Child Protection Recognition and Response (CPRR)

Participants Training Module

Nepal Paediatric Society
(NEPAS)

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श्री नेपाल पेडियाट्रिक सोसाइटी

काठमाडौं ।

विषयः- सूचना सामग्री प्रमाणीकरण गरिएको सम्बन्धमा ।

उपर्युक्त सम्बन्धमा तहाँ सोसाइटीले सम्बन्धित विज्ञहरुको सहभागीतामा बालबालिकाका निम्ति स्वास्थ्य उपचार लगायतमा काम गर्ने स्वास्थ्यकर्मी(चिकित्सक र नर्स)हरुलाई केन्द्रित गरी बाल अधिकार संरक्षण तथा सम्वर्धन, अभिलेखीकरण, समन्वय, समहजीकरण र क्षमता अभिवृद्धि गर्ने कार्य प्रयोजनका लागि Child Protection Recognition and Response नामको स्रोत पुस्तिका तर्जुमा गरी पेश गरेकोमा नेपास लगायत सो कार्यमा संलग्न सम्बन्धित सबै व्यक्ति तथा पदाधिकारीहरुलाई हार्दिक धन्यवाद दिन चाहन्छु । उल्लिखित तालीम स्रोत पुस्तिका दोस्रो संस्करणमा समावेश गरिएका स्रोत सामग्रीहरु बाल स्वास्थ्यकर्मीका लागि अति उपयोगी र सान्दर्भिक रहेको हुँदा तहाँ नेपासको मिति २०८१/०९/२८ को पत्रबाट माग गरिए अनुसार प्रमाणीकरण गरिएको व्यहोरा अनुरोध छ ।

इन्द्रादेवी ढकाल
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Message from President

Child Protection Recognition and Response lies at the heart of safeguarding children from violence, exploitation, abuse, and neglect. The United Nations Convention on the Rights of the Child (UNCRC) of 1989 guarantees children's rights through its core principles of Provision, Protection, and Participation. Article 19 of the UNCRC specifically emphasizes the protection of children in and beyond the home. Additionally, the Universal Declaration of Human Rights underscores child protection as a critical human rights issue.

Despite concerted efforts by governmental and non-governmental organizations, the progress in child protection in Nepal remains insufficient. The National Planning Commission's SDG Roadmap (2017) reveals that 81% of children in Nepal experience some form of violence at home or school. Furthermore, it is said that nearly 400,000 children annually seek hospital care for physical injuries. However, data on psychological harm, emotional abuse, neglect, and malnourishment—often resulting from parental negligence or poverty—remains largely undocumented.

Health care providers are often the first to encounter children at risk. With heightened awareness and training in Child Protection Recognition and Response, they can identify signs of harm early and intervene effectively. Timely action by healthcare professionals can prevent further harm, reduce mortality risks, and uphold the rights and well-being of children.

On behalf of NEPAS, I am proud to congratulate and express deep gratitude to the members of the editorial board for their outstanding work in developing the Trainee Manual. These resources are invaluable in empowering healthcare providers with the skills and knowledge to lead the way in Child Protection Recognition and Response.

Let us unite in this vital mission to ensure a safer and brighter future for all children.

Sincerely,
Maj. Gen. Dr. Arun Kumar Neopane (Retd.)
President (2023-25)
Nepal Paediatric Society (NEPAS)
Baluwatar, Kathmandu, Nepal

1st January 2025

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Editorial Committee

Abbreviations:

ALTE: Apparent Life-Threatening Event
CAT: Convention Against Torture
CCWB: Central Child Welfare Board
CEDAW: Convention to End all forms of Discrimination Against Women
CERD: Convention to End all forms of Racial Discrimination
CNFN: Child NGO Federation Nepal
CPCS: Child Protection Centers and Services
CPRR: Child Protection Recognition and Response
CPS: Child Protection Services
CSA: Child Sexual Abuse
CSE: Child Sexual Exploitation
CWIN: Child Workers In Nepal
DCWB: District Child Welfare Board
FII: Fabricated or induced illness
FMG: Female Genital Mutilation
FY: Fiscal Year
ITP: Idiopathic Thrombocytopenic Purpura
NAHI: Non Accidental Head Injury
NAI: Non Accidental Injury
NCPA: National Child Protection Alliance
NGOs: Non-Governmental Organizations
RTA: Road Traffic Accident
SDG: Sustainable Development Goal
SHN: School Health Nurse
SN: School Nurses
STI: Sexually Transmitted Infection
UNCRC: United Nations Convention on rights of Child
UNCRPD: United Nation Convention on the Rights of Person with Disability
UNICEF: United Nations International Children's Emergency Fund

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Chapter 1

Introduction to Child Protection

Aim

- To provide a background and context to Child Protection

Objectives

After completion of this chapter, candidates will be able to

- Elaborate the history of Child right
- Define Child Right, Child protection Recognition and Response (CPRR)
- Understand the Situation of Nepal regarding CPRR

Introduction

Child protection is the protection of children from violence, exploitation, abuse and neglect. The United Nation Convention on the Rights of the Child (UNCRC), 1989 has universally guaranteed the rights of the child: Provision, Protection and Participation. Article 19 of the UN Convention on the Rights of the Child provides the protection of children in and out of the home. The United Nations has addressed child abuse as a human rights issue, adding a section specifically to children in the Universal Declaration of Human Rights.

Recognizing that the child, for the full and harmonious development of his or her personality, should grow up in a family environment, in an atmosphere of happiness, love and understanding should be afforded the right to survival; to develop to the fullest; to protection from harmful influences, abuse and exploitation; and to participate fully in family, cultural and social life. UNICEF defines child protection system as: the set of laws, policies, regulations and services needed across all social sectors – especially social welfare, education, health, security and justice – to support prevention and response to protection-related risks.[1] These systems are part of social protection, and extend beyond it. At the level of prevention, their aim includes supporting and strengthening families to reduce social exclusion, and to lower the risk of separation, violence and exploitation. Responsibilities are often spread across government agencies, with services delivered by local authorities, non-State providers, and community groups, making coordination between sectors and levels, including routine referral systems, a necessary component of effective child protection system.

The council of Europe in line with recommendation of UN committee on the rights of the child and of the UN's study on violence against children, have also issued guidelines to promote the development.

Maltreatment in children:

Children encounter different types of problem and the burden varies between places. In developing countries like Nepal, child labor, child abuse, and child maltreatment are common. Endangerment and infanticide is also a problem. A 2014 European Commission survey on child protection systems listed the following categories of children needing help:[2]

- Child victims of sexual abuse/exploitation
- Child victims of neglect or abuse
- Child victims of trafficking
- Child labor
- Children with disabilities
- Children in situation of migration especially if unaccompanied.
- Children without parental care/in alternative care
- Children in police custody or detention
- Street children
- Children of parents in prison or custody
- Children in judicial proceedings
- Children in or at risk of poverty
- Missing children (e.g. runaways, abducted children, unaccompanied children going missing)
- Children affected by custody disputes, including parental child abduction
- Children of parents who are abroad.
- Children belonging to minority ethnic groups
- Child victims of female genital mutilation or forced marriage
- Children who are not in compulsory education or training or working children below legal age for work
- Child victims of bullying or cyber bullying

Situation of Nepal

Despite the numerous efforts made by different governmental and nongovernmental organizations in improving the child's protection issues, only little progress has been made and there is a long way to go.

According to the census 2022, 33.84% of the population are children. As per Nepal Demographic and Health Survey (NDHS) 2022, 25% of children under 5 are stunted, 19% underweight, and 8% wasted. Similarly, under 5 mortality rate is 33 per 1000

children, infant mortality rate is 28 per 1000 and neonatal mortality rate is 21 per 1000 live birth. Nepal Population and health survey 2022 showed that 14% of teenagers between 15-19 years were pregnant. In the Fiscal year 2079/080, a total of 650 children at risk were rescued and provided with necessary relief, psycho-counseling, family reunification and social rehabilitation services as per their need through the Toll-Free Child Helpline 1098.[3]

The National Planning Commission (2017) in SDG Roadmaps presents that 81 percent of children in Nepal has suffered one or more forms of violence at home and schools. The study report in Nepal suggests every year almost 400 thousand children visit hospitals with complaint of physical injuries (Panta, 2012). The status of psychological problems and harms, emotional abuse and neglect remains unknown as is lack of information on malnourishment due to parental negligence or incapability of parents and families.

