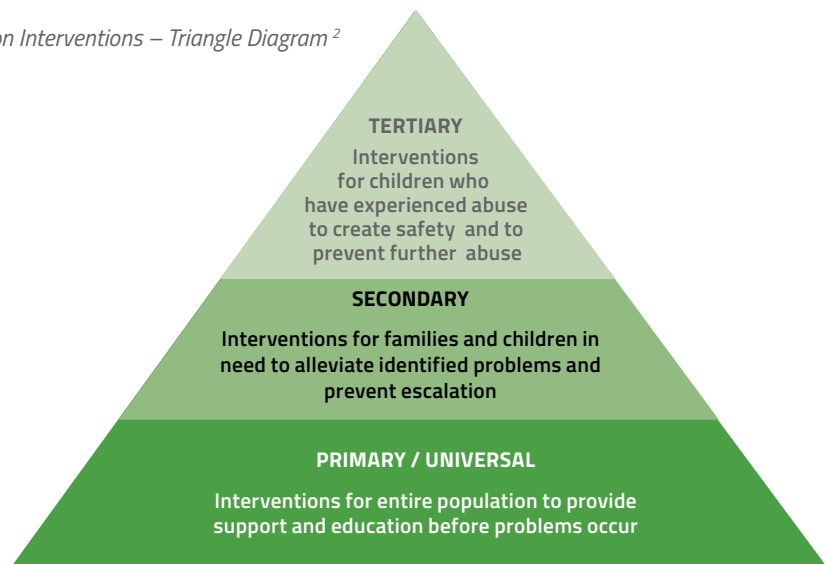


Figure 2.1 shows the three levels of intervention.

- The triangle shape highlights the relative number of children at each level; that is, most interventions are at the primary level and only few interventions are at the tertiary level.
- The better identification and support that can be provided to families at the primary and secondary levels, the more child abuse and neglect can be prevented.
- Even in the worst situations, where children have already experienced violence, abuse or neglect, tertiary interventions can play a preventative role, preventing continued neglect or further abuse of an individual child or possible abuse by the same perpetrator to siblings or other children.

## 2.2 THE MEDICAL APPROACH TO CHILD ABUSE

- The medical approach to child abuse is one of the measures envisioned to alleviate some of the effects and health consequences of violence against children.
- Such approach has potential to achieve desired goals in child protection compared to specific programmes that address selected sub-types of violence against children or its effects in specific populations and settings.
- The approach however, is a complex phenomenon and needs to be addressed in a more comprehensive and holistic manner.

Health workers (including doctors, nurses, psychiatrists, public health practitioners, clinical psychologists and dentists) can play a big role in three major ways

- First, preventing abuse from occurring in the first place.
- Second, provision of prompt medical exam and treatment, including stabilization and/or referral for medical or psychological care for victims as needed.
- Third, collection of evidence from victims and documentation of findings, which may aid investigation and prosecution.

<sup>2</sup> Adapted from Bromfield, L., & Holzer, P. (2008).

# MODULE THREE:

## TYPES OF CHILD ABUSE

### 3.1 INTRODUCTION

Child abuse occurs in various situations, for various reasons. Abused children will often experience more than one type of abuse and other difficulties in their lives. It is difficult to measure the prevalence of abuse in our society and attempts to measure so far have been faced with difficulties of underreporting for many reasons.

### 3.2 PURPOSE

- The purpose of this module is to describe the common types of abuse in children, their definition, the possible physical signs and possible behavioural signs exhibited in children

### 3.3 MAJOR TYPES OF CHILD ABUSE:

Although classifications of child abuse differ, these have classified the various forms of child abuse under five types:

- Physical Abuse
- Sexual abuse
- Emotional or Psychological Abuse
- Commercial or other exploitation of a child /Economic Abuse
- Neglect (Physical neglect, educational neglect, emotional neglect)

Table 3.1 Type, Definition, and Possible Signs and Indicators of Abuse in Children <sup>3</sup>

| Type of Abuse         | Definition  | Possible Physical Signs   | Possible Behavioural Signs   |
|-----------------------|---|---|--|
| <b>Physical Abuse</b> | Any intentional act causing injury or trauma to a child by way of bodily contact. It involves beating, kicking, punching, biting, spanking, corporal punishments, poisoning, burning and other ways of harming a child.                             | <ul style="list-style-type: none"> <li>■ Bruises, bruising which looks like hand or finger marks, burns, cigarette burns, scalds, sprains, dislocations, human bites, cuts</li> <li>■ Injuries that the child cannot explain or explains unconvincingly</li> <li>■ Untreated or inadequately treated injuries</li> <li>■ Injuries to parts of the body where accidents are unlikely, such as thighs, back, abdomen</li> </ul> | <ul style="list-style-type: none"> <li>■ Becoming sad, withdrawn or depressed</li> <li>■ Having trouble sleeping</li> <li>■ Behaving aggressively or being disruptive</li> <li>■ Showing fear of certain adults</li> <li>■ Fear of returning home or of parents being contacted</li> <li>■ Showing lack of confidence and low self-esteem</li> <li>■ Being very passive and compliant</li> <li>■ Using drugs or alcohol</li> <li>■ Chronic running away</li> </ul>   |
| Type of Abuse         | Definition  | Possible Physical Signs   | Possible Behavioural Signs   |
| <b>Sexual Abuse</b>   | Occurs when dependent, developmentally immature children and adolescents participate in sexual activities that they do not fully comprehend, to which they are unable to give informed consent, and that violate the social taboos of family roles. | <ul style="list-style-type: none"> <li>■ Pain, itching, bruising or bleeding in the genital or anal areas.</li> <li>■ Genital discharge or urinary tract infections</li> <li>■ Stomach pains or discomfort walking or sitting</li> <li>■ Sexually transmitted infections</li> </ul>   | <ul style="list-style-type: none"> <li>■ A marked change in the child's general behaviour. Unusually quiet and withdrawn, or unusually aggressive.</li> <li>■ Showing unexpected fear or distrust of an adult/s.</li> <li>■ Child starts using sexually explicit behaviour or language, particularly if the behaviour or language is not appropriate for their age.</li> <li>■ The child may describe receiving special attention from a particular adult, or refer to a new "secret" friendship with an adult or young person.</li> <li>■ Recent onset of /sudden bedwetting</li> </ul> |

<sup>3</sup> Table has been modified from information provided by the National Society for the Prevention of Cruelty to Children (NSPCC) -

| <b>Emotional Abuse</b>  | Involves acts or omissions by guardians and caregivers that cause or could cause serious behavioural, cognitive, emotional or mental disorders. This includes parents/care givers using extreme and bizarre forms of punishment, such as confinement in a closet or dark room or being tied to a chair for long periods of time, threatening or terrorizing a child. This form of abuse often accompanies the others. | <ul style="list-style-type: none"> <li>Physical, mental and emotional development is delayed</li> <li>Highly anxious</li> <li>Showing delayed speech or sudden speech disorder</li> <li>Low self-esteem</li> <li>abnormal emotional responses to painful situations</li> <li>Extremes of passivity or aggression</li> </ul> | <ul style="list-style-type: none"> <li>Dressed inappropriately for the season or the weather</li> <li>Poor personal hygiene</li> <li>Is inadequately supervised or left in the care of an inappropriate care giver.</li> <li>Untreated medical problems</li> <li>Frequently hungry</li> <li>Malnourishment</li> <li>Frequent lateness or non-attendance at school</li> <li>Untreated medical problems</li> <li>Poor social relationships Drug or alcohol abuse</li> <li>Chronic running away</li> <li>Compulsive stealing</li> </ul> |
|---|---|---|--|
| Type of Abuse   | Definition  | Possible Physical Signs   | Possible Behavioural Signs   |
| <b>Commercial and other exploitation of a child/<br/>Economic Abuse</b> | Refers to the use of the child in work or other activities for the benefit of others. This includes, but is not limited to, child labour and child prostitution. These activities are to the detriment of the child's physical or mental health, education, or spiritual, moral or social and emotional development   | <ul style="list-style-type: none"> <li>Injuries</li> </ul>  | <ul style="list-style-type: none"> <li>Child abandons schooling</li> <li>Child combines school attendance with excessively long and heavy work.</li> <li>Child involved in prostitution</li> <li>Parents push girls into sexual activities to earn some money</li> </ul>   |
| <b>Neglect</b>  | <p>The persistent failure to meet a child's basic physical and /or psychological needs, likely to result in the serious impairment of the child's health or development.</p> <p>Examples include child overburdened with household chores, child denied money for food in school and this lead to truancy, disabled children neglected, and lack of attention for medical, dental or psychological problems</p>       | <ul style="list-style-type: none"> <li>Anaemia as result of poor feeding</li> <li>Lack of clothing, food, or supplies to meet physical needs</li> <li>Evidence of poisoning</li> <li>Signs of malnutrition</li> </ul>   | <ul style="list-style-type: none"> <li>Children roaming around the village both during day and night</li> <li>Taking food or money without permission</li> <li>Eating a lot in one sitting or hiding food for later</li> </ul>   |

### 3.4 PURPOSE

- The purpose of this module is to describe the common types of abuse in children, their definition, the possible physical signs and possible behavioural signs exhibited in children

### 3.5 MAJOR TYPES OF CHILD ABUSE:

Although classifications of child abuse differ, these have classified the various forms of child abuse under five types:

- Physical Abuse
- Sexual abuse
- Emotional or Psychological Abuse
- Commercial or other exploitation of a child /Economic Abuse
- Neglect (Physical neglect, educational neglect, emotional neglect)

### 3.6 IMPORTANT NOTES ON IDENTIFYING CHILD ABUSE

- Child abuse often occurs in the context of multiple problems within a family or social environment, including poverty, violence, substance abuse, and unemployment.
- Distinguishing consequences that are associated directly with the experience of child abuse itself rather than other social disorders can be a daunting task
- Fabricated or induced illness is a well-recognised category though it is not documented cases in Ghana

#### Note about diagnosing Child Abuse:

- You should be aware of the various terminologies used in violence against children
- A child may be subjected to a combination of different kinds of abuse and some of the signs may cut across the various types of abuse.
- A child may show no outward signs and hide what is happening from everyone
- You need to define and understand the various forms of child abuse
- Caretakers admit telling lies to care providers when they have hurt their children during child discipline.



# MODULE FOUR

## ETHICS AND PRINCIPLES FOR HANDLING ABUSED CHILDREN

### 4.1 INTRODUCTION

Ethics refers to the moral principles that govern a person's behaviour or the conducting of an activity. It deals with right and wrong conduct, with what we ought to do and what we should refrain from doing. Each case will come with a different set of situations, but the ethics and principles of handling the case remain the same.

### 4.2 PURPOSE

To summarise the good practices to be observed by health workers in the provision of services to abused children

### 4.3 GENERAL PRINCIPLES

The general principles that underline the ethics of the various professionals that deal with abused children are:

- i) Child rights approach
- ii) Multi-disciplinary approach
- iii) Human rights approach
- iv) Victim friendly approach
- v) Gender consideration

### 4.4 GOOD PRACTICES

#### 1. Identification and Establishment of Abuse

- The basis for addressing child abuse is the identification and/or establishment of abuse or potential abuse.
- You must have the instinct and judgement to suspect abuse even when it is not reported as the reason for visiting the health facility.
- Do not look for only physical signs as indicators of child abuse since child abuse may take place when the child has no physical signs.

## 2. Assessment

- Be aware that a complete evaluation of the child's physical medical and psychosocial needs would inform appropriate interventions.
- In conducting the assessment always consider the safety of the child and if applicable, remove the child to safety.
- You may have to ask the parent or caretaker to step out so that the child will be free to tell you whatever happened to him or her.

## 3. Intervention

### a) Individualized treatment and care

- Referral to the nearest medical facility is important in aiding in the recovery of abused children, thereby offering a comprehensive continuum of care in accordance with the physical, psychological and social state of the victims.
- Positive attitudes and rapport help build trust, self-confidence, and nurture hope for the future. Negative experiences however cause individuals to feel ashamed, stigmatized, disempowered, and hopeless.

### b) Counselling

- Every abused child needs some form of counselling irrespective of the type of abuse experienced. This must be done with the consent of the victim/guardian and with confidentiality. Counselling should be extended to the perpetrators of the abuse if necessary.

### c) Shelter

- The provision of shelter affords victims access to a safe, temporary accommodation and access to other necessities of life. It is important to ensure the continued provision of education and bio-psychosocial needs of the child.
- There are no district/regional shelters for abused children in Ghana. There is only the state run shelter at Osu in Accra.
- Some districts have orphanages that offer temporary shelter for children who face abuse in their homes.
- The emphasis is to discourage the use of such shelters across the country as this is another form of institutionalization.
- Actors in child protection need to look for community based alternatives some which have largely worked in the past for such children.

### d) Rehabilitation and Reintegration

- Rehabilitation aims at restoring the child to previous levels of functioning while reintegration puts the child back into the family or community setting and can be achieved through foster placement. This is however done only when the biological family cannot be entrusted with the child.
- Reintegration on the other hand, aims at enabling victims to resume life and participate more effectively in the socio- economic aspect of society.

## 4. Provide information

- It is necessary to provide information to the guardian and child on the procedures and processes being followed in helping them and how these will impact their lives.
- This should be done with the active participation of the children and their guardians.

#### 4.5 POINTS TO REMEMBER

- The child's safety and comfort comes first
- Remain objective and attentive. The caretaker may seem like a nice family but that does not rule out that they have not abused the child.
- Any suspicion of child abuse should be alerted to the appropriate agencies that have the responsibility of responding to child abuse.
- If any concern of a child protection issue arises you have a duty to inform the relevant authorities. This overrides any such duty of keeping medical information confidential.
- Discuss your concerns with the child as appropriate for their age and their guardians, unless you consider such a discussion would place the child at risk of significant harm.
- A child under child protection services may have supervised visitation whilst in the hospital. Such a child must only be discharged on the decision of the most senior doctor in the hospital after the advice of the social welfare officer.
- You must work with other professionals such as welfare officers, counsellors, psychologists, and other professionals to offer complete services to the child.
- It is the department of social welfare that has the mandate to place a child in a shelter or foster home.