Suspected cases of child abuse are likely to present to health care providers and therefore, appropriate training and knowledge is essential to recognize and respond abuse to prevent further harm and death. Health professional working with children are duty bound to advocate for the rights of children, protect them and put their best interest high priority.

Definitions

Child protection: Refers to preventing and responding to violence, exploitation and abuse against children – including commercial sexual exploitation, trafficking, child labor and harmful traditional practices, such as female genital mutilation/cutting and child marriage.[4]

Child Right: Children's rights are the human rights of children with particular attention to the rights of special protection and care afforded to minors.[5]

Child Abuse: Behavior of adults or harm suffered by child; Commission of Act or Omission of Act by adults or caregivers. As explicit form, child abuse can be categorized as: Physical abuse, Emotional Abuse, Sexual Abuse. The commission of act means any action against children that result in harm to the child or group of children. It includes behavioral, verbal, physical and other activities.

Neglect: Child neglect is the failure to provide for the shelter, safety, supervision and nutritional needs of the child. Child neglect may be physical, educational, or emotional neglect.[6] The Neglect is all about Omission of Act. The Omission of Act is the inaction of the caregivers or adult responsible for the child that results in harm against children. It includes unintentional injuries, ignoring child and often depriving the children form parental and guardians' care.

Way forward:

In Nepal, most health care providers dealing with children are unaware of the country's legal framework and international prospective related to child protection. As

of date, there is lack of guidance to doctors to manage case through appropriate history, examination, documentation, consent and liaising with multidisciplinary team within an outside the hospital. Failure to take appropriate action often leads to abused cases being sent home from the hospital with risk of future abuse.

NEPAS, being a professional body, had been an advocate for child welfare and had taken the initiative to incorporate this agenda at the national health level. NEPAS has been conducting training sessions to raise awareness at different levels throughout Nepal.

A study conducted in 2021 with school health nurses demonstrated lack of knowledge and awareness in recognition and response to suspected child abuse. They demonstrated good understanding of child right, physical and sexual abuse but limited knowledge of child neglect and existing legal arrangements and therefore, a gap between their knowledge and putting it to practice.[7]

During the Nepal pediatric conference 2023, paediatricians raised awareness through paper presentations and conducted a pre-congress training workshop on child protection recognition and response. It was identified that child protection was a key training need for paediatrician and paediatric nurses. A focus training on child protection would enhance their skill and knowledge, empower them to manage cases effectively and appropriately and also contribute to an increase in the case detection rate.

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Chapter 2

Legal Arrangements on Child Protection in Nepal: Norms and Mechanisms

Aim

- To understand legal arrangements for child protection in Nepal.

Objectives

By the end of this session, participants will be able to

- Recall the key legal provisions related to violence against children.
- Name mandate holder agencies for case management
- Practice mandatory communication of suspected incidence of child abuse

Nepal's Governance and Political Structure

Nepal has adopted its new constitution in 2015 September that changed the political and governance structure of the Nation. The Constitution of Nepal has adopted Federal Republic Governance system with devolution of power to the local government level from almost 250 years old unitary governance structure.

With the present political structure there are 753 Local Governments, 7 State Governments and 1 Federal Government. They all function in the principle of Co-existence, coordination and cooperation. The list of power as single authority and concurrent power has been listed by the constitution of Nepal.

In the issues mentioned as single power, the respective government can formulate laws and policies with its own context and requirements without contradicting with federal and state laws and policies. On the area of concurrent power, the federal government function as standards setting, state government as rule setting and local government as procedure and delivery.

With the new constitution, the basic health service has been the single power of local governments, health standards are the power of Federal Governments and health service management are power of state government.

In terms of responding child abuse following are the authorities set by the constitution:

Local Government	State Government	Federal Government
• Formation and Functioning of Local Child Rights Committee and appoint child welfare officer. • Listing of Local Social Worker and Child Psychologist/Counsellor • Establishing Child Protection Support Fund and special social protection fund. • Organize local capacity building activities, awareness raising activities. • Adjudicate Neglect cases. • Refer criminal offences against child. • Adjudicate violation of child rights. • Register and support children clubs. • Implement Disaster Risk Management and Child Trafficking. • Develop and implement child safety standard for local institutions and public places. • Child health services through local health facilities. • School health and safety Programs. • Activities to end child labor, child marriages, trafficking and child abuse.	• Formation of State Child Rights Board. • Establishing special fund for children including child protection fund. • Provide rehabilitation support and services for victim. • Provide alternative and interim compensation for crime victim. • Develop and implement police investigation, medico-legal standards and guidelines. • Implement capacity building activities. • Develop health service rules and procedures. • Adjudicate child labor and crime against children.	• Formation of National Child Rights Council. • Establish special fund for children including child protection fund. • Develop health service standards, medico- legal standards and procedures. • Implement capacity building activities. • Monitor and promote child rights, child protection and child safety standards and rules.

Applicable Nepalese Legal Provision

There are specific legal provisions that address and respond the cases of child abuse in Nepal. Based on the constitution and its provisions, Children Act 2075 is in place. The constitution of Nepal has provisioned unique and specific rights for children, which has made the Nepal's constitution as outstanding constitution from child rights perspective in the world.

Constitutional Provision

The Constitution of Nepal is the supreme law of land. Provisions of constitution supersede all other laws and policies in Nepal. The constitution has provisioned Fundamental Rights and duties in Part 3. The provision mentioned in fundamental rights and duties are legally binding to the state. The constitution has provisioned right to live in dignity (Art.16), Right to Justice along with state support to access justice for incapacitated person (Art.20), Rights of Crime Victims specially right to access information on own case and social rehabilitation, compensation as per the law (Art.21), Rights against exploitation including prohibition and criminalization of traditional harmful practices, forced labor and slavery and trafficking (Art.29), Right to education (Art.31) and Right to fair labor practices (Art.34). The Constitution has specially provisioned list of child rights in Article 39. The government of Nepal has enacted several laws for the implementation of fundamental rights provision.

The Constitution of Nepal Article 39: Rights of the Child

Every child shall have the right to name and birth registration along with his or her identity.

Every child shall have the right to education, health, maintenance, proper care, sports, entertainment and overall personality development from the families and the State.

Every child shall have the right to elementary child development and child participation.

No child shall be employed to work in any factory, mine or engaged in similar other hazardous work.

No child shall be subjected to child marriage, transported illegally, abducted/kidnapped or taken in hostage.

No child shall be recruited or used in army, police or any armed group, or be subjected, in the name of cultural or religious traditions, to abuse, exclusion or physical, mental, sexual or other form of exploitation or improper use by any means or in any manner.

Part 4, the constitution has provisioned Directive Principles, Policies and Responsibilities of State. Generally, this chapter is considered as ornamental and have lack of power to be enforced, but the constitution of Nepal has made it enforceable through provisioning a monitoring committee in Federal Parliament that receive the government annual report on the progress made on Directive Principles, Policies and Responsibilities of State. On Article 51 the constitution provisioned elimination of all forms of child labor and also considered "Best Interest of Child as State Policy".

International Human Rights Law

As per the Nepal's Treaty Act (2048), the International Human Rights Laws are equally applicable as national laws and supersedes the domestic law in case of domestic legal provision contradicts with international law. Nepal is party to the seven out of nine UN core human rights treaties including UN Convention on the Rights of the Child (1989). Further the issues of civil rights and welfare from International Covenant on Civil and Political Rights (1966), issues of economic, social and cultural rights as well as development rights from International Covenant on Economic, Social and Cultural Rights (1966), Issues of Girls from Convention to End All Forms of Discrimination Against Women (CEDAW, 1979), Issues of Dalit Children from Convention to End All Forms of Racial Discrimination (CERD, 1965), issues of children with disability from Convention on the Rights of Person with Disability (UNCRPD,2006), issues of Tortures and degrading treatment from Convention Against Torture (CAT, 1984) can be invoked in Nepalese legal system. In addition to this ILO convention 29, 105, 138 and 182 can be invoked on enforcing anti child labor laws.

Domestic Legal Provision

In Nepal several laws can be invoked for child safety and child protection. Generally, we can divide the Nepalese legal provisions on child safety and child protection as General Law and Specific Law. General Law is normally applied in absence of specific law, but in the availability of specific law, specific law must be invoked for claiming.

The National Civil Code (2074) and **National Criminal Code (2074)** can be considered as general law in Nepalese context and that is also applicable on child rights and child protection provisions. Some specific provisions from these codes are mentioned below. The National Civil Code has defined any individual less than 18 years as child (Part 1, Section 2, "nga"). The code has also prohibited forced employment (Chapter 2 Section 24), prohibited marriage under 20 years (Part 3, Chapter 1, Section 70 "Gha"), Compulsory birth registration within 3 months of birth (Part3, Chapter 4, Section 113), prohibited employing children under 14 years and under 16 years in hazardous work (chapter 14, section 640,642 and 643), rules on employing domestic worker (section 644). The Civil Code has also set out rules for in country and inter country child adoption to make it safe and protective for children.
The National Criminal Offence Code (2074) has provisioned some significant protection for children, this includes:

- No criminal liability for children under 10 years, half liability for children of 10-14 years and 2/3rd liability for children 15-18 years.
- No recognition of children (under 18 years) consent for any act against him/her or other criminal offences.
- Adult for engaging children in criminal acts must fulfill criminal liability.
- Right to information of crime victims.
- Provision of multiple accusations in case of multiple crimes in single incidence and increased punishment for the criminal.
- Provision of protection services and interim compensation for victim through court order.
- Production, possession, sale and distribution of porn material are defined as criminal offence.
- Engaging children in begging, street performing and in performance to raise donation is defined as offence.
- Physical Assault, violence has been defined as offence and punishable
- Forced employment and children's employment beyond the legal provision has been defined as offence
- Chapter 18 of the Criminal Code has defined and provisioned punishment on Child Sexual Exploitation and Abuse.

Similarly, the Labor Act (2074) has prohibited use of children in employment against the law and made it punishable.
The Crime Victim Protection Act (2075) has provisioned interim and alternative compensation through establishing compensation fund. The act also provided provision of right to information, psychosocial care, rehabilitation support and safety and protection during adjudication of case.
The Government of Nepal has enacted new Children Act (2075) since September 2018 in the spirit of fundamental rights of children provisioned in the constitution. The children act is the special act on rights and protection of children and child labor prohibition act is the special act on addressing child labor issues. The Children Act 2075 has some significant provision on child protection: this includes children's right against discrimination, right to receive care and protection from caregivers and parents, right to education, right to privacy, right to protection against harm and risk and special right of children with disability. The Act also provisioned rights of juveniles and juvenile procedures, crime victims' children.

The Children Act (2075) has defined Children in Need of Special Protection (Section 48), defined crime against children (section 66) with details of abusive practices and sexual abuse acts. The Act has provisioned mandatory reporting by teacher, health workers and frontline workers with children in case of reported and suspected abuse of child. The Act has defined the prosecution of crime against children would be considered as state offence act and Public Attorney on behalf of Government of Nepal would file the cases. The timeline for complaining is up to one year generally and if there is other provision in applicable laws that is applied; it has also provisioned that a person can file case within a year after accomplished 18 years.
The act has also made it mandatory for public places that have children as users must adopt child safety standards.

Designated Child Protection Mechanisms and their Role

The government of Nepal has provisioned specific mechanism on protecting children from local governments to federal government.

At Local Government level, a child rights committee has been designated with employment of child welfare officer. The committee would be led by deputy mayor or vice chair or designated member of local government executive council. The committee is responsible for planning local child rights and child protection program along with responding and referring cases of child abuse and providing protection services. Similarly, Local Judicial Committee is responsible to adjudicate cases of child rights violation and neglect as well as refer criminal offence against children.
At State Government Level, State Child Rights Board has been envisioned with mandate to advise policies, programs and implement state-wide activities for child rights and child protection.
There is National Child Rights Council led by Minister to advise federal government on national child rights policies, programs and interventions as well as to implement nationwide campaigns and programs.
The Judiciary has provisioned Central Juvenile Justice Coordination Committee to be placed in Supreme Court and state level Juvenile Justice Coordination Committee to be placed in high court.
Nepal police has special department on children issue at Central level, it has women and children service directorate and at district level it has women and children service center.
Further, there are number of hotline services for child protection. The Helpline Service (1098) and Missing Child Service (104) are two major toll free helpline services that provide child protection services including rescue and rehabilitation as well as other supports as required.

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Chapter 3

How do you feel?

Aim

- To Understand about the individual perceptions on the same scenarios regarding child protection.

Objectives

By the end of this session, participants will be able to:

- Understand Personal Influences
- Understand the ways in which their values, beliefs, experience and attitudes might affect their personal feelings and professional response to child protection work.
- Develop strategies to manage personal biases and maintain professional objectivity.

- Recognize Social Influences
- Understand how social class, culture, race, religion and gender issues might influence their response to child abuse.
- Explore case studies and scenarios that highlight the influence of these factors.
- Develop culturally competent approaches to child protection that respect diversity and promote equity.

- Identify Support Needs
- Recognize the need for emotional support and supervision and know where to go for the help.
- Understand the emotional challenges of child protection work.
- Know the available resources for supervision, peer support and professional help.

- Navigate Conflict and Difference of Opinion
- Recognize common sources of conflict and differences of opinion in child protection work.
- Learn conflict resolution and communication skills to manage disagreements constructively.

Please follow the instruction from the facilitator and give your personal view in following situations.

Score 1 to 5 for each item (eg.1 being the least acceptable and 5 being the most acceptable)	Personal view Not Acceptable/Acceptable 1 2 3 4 5
1. 8-year-old who is hit by her mother.	
2. An adolescent girl who is confined to her room and not allowed inside kitchen and puja room during her periods.	
3. 11-years-old girl with cerebral palsy whose father allows her to cuddle up to him in bed when she is upset.	
4. A 6-year-old who witnesses his father slapping his mother after an argument.	
5. A toddler whose father usually drinks a bottle of alcohol before noon.	
6. Guests allowed to sleep in children's room with children.	

Chapter 4

Physical Abuse

Aim

- To raise the candidates' awareness and capacity to recognize physical abuse and neglect

Objectives

By the end of the training the candidates will be able to:

- Know and recognize the indicators of possible abuse or neglect.
- Recognize signs and symptoms of the range of abuse in children of all ages.
- Know what knowledge and skills doctors need in order to recognize child abuse.

Introduction

Child maltreatment is the abuse and neglect that occurs to children under 18 years of age. It includes all types of physical and/or emotional ill-treatment, sexual abuse, neglect, negligence and commercial or other exploitation, which results in actual or potential harm to the child's health, survival, development or dignity in the context of a relationship of responsibility, trust or power.[1] Regardless of the type of maltreatment perpetrated against a child, the potential for lifelong physical and emotional consequences is significant.[2]

Definition

Child physical abuse has been defined by the World Health Organization as the intentional use of physical force against a child that results or has a high likelihood of resulting in harm for the child's health, survival, development or dignity.[3]

Physical abuse of children is also defined as any non-accidental injury or act of omission of those responsible for the child, which results in some injury or substantial risk of death or harm to the child's health.[4]

Burden

Approximately one in four children experience child abuse or neglect in their lifetime. Among maltreated children, 18% are abused physically, 78% are neglected, and 9% are abused sexually. The fatality rate for child maltreatment is 2.2/1000 children

annually, making it the second leading cause of death in children younger than age one.[5-7]

Physical punishment of children is common across Nepal with varying severity. An analysis using data from Nepal Multiple Indicator Cluster Survey 2014 collected from 13,000 households in 520 sample enumeration areas were assessed on the prevalence of physical punishment and different child violence related acts on 5081 children aged 3-14 years. One in every second child was found to be physically punished. One in every third (33%) children were spanked, hit or slapped on the bottom, 25% were hit or slapped on the face and approximately 3% were beaten up hard.

Physical punishment was higher among children aged 3-5 years & 6-8 years, those engaged in child labor activities, with mother that accepted wife beating by husband as justified, and whose father was away from home (inside or outside the country).[8]

Risk factors[9-14]

Young age	Prematurity	Special needs
Twins	Colic/crying	Behavior problems
Poverty	Substance abuse	Single parenthood
Young maternal age	Parental depression or other mental illness	Exposure to intimate partner violence

Recognition of Physical abuse[15-18]

Injuries from abuse are not always obvious and identifying child physical abuse can be challenging.