#### The DO NOTs in Handling Child Abuse

- Do not accuse anybody of harming the child
- Do not be too quick to place children into foster care.
- Do not push children into communities which may not be able to safeguard their best interest, just to enhance their statistics.



# MODULE FIVE:

## PREVENTION OF CHILD ABUSE

### 5.1 INTRODUCTION

Children raised in supportive, nurturing environments are more likely to have better social, behavioural and health outcomes. Likewise, children who have been abused or neglected often have poor social, behavioural and health outcomes immediately and later in life. A child of any age, sex, race, religion, and socioeconomic background can fall victim to child abuse and neglect. Prevention efforts are directed at reducing the chances that undesired future outcomes will occur.

### 5.2 PURPOSE

- Health providers to fully utilize their infrastructure and resources to educate patients/clients/communities on child abuse through the health education sessions at the facilities and outreach services.
- To prevent abuse from occurring rather than victims seeking services at health facilities.

### 5.3 RATIONALE FOR PREVENTING CHILD ABUSE

Three main reasons why child abuse must be prevented

1. To give children the best opportunity for their development
2. Support families before it is harder to change
3. It is cheaper to prevent abuse than incurring expenses in treating the child when abused has occurred

### 5.4 PROCEDURES

- Plan and conduct outreach programs for the neighbourhood within the vicinity of the health facility including schools
- Identify and work with a network of government actors and other stakeholders in child protection for collaboration and coordination in preventing child abuse
- Ensure you have the correct information on child abuse to use in health education programs both at the health facility or during community outreach

- Use information, education, and communication materials on child protection in preventing child abuse
- Have programmes that cater for both boys and girls. It is very important to include programmes that involve boys because they have been ignored in public health programs for a very long term yet they must be protected from abuse.
- The health workers should get talking points with concrete and practical 'tips' on positive parenting to use in child abuse prevention programs

### 5.5 HEALTH EDUCATION AT HEALTH FACILITIES

- As a health worker, your mandate includes providing preventative services of child abuse and not only clinical management of the consequences of child abuse.
- Every health facility must schedule health workers with the responsibility of health promotion and health education in the facility
- Public and community health nurses have the prime responsibility of conducting health promotion and health education at health facilities
- Provide health education on preventing child abuse on selected days in the outpatient department.

### 5.6 OUTREACH IN COMMUNITIES AND SCHOOLS

- Outreaches are usually carried out by public and community health workers
- One of your responsibilities as a health worker in preventing child abuse is to provide health education during community outreach programs
- Plan and conduct health education programmes on child protection in your communities
- Plan and conduct health education programs for schools enable children recognize signs of abuse and encourage them to seek redress.

### 5.7 PARENTING SKILLS

- Efforts and resources should be targeted at educating parents/guardians on processes of child development to enable them understand and manage the child's behaviours as they grow up.
- This will help increase positive parent-child interaction and promote pleasant experiences between the parent and the child.
- Parents/guardians should be trained in basic child rearing skills, anger and stress management social competence, given marital counselling and similar efforts to manage family resources and attend to children's needs.
- Parents/guardians should be encouraged to access information on parenting which exists in various sources and formats.
- In some situations, the child may also be the focus of child prevention activities, like in case of children who hyperactive, who may need guidance and counselling, or assessment for psychological help.

### 5.8 OBSTACLES IN PREVENTING CHILD ABUSE

In the design of prevention programmes for your facility take into consideration the following challenges:

- i. Parents or guardians who have children that are abused are the least likely to seek help of their own.
- ii. Child abuse with such parents and guardians usually comes to the attention of health workers because of other concerns, usually after expected norms or laws have been violated.
- iii. Most parents or guardians do not want to admit to problems because of fear of losing their children to child protection services, being charged with a crime or accused of being irresponsible.
- iv. Parents who use drugs or alcohol may be more likely to abuse their children.

# MODULE SIX:

## CARING FOR AND HANDLING ABUSED CHILDREN AT HEALTH FACILITIES

### 6.1 INTRODUCTION

Health workers need to be supported in their efforts to address and mitigate the effects of child abuse. Health workers need guidance on ensuring children's safety and development, thereby giving children the best start in life, critical for their future and that of Ghana.

### 6.2 PURPOSE

To assist health workers in providing consistent and quality services to abused children brought seen at health facilities.

### 6.3 PROCEDURE FOR HEALTH FACILITY STAFF WHEN CHILD ABUSE IS SUSPECTED

1. Inform the doctor or a Paediatrician (if available). In facilities without a doctor any available health worker such as physician assistant, nurse prescriber, nurse, midwives, or community health nurse should handle the suspected case.
2. The health worker should attend to the child and examine him/her.
3. If need arises and conditions allow, refer to the nearest hospital where there is a doctor with child protection expertise.
4. If after initial evaluation the health worker cannot confirm abuse, a second opinion from a senior doctor should be sought
5. If abuse is proven, the child may be admitted for treatment, safety and investigations. The reasons for the admission of the child must be explained to the guardians.
6. The Health facility social worker should be contacted so that they play their role in the case.
7. Every health facility should designate a focal person who will ensure that abused children are attended to, get treatment, and followed-up in case of referral.

## 6.4 ESTABLISHING RAPPORT

- Rapport means creating a close and harmonious relationship in which the people or groups concerned understand each other's feelings or ideas and communicate well.
- Welcome the client in a professionally relevant and age appropriate manner as outlined below.

### Setting of the Consultation Room

- Where possible endeavour to make the consulting room child friendly, have decorations in primary colours.
- Ensure easy accessibility and the comfort of the child with disability.
- Find a place for the interview that is neutral, quiet and secure.
- There should not be many things in the room, as these may distract the child.
- If available, make paper and crayons ready as drawings help in building rapport with the child.
- Sit in such a way as to allow an eye level contact with the child. If a small child is sitting on the floor, sit on the floor as well.
- Do not talk sitting behind a desk or a table: it better to sit at the table together with the child.
- Sit close to the child but not too close to make the child uncomfortable.
- Meet the child alone as much as possible to build trust and confidentiality.
- Beware that children may have immediate needs to be addressed such as first aid, food, water, need to use the toilet and other. Be sensitive to such immediate needs of the child and address them.

### Greeting during the first contact with child

- Be open and friendly.
- Greet child by his/her first name and use the child's name right away
- Introduce yourself to the child, introduce other people; tell the child who you are and what your role is.
- Tell him/her what you are going to do.

### Inform the child and guardian that

- i. You understand and share their feelings
- ii. You are available to do everything you can to help them
- iii. You will do everything possible to protect the privacy of the child
- iv. You will make assessment, plan, and treat the child
- v. The treatment process may involve laboratory and other investigation if need arises
- vi. You may call in another care provider for consultations and assistance
- vii. You may make referral to other level of service if need arises
- viii. Other professionals such as social workers and psychologists may come in to help
- ix. You will help and guide them with the process of working with law enforcement to have the perpetrators brought to justice
- x. They are free to ask questions
- xi. There are situations where the guardian will be asked to leave the room so that the provider can talk to the child on a one to one basis.



## 6.5 HISTORY TAKING

1. Document- where, when, how
2. Separate History from Examination
3. Always be polite and considerate to guardians whatever the injuries of the child.
4. Explain to the guardian and the child exactly what you plan to do including any investigations
5. Take the child's history separately from the guardian/parent's history
6. Tell the child where, during the interview, his/her parents or caretakers will be
7. Take a detailed history as to how injuries occurred from the child and/guardians.
8. Ask about any medical problems especially regarding bruising or bleeding or family history of fractures, and osteogenesis imperfecta (genetic disorders that mainly affect the bones resulting in bones easily breaking away).
9. Ask whether the child has had problems with constipation, faecal and urinary incontinence, worms, urine infections, vulvitis and proctitis.

### REMEMBER:

- Genuine accidents do occur, the child may have had an accident and was not abused.
- Be familiar with cultural practices which mothers perform on their children such as piercing ears, massaging the child, and applying hot water to the children's head to close the anterior fontanelle.
- Most of these cultural practices are not intentional child abuse and are assumed to be beneficial to the child by the parents.
- However, in many cases these practices are harmful to the child and need to be addressed through health education.

## 6.6 CONSENT TO MEDICAL EXAMINATION

1. Where possible seek the consent of the guardian for the child to undress and to enable you carry out medical examination.
2. On school or nursery premises, the Head Teacher or officer in charge is in loco parentis (acting in the position of a guardian).
3. Acting in loco parentis, the Head of school may ask a medically qualified member of the community to examine the child.
4. If parental consent is sought and refused, the Social Welfare Officer should be alerted immediately. This will allow the examination process to continue. (The Social Welfare Officer is empowered to ensure the best interest of the child)

In an emergency, or where the guardian cannot be contacted, it is a matter for professional judgment by the health worker as to whether the action taken in the interest of the child is so important as to justify the risk of legal action by the guardian, if that situation ever rises.

## 6.7 EXAMINATION

1. Examine children with sensitivity considering the delicate nature of dealing with them. Where possible and as conditions allow, the examination should be in a designated Children's Area
2. Avoid undue questioning of a child and never force examination. Go at the child's pace
3. Always do a full general examination with the child undressed including examination of the anal and genital areas.
4. Always measure height and weight and plot on centiles, noting relationship to any previous known measurements
5. Take note of the cleanliness and emotional state of the child, and how the child reacts to the guardian.
6. Consider whether other children of the household need examination and weight and height assessment, especially if one is known to have been previously non-accidentally injured, and if injuries are found on child you are examining.
7. If forensic samples are required by the police these should be taken by a doctor with forensic training, preferably also with paediatric training. In health facilities where there are no doctors, this should be handled by a provider that has been designated by the health facility to handle such cases.
8. If abuse is suspected, a full examination should be conducted by a suitably trained doctor or designated health profession depending on the location and level of health facility.
9. If the doctor does not feel confident that he/she is sufficiently skilled to recognise normality or significant abnormality, he/she should refer to a forensically trained Paediatrician or Gynaecologist with experience in child protection (in case they are available). If there is no forensically trained doctor, the doctor consults a senior colleague with experience in handling child abuse.

## 6.8 INTERVENTION

Intervention includes a range of problem solving strategies directed at helping the child and family adapt more effectively to their current and future circumstances. These strategies are part of a spectrum of activities for treatment and maintenance

- i) Treatment refers to corrective actions that will permit successful adaptation by eliminating or reducing the impact of an undesired outcome that has already occurred.
- ii) Maintenance refers to efforts to increase adherence with treatment over time to prevent relapse or recurrence of a problem
- iii) Refer to Guidelines, Protocols, Manuals, Standard Operating Procedure that are available to you in handling an abused child
- iv) Module seven presents an overview of management of children with injuries while module eight presents management of sexual abuse and rape

## 6.9 ADMISSION TO HOSPITAL

- Most abused and neglected children may not require admission to hospital but consider admission for physically injured children requiring treatment and for obviously psychologically traumatized children.
- Where the family or social situation indicates an immediate need for a temporary safe and supportive space while the investigations take place, admission into a shelter temporarily may be helpful.
- Admit any children who needs admission

## 6.10 REFERRAL.

1. Refer children to appropriate level of care using the standard referral form. This Referral Form should have the following features;
  - I. About You (Referring health facility)
    - Name
    - Job Title
    - Health facility
    - Contact Details (telephone number(s), email address, postal address and physical address)
  - II. About the Child / Children
    - Name
    - Sex
    - Age
    - Language(s) Spoken
    - Residential Address
    - Contact Details of School
    - Contact Details of Parents / Guardians
  - III. Reasons for Referral / Your Expectation(s)
  - IV. What You Did for the Child / Children; Your Observation (clearly distinguish between what the child has said and the inferences you may have made).
  - V. Narration of Case Details (prior intervention(s) before your intervention, and the present condition of child being referred).
  - VI. You or Your Health Facility's Support (resources uniquely available to you) Throughout the Process.
2. Keep a copy of the referral form(s) for your records
3. Explain reasons for referral adequately to child and be ready to answer every question asked by the child.
4. Assure the child of your support throughout the process

## 6.11 FOLLOW UP.

- It is important that children in whom abuse or neglect has been identified are offered appropriate follow up to ensure the following:
  - Monitoring of child's overall progress
  - Attending to areas of developmental need (e.g. Failure to thrive, language delay, behavioural disturbance) that as far as possible the child will return to a safe environment
  - Performing further medical examination as appropriate (e.g. To check for signs of healing)
  - Making appropriate referrals for therapeutic support (e.g. To mental health services)
  - In some cases, follow up by a social worker or another health professional may be appropriate
- 1. Follow up with the contact person at least once every week
- 2. For the One Following Up and The One Currently in Charge of The Case;
  - Document everything
  - Write down accurately every conversation on the child / children
  - Sign and date your notes
  - Keep all notes in a secure place for an indefinite period.

These are essential in helping your health facility, other Healthcare providers and the police decide what is best for the child, and as evidence if necessary.

3. Find out what you / your health facility can do to assist while the child is receiving help.
4. Speak to the child during the period and assure him/her of your support.
5. Follow up ends when the case is officially discharged and the best interest of the child is protected.

### 6.12 CASE CONFERENCE

1. A case conference or meeting of professionals to discuss a particular case of child abuse may be periodically held or as need arises at the health facility.
2. The conference should be attended by all relevant stakeholders such as doctors, healthcare providers, psychologists, social workers and other professionals
3. A written report must be provided for all Case conferences or review conferences
4. Where possible the consultant paediatrician concerned or junior doctor representative (appropriately briefed) must attend initial conference and follow up conferences.
5. Case conferences should be coordinated by the department of social services.

Summary of what healthcare providers should know when handling child abuse

- a) Know how to create rapport and make both the child and guardian feel at ease
- b) Know how to take history
- c) Know how to make a physical examination
- d) Know how to identify signs of abuse and probe where necessary
- e) Know how to write a report that can be used in court if necessary
- f) Know what to document
- g) Know how to preserve evidence in case it will be needed in forensic management
- h) Know how and where to seek referral
- i) Know how to make follow up of the child whom you have treated

# MODULE SEVEN:

## MANAGEMENT OF CHILDREN WITH INJURIES

### 7.1 INTRODUCTION

Patients with severe, life-threatening conditions should be managed or referred for emergency treatment immediately to the appropriate level of care. Patients with less severe injuries, for example, cuts, bruises and superficial wounds can usually be treated by the examining healthcare worker or another nursing staff. Any wounds should be cleaned and treated as necessary.