History	• Inaccurate/ Inconsistent/Vague/ Discrepant; Does not make sense
Presentation	• Time delay (delay in seeking care); No believable explanation • Injuries to non-ambulatory infants
Examination	• Injuries that are not explained by the history provided • Multiple or patterned injuries; Injuries to multiple organ systems • Bruises in protected areas (ears, genitals, buttocks). • Multiple and unexplained fractures • Multiple injuries in various stages of healing • Burn injury with a clean line of demarcation or a burn pattern inconsistent with the injury account • Uniform depth of immersion burn with distinct borders and areas of sparing • Doughnut pattern burns in the buttocks; Stocking or glove pattern burns Well defined crater cigarette burn/Multiple cigarettes burn; Multiple burns of varying ages and types • Human hand marks or bite marks; Evidence of poor care or failure to thrive • Unexplained retinal hemorrhages; Cigarette burns on a child's back or Buttocks

Abusive injuries to children are most commonly found on the skin, but the most serious injuries occur to the brain, abdomen and other internal organs.[15,16]

It is important to recognize that there is a differential diagnosis for every potential injury, and objective and thorough evaluation is required in order to identify abuse with reasonable confidence.[17, 18]

Sentinel Injuries: Sentinel injuries are minor injuries such as bruises and intraoral injuries in non-mobile infants that often precede more serious abuse. When providers appropriately diagnose and respond to sentinel injuries, escalation of the abuse can be prevented. These injuries occur in 25% of abused infants. They are known to providers 42% of the time but rarely reported.

Bruises: Suspicious bruising includes bruises that are:

Present in non-cruising infants	Patterned (such as a looped cord or bite)
In protected areas (ears, genitals, buttocks)	

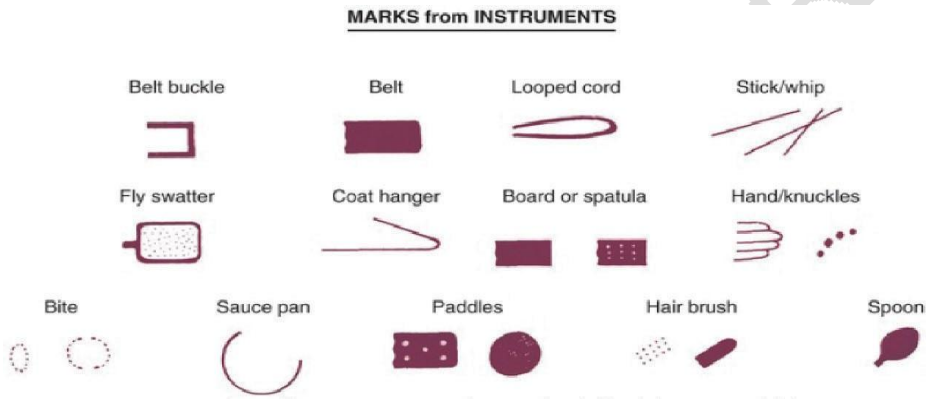


Figure 1: Pattern that suggest child abuse: A variety of instruments may be used to inflict injury to a child. Marks tend to silhouette or outline the shape of the instrument.

Head Trauma: Abusive head trauma (AHT) is the leading cause of death from physical abuse in children younger than two years of age. Crying is the usual trigger for AHT. Some children present with shock/coma, but others present with non-specific symptoms like irritability, sleepiness, fever, vomiting, respiratory distress, or apnea. One third of AHT cases have a history of a sentinel injury, 85% have retinal hemorrhages, and 30% to 70% have other injuries like rib fractures and bruises.

Fractures: In children younger than one year, 25% of fractures are abusive.
Concerning fractures include those that are:

- Found in a non-mobile infant; Multiple and unexplained; of varying ages
- Bucket handle/corner fractures/Classic Metaphyseal lesions (CMLs)
- Rib fractures younger than 1.5 years (7 in 10 are abusive)
- Femur fractures and skull fractures younger than 1.5 years (1 in 3 are abusive in both)

Burns: Scalding and immersion burns are the most common forms of inflicted burns. Burns that are symmetric, uniform in depth, spare skin creases, and lack splash burns suggest forced immersion. Patterned contact burns with distinct margins and lack of a grazing pattern should raise concern for abuse. Mimics like chemical burns

(Senna), toxic epidermal necrolysis, and staphylococcus scalded skin should be considered.
Accidental burns are usually shallower, irregular, and less well defined than deliberate burns.

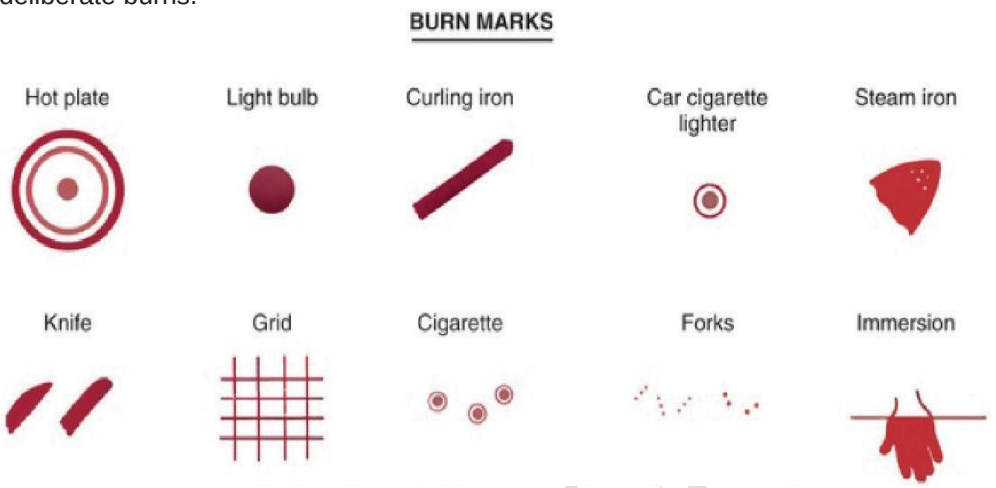


Figure 2: Marks from heated objects cause burns in a pattern that duplicates that of the object.

Effects of shaking a baby or infant

- Head or brain injuries
- Hearing and speech
- Brain damage & death
- Learning problems
- Internal injuries
- Behavior issues
- Long-term disabilities
- Problems
- Fractures
- Vision issues or blindness
- Seizures

How to respond?

A child who is being physically abused might not realize that what is happening is wrong. Some children might even blame themselves so we have to

- Listen carefully to what the child is saying
- Let the child know that he/she has done the right thing by telling you
- Tell the child that it's not his/her fault, and say you will take this seriously
- Don't confront the alleged abuser, explain what you will do next
- Report what the child has told you as soon as possible

Effects of Physical abuse

Poor physical or mental health later in life, including:

- Anxiety
- Depression
- Criminal behavior
- Eating disorders

- Issues at school
- Obesity
- Suicidal thoughts and/or attempts
- Risky sexual behavior
- Behavior issues
- Drug and alcohol problems

Skin Conditions that May Simulate Abuse

One should be aware that it is sometimes difficult to distinguish between burns caused by abuse and certain diseases or medical conditions:

Cutaneous (skin) infections	Impetigo, severe diaper rash, and early scalded skin syndrome sometimes resemble a scald injury. A careful history, microbiological tests, and observation of the lesions over a 2 to 3 week period usually determine whether or not these are deliberate burn injuries or just infections.
Hypersensitivity Reactions	A substance in citrus fruits such as limes, when in contact with the skin and exposed to sunlight, can produce a form of photodermatitis with a pattern that resembles a splash burn. An allergic reaction causing a severe local skin irritation may be mistaken for a burn. Skin preparations such as topical antiseptics can cause a similar burn appearance. The exposure history will allow differentiation of these reactions from burns.
Marks left by folk remedies	Moxibustion is an Asian folk remedy that entails placement of a hot substance, often burning yarn, on the skin of the abdomen or back, causing circular lesions that can be mistaken for other types of burn injuries. The practice of cupping, which is the placement in a cup or glass of a small amount of flammable substance that is ignited and placed on the skin, may cause a burn lesion.

Helpful Investigative Techniques

The following investigative steps and techniques will help determine if burns have been purposely inflicted.