### 7.2 PURPOSE

To guide health workers in handling children brought to health facilities with injuries

### 7.3 PROCEDURE

Follow the procedure in Module Six: Caring and Handling Abused Children at Health Facilities

### 7.4 PATTERNS OF INJURIES SUGGESTING CHILD ABUSE

The types of injuries suggestive of child abuse are:

- Bruising
- Multiple injuries
- Severe head injury
- Rib fractures
- Retina haemorrhage
- Burns
- Fractures

### 7.5 INVESTIGATIONS

1. If there is significant bruising, petechiae or bleeding do full blood count, platelets and clotting factors
2. Full skeletal x-ray including axial and appendicular skeleton should be done in:
  - all children less than two years of age who have clinical evidence of abuse
  - all children less than one year who show evidence of significant neglect or deprivation or where there is evidence that siblings have been physically abused.

- A selective approach should be used for 2-5 year olds
  - Skeletal survey is rarely indicated in over 5 year olds
  - X-rays may need to be repeated after 2-3 weeks for evidence of callus formation
3. Laboratory and Other Investigations (where the capacity to carry out these tests exists) should be carried out per the national treatment guidelines

## 7.6 MANAGEMENT OF PHYSICAL INJURIES

1. Any injuries should be treated appropriately
2. The following medications may be indicated:
  - antibiotics to prevent wounds from becoming infected;
  - a tetanus booster or vaccination (per MOH Guidelines);
  - medications for the relief of pain, anxiety or insomnia.
3. Where any physical injuries result in breach of the skin and mucous membranes, manage as in the box below

- Clean abrasions and superficial lacerations with antiseptic and either dress or paint with tincture of iodine, including minor injuries to the vulva and perineum;
- If stitching is required, stitch under local anaesthesia. If the survivor's level of anxiety does not permit, consider sedation or general anaesthesia;
- High vaginal vault, anal and oral tears and 3rd/4th degree perineal injuries should be assessed under general anaesthesia by a gynaecologist or other qualified personnel and repaired accordingly;
- In cases of confirmed or suspected perforation, laparotomy should be performed and any intra-abdominal injuries repaired in consultation with a general surgeon;
- Provide analgesics to relieve the survivor of physical pain

4. Immunize with 0.5mls of tetanus toxoid per the revised schedule demonstrated in the table below

Table 7.1 Tetanus toxoid immunization schedule for women of childbearing age and pregnant women without previous exposure to TT, Td or DTP

|   | Vaccines         | Doses      | Route and Site of Injection                   |
|---|------------------|------------|---|
| <b>At Birth</b>   | BCG              | 0.05ml     | Intra-dermal, right upper arm                 |
|   | OPV0             | 2 Drops    | Oral  |
| <b>6 Weeks</b>  | DPT-HepB-Heb1    | 0.5ml      | Intra-muscular, lateral aspect of left thigh  |
|   | OPV1             | 2 Drops    | Oral  |
|   | Pneumo 1         | 0.5ml      | Intra-muscular, lateral aspect of right thigh |
|   | Rota 1           | 1.5ml vial | Oral  |
| <b>10 Weeks</b>   | DPT-HepB-Heb2    | 0.5ml      | Intra-muscular, lateral aspect of left thigh  |
|   | OPV2             | 2 Drops    | Oral  |
|   | Pneumo 2         | 0.5ml      | Intra-muscular, lateral aspect of right thigh |
|   | Rota 2           | 1.5ml vial | Oral  |
| <b>14 Weeks</b>   | DPT-HepB-Heb3    | 0.5ml      | Intra-muscular, lateral aspect of left thigh  |
|   | OPV3             | 0.5ml      | Oral  |
|   | Pneumo 3         | 2 Drops    | Intra-muscular, lateral aspect of right thigh |
|   | IPV              | 0.5ml      | Oral  |
| <b>6 Months</b>   | Vitamin A        | 100,000 IU | Oral  |
| <b>9 Months</b>   | Measles-Rubella1 | 0.5ml      | Subcutaneous, left upper arm                  |
|   | Yellow Fever     |            | Subcutaneous, right upper arm                 |
| <b>12 Months</b>  | Vitamin A        | 200,000 IU | Oral  |
| <b>18 Months</b>  | Measles-Rubella2 | 0.5ml      | Subcutaneous, left upper arm                  |
|   | Men A            | 0.5ml      | Subcutaneous, right upper arm                 |
|   | Vitamin A        | 200,000 IU | Oral  |
| After 18 Months Vitamin A is given every 6 Months till the child is 5 years old |                  |            |   |
| 18 Months – Give Long Lasting Insecticide Treated Nets (LLTINs) to the child    |                  |            |   |

Source: Core information for the development of immunization policy. 2002 update. Geneva. World Health Organization, 2002 (document WHO / V&B/02.28), page 130.

- Tetanus toxoid should be given to all children who have experienced sexual and physical abuse (all sexes and all ages) if there are any physical injuries of the skin and/or mucous membranes.
- Referral to clinical psychologist must be considered and discussed with social welfare services and the family







# MODULE EIGHT:

## MANAGEMENT OF CHILD SEXUAL ABUSE

### 8.1. INTRODUCTION

Sexual abuse (including rape and defilement) is a very common forms of child abuse in Ghana and is the most prevalent cases of child abuse reported at health facilities. Chances are high that most health workers will encounter cases of sexual abuse.

### 8.2 PURPOSE

- To assist health workers, carry out vaginal exams and other necessary examinations and tests when a child experiences child abuse.

### 8.3 PROCEDURE WHEN CHILD SEXUAL ABUSE IS SUSPECTED

- Follow the procedure in Module Six: Caring and Handling Abused Children at Health Facilities
- Taking medical history is the most common way of gathering of information from the child (or caregivers) in cases of alleged child sexual abuse.
- The aim of the medical or health history is to find out why the child is being brought for healthcare now and to obtain information about the child's physical or emotional symptoms.
- It also provides the basis for making a medical diagnostic impression before a physical examination is conducted.
- The medical history may involve information about the alleged abuse, but only in so far as it relates to health problems or symptoms that have resulted there from, such as bleeding at the time of the assault, or constipation or insomnia since that time.
- Ask more about the circumstances.
  - whether there was violence involved.
  - whether there was sexual penetration
  - whether the person used protection or not.
  - whether the person has missed the monthly period because you need to ascertain whether the girl is already pregnant or whether in future she misses her period you can tell whether it is because of the abuse.

- The medical history should be taken by a health professional.
- After you have taken the history go ahead and examine the child from head to toe.
- The examination of pre-pubescent children should be performed, or the findings interpreted, by practitioners who have specialist knowledge and skills in the field of child sexual abuse
- The medical history should be taken in a manner so that the child is not further traumatized by unnecessary repetition of questioning, which may lead to losing or distorting the information.

Health workers should find the examination of children greatly eased by following a few simple general rules of conduct, namely:

- Always ensure patient privacy. Be sensitive to the child's feelings of vulnerability and embarrassment and stop the examination if the child indicates discomfort or withdraws permission to continue.
- Always prepare the child by explaining the examination and showing equipment; this has been shown to diminish fears and anxiety. Encourage the child to ask questions about the examination.
- If the child is old enough, and it is deemed appropriate, ask whom they would like in the room for support during the examination. Some older children may choose a trusted adult to be present.

#### **Important Note:**

- Never ask a girl who has been sexually abused to take a shower before you can examine her. This will destroy the evidence yet all evidence is needed to prosecute perpetrators of sexual abuse
- The physical examination of children consists of a head-to-toe review plus a detailed inspection of the genito-anal area.

## **8.4 THE FORENSIC INTERVIEW**

### Purposes of Forensic Interviewing

- i) To obtain information from a child that may be helpful in a criminal investigation
- ii) To produce evidence that will stand up in court if the investigation leads to criminal prosecution
- iii) To assess the safety of the child's living arrangements
- iv) To assess the need for medical treatment and psychological care

### Tips in Conducting Forensic Interviews

- i) Non-leading open-ended conversation with a child intended to elicit detailed information about a possible abuse the child may have experienced or witnessed.
- ii) An extended forensic interview is a multi-session structured interview for children who may need more than one session to talk about allegations of abuse.
- iii) Such children include those with special developmental considerations, and children who are particularly anxious or frightened.
- iv) Whereas there are dangers of repeated questioning and duplicative interviews, some children require more time to become comfortable with the process and the interviewer.
- v) Allow for silence or hesitation without moving to more focused prompts too quickly.

## 8.5 HEAD TO TOE EXAMINATION

- First observe the child's general appearance and demeanour.
- When performing the head-to-toe examination of children, the following points are particularly noteworthy:
- Record the height and weight of the child (neglect may co-exist with sexual abuse).
- Note any bruises, burns, scars or rashes on the skin.
- Carefully describe the size, location, pattern and colour of any such injuries.
- In the mouth/pharynx, note petechiae of the palate or posterior pharynx, and look for any tears to the frenulum.
- Check for any signs that force and/or restraints were used, particularly around the neck and in the extremities.
- Record the child's sexual development stage and check the breasts for signs of injury.

### The Genito-Anal Examination for Girls

- To conduct the genital examination in girls, it is helpful to ask the child to lie supine in the frog-leg position, and/or, if comfortable, in the knee-chest position.
- A good light source is essential; an auroscope provides both a light source and magnification. A colposcope may also be used; however, although it is useful for documenting some types of injury and/or anatomical abnormalities, it is very expensive and generally does not reveal any additional medical findings.
- Carry out a pelvic examination, inspecting and seeing whether there is semen or discharge around the genital area.
- Look out for the hymen if it is intact or broken. If broken, observe whether it is freshly broken or has been broken over a long period.
- Look at the vagina wall whether there are any scratch marks or not, and then look at the pelvis for scratch marks.

Remember that in most cases, a speculum exam is not indicated. It is only indicated when the child may have internal bleeding arising from a vaginal injury because of penetration.

- In such case, do a speculum examination under general anaesthesia;
- Examine the anus. Look for bruises, tears or discharge. Help the child lie on her back or on her side;
- The child may need to be referred to a higher-level health facility for this procedure;
- As much as possible do not conduct a speculum exam on girls who have not reached puberty. It might be very painful and cause additional trauma.
- Make photo documentations for the investigations you make because it may be needed in court (see module 13 on medical reports when handling child abuse)

### The Genito-Anal Examination for Boys

- Check for injuries to the skin that connects the foreskin to the penis;
- Check for discharge at the urethral meatus (tip of penis);
- If the child is not circumcised pull the foreskin gently back to examine the penis. Do not force it since doing so can cause trauma, especially in a young child.
- Examine the anus. Look for bruises, tears, or discharge. Help the boy to lie on his back or on his side. The boy should not be placed on his knees as this may be the position in which he was violated;
- Consider a digital rectal examination only if medically indicated, as the invasive examination may mimic the abuse.

### Examination of The Anal Area

- To examine the anal area (in boys and girls), place the child in the lateral position and apply gentle traction to part the buttock cheeks.
- During an anal examination, the following tissues and structures should be inspected, again looking specifically for signs of injury (e.g. bruising, fissures, lacerations, bleeding, discharge):
  - anal verge tissues;
  - ano-rectal canal;
  - perianal region;
  - gluteal cleft

## 8.6. INVESTIGATIONS

### Investigations for Clinical Management of the Child

Basic investigations to know the general condition of the child will include urine specimens and blood tests as indicated below.

#### Urine

- Urinalysis – microscopy
- Pregnancy test

#### Blood

- HIV Test
- Hepatitis B
- Haemoglobin level
- Liver Function Tests
- VDRL
- Syphilis

### Investigations Carried Out for Evidence Purposes

- Urine analysis for epithelial cells;
- High vaginal swab for evidence of spermatozoa.

The health worker should collect the specimen, preserve it for appropriate storage and hand it over to the police for further investigations and processing in the courts.

## 8.7 TREATMENT

1. Any injuries should be treated appropriately
2. Referral to child guidance for counselling must be considered and discussed with social welfare services and the family
3. Give post coital pregnancy prevention
4. Provide counselling on abortion to victims who become pregnant because of sexual abuse as per Guidelines from the Ministry of Health.
5. Treat Trichomonas, gonorrhoea, Chlamydia and syphilis with appropriate antibiotics
6. Provide routine Post Exposure Prophylaxis for HIV in defilement and rape cases.

### 8.7.1 PEP FOR SURVIVORS OF SEXUAL VIOLENCE

It is important to recognize that rape and defilement are criminal offences in Ghana. Survivors and the general public should be encouraged to report such occurrences to law enforcement agencies.

The healthcare provider must therefore be abreast with the legal requirements regarding the management of the survivor. This includes documentation and reporting as well as the provision of emergency contraception, abortion, counselling, testing and prevention of STIs such as HIV infection.

Healthcare workers must understand that their duty is to provide basic medical and psychological intervention to survivors and referral to relevant agencies for other needed services.

- These guidelines are to be used in the context of the clinical management of survivors of sexual assault within the regular health care setting. This includes:
  - Screening for prevention/management of pregnancy
  - Screening for and treatment of Sexually Transmitted Infections (STIs),
  - Collection of evidence for possible future prosecution
  - Rendering of psychological support.
- These guidelines focus on female victims of sexual assault but the principles are the same in the management of male victims as well as for minors.
- There are no conclusive data on the effectiveness of PEP in preventing transmission of HIV after the occurrence of rape. Experience with prophylaxis relating to occupational exposure and prevention of mother-to-child transmission (PMTCT) however suggest that starting PEP as soon as possible and indeed within 72 hours after the rape is most beneficial.