Medical Examination

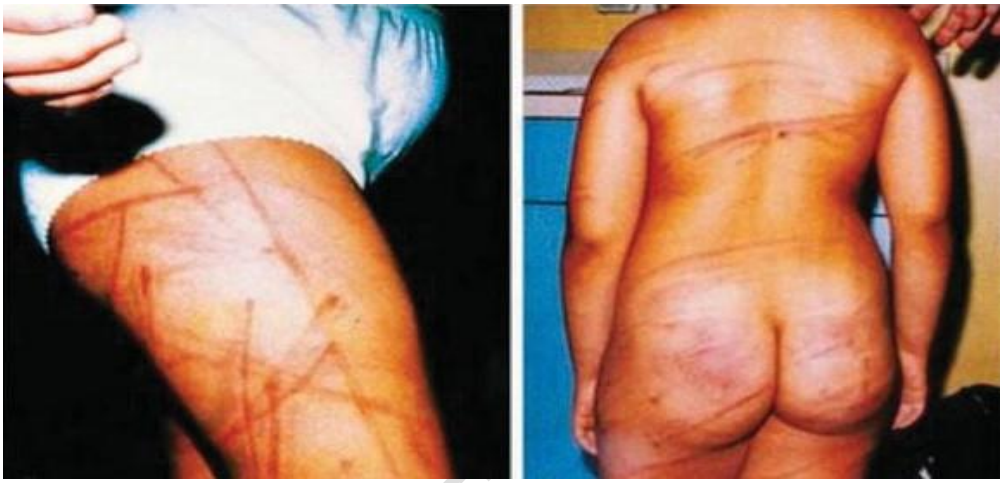
The physical examination of all burned children includes careful evaluation of the entire skin surface for the presence of other signs of abuse such as: Healed burns, Multiple simultaneous burns, Bruises, slaps, and bite or whip marks & Evidence of sexual abuse.

Evaluation and documentation of the burn pattern should be precise. Multiple burns of varying ages and types that obviously could not have occurred from the same accident (for example, cigarette and scald burns or different types of scald burns) are strong indicators of child abuse. However, the absence of other injuries does not rule out child abuse, since 80% of deliberately inflicted burns are not associated with other trauma.

Long bone, chest, and a skull radiographic (X-ray) series need to be performed on all burned children with suspected abuse. Unfortunately, there are no specific laboratory studies that will help distinguish deliberate from accidental burn injury.

Case Study 1

9-year-old boy brought with history of fall on to a pile of bamboo sticks while playing.

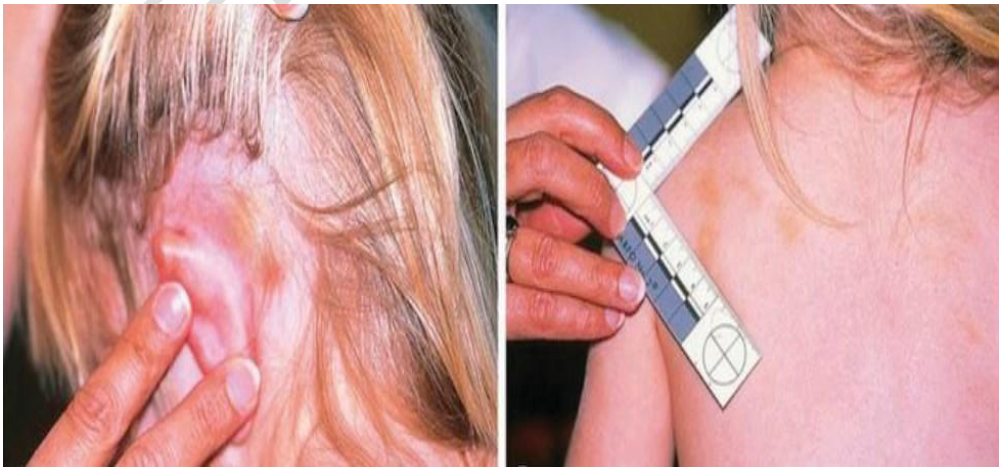


Groups are required to discuss and Identify this picture as physical abuse versus accidental injury.

What will be there in history, examination and risk factors?

Case Study 2

4-year-old girl brought with history of rashes

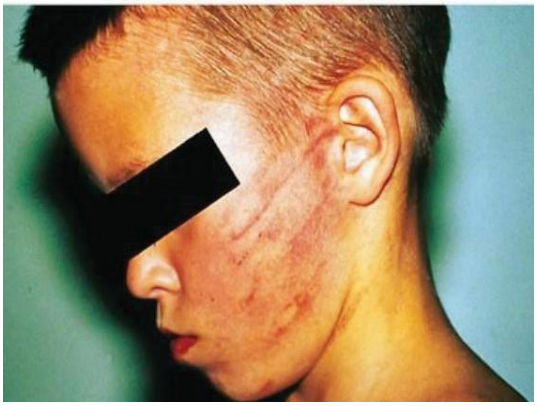


Groups are required to discuss and Identify this picture as physical abuse versus accidental injury.

What will be there in history, examination and risk factors?

Case Study 3

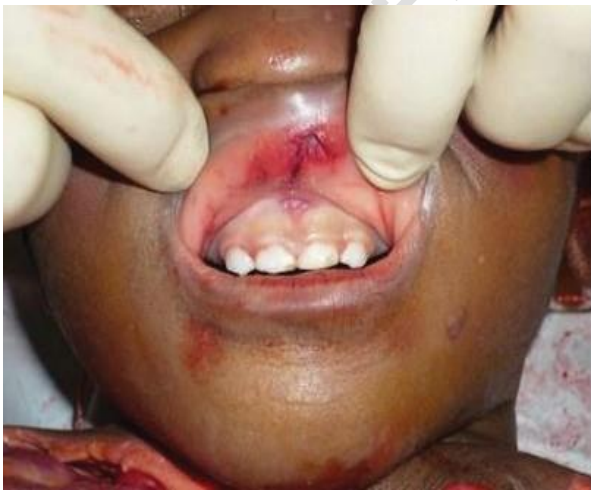
10-year-old boy brought with history of itchy rashes



Groups are required to discuss and Identify this picture as physical versus accidental abuse.
What will be there in history, examination and risk factors?

Case Study 4

7-year-old girl brought with history of fall from stairs



Groups are required to discuss and Identify this picture as physical abuse versus accidental injury.
What will be there in history, examination and risk factors?

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Chapter 5

Non Physical Abuse

A. NON-PHYSICAL ABUSE

Aims

- To increase the participants' awareness of recognizing child, abuse and neglect.
- To emphasize the essential knowledge participants', need to identify child abuse and neglect.
- To inform participants on when to seek guidance from a senior colleague.

Objectives

By the end of this training, participants will be able to:

- Define emotional abuse and neglect.
- Recognize signs and symptoms of various forms of abuse in children of all ages.

Child Abuse

Abuse is a form of maltreatment of a child. It can occur at different places by different people for different reasons. Recent research showed that the children rarely experience one form of abuse at once. They often occur together with other forms of maltreatment.[1]

Child abuse usually takes in the following forms: Physical abuse, Emotional abuse, Sexual abuse, Neglect.

Emotional abuse

Emotional abuse is defined as persistent, non- physical, harmful interaction with the child by the caregiver.[2] It includes act of omission (what is not done) like not expressing love and affection and act of commission (what is done) like humiliation, restriction.

It imparts negative effects on child's competency and emotional development. Children can be abused emotionally at home, school, or other different places by the parents, teachers, or other adults. The exact data regarding the emotional abuse is not known but it is said that 1 in14 children have experienced emotional abuse by a parent or guardian.[3]

Risk factors:

- Parental mental health problems, poor parent- child relationship and negative interaction.
- Young, single, non -biological parents.
- Parent's history of domestic abuse Domestic violence
- Substance abuse in family
- Disabilities or mental retardation in children that increase the caretaker's burden

Clinical Presentation:

A variety of features of emotional abuse can be observed at different stages of the child.

Infants:

- Feeding difficulties, delayed development
- Demanding, irritable
- Described as difficult infant, not belonging to me.

Toddler and preschool:

- Behavioral problems (head banging, rocking, bad temper, overactive to apathetic, noisy to quiet)
- Developmental delay (language and social skills)

School Children:

- Poor school performance
- Poor behavior Wetting/soiling
- Feels worthless, unloved, frightened

Adolescent:

- Depression
- Self-harm, substance abuse, eating disorder

Examination:

On examining the child following features can be noted.