### MEDICO-LEGAL CONSIDERATIONS

- Healthcare providers must appreciate that the establishment of the case of rape is a legal matter to be determined by a court of competent jurisdiction and not a decision for the healthcare worker to make. The healthcare worker is providing a service with the presumption that there has been an alleged case of rape or defilement which may or may not be proven
- For the purpose of these guidelines, the term “rape” means “rape, defilement or non-consensual carnal knowledge”.
- This document should not be used as an absolute guide for a forensic examination and the collection of specimens for prosecution. Such a requirement will need a referral to a gynaecologist, a clinician trained in forensic medicine, or other specialist.
- Although only a small percentage of alleged rape cases actually go on trial, it is important that the healthcare worker keeps detailed and accurate documentation in the event of the need to testify in court.

### CLINICAL ASSESSMENT OF SURVIVOR

- i. Take accurate and detailed history, considering the fact that this could be very sensitive and emotionally traumatic for the client.
- ii. Ensure right to privacy, confidentiality, information and nondiscrimination.
- iii. Clarify the kind of sexual assault and orifices involved in the assault.
- iv. Determine whether the perpetrator constitutes a high risk or otherwise
- v. Find out the sexual history of the client both before and after the assault. Assess the overall risk of client

- vi. Perform all relevant physical and genital examinations, and collect forensic evidence as may be required by law if you are the clinician primarily responsible for the case.
- vii. Offer counselling and testing for HIV and screen for other STIs including Syphilis, Hepatitis B where screening tests are available.

Where client is found to be HIV positive, she/he must be counselled and referred to an ART centre for comprehensive HIV care and support services.

- viii. Treat any STIs found or suspected on screening. In the case of a child survivor:
- ix. History should be taken from both the minor and the parent or legal guardian.
  - a. It is preferable to have the parent or guardian wait outside during the interview and have an independent trusted person/chaperone present.
  - b. Avoid asking leading questions.
  - c. For the examination either a parent and/or chaperone must be present.
  - d. Document all findings of the assessment and interventions including the outcome of the HIV test, STI and Hepatitis B screening.
- x. Where the client declines to undertake the HIV test, document this refusal and make client fill and sign the National PEP and Management Record Form for Rape Survivors indicating the refusal.

### ASSESSMENT OF EXPOSURE RISK

The following factors must be considered in the assessment of risk:

- a. Perpetrator is unknown or HIV status of perpetrator is unknown.
- b. Perpetrator's HIV status is known to be positive.
- c. Perpetrator is an injection drug user or armed robber.
- d. Whether the alleged sexual violation involved anal penetration.
- e. Whether the survivor was allegedly raped by more than one person.
- f. Vaginal penetration with associated genital injuries.
- g. Whether survivor is a minor

### PROTOCOL FOR PEP AND PREVENTIVE TREATMENT OF STI

#### If survivor presents within 72 Hours of the Incident

- a. Prevent HIV Transmission through the provision of PEP using three ARVS according to the national protocol and as spelt out under Appendix 6.
- b. Treat STIs according to national guidelines.
- c. If HBsAg result is negative prevent Hepatitis B infection by initiating the appropriate vaccination protocol.
- d. Pregnancy can be prevented by providing emergency contraception in accordance with the National Reproductive Health Service Policy. Pregnancy test must be done to first exclude an existing pregnancy.
- e. Clean and treat any tears, cuts, abrasions and other injuries. If there are major contaminated wounds consider giving antibiotic cover.
- f. Tetanus prophylaxis (tetanus toxoid – TT) may also be indicated where there are wounds or break in mucosa.

**If survivor presents more than 72 Hours after the Incident**

- a. PEP may not be beneficial when started after 72 hours but decision to start should be made on case by case basis. Client should be offered CT and appropriate follow up instituted.
- b. Assess and examine for STIs and provide treatment according to national STI treatment guidelines.
- c. If HBsAg test result is negative recommend vaccination against Hepatitis B infection, using the appropriate protocol.
- d. If the survivor presents after 72 hours but within 120 hours (5 days) provide emergency contraception in accordance with the National Reproductive Health Service Policy and Standards.
- e. Pregnancy test must be done to exclude an existing pregnancy.
- f. Treat or refer all wounds, abscesses and other injuries and complications. Vaccinate against tetanus if client has not been fully vaccinated.

**FOLLOW-UP CARE****I. For Survivors who received PEP.**

- a. One-week follow-up visit:
  - i. Evaluate PEP, STI and other treatment.
  - ii. Evaluate for STI and provide treatment as appropriate.
  - iii. Discuss CT for future HIV testing.
- b. Six-week and three-month follow-up visits:
  - i. Offer CT for HIV
  - ii. Evaluate for STIs and treat as appropriate Evaluate for
  - iii. pregnancy and provide counselling

**II. For Survivors who do not receive PEP.**

- a. Two-week follow-up visit:
  - i. Check if STI and/or other treatment have been adhered to.
  - ii. Evaluate for pregnancy and provide counselling
  - iii. Discuss TC for future HIV testing
- b. Three-month follow-up visit:
  - i. Offer TC for HIV
  - ii. Evaluate for STIs and treat as appropriate
  - iii. Assess pregnancy status

## DOCUMENTATIONS AND OTHER POTENTIAL FORENSIC EVIDENCE

- i. In all cases evaluate mental and emotional status at every visit, and refer or manage as needed. For minors assess the safety of their environment (Place of residence and school etc.) for possible re-location. All information gathered from history, referral notes, assessments, and from physical and genital examination must be clearly documented, dated, signed and appropriately filed under strict confidentiality.
- ii. All laboratory test results must be acknowledged and stored with patient records.
- iii. Document all referrals to and from or within your facility
- iv. Fill all forms required under these guidelines and according to national policies and guidelines.
- v. Note that proper documentation will facilitate testimony in a court of law

Source : *The sixth edition of the Ghana Antiretroviral Therapy Guidelines (updated, 2017).*

### 8.7.2 EMERGENCY CONTRACEPTION

- Emergency contraception, or post-coital contraception, refers to methods of contraception that can be used to prevent pregnancy in the first five days after sexual intercourse.
- It is effective only in the first few days following intercourse before the ovum is released from the ovary and before the sperm fertilizes the ovum. Emergency contraception cannot interrupt an established pregnancy or harm a developing embryo.

#### Methods of Emergency Contraception

There are three methods of emergency contraception:

- emergency contraception pills (ECPs)
- combined oral contraceptive pills
- copper-bearing intrauterine devices (IUDs).

#### 1. Emergency contraception pills

The National Guidelines recommends either of the following drugs for emergency contraception, for use within 5 days (120 hours) of unprotected sexual intercourse:

- Levonorgestrel taken as a single dose (1.5 mg) Or alternatively, levonorgestrel taken in 2 doses (0.75 mg each, 12 hours apart).
- Ulipristal acetate, taken as a single dose at 30 mg.

#### Mode of action

Levonorgestrel emergency contraceptive pills prevent pregnancy by preventing or delaying ovulation. They may also work to prevent fertilization of an egg by affecting the cervical mucus or the ability of sperm to bind to the egg.

Levonorgestrel emergency contraceptive pills are not effective once the process of implantation has begun, and they will not cause abortion.

Post coital pregnancy prevention is only effective if started within 72 hrs of a single episode of unprotected coitus and should be discussed with the guardians and child where appropriate. Dosage: ethinyl oestradiol 2.5mg bd for 5 days or levonorgestrel 1500mcg within 72 hrs to 96 hours. currently Ulipristal acetate has been licensed for use 72 and 120 hours after unprotected sexual intercourse. A copper containing IUD can also be inserted.



### 8.7.3 PROPHYLAXIS OF SEXUALLY TRANSMITTED INFECTIONS

- STI prophylaxis should be offered to all survivors of sexual violence.
- It need not be given at the same time as the initial doses of PEP and EC as the pill burden can be intolerable.
- It should preferably be prescribed for the survivor and given for uptake within 24 hours.
- The HVS performed at presentation is done for forensic reasons and not to screen for STIs and/or guide antibiotic administration.
- People with a “normal” HVS should still be offered STI prophylaxis.
- Encourage and promote partner treatment to avoid re-infection

#### IMPORTANT NOTE:

Encourage and promote partner treatment to avoid re-infection





### 8.7.4. HEPATITIS B PREVENTION

The generally available Hepatitis B Vaccines do not provide any protection from infection if given after an exposure (e.g.: sexual assault), but they do provide protection from future exposures.

It is much less costly to vaccinate all victims of rape/sexual violence, rather than to test everyone for Hepatitis B antibodies to see who might benefit. Ideally, if Hepatitis B Vaccines is available, it should be considered for victims of sexual violence per the revised schedule in the table below.

| Dose of Hep B  | When to Give                  | Expected Duration of Protection |
|----------------|-------------------------------|---------------------------------|
| 1st Hep B dose | At first contact              | None                            |
| 2nd Hep B dose | 1 month after 1st Hep B dose  | 1-3 years                       |
| 3rd Hep B dose | 5 months after 2nd Hep B dose | 10 years                        |

Source: National Hepatitis B Guidelines



# MODULE NINE:

## SPECIAL CONSIDERATIONS IN THE PROVISION OF SERVICES TO ABUSED CHILDREN

### 9.1 INTRODUCTION

There are vulnerable children and situations that need special attention while offering services for child abuse. These include among other children who come to health facilities not accompanied by parents or guardians

### 9.2 PURPOSE

To guide health workers on how to handle children who are not under parental care such as children on streets, in home care institutions, who bring themselves to health facilities, and those who may not have health insurance

### 9.3 PROCEDURE

- If the health facility has assigned a staff with the responsibility of ensuring that abused children are properly catered for at health facilities, as advised in these Guidelines, that person should ensure that these special needs are addressed.

### 9.4 CHILDREN WITH DISABILITIES

- Children with disabilities are particularly vulnerable and at greater risk of all forms of abuse, including abuse whilst being cared for in institutions.
- Research has shown that the presence of multiple disabilities increases the risk of both abuse and neglect.
- Health workers should take note that children with disabilities have the same rights to protection as any other child.
- You need to be on high alert in identifying and caring for children with disabilities.
- You must respond, handle, and treat children with disabilities as individuals with their own specific needs, feelings, thoughts and opinions.

### 9.5 CHILDREN NOT ACCOMPANIED BY CARETAKERS

- Health workers should be aware that it is mandatory for them to give services to all abused children that present to health facilities irrespective of the condition of the social and economic background of the child
- When a child presents to a health facility unaccompanied by a guardian or parent, first respond to the child, offer him or her the necessary treatment without any discrimination
- After providing services to the child, hand the child to the social welfare officer at the health facility to pursue the case
- It is the social welfare officer who will sort out the payment for the services provided, including recommending waivers for the treatment costs.
- You should work hand in hand with the social welfare officer to ensure that the child receives all the help he or she needs including referral to other places of service, if that is necessary.

### 9.6 CHILDREN IN INSTITUTIONAL CARE

- You should be aware that children who are exposed to physical and moral dangers in their home are taken into institutional care. These children at times experience abuse and are brought to health facilities for treatment
- Such children include those who are abandoned, have mentally challenged mothers, from prison inmates, whose parents are on drugs and parents not able to give their adequate care.
- Orphans, abused by parents, surrendered by parents due to lack of care, intercepted due to trafficking, and missing or loitering children and children with mental illness are other children in institutional care.
- The health facility should have a working relationship with the child care institutions
- Where possible the health facility should have arrangements where it periodically sends health workers including pediatricians and other specialist periodically to the home care facility.
- Bigger hospitals can have a nurse stationed at this Home every day taking caring of the children's health needs. Other specialists such as clinical psychologists may visit the facility periodically such as every two weeks.

### 9.7 YOUNG BOYS WHO ARE VICTIMS OF SEXUAL VIOLENCE

- Young boys most commonly experience sexual violence in the form of:
  - ⦿ Receptive anal intercourse;
  - ⦿ Forced masturbation of the perpetrator;
  - ⦿ Receptive oral sex;
  - ⦿ Forced masturbation of the victim.
- Young boys who are victims of sexual violence should be triaged in the same manner as girl victims.
- The same procedures for obtaining consent, taking a history, conducting the physical examination (although the genital examination will be different) and ordering diagnostic laboratory tests should be followed, that is:
  - ⦿ Perform a top-to-toe examination looking for any signs of injury;
  - ⦿ Conduct a thorough examination of the genito-anal area;
  - ⦿ Treat any injuries (men also need to be treated for STIs, hepatitis B and tetanus).

- Young boys should be informed about, and offered, a HIV test and the option of post-exposure prophylaxis, if available.
- Young boys should receive follow-up care for wound healing, any prescribed treatments (including those for STIs), completion of medications and counselling.

## 9.8 CHILD BETWEEN 14 AND 18 YEARS OF AGE

- Health workers should pay attention to children aged between 14 and 18 years because they need to be handled with care at health facilities.
- This is because this is the age at which most children:
  - ⦿ Have difficulties with parents as they grow up
  - ⦿ abuse their fellow children
  - ⦿ are prone to abuse by perpetrators of child abuse
  - ⦿ need guidance on their reproductive health needs
  - ⦿ may be shy to open upon the abuse they experienced
- Health workers should take extra caution while creating rapport, make the child feel at ease, adhere to the principles of privacy and confidentiality, and let the child know that you have his or her interests at heart.

## 9.9 PERPETRATORS OF CHILD ABUSE

- Many perpetrators of child abuse need to be supported.
- The support could be mental health evaluation, prophylaxis and treatment for HIV and sexually transmitted infections.
- Usually the perpetrators of child abuse are neglected and not given any treatment and help.
- From an ethical point of view, Health Workers need to take care of the perpetrators of the abuse also.
- Perpetrators of child abuse have the right to medical treatment to ensure they access prophylaxis for HIV/AIDS and STIs and management of physical injuries
- Health workers should accord the perpetrator the necessary treatment
- The treatment of perpetrators should be the same as for the survivors including collection of forensic specimens and counselling.

## 9.10. CHILD ABUSE UNDER EMERGENCY SITUATIONS

- Child abuse increases under emergency situations due to:
  - ⦿ The breakdown of law and order;
  - ⦿ The absence of systems that would respond to distress signals;
  - ⦿ The lack of adequate services that would minimize the effects of child abuse.
  - ⦿ The continual reproductive roles of women and girls such as looking for food and/or water in unsecure areas which predispose them to the dangers of being abused;
  - ⦿ The possible abuse of power by the security and humanitarian workers who demand sexual favours in return of goods and services.
  - ⦿ Harmful cultural practices are exacerbated - e.g. – forceful early marriage of the girls to meet the lack of resources in the family
- You should therefore assume and believe that child abuse is taking place and is a serious and life-threatening protection issue, regardless of the presence or absence of concrete and reliable evidence.
- In theory interventions of child abuse under emergencies must take place at three levels.



- ◎ **Structural level (primary protection):** preventative measures to ensure rights are recognized and protected (through international, statutory and traditional laws and policies);
  - ◎ **Systemic level (secondary protection):** systems and strategies to monitor and respond when those rights are breached (statutory and traditional legal/ justice systems, healthcare systems, social welfare systems and community mechanisms);
  - ◎ **Operative level (tertiary protection):** direct services to meet the needs of women and girls who have been abused.
- Management of child abuse is a cross-cutting issue, and professionals and institutions must work together to address this serious human rights and public health problem.
  - To save lives and maximize protection, a minimum set of activities must be rapidly undertaken in a co-ordinated manner to prevent and respond to child abuse from the earliest stages of an emergency.
  - Survivors/victims of abuse need assistance to cope with the harmful consequences of this nature of violence;
  - They need healthcare, psychological and social support, security, and legal redress;
  - The health facility must have prevention activities in place to address causes and contributing factors to child abuse in the setting;
  - Providers of all these services must be knowledgeable, skilled, and compassionate to help the survivor/ victim, and to establish effective preventive measures;
  - The healthcare provider's responsibility includes:
    - i. To provide appropriate care to survivors of child abuse as is documented in these guidelines;
    - ii. To collect forensic evidence that might be needed in a subsequent investigation either during or post crisis period
  - It is not the responsibility of the healthcare provider to determine whether a person has been abuse. That is a legal determination.
  - However, all healthcare providers must be aware of relevant laws and policies governing healthcare provision in cases of child abuse.

# MODULE TEN:

## COUNSELLING IN CHILD ABUSE

### 10.1 INTRODUCTION

Counselling is the provision of professional assistance and guidance in resolving personal or psychological problems from child abuse. It is a type of talking therapy that allows a person to talk about their problems and feelings in a confidential and dependable environment.

### 10.2 PURPOSE

- To enable health workers have empathy, sensitivity, and compassion for abused children and help them deal with any negative thoughts and feelings to cope with the consequences of the abuse.

### 10.3 PROCEDURE

- The ideal situation is to have a trained counsellor handle children who have been abused.
- In most cases, it is the health workers who provides counselling to the abused child, which takes his or her time from clinical work and the associated workload.
- In the absence of a counsellor, the health facility assigns a health worker (s) such as a nurse or any other healthcare provider and trains them with skills to perform the functions of counsellor.
- The public health nurse is a good example of a professional who can take this responsibility.
- A clinical psychologist or trained counsellor trains the person designated to handle social issues child abuse in the principles, processes, procedures, and approaches of child counselling
- The health facility can use the services of professionals trained as counsellors such as those working with HIV/AIDS, Adolescent Places, and other departments.
- It is recommended that tertiary and secondary facilities establish psycho-social units to take care of the traumatized cases of child abuse after the clinical management.



## 10.4 CHILD-CENTRED APPROACH TO COUNSELING

The health worker carrying out the counselling should apply the principles of doing “good” and not “doing harm” in counselling a child.

When providing services to children who have experienced child abuse, counsellors should adhere to the following fundamental principles of counselling:

- **Autonomy:** The right of patients to make decisions on their own behalf (or in the case of patients under 18 years of age, individuals acting for the child, i.e. parents or guardians). All steps taken in providing services are based on the informed consent of the survivor.
- **Beneficence:** The duty or obligation to act in the best interests of the survivor.
- **Non-maleficence:** The duty or obligation to avoid harm to the survivor.
- **Justice or fairness:** Doing and giving what is rightfully due to the survivor.
- **Privacy and confidentiality:** ensuring that the privacy of the abused and their guardians are protected.

## 10.5 CORE CONDITIONS ESSENTIAL TO A PRODUCTIVE COUNSELING SESSION

- **Unconditional Positive Regard:** Counsellors should perceive and deal with the survivor as s/he is while maintaining a sense of their innate dignity and personal worth.
- **Non-judgmental attitude:** Counsellors should not assign guilt or innocence or a degree of survivor responsibility for causation of the problem, and they should not make evaluative judgments about the attitudes, standards or actions of the survivor/perpetrator.
- **Genuineness or Congruence:** Counsellors should freely and deeply be able to relate to survivors/perpetrators in a sincere and non-defensive way.
- **Empathy:** The counsellor should be able to understand the client’s reactions from the inside, with a sensitive awareness of the emotions and the situation of the survivor. (Rogers 1967 304-311)

## 10.6 INTERVENTIONS

- Child abuse is a multi-factorial problem and therefore requires many pronged solutions and multidisciplinary approaches.
- Intervention includes a range of problem solving strategies directed at helping the child and family adapt more effectively to their current and future circumstances.
- These strategies are part of a spectrum of activities for treatment, maintenance and prevention.
- Treatment refers to corrective actions that will permit successful adaptation by eliminating or reducing the impact of an undesired outcome that has already occurred.
- Maintenance refers to efforts to increase adherence with treatment over time to prevent relapse or recurrence of a problem
- Prevention efforts are directed at reducing the chances that undesired future outcomes will occur.
- Individual treatment is client specific and is dependent on the outcome of assessment.

### Treatment

- A child identified as abused or with the possibility of being abused, should be referred to the psychologist or counsellor for professional management.
- If the psychologist is the first to see the child he/she should determine and prioritize the immediate needs of the child and refer to the appropriate agency e.g. (health institution, social worker, and police)
- Psychological assessment should go on in parallel with medical assessments
- Depending on the outcome of assessment, interventions may be extended to the guardians, whole families or even to the teachers.
- If there are no trained psychologists and counsellors, refer the child to the regional hospital
- However, try as much as possible to avoid referral and handle the child at your level of service to cut costs and other challenges associated with referral

### Sexual abuse

- In sexual abuse the victim is the primary focus of intervention, although parents and other adults may also be considered for interventions
- Children are affected unpredictably so treatment should match the wide range of needs including helping to restore child's sense of trust, safety and guiltlessness.
- The child needs to be educated and supported to understand why the sexual abuse has happened to him/her and how they can be safe again.
- Information and education about the nature of sexual abuse helps clarify false beliefs that might result in self-blame and the child's feeling of stigma and isolation.
- The guardians need to be counselled to understand and manage the child's behaviours and helped to deal with their own fears and worries because of the disclosure.

## 10.7 COUNSELING DIFFERENT GROUPS AFFECTED BY CHILD ABUSE

### Children Survivors of Abuse

- The dynamics of child abuse differ from those of adults: children rarely disclose abuse immediately after the event.
- Moreover, disclosure tends to be a process rather than a single episode and is often initiated following a physical complaint or a change in behaviour.
- The counsellor should try to believe in and trust the child, create rapport, let the child go at her/his own pace and listen carefully with understanding.
- The counsellor needs to be familiar with the protocol on counselling children.
- In case the child must be removed from an abusive environment, the counsellor should work with the social worker to identify an appropriate place where the child can temporarily stay as his or her problems are addressed.

### Persons with Disabilities - Survivors of Child Abuse

- The health worker need to be aware that people with developmental disabilities who have been abused have challenges to "work through" or talk about their traumatic experiences in a treatment or therapeutic setting.
- Guardians may also need assistance as caretakers of the abused. Counsellors should not have prejudices about people with disabilities.
- For example, the benefit of psychotherapy for people with mental retardation as well as the impact of the abuse should not be questioned. Counsellors should debrief the guardian and/or family members and make appropriate referrals.

### Male Survivors of Child Abuse

- When counselling male survivors of child abuse, counsellors need to be aware that men have the same physical and psychological responses to abuse as women.
- Men experience abuse trauma syndrome in much the same way as women.
- However, men are likely to be particularly concerned about their masculinity; their sexuality; opinions of other people (i.e. afraid that others will think they are homosexual); the fact that they were unable to prevent the rape.

### Perpetrators of Child Abuse

- Perpetrators of child abuse are offered help and support only if they show up at the health facility.
- Counsellors need to be aware of their own fears about how they would counsel a suspected perpetrator.
- When a perpetrator enters, the clinic escorted by police or a relative, the counsellor will let them know that everything discussed between the counsellor and the perpetrator is confidential
- The counsellor is not under obligation to disclose any test results, except when the counsellor is required to do so by law.
- If the perpetrator is the parent or guardian of the child, the counsellor should take note of this, ask the perpetrator leave the consultation room, and report to appropriate authorities as required by law.

## 10.8 FOLLOW UP

- The child who has been abused should be followed up over a period depending on their needs following assessment and how their status improves
- Clinical psychologists play a very important role in helping children that have been abused be restored to their normal status

# MODULE ELEVEN:

## FORENSIC SPECIMENS IN CHILD ABUSE

### 11.1 INTRODUCTION

Forensic management is based on Locard's principle that the perpetrator of a crime will bring something into the crime scene and leave with something from it, and that both can be used as forensic evidence. Forensic management in medical care is essential in presenting credible evidence to court to prove that abuse indeed occurred and link the perpetrator to the crime. Health workers need knowledge and experience in forensic management because they should handle child abuse with an intuition that they may be involved in providing evidence to prosecute the perpetrator of child abuse.

### 11.2 PURPOSE

- The purpose of collecting forensic samples is to prove or exclude a physical connection between perpetrators of child abuse and the child.
- Such evidence comprises a wide variety of substances or objects, the analysis of which requires specific, often specialized scientific skills.
- It is important that health workers are conversant with forensic management because they may be called upon to provide evidence that the child was abused.
- This Module elaborates on the procedures of forensic management while highlighting the processes of collecting, handling and preserving evidence.

### 11.3 TYPES OF EVIDENCE TO COLLECT

There are two types of evidence that need to be collected:

- i) Evidence to confirm that abuse has occurred e.g. for sexual abuse, evidence of penetration (torn hymen), if performed by force there might be bruises, tears and cuts around the vaginal area and the clothing may be stained.
- ii) Evidence to link the alleged assailant to the assault e.g. perpetrators torn clothes, used condoms, blood stains, scratches and bite marks on the perpetrator, and eyewitness testimony i.e. people last saw the perpetrator walking away with the child (this is because circumstantial evidence can help the court adduce the guilt of the accused).

### 11.4 FORENSIC SPECIMENS

- There is a wide range of specimens that could be collected to assist the criminal investigation process. (See Table 11.1 for the possible specimens that health workers will manage).
- Health workers should be aware that all aspects of the collection, transport and analysis of forensic specimens may be subject to legal scrutiny, the results of which may affect the outcome of criminal proceedings.
- Health workers must have a clear understanding of circumstances of the specimens that need to be collected for forensic purposes. For instance:
  - What specimens can be tested?
  - How should individual specimens be collected, stored and transported?
  - How are results made available?
- Health facilities should have a sexual assault evidence kit which may be a container that includes a checklist, materials, and instructions, along with envelopes and containers to package any specimens collected during the exam
- All these questions need to be considered before a forensic service is provided.
- There is no point collecting specimens that will not or cannot be tested

### 11.5 COLLECTION AND HANDLING OF FORENSIC SPECIMEN

When collecting specimen for forensic analysis, the following principles should be strictly adhered to:

**Avoid contamination:** Ensure that specimens are not contaminated by other materials. Store each exhibit separately. Wear gloves always for your own protection and to ensure that the exhibit is not contaminated.

**Collect early:** Try to collect forensic specimens as soon as possible. The likelihood of collecting evidentiary material decreases with the passing of time. Ideally, specimens should be collected within 24 hours of the assault; after 72 hours, yields are reduced considerably. Collect the same before requiring the victim to bathe.

**Handle appropriately:** Ensure that specimens are packed, stored and transported correctly. As a rule, some of the fluids (e.g. urine) should be refrigerated; anything else should be kept dry. In some instances, blood can be dried on gauze and stored as such. Biological evidence material (e.g. body fluids, soiled clothes) should be packaged in paper envelopes or bags after drying, avoiding plastic bags.

**Label accurately:** All specimens must be clearly labelled with the child's name and date of birth, the health worker's name, name of hospital, district, region, the type of specimen, and the date and time of collection.

**Ensure security:** Specimens should be packed to ensure that they are secure and tamper proof. Only authorised people should be entrusted with specimens. Never give samples to parents/guardians or non-health workers.

**Maintain continuity:** Once a specimen has been collected, its subsequent handling should be recorded. Details of the transfer of the specimen between individuals should also be recorded. An exhibit register should be maintained at each facility. It is not a good practice for the child to move any samples taken from them from one facility to another for any analysis.

**Document collection:** It is good practice to compile an itemized list in the child's medical notes or reports of all specimens collected and details of when, and to whom, they were transferred.