- Poor growth (underweight and/or stunted)
- Signs of failure to achieve milestones, FTT, academic failure
- Behavioral signs: restless, very active, over friendly
- Emotional signs: sad, withdrawn, angry, and apathetic

Most of the time, there is hesitancy in diagnosing emotional abuse and remains

undercover. It can be assessed by simple description of observation of child/ caretaker relationship.
The severity of the emotional abuse has to be assessed along with the possible need for immediate protection. Suspected emotional abuse requires a multiagency referral along with the treatment.

Neglect

Neglect is a broad term describing one of the primary maltreatment types that refer to deprivation, or "the absence of sufficient attention, responsiveness, and protection appropriate to the age and needs of a child" [4]. It can result in impaired functioning or development of a child. It is the most common form of child abuse, but is hard to identify.

Categories:

- Physical- Failure to provide basic needs of food, shelter or warmth.
- Medical- Failure to seek, obtain or follow through with medical care for the child.
- Abandonment- Leaving young children without adult supervision/ care.
- Emotional- Persistent emotional unavailability and unresponsiveness towards a child. Failure to provide supervision and guidance- Failing to ensure that the child is physically safe and protected from harm.

Presentation:

Poor uptake of immunization, failure to seek appropriate medical advice. Persistently poor attendance at school Inappropriate clothing, poor hygiene, severe and persistent infestations, hypothermia.
The child's health can invariably be affected even when they are in utero. Several factors like maternal nutrition and general health during pregnancy can have an effect on the susceptibility of the child to a wide range of diseases. Likewise, drug use, violence, and antenatal care leading to delay in seeking medical help can also affect the unborn child's health.
In order to recognize the neglected children, there should be a proper assessment which should include the entire picture, chronicity and extent of child health needs[5]

1. Assessing parent/ careers knowledge and understanding of child's health, development and needs.
2. Family and social history- employment status, physical and mental health
3. Relationship with family members- unwanted child/ wrong sex
4. Child's language and cognitive abilities, past illness, accident history, schooling, socializing behaviors, self -injurious behavior
5. Specific vulnerabilities like sexual orientation or racial harassment.
6. Associated risk factors- parental mental health issues, learning disability and parental history of poor parenting.

Examination:

To observe the parent/ care giver, the child and their interaction.

- How do they care for and supervise?
- Way of interaction with child
- Do they focus on child/ needs?
- Child behavior and interaction
- Child's growth, development, signs of nutritional deficiency

The children's concerns should be well assessed, understood and communicated. Appropriate treatment plan including the follow up of the child should be ensured.

Fabricated or induced illness (FII)

Fabricated or induced illness (FII) is an uncommon type of child abuse in which a parent or caregiver either exaggerates or intentionally creates symptoms of illness in a child. This behavior can lead to considerable physical and emotional harm.

FII can manifest when a healthy child is portrayed as being sick or disabled by their parent or caregiver, or when a child with an existing illness or disability is described as having a more severe condition than they truly do.

History of Fabricated Illness

The history of Fabricated or Induced Illness (FII) involves a pattern of behavior in which a caregiver, usually a parent, intentionally causes or fabricates symptoms in a child, leading to unnecessary medical examinations, treatments, or hospitalizations. This can have significant consequences for the child's health, development, and overall well-being.

Signs and Symptoms:

Children who are victims of FII typically exhibit a variety of signs and symptoms that may seem unexplained, inconsistent, or unusual. These symptoms often do not fit a recognizable pattern of illness, and they may include:

- **Recurrent** episodes of unexplained illness or medical complaints that do not respond to treatment.
- **Persistent** symptoms that continue despite medical intervention, causing ongoing concern for health professionals.
- **Unusual** or bizarre medical conditions that are not easily diagnosed, such as hematuria (blood in urine), seizures, or unexplained collapses.
- **Unresolved** symptoms that fail to improve, even with extensive investigation and treatment, contributing to confusion for healthcare providers.

Presentation of Illness:

- **Sudden death** in severe cases, when a fabricated or induced condition escalates to a fatal outcome.
- **ALTE (Apparent Life-Threatening Events):** These are frightening episodes where a child may appear to stop breathing or become unresponsive, leading to emergency medical attention.
- **Seizures** may be one of the fabricated or induced symptoms, particularly if they do not respond to standard treatments or diagnostic findings are inconsistent.

- **Repeated and frequent medical presentations**, often involving multiple healthcare providers or hospitals, raising suspicion as different professionals struggle to find a coherent explanation for the child's illness.

Examination:

- There can be a disconnection between the physical appearance of the child and the severity of the reported symptoms. For example, a child might appear well and healthy despite claims of grave, life-threatening symptoms by the caregiver.
- **A wide range of fabricated or induced symptoms:** These can include anything from gastrointestinal issues, skin conditions, and respiratory problems to severe infections and neurological symptoms. This makes FII particularly challenging to detect, as the caregiver may be skilled in simulating various illnesses.

Family Factors:

The family dynamic plays a significant role in FII cases, with some common characteristics being:

- **Medical knowledge or training** on the part of the caregiver: This allows the person to convincingly fabricate symptoms, manipulate medical evidence, or understand how to induce illness without causing easily detectable harm.
- **Mental health problems** in the caregiver, often contributing to their behavior of fabricating or inducing illness in the child. Conditions like personality disorders or Munchausen syndrome by proxy may be present.
- **Overly attentive and involved caregivers**: These individuals may appear to be highly devoted and protective, but their level of involvement raises red flags for professionals. They may insist on invasive treatments or frequent medical evaluations.
- **Family history of similar patterns of ill health:** There may be a background of unexplained medical issues or similar behaviors in other family members, which can indicate a pattern of FII across generations.

Case studies:
Case 1

Ramesh, a 9-year-old boy lives with his mother. His father is not in regular contact and there is no known history of physical abuse in the household. He had long history of soiling. On further questioning, it was found that he has become increasingly withdrawn, often seems anxious and has shown a decline in academic performance over a past few months. He had poor attendance in his school, suspended twice because of his behavior and mother also says that he is evil. In addition, he also gets bullied by his friends in school.

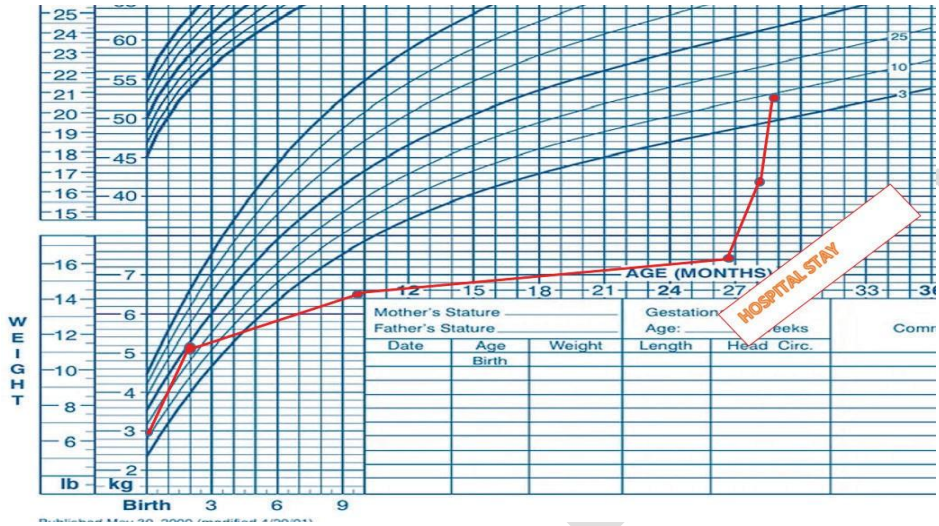
Groups are required to discuss and present under following topics:

History
Presentation Examination Child
Family

Interpretation: …….

Case 2

Babu Shrestha, 27 months old boy was referred to the hospital by Primary health center. A growth chart is provided which is to be evaluated and interpretation is to be done.



The growth chart shows falling away across the centiles during infancy, followed by dramatic weight gain in hospital stay.

Interpretation: ……..