Table 11.1: Possible Specimens, Methods of Preservation, Tests and Purpose of Test<sup>4</sup>

| Specimen                                 | Method of preservation   | Test for   | Purpose for testing   |
|--|--|--|---|
| <b>Mouth swab</b>                        | Air dry and store in a clean dry bottle with screw top   | DNA  | Identify assailant/victim   |
| <b>Urine</b>                             | Clean dry bottle with screw top, refrigerated  | Alcohol and drug   | Ability of health worker to confirm whether the assailant/victim uses drugs   |
| <b>Pubic hair/ head hair</b>             | Pick the hair using non-powdered gloves and store in an envelope or sterile container <sup>5</sup>   | DNA<br>Transfer evidence analysis                                      | Identify assailant and abused child   |
| <b>Foreign fibres/grass/ soil</b>        | Hand pick the foreign fibre/ grass/soil using non-powdered gloves and store in a hard envelope or lift using tape  | Fibres found at the incident for transfer evidence analysis            | Verify claim i.e. corroborative evidence  |
| <b>Liquid blood</b>                      | Clean sterile dry bottle with screw top or transfer liquid blood onto sterile cotton gauze and air dry (only for control samples)<br><br>For drug analysis, whole liquid blood should be taken and submitted | DNA, Alcohol/ drugs  | Identify assailant and abused child<br><br>Whether the assailant/victim abuses drugs<br>Ability of the child to consent |
| <b>Semen</b>                             | HVS, dry semen stained clothes in open air. Do not dry in front of fire or artificial means or directly under sun. Preserve in hard paper<br><br>Avoid using plastic bags                                    | Secretor, Blood group assailant<br>DNA proteins in semen (PSA2 or P30) | Identify assailant  |
| <b>Fingernail, crapping or clippings</b> | Pick the finger nail scrapings/clippings using non-powdered gloves and store in an envelope  | DNA  | Identify assailant and victim   |
| <b>Blood stained clothes</b>             | Dry blood stained clothes in open air. Do not dry in front of fire or artificial means or directly under sun. Preserve in a hard paper. Avoid polythene bags   | DNA, Alcohol/ Drugs  | Identify assailant and abused child   |
| <b>Bite marks</b>                        | Plasticine   | Dental impressions   | Identify assailant  |

<sup>4</sup> Modified from the National Guidelines on Sexual Violence in Kenya

<sup>5</sup> The victim's pubic hair may be combed if seeking the assailant's pubic hair; the combings should be transported in a sterile container.

**Note:**

- All tests and results should be recorded in a laboratory rape register that should contain information on: name, registration number, date, age, sex, investigations done, results and a place for anyone who takes specimen to sign to maintain a chain of custody of evidence.
- The laboratory register should indicate whether the child is referred or not
- The Laboratory rape register should be kept well locked away and only accessible to authorized health facility personnel as a measure towards preserving confidentiality.
- The above tests can be carried out on the survivor and on the perpetrator.
- Regarding the perpetrator, the court can order that certain specific samples be collected by the health worker.

**11.5. CHAIN OF CUSTODY OF EVIDENCE**

- This refers to the process of obtaining, preserving and conveying evidence through accountable tracking mechanisms from the community, health facility and finally to the police.
- Also, refers to a paper trail where the movement of evidence is traceable through the different persons in the chain of sample collection, analysis, investigation and litigation)

**11.6 DOCUMENTATION AND REPORTING**

- Effort should be expended on documenting evidence that can corroborate the child's evidence in a court of law. Such evidence includes:
  - ⦿ Evidence that sexual intercourse (penetration) has taken place – engorgement of the genital and maybe increased epithelial cells in the urine. Broken hymen. If the hymen is not broken it does not mean that penetration didn't take place.
  - ⦿ Evidence that ejaculation has taken place – presence of semen around the genitalia. Semen inside the vagina is evidence that ejaculation did take place inside the vagina – hence the importance of a high vaginal swab. It is important to know that ejaculation doesn't always have to take place.
  - ⦿ Evidence that force was used – Torn clothes including undergarments, bruised genitalia. Significant levels of epithelial cells in the urine.
  - ⦿ Evidence linking the suspect with the offence. This will mainly be police work but the health worker will collect the various specimens.



# MODULE TWELVE:

## WORKING WITH NON-MEDICAL PARTNERS IN MANAGING CHILD ABUSE

### 12.1 INTRODUCTION

Child protection cuts across various spheres of influence in a child's life and interventions must use a multi-sectoral approach. This approach involves providers with diverse social, medical, psychological, legal, and law enforcement capacities to be effective. The main non-medical partners you work with include social welfare officers, police, and judiciary

### 12.2 PURPOSE

- To enable health workers understand, recognise, and appreciate the roles played by non-medical partners while handling child abuse.
- To define the roles of the non-medical professionals that work with health workers in handling child abuse
- To enable health workers know what they are supposed to do with the various stakeholders when handling child abuse

### 12.3 PROCEDURE

- First stabilise the child before engaging social workers, psychologists, police, and other professionals.
- The health facility should have a designated focal person such as public health nurse specifically assigned to ensure that all abused children receive all the care and services they need

### 12.4. SOCIAL WORKERS

- The health facility administration should recognise, emphasise, and promote the role played by social welfare officers in child protection
- You should know the functions of the social welfare officers and when and how to contact them in case of child abuse
- You must ensure that report you make on the abused child is sent to social worker assigned to the case.

### **Main Functions of Hospital Social Workers**

- Work with healthcare insurers and the hospital administration to authorize care for abused children whose parents or guardians are not able to pay their medical bills
- Help patients and their families who are coping with the many problems that accompany illness or inhibit recovery and rehabilitation, such as economic need, disability, and lack of resources after discharge to home.
- Collect and analyze patient information to help other health professions understand the needs of patients and their families.
- Liaise with the public health nurse or any other person designated by the health facility to ensure services for home care and equipment following discharge.
- Make referrals to child rehabilitation facilities.
- In outpatient settings – hospital social workers provide referral services, supportive counseling, and coordinate after care and follow up services.
- Function as part of hospital interdisciplinary team

### **12.5. THE POLICE**

- All health workers should know how to work with the police in case need arises when you are handling a suspected case of child abuse
- If a victim of child abuse is brought to the health facility before reporting the police, health workers should first stabilise the child, take evidence they can take, offer treatment before sending the victim to the police
- The health worker may call the police to let them know that they have sent a case of child abuse to their station.

### **Health Workers' Interactions with the Police**

- Considering the nature of the case, the police investigator may issue a police medical form immediately to the victim to be sent to hospital for examination or treatment and a report to be submitted on the victim.
- The police may call the doctor at the health facility to inform him or her that they have sent a victim of child abuse to the health facility for examination
- Normally the police contact the doctor who prepared the report when the victim returns the medical report form to the police
- The police will call the doctor if there is an expression or term in the report they don't understand
- Sometimes the police call the doctor to go to court and explain so expressions, terms, and language in the report which the police can not understand.
- Health workers should know the police stations in their jurisdiction and establish rapport with the police for smooth collaboration in child protection.

### Handling Specimens in Child Abuse

- If forensic samples are required by the police these should be taken by a health workers with experience in handling forensic specimens
- Material evidence of the crime such as torn pieces of clothing, soiled underwear or other materials (in case of sexual abuse) which can be used as evidence must be taken from the victim and preserved, stored properly and proper records kept
- Where possible, pictures of the victim must be taken especially where he/she looks traumatized, injured, bruised, dishevelled or has visible marks of violence.
- Details of handling forensic specimen are provided in module 11, Forensic Specimens in Child Abuse

### Treatment Costs

- A victim of child abuse who is assisted by the police to obtain medical treatment at the health facility is entitled to free medical treatment from the State.
- In case of emergency or a life-threatening situation, a victim of child abuse may receive free medical treatment pending a complaint to the police and the issuance of a report.

### Reporting Child Abuse to the Police

- The Human Trafficking Act, 2005, requires medical practitioners, nurses, and all public officers to report suspicious cases of child abuse to the police.
- These include fondling a child's genitals, making the child fondle the adult's genitals, intercourse, incest, rape, sodomy, exhibitionism and sexual exploitation.
- Health workers should encourage parents/guardians of abused children to report the abuse to the police immediately after medical treatment.
- A victim of child abuse or a person with information about child abuse may file a complaint about the violence with the Police.
- A child may be assisted by a family member or friend to file a complaint on child abuse.

## 12.6 THE JUDICIARY

- Key actors in the criminal Justice system include the Police, Social workers, Courts, Defence Lawyers, Witnesses and the Prisons.

### Health Workers and the Justice System

- Health workers who handle an abused child at the health facility should know that they may be called to be part of the witnesses in court
- Health workers should therefore be bold to stand the defense layers by providing clear evidence that provides justice for child victims and punishment for offenders.
- This is by knowing what to say, how to say it, and what to document when handling child abuse.
- Module 13 provides details of how to prepare medical reports that can be effectively used in court.
- Health workers should be conversant with the Justice system, how it defines abuse within the context of the law, and the guidelines it has laid down for effective enforcement of the law.
- Health workers should inform the parents/guardians of the child who has been abused that there can be no prosecution without a formal complaint of child abuse being lodged with the Police.

### Health Facility Management and the Justice System

- The hospital management has a major role to play in supporting health workers work with the justice system
- The role of the management includes:
  - Knowing about the child abuse
  - Keeping a photocopy of the medical report
  - Ensuring that medical records of the abused child are kept in a safe register
  - Identifying and meeting the legal costs of the lawyer to assist the health facility with the case
  - Facilitating the health worker to present the case in court
  - Administering the money collected from the police medical forms so that it is in the health coffers where it is properly managed
- The health facility management should realise that the health workers works for the hospital as an institution and that it is the institution and not the individual health worker to handle the legal aspects of child abuse



# MODULE THIRTEEN:

## HOW TO WRITE MEDICAL REPORTS

### 13.1 INTRODUCTION

The medical report is a vital piece of evidence for prosecution. For a medical report to be admitted in evidence to assist the court arrive at a fair decision the following must be noted. The medical report must be tendered in by the doctor who examined the victim. The medical doctor must be prepared to defend the doctor's findings made in the medical report in court.

### 13.2 PURPOSE

Three Reasons why healthcare providers should document child abuse

- 1) For the health professional's legal issues: Healthcare providers have a professional obligation to record the details of any consultation with a patient. The notes should reflect what was said (by the patient) and what was seen and done (by the healthcare provider) and be kept in confidentiality.
- 2) For the patient's legal issues: Medical records can be used in court as evidence, for example in criminal proceedings or child custody proceedings. Documenting the health consequences may help the court with its decision-making, as well as provide information about past and present violence. Lack of coordination between healthcare providers and police/prosecutors can result in evidence getting lost. To this end, it is critical that healthcare providers understand the links between forensic medicine and criminal justice to facilitate women's access to the criminal justice system.
- 3) For good clinical care: Documentation can alert other healthcare providers, who later attend the survivor about his/her experience with abuse and thereby assist them in providing appropriate follow-up care (adapted from Warshaw/Ganley 1996, WHO 2003).

### 13.3 PROCEDURE

#### Recording and classifying injuries

- Health workers should carefully describe any injuries assessed.
- The description should include the type and number of injuries, as well as their location, using a body map.

- In case a survivor does not disclose, Health Workers should note whether the injuries are compatible with her explanations.
- This may help clarifying the situation at a future visit and provide documentation in case he/she decides to pursue legal action (Warshaw/Ganley 1996).

**Interpretation of injuries** for medico-legal purposes is a complex and challenging matter.

- In practice, clinicians and pathologists are often being asked by police, courts or lawyers to determine the age of an injury, how it was produced or the amount of force required to produce the injury.
- This requires proven expertise on the part of the practitioners performing it, based on continuing education, exposure to peer review, and quality assurance. Without accurate documentation and expert interpretation of injuries, conclusions on how injuries occurred might be seriously flawed.
- Therefore, Health Workers who are not trained in the interpretation of injuries should document injuries, using standard terminology as provided in WHO 2003 (i.e. abrasions, bruises, lacerations, incisions, stab wounds or gunshot wounds) and refer the task of injury interpretation to a forensic specialist (or senior doctor in case there are no forensic specialists).
- Refer to other resources such as from the World Health Organization for more information on the standard terminology for classifying wounds and the main features of each category, as well as for a list of violent acts and their most probable associated pattern of injury.

#### **How and what should be documented**

- Mechanisms for documenting consultations include hand-written notes, diagrams, body charts and photography (WHO 2003). Through the entire process of documentation, Health Workers should ensure the patient's informed consent.
- The World Health Organization has a sample form for recording consultations with survivors of sexual (and other) abuse, which may be used as it stands, or can be adapted to meet local needs and circumstances.

In cases of child abuse, documentation should include the following (WHO 2003):

- |   |                                    |
|---|------------------------------------|
| ■ demographic information (i.e. name, age, sex);            | ■ tests and their results;         |
| ■ consents obtained;  | ■ treatment plan;                  |
| ■ history (i.e. general medical and gynecological history); | ■ medications given or prescribed; |
| ■ an account of the assault;                                | ■ patient education; and           |
| ■ results of the physical examination;                      | ■ referrals given.                 |

#### **Photography**

- Photography is an important tool that should be used by all healthcare providers – specialized and non-specialized in forensic medicine – to document injuries resulting from child abuse, as photos are important evidence in possible future criminal proceedings instituted against the perpetrator.
- When using photography, it is however important to keep in mind that photos may supplement, not replace, the other methods of recording findings mentioned above (WHO 2003).
- For more information on the use of photography, see box 13.1 below.



**Box 13.1: Checklist for using photography to document findings**

- **Consider the patient and obtain informed consent:** Many survivors will be uncomfortable, unhappy, tired or embarrassed. Communicate the role of photography and obtain informed consent for the procedure.
- **Identification:** Each photograph must identify the subject, the date and the time that the photograph was taken. The photographs should be bound with a note stating how many photographs make up the set. Ideally, a new roll of film should be used for each subject (if you are not using a digital camera); alternatively, there should be a clear indication of where a new series commences.
- **Scales:** A photograph of the color chart should commence the sequence of photographs. Scales are vital to demonstrate the size of the injury. They may be placed in the horizontal or vertical plane. Photographs should be taken with and without a scale.
- **Orientation:** The first photograph should be a facial shot for identification purposes; this may not be required if the photographs have been adequately identified (see above). Subsequent shots should include an overall shot of the region of interest followed by close-up shots of the specific injury or injuries.
- **Chain of custody:** This should be logged as for other forensic evidence.
- **Security:** Photographs form part of a patient record and as such should be accorded the same degree of confidentiality. Legitimate requests for photographs include those from investigators and the court. If, however, a copy is made for teaching purposes, the consent of the subject or his/her parents/guardian should be obtained.
- **Sensitivity:** The taking of photographs (of any region of the body) is inappropriate behavior in some cultures and specific consent for photography (and the release of photographs) may be required. Consent to photography can only be obtained once the patient has been fully informed about how, and why, the photographs will be taken. The briefing should also explain how this material may be used (e.g. released to police or courts and cited as evidence).

Source: WHO 2003

**Box 13.2: Documenting cases of child abuse: a check-list for health workers**

The following check-list is intended to assist health workers to develop their documentation skills:

- Record the extent of the physical examination conducted and all "normal" or relevant negative findings.
- Document all pertinent information accurately and legibly.
- Notes and diagrams should be created during the consultation; this is likely to be far more accurate than if created from memory.
- Notes should not be altered unless this is clearly identified as a later addition or alteration. Deletions should be cancelled once and signed, and not erased or blotted out with correction fluid.
- Ensure that the notes are accurate; deficiencies may cast doubts over the quality of the assessment.
- Use the survivor's own words in quotes, whenever possible. This is preferable to writing down your own interpretation of the statements made. For example, write "My father hit me with an electric cable" instead of "Patient has been hit with an electric cable."
- Use neutral language, such as "Mr Twumasi says..." rather than "The patient alleges."
- Do not exclude information that is extraneous to the medical facts, such as "It was my fault he hit me, because..." or "I deserved to be hit because I was..."
- When documenting referrals, the names, addresses or phone numbers of shelters given to the patient should not be noted, in the interest of the patient's safety.

Source: WHO 2003, Warsaw et al 1996



### 13.3 TAKING CLINICAL NOTES

- Health workers should take notes from the examination of the child at the time of, or immediately after the consultation.
- i) The notes and records must be accurate, legible, clearly dated and signed with place of examination and persons present.
- ii) Record all clinical findings including state of puberty.
- iii) List injuries giving type, size (cm) site, colour, probable age and possible cause.
- iv) Number the injuries and relate to body drawing
- v) Using your notes to make a full report about the abuse to share with the relevant people and authorities
- vi) Health facilities should have a standardized format for recording history and examination findings

### 13.4 PREPARING FORMAL REPORT

- Health workers should make a formal report that will be submitted to police, courts of law, hospital administration or any other person or individuals that

It is important to have the following clearly indicated in the report;

- i. Details of the medical personnel such as name, address, date of report, date of examination and place of examination.
- ii. Child's name, age and address (guardians' parents surname if different)
- iii. People present at the time of examination should be included in the report
- iv. Reasons for examination i.e. at whose request – history as given by police, social worker etc.
- v. Details of previous medical history, birth details if known and if significant.
- vi. Records of child's school (if the child goes to school)
- vii. Growth indicators of the child e.g. height in cm, weight in kg and centiles.
- viii. Records of clearly and concisely examinations with sex, state of cleanliness, state of development,
- ix. List of injuries numbered and an attachment of appropriate body diagrams with injury numbers.
- x. Type, size, site, colour, possible cause and whether the injury is accidental or non-accidental and give reasons for your opinion.
- xi. Comments on any abnormal or normal clinical findings
- xii. Comments on development in areas of motor, social, speech, eye hand coordination
- xiii. Comments on guardian child interaction
- xiv. Records of any further investigations, referrals and, advice on management.

#### Important Aspects of the Medical Report

- The report must be clear and in simple language, signed and stamped with medical terms explained in parenthesis.
- Where the semen of the perpetrator is found in the vagina of the victim this should be matched against the accused person to determine if indeed it is his semen and that should be recorded in the report.
- The report should state whether an abuse has taken place from both a physical examination of the vagina (in case of sexual abuse) and forensic tests conducted.
- Even where the victim has washed her vagina after the sexual act, a test should be conducted and findings made as to whether a sexual act has taken place.
- The report should indicate specific marks of violence as well the mental state of the victim. Where findings indicate repeated violence, this should be stated as well.
- Health workers can use additional paper for the report but should sign and date the additional sheets

# MODULE FOURTEEN:

## KNOWLEDGE AND DATA ON CHILD ABUSE

### 14.1 INTRODUCTION

Quality and timely data on child abuse is required at all levels of the health system to assist government and other policy makers in planning to improve child protection. The availability of quality data on child abuse in the health sector depends on how the data is collected and documented. It also depends on the questions asked by providers, the capacity of staff to collect data, the information system available, and the policy adopted by the health sector.

### 14.2 PURPOSE

- To help health workers in the collection and analysis of data on child abuse that will enable planners have an accurate picture and better understand of child abuse related issues

### 14.3 DATA MANAGEMENT PROCEDURE

- The District Health Information Management System (DHIMS) captures data on patients who have contact with health facilities and so it is a service utilization based information system.
- Healthcare providers in the consultation room record detailed information about the patient in the consultation room Register.
- This information is transferred to the outpatient morbidity form which is entered in the DHIMS database.
- Health facilities have patient registers, Out-patient Department (OPD) Forms, and summary forms as primary data capture tools.
- Information from the summary forms are entered in the DHIMS at the district office by the district health information officer.
- The district hospitals enter the data directly into the system.
- You must record the child abuse in the patient register at the health facility after the clinicians have diagnosed the patient.

#### 14.4 ROUTINE COLLECTION AND DOCUMENTATION OF DATA

- It is your responsibility to classify the condition as an injury inflicted by other causes other than another person for example injuring self-etc. or injuries caused by another person whether intentional or not.
- If you can prove that the injuries are intentionally inflicted, then classify this as child abuse.
- If injuries are unintentionally inflicted by accident, as in the case of disciplinary action gone wrong, classify this as child abuse.
- Health workers should work with the staff handling data at health facilities to ensure that information related to child abuse is properly documented by the health facility.
- A photocopy of the police medical report should be kept by the administrator of the health facility and should be referred to when collecting data on child abuse
- Health facility administrator should make arrangement to train health workers on how to access data on child abuse in the DHIMS system.
- It is very important to have the health facility data on child abuse readily available for analysis

#### 14.5 ANALYSIS OF DATA AND TRENDS

- If you are interested in analysing data on child abuse you can track in the DHMIS database.
- However, this data extraction exercise will require specific skills and time.
- Data on child abuse is captured under four variables; adolescent pregnancies (although not all adolescent pregnancies will fall under child abuse), domestic abuse, sexual abuse, and, injuries and others.
- Data on child abuse can be extracted by using age as a filter and selecting those cases that are in the children age bracket in the database.
- Apart from the DHIMS, there are other sources of data on child abuse, such as statistics from the Domestic Violence and Victims Support Unit of Ghana police.
- Other nongovernment organisations working on child protection have data from their program activities, although such data was limited in scope and content.
- The DHIMS data is not accessible to the public and has restrictions of access because it is a national database. Access to the data is only given as requested.
- If you want to use the data, write to the designated officer in-charge of the DHMIS expressing the desire to use the data, after which the request is granted.
- For staff at hospitals and other health facilities, the DHIMS officer at health facilities and in the districts, create a username and password for all health workers so that they can access the data.

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# APPENDIX I

## DEFINITION OF COMMON TERMINOLOGY IN CHILD ABUSE<sup>6</sup>

### **Descriptive Terminology in Child sexual abuse Evaluations.**

Hymenal morphology - annular – circumferential hymenal membrane tissue extends completely around the circumference of the entire vaginal orifice.

Cribiform - hymen with multiple small openings

Crescentic - Hymen with attachments at approximately the 11 and 1 O'clock positions without tissue being present between the two attachments.

Imperforate - a hymenal membrane with no opening

Septate - the appearance of the hymenal orifice when it is bisected by a band of hymenal tissue creating two or more orifices

### **Descriptive Terms Relating to The Hymen**

ESTROGENIZED - hymen takes on a thickened, redundant, pale appearance as the result of estrogenization. These changes are observed in neonates, with the onset of puberty and the result of exogenous estrogen.

REDUNDANT - abundant hymenal tissue which tends to fold back on itself or protrude

### **Findings**

Acute laceration - a tear through the full thickness of the skin or other tissue

attenuated - the term refers to a documented change in the width of the posterior portion of the hymen following an injury

erythema - redness of tissues  
external hymenal ridge - a midline longitudinal ridge of tissue on the external surface of the hymen. may be either anterior or posterior.

<sup>6</sup> These terms come from the American Professional society on the Abuse of Children and the Royal College of Paediatrics and Child Health

O'clock designation - a method by which the location of structures or findings may be designated by using the numerals on the face of a clock. the 12'O clock position is always superior (up). The 6'O clock position is always inferior (down). The position of the patient must be indicated when using the designation scar - fibrous tissue which replaces normal tissue after the healing of a wound

Transection of the hymen - (complete) a tear or laceration through the entire width of the hymenal membrane extending to (or through its attachment) to the vaginal wall

Transection of the hymen- (partial) - a tear or laceration through a portion of the hymenal membrane extending to (or through its attachment) to the vaginal wall.

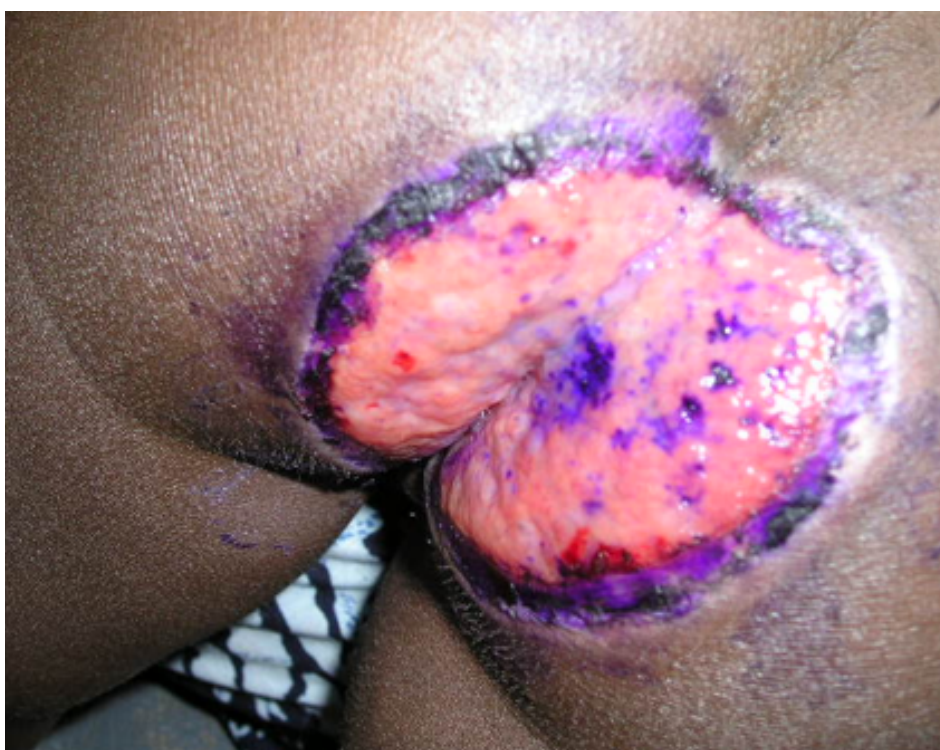
**Terms no Longer Recommended to Use**

- Anal fissure - always use the term laceration
- anal funneling
- anal gaping
- attenuated hymen
- hymenal gaping
- reflex anal dilatation
- twitching
- visibly relaxed anus

Also, note: measurement of the hymenal orifice is no longer recommended

## APPENDIX II

### SELECTED PHOTO ILLUSTRATIONS OF CHILD ABUSE



Courtesy of Dr. Ebenezer Badoe, Department of Child Health, School of Medicine and Dentistry, University of Ghana

**Photo 1** Burn of The Perineum and Buttocks Which Is Diagnostic of a Hot Water Burn and Therefore a Non-Accidental Injury Because Of The Location





Courtesy of Dr. Ebenezer Badoe, Department of Child Health, School of Medicine and Dentistry, University of Ghana

**Photo 2** Classic Sex Abuse Injury with Multiple Tears and Transections



Courtesy of Dr. Ebenezer Badoe, Department of Child Health, School of Medicine and Dentistry, University of Ghana

**Photo 3** Urethral Prolapse: A Classic One and A Common Cause of Confusion Regarding Sex Abuse



Courtesy of Dr. Ebenezer Badoe, Department of Child Health, School of Medicine and Dentistry, University of Ghana

**Photo 4**      **Estrogenized Hymen In 11 Year Alleged Abused Child: Normal Hymen After Examination**





# APPENDIX III:

## FORMS USED IN CHILD ABUSE

### NATIONAL SECRETARIAT DOMESTIC VIOLENCE AND VICTIM SUPPORT UNIT [DOVVSU]

*In case of reply the  
Number and date of this letter should be quoted*

My Ref: No: NS/DOVVSU.....

TEL: NO: 021-775677/775671



GHANA POLICE SERVICE  
ACCRA

#### COMPLAINT FORM

DATE: .....

NAME OF COMPLAINT:.....

TEL: .....

CONTACT ADDRESS:.....

NAME OF RESPONDENT: .....

TEL:.....

CONTACT ADDRESS: .....

SUMMARY OF COMPLAINT/ISSUE:.....

ACTION TAKEN:.....

NEXT MEETING:.....

TEL. NOS:.....

Page 1



## SECTION A: GENERAL MEDICAL FORM

.....POLICE STATION

.....REGION

.....DISTRICT

.....DATE

THE MEDICAL OFFICER.....

WILL YOU PLEASE EXAMINE AND REPORT IN THE CASE OF.....

.....OF.....

DATE OF BIRTH: AGE: ☐ MALE ☐ FEMALE

WHO COMPLAINS THAT HE/SHE WAS.....

SIGNATURE.....

..... OF POLICE  
STAMP

DATE AND TIME OF ALLEGED INCIDENT: DATE:..... TIME:.....

DATE AND TIME OF HOSPITAL EXAMINATION: DATE:..... TIME:.....

RETURNED TO POLICE STATION: ..... ON.....