Case 3

Ramila, a 6 years old girl lives with her mother. Her father is not involved in her life and there are no siblings. The mother appears very attentive and concerned about Ramila's health, frequently seeking medical attention for her. Ramila has been repeatedly admitted to the hospital over the past two years for various symptoms, including severe vomiting, chronic fatigue and frequent infections. Despite extensive testing including blood tests, imaging scans, doctors have been unable to identify any underlying medical conditions. Her mother often reports symptoms worsen at home but improve when she is in the hospital, insisting on invasive treatments. Nurses noticed that Ramila's symptoms sometimes appear to worsen after she has been alone with her mother. Ramila has been frequently absent from school and seems socially isolated from her peers. There is no evidence of physical abuse.

Groups are required to discuss and present under following topics:

History
Presentation Examination Child Family.

Interpretation: .....

References

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B. RECOGNISING PATTERNS OF SEXUAL ABUSE

Aims

- To increase the participants' awareness of recognizing child sexual abuse.
- To emphasize the essential knowledge participants', need to identify child sexual abuse.
- To inform participants on when to seek guidance from a senior colleague.

Objectives

By the end of this training, participants will be able to:

- Recognize signs and symptoms of sexual abuse in children and adolescents.

Definition:

According to the World Health Organization (WHO) sexual abuse (SA) occurs when a child is involved in sexual activity that it does not fully understand, to which it cannot give informed consent, for which it is not developmentally prepared, or that violates the standards of the society in which the child lives.

Sexual abuse includes physical contact, including penetrative and non- penetrative acts, non- contact activities such as exposure to sexually explicit material, and child sexual exploitation.[6]

A review of 217 studies found that one in eight children across the world (12.7%) had been sexually abused before reaching the age of 18. Child sexual abuse is usually associated with other forms of abuses eg. Physical abuse and emotional abuse. Sexual abuse has been found to have particularly severe consequences and is often associated with stigma and secrecy.

Most of the sexual abuse isn't reported, detected or prosecuted. The disclosure about the abuse immediately after the event is rarely done by the children. Over 90% sexually abused children were abused by someone they knew.[7]

According to the data collected from the Women and Children Service Directorate of Nepal Police, the total number of abused children in 2074/2075 was 995. Total number of registered rape case was 1480 among which 727 were attempt to rape, 261 cases belong to less than 10 years of age and 734 up to 18 years of age.

Child abuse may also increase when

- Caregivers or their communities experience financial difficulties,
- Housing problems,
- Unemployment
- Severe stress
- Abuse of alcohol and drugs,
- Gender and social inequality,
- Involvement in criminal activity,
- Isolation,
- Family breakdown
- Violence between family members.
- Caregivers are more likely to abuse those in their care if the caregivers themselves were abused, have low self-esteem, have poor impulse control, or lack understanding of child development.

Risk Factor:

- Age: Any child of any age can be affected. One research showed that the teenage girls between the age of 15 and 17 years get mostly affected.[3]
- Gender: It is observed that the girls are abused mostly by the family members and boys by the strangers.[8]
- History of previous sexual abuse Disability

- Broken homes
- Social isolation (lacking an emotional support network) Parents with mental illness, or alcohol or drug dependency.

Presentation:

- Pregnancy and sexual activity: intentionally rape, sexually assault by penetration, sexual assault by touching, making a child to engage in sexual activity.
- Sexually transmitted infection Ano-genital injury
- Unexplained vaginal/ rectal bleeding in the absence of accidental trauma
- Vaginal discharge/ vulvo-vaginitis
- Soiling/ bowel disturbance/ enuresis
- Foreign body in anus/vagina
- Emotional and Behavioral features- self harm, aggression, anxiety, depression, poor school performance, dissociative symptoms, abdominal pain, enuresis, masturbation, sexualized behavior.

Approach:

A detailed interview should be taken about the incident. So, while interviewing the child victims of sexual abuse, following points have to be taken into consideration.[9]

- All children should be approached with extreme sensitivity and their vulnerability recognized and understood.
- A friendly environment with the child should be established before interviewing.
- The event should be explained by the children in their own words.
- Open ended questions should be asked.
- Consider examining the child's siblings and the caretaker of the child in the absence of child.

Special skills and techniques are required for the evaluation of children in history taking, forensic examination followed by multiagency management plan.

1. Management of acute health needs:

- Treating bleeding/ urinary retention
- Emergency contraception
- Post Exposure Prophylaxis following Sexual Exposure for HIV, Hepatitis B

2. The abused child should be assessed by the doctor with the appropriate expertise.
3. Involvement of police
4. Forensic Assessment [10, 11]
    a. The clinical history
    b. The general examination
    c. The examination relevant to the abuse
    d. Detailed documentation of clinical findings
    e. Obtaining any relevant forensic samples for trace evidence and toxicology
    f. Appropriate screening for STI; with chain of evidence where appropriate
    g. Risk assessment for post-exposure prophylaxis (Hepatitis B and HIV infection)

i. Emergency contraception where appropriate
j. Attending to child protection needs
k. Arranging any necessary aftercare
l. Writing a report

Specialist support and help is needed throughout the process. Confidentiality needs to be maintained and emotional, behavioral and psychological consequences of the abuse should be addressed, thereby, a follow up consultation is strongly recommended.

Case Studies

Case1

Radha, a 10-year-old girl lived with her mother. Her mother is a single mother who works as a cleaner in a school. Since a few weeks, Radha started becoming very scared and anxious. She was afraid to be on her own, and feared closed places. She stopped going to school because she couldn't concentrate. She was scared when she saw the school gate and refused to go in. She had nightmares and sometimes her mother said she woke up at night and stared into space. She was afraid of harming herself. She was also hospitalized multiple times because of a stomach ache.

Groups are required to discuss and present under following topics:

History
Presentation Examination Child
Family

Interpretation: ……

Case 2

Asma a 9 year old girl, staying with her mother and her sister. Her parents were divorced and she would visit her father on holidays. One day when she returned to her mother's house from her father's house, she had change in her behavior. She was fearful and refused to go to the school. She stopped playing with her sister. She started to have nightmares. A short time afterwards, she began wetting her bed. She displayed severe fear reactions when she heard her father's name. At the time, her mother did not understand what was wrong. When the next holiday came and she was expected to visit her father again, she started crying. She avoided talking about her father, refused to go to school, lost her appetite and felt sad. At night she felt anxious: darkness triggered bad memories.

Groups are required to discuss and present under following topics:
History
Presentation Examination Child
Family

Interpretation: ……

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C. FEMALE GENITAL MUTILATION (FGM)

Key facts

- More than 230 million girls and women alive today have undergone female genital mutilation (FGM) in 30 countries in Africa, the Middle East and Asia where FGM is practiced.
- FGM is mostly carried out on young girls between infancy and age 15.
- FGM is a violation of the human rights of girls and women.
- Treatment of the health complications of FGM is estimated to cost health systems US 1.4 billion per year, a number expected to rise unless urgent action is taken towards its abandonment.

Overview

Female genital mutilation (FGM) comprises all procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons. The practice has no health benefits for girls and women and cause severe bleeding and problems urinating, and later cysts, infections, as well as complications in childbirth and increased risk of newborn deaths.

The practice of FGM is recognized internationally as a violation of the human rights of girls and women. It reflects deep-rooted inequality between the sexes and constitutes an extreme form of discrimination against girls and women. It is nearly always carried out by traditional practitioners on minors and is a violation of the rights of children. The practice also violates a person's rights to health, security and physical integrity; the right to be free from torture and cruel, inhuman or degrading treatment; and the right to life, in instances when the procedure results in death. In several settings, there is evidence suggesting greater involvement of health care providers in performing FGM due to the belief that the procedure is safer when medicalized. WHO strongly urges health care providers not to perform FGM and has developed a global strategy and specific materials to support health care providers against medicalization.

Types of FGM

Female genital mutilation is classified into 4 major types:

Type 1: This is the partial or total removal of the clitoral glans (the external and visible part of the clitoris, which is a sensitive part of the female genitals), and/or the prepuce/clitoral hood (the fold of skin surrounding the clitoral glans).

Type 2: This is the partial or total removal of the clitoral glans and the labia minora (the inner folds of the vulva), with or without removal of the labia majora (the outer folds of skin of the vulva).

Type 3: Also known as infibulation, this is the narrowing of the vaginal opening through the creation of a covering seal. The seal is formed by cutting and repositioning the labia minora, or labia majora, sometimes through stitching, with or without removal of the clitoral prepuce/ clitoral hood and glans.