Page II

**THE MEDICAL OFFICERS REPORT (PLEASE WRITE CLEARLY)**

Page II

**THE MEDICAL OFFICERS REPORT (PLEASE WRITE CLEARLY)**

**SECTION B: VICTIMS MEDICAL HISTORY AND SEXUAL ASSAULT/ACCIDENT INFORMATION**

1. Victim's Name: ..... (PLEASE PRINT)
2. Date of Birth ..... 3. ☐ Male ☐ Female 4. Ethnicity ..... \*Nationality ..... Race .....
5. Marital Status ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed
6. Date and time of alleged assault/Accident: ..... / ..... / ..... :AM ..... :PM
7. Date and time of Hospital Examination: ..... / ..... / ..... :AM ..... :PM Which Hospital / Clinic ..... Contact No. / Tel: .....
8. Examining Physician..... 9. Nurse (Name).....
10. Between the assault and now, has the victim:
 

|  |  |                                    |
|--|--|------------------------------------|
| <input type="checkbox"/> Bathed / Showered | <input type="checkbox"/> Used Mouth Wash | <input type="checkbox"/> Defecated |
| <input type="checkbox"/> Douched           | <input type="checkbox"/> Changed Clothes | <input type="checkbox"/> Vomited   |
| <input type="checkbox"/> Brushed Teeth     | <input type="checkbox"/> Urinated        | <input type="checkbox"/> Drunk     |
11. Was there penetration of the
 

|        |                          |                          |                          |                          |                          |                          |
|--------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
|        | Attempted                | Successful               | Ejaculated               | Yes                      | No                       | Unsure                   |
| Vagina | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Mouth  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Anus   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
12. Oral / Genital Sexual Contact ☐ Fellatio ☐ Cunnilingus
13. Did assailant use: ☐ Lubricant ☐ Condom ☐ Insert Foreign object(s).....
14. Was the victim menstruating at the time of the assault: ☐ YES ☐ NO
15. Any consensual coitus in the last 72 hours? ☐ YES ☐ NO
- If yes, date: ..... and time.....
- If yes, was a condom used? ☐ YES ☐ NO
16. Is the victim pregnant? ☐ YES ☐ NO
- If yes, duration of the pregnancy.....
17. Any injuries to the victim resulting in bleeding? ☐ YES ☐ NO
- If yes, describe.....
18. Number of assailant(s) .....
19. Ethnicity / Race of assailant(s) if known.....
20. Assailant(s) relationships to victim:
 

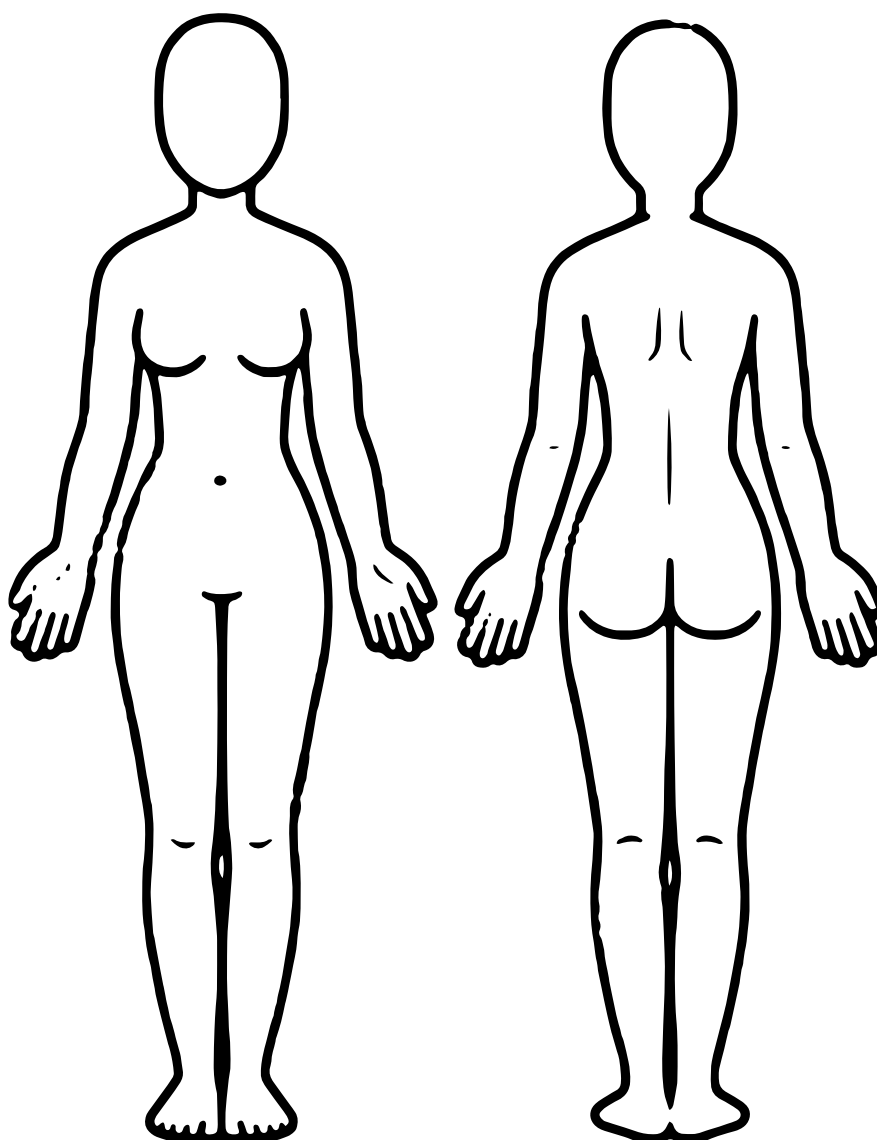
|                                   |                                      |  |
|-----------------------------------|--------------------------------------|--|
| <input type="checkbox"/> Stranger | <input type="checkbox"/> Acquittance | <input type="checkbox"/> Relative (Specify)..... |
|-----------------------------------|--------------------------------------|--|
21. Any injuries to the assailant(s) resulting in bleeding? ☐ YES ☐ NO ☐ Unsure
- If yes, describe.....
22. Was any medication taken by the victim prior to or after the assault? ☐ YES ☐ NO
- If yes, describe.....
23. Was any coercion used? ☐ YES ☐ NO ☐ Sweets ☐ Money ☐ Gifts ☐ Others
- Was any treats used? If yes ☐ Knife ☐ Gun ☐ Stick ☐ First ☐ Verbal Threats ☐ Others.....
24. Emotional demeanor of the victim; i.e., Crying, Angry, Agitated, Lethargic, Frightened, Shocked, Depress etc.
25. Description of the Victim's outward appearance; i.e., Clothes torn, Shoe(s) missing etc:
26. Victim's (SUMMARY) description of the alleged assault / Accident (REFER TO VICTIM'S STATEMENT)



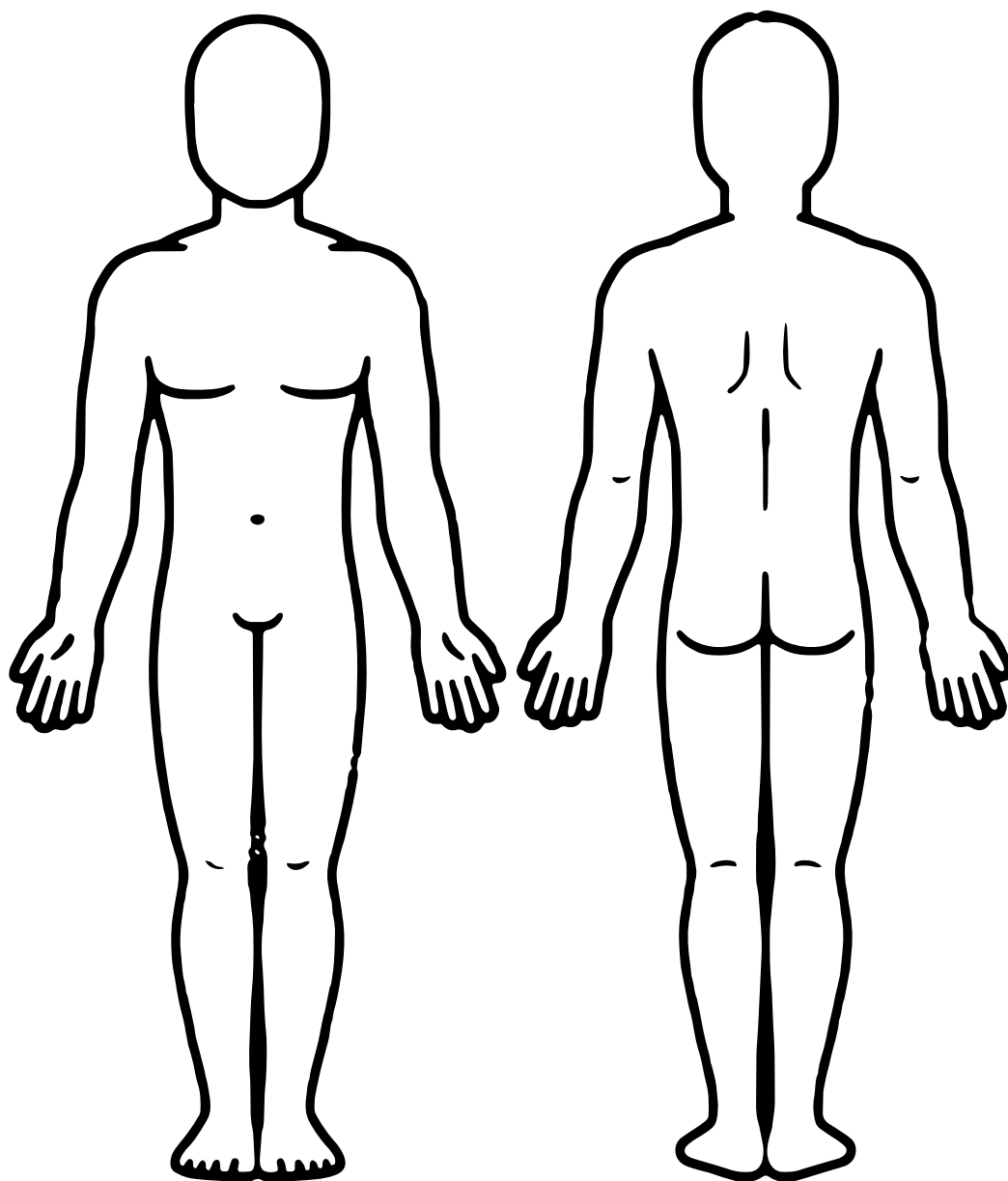
Page IV

**ANATOMY: SKETCH OF THE HUMAN BODY**

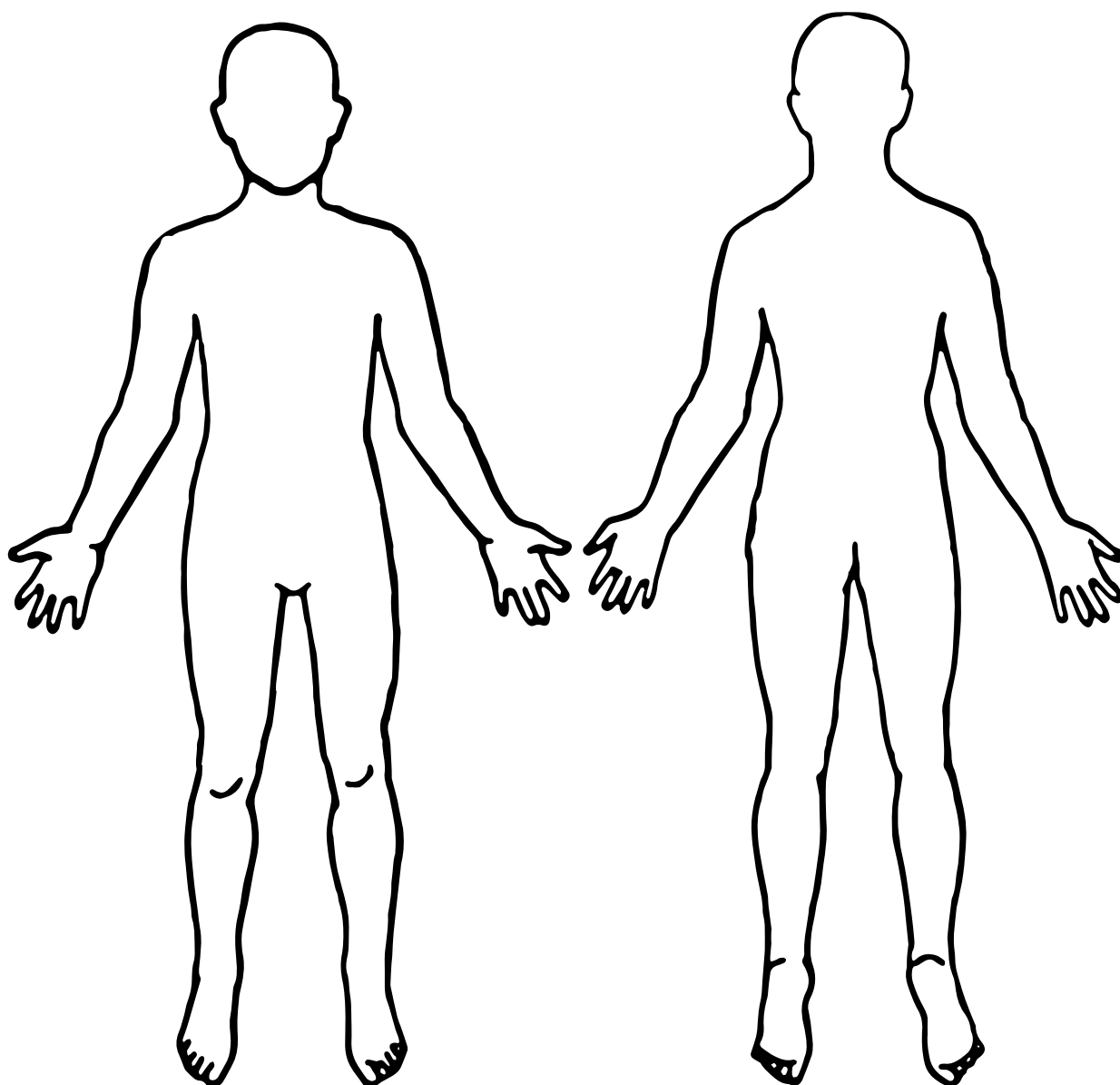
**FEMALE**



## MALE



## GENDER NEUTRAL















Canada 

unicef   
for every child