Type 4: This includes all other harmful procedures to the female genitalia for non-medical purposes, e.g., pricking, piercing, incising, scraping and cauterizing the genital area.

No health benefits, only harm

FGM has no health benefits, and it harms girls and women in many ways. It involves removing and damaging healthy and normal female genital tissue, and it interferes with the natural functions of girls' and women's bodies. Although all forms of FGM are associated with increased risk of health complications, the risk is greater with more severe forms of FGM.

Immediate complications of FGM can include:

- Severe pain.
- Excessive bleeding (hemorrhage).
- Genital tissue swelling.
- Fever.
- Infections e.g., tetanus.
- Urinary problems.
- Wound healing problems.
- Injury to surrounding genital tissue.
- Shock.
- Death.

Long-term complications can include:

- Urinary problems (painful urination, urinary tract infections);
- Vaginal problems (discharge, itching, bacterial vaginosis and other infections);
- Menstrual problems (painful menstruations, difficulty in passing menstrual blood, etc.);
- Scar tissue and keloid.
- Sexual problems (pain during intercourse, decreased satisfaction, etc.);
- Increased risk of childbirth complications (difficult delivery, excessive bleeding, caesarean section, need to resuscitate the baby, etc.) and newborn deaths;
- Need for later surgeries: for example, the sealing or narrowing of the vaginal opening (type 3) may lead to the practice of cutting open the sealed vagina later to allow for sexual intercourse and childbirth (deinfibulation). Sometimes genital tissue is stitched again several times, including after childbirth, hence the woman goes through repeated opening and closing procedures, further increasing both immediate and long-term risks; and
- Psychological problems (depression, anxiety, post-traumatic stress disorder, low self-esteem, etc.).

Who is at risk?

FGM is mostly carried out on young girls between infancy and adolescence, and occasionally on adult women. According to available data from 30 countries where FGM is practiced in the western, eastern, and north-eastern regions of Africa, and some countries in the Middle East and Asia, more than 200 million girls and women alive today have been subjected to the practice with more than 3 million girls estimated to be at risk of FGM annually. FGM is therefore of global concern.

Cultural and social factors for performing FGM

The reasons why FGM is performed vary from one region to another as well as over time and include a mix of sociocultural factors within families and communities.

- Where FGM is a social convention (social norm), the social pressure to conform to what others do and have been doing, as well as the need to be accepted socially and the fear of being rejected by the community, are strong motivations to perpetuate the practice.
- FGM is often considered a necessary part of raising a girl, and a way to prepare her for adulthood and marriage. This can include controlling her sexuality to promote premarital virginity and marital fidelity.
- Some people believe that the practice has religious support, although no religious scripts prescribe the practice. Religious leaders take varying positions with regard to FGM, with some contributing to its abandonment.

Reasons for medicalized FGM

There are many reasons why health-care providers perform FGM. These include:

- The belief that there is reduced risk of complications associated with medicalized FGM as compared to non-medicalized FGM.
- The belief that medicalization of FGM could be a first step towards full abandonment of the practice.
- Health care providers who perform FGM are themselves members of FGM-practicing communities and are subject to the same social norms; and
- There may be a financial incentive to perform the practice.

However, with WHO's support and training, many health care providers are becoming advocates for FGM abandonment within the clinical setting and with their families and communities.

WHO response

In 2008, the World Health Assembly passed resolution WHA61.16 on the elimination of FGM, emphasizing the need for concerted action in all sectors: health, education, finance, justice and women's affairs.

WHO supports a holistic health sector response to FGM prevention and care, by developing guidance and resources for health workers to prevent FGM and manage its complications and by supporting countries to adapt and implement these resources to local contexts. WHO also generates evidence to improve the understanding of FGM and what works to end this harmful practice.

Since then, WHO has developed a global strategy against FGM medicalization with partner organizations and continues to support countries in its implementation.

D. ONLINE ABUSE

The online abuse is any type of abuse that can happen across a device like computer, mobile phones, through social media, emails, text messages, multimedia message.

What is online abuse?

Online abuse is any type of abuse that happens on the internet. It can happen across any device that's connected to the web, like computers, tablets, and mobile phones. And it can happen anywhere online, including:

- social media
- text messages and messaging apps
- emails
- online chats
- online gaming
- live-streaming sites.

Children can be at risk of online abuse from people they know or from strangers. It might be part of other abuse which is taking place offline, like bullying or grooming. Or the abuse might only happen online.

Types of online abuse

Children and young people might experience different types of online abuse, such as:

- Cyber bullying
- Emotional Abuse
- Grooming
- Sexting
- Sexual abuse
- Sexual exploitation

Signs of online abuse

A child or young person experiencing abuse online might:

- Spend a lot more or a lot less time than usual online, texting, gaming, or using social media.
- Seem distant, upset, or angry after using the internet or texting.
- Be secretive about who they're talking to and what they're doing online or on their mobilephone.
- Have lots of new phone numbers, texts or email addresses on their mobile phone, laptop, or tablet.

Some of the signs of online abuse are similar to other abuse types.

If a child reveals online abuse

It can be difficult to know what to say and do if a child tells you they're being abused online. They might not realize what's happening is wrong. And they might even blame themselves. If a child talks to you about online abuse it's important to:

- listen carefully to what they're saying.
- let them know they've done the right thing by telling you.

- tell them it's not their fault.
- say you'll take them seriously.
- don't confront the alleged abuser.
- explain what you'll do next.
- report what the child has told you as soon as possible.

Effects of online abuse

Online abuse can have long-lasting effects on children and young people. It can lead to:

- Anxiety
- Self-harm
- Eating disorders
- Suicidal thoughts

Some of the effects of online abuse are like other abuse types.

Who's at risk?

Any child who uses the internet can be at risk of online abuse. It's important parents are aware of the risks and talk to their child about staying safe online. It is important that we professionals also should be aware of online abuse and should be able to give appropriate help and support.

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Chapter 6

Multidisciplinary Approach

Aim

- To understand the different stakeholders and their role in Child Protection.

Objectives

By the end of this training, candidates will be able to:

- Emphasize that child protection is a complex endeavor.
- Identify mechanisms involving professionals from a wide range of specialties are required.
- Understand our role and the importance of professionals in other areas.
- Emphasize that it is a duty to work on child protection.

Let's imagine that while working in a busy OPD in your hospital you come across a 12 months old boy with cough. He also has bruises over the cheek and buttock. The mother seems worried and says it happened after he fell off from the bed few days ago. There is no other significant medical history. The family of three with the parents and child X lives in a 1 room rented accommodation. The father is a labourer and would drink daily. Mum denied any domestic violence and baby X had no other carers except his parents. On further interrogation you conclude that this is a child protection issue. You try calling the police on duty in your hospital; he is on leave today and not reachable by phone. What do you do next?

Addressing a child protection issue needs many more people and agencies. It involves consideration of social, cultural, legal, financial, and health related issues, which is not possible via a single agency.

Our role as health professional is important and it involves the following:

- If suspicion arises of potential child protection issue, consult and involve the social service or the police else, consult and engage a colleague with expertise in this area (designated doctor or nurse) in the institution.
- All doctors are required to be able to recognize the signs and symptoms of child abuse and identify children in need of safeguarding or families needing help in caring of their children.
- Be aware of local practices and procedures for contacting child protection agencies and consult colleagues with skills in assessing children with child protection issues.
- Assess the family structure and identify other children who may be at risk
- Ensure medical care for the child when needed. Examine the child, document the findings and if necessary, collect specimens for forensic evaluation.

- Contribute to inquiries and provide written reports and recommendations when needed.

- Contribute to a child protection plan.
- Maintain one's training up to date or as required by existing policy.

National Child Rights Council (NCRC)

In Nepal, the NCRC is the apex body responsible for the protection and promotion of children's rights. It has been established under the Children's Act of 2018 (2075) and progressed from the Central Child Welfare Board, which was formed in 1992. The council operates under representatives from federal ministries, provincial governments, and civil society.

The NCRC has several key responsibilities aimed at ensuring children's rights are protected and promoted throughout the country. These include approving long-term policies and annual budgets related to child welfare, advising federal, provincial, and local governments on necessary legal and institutional measures to uphold children rights, preparing periodic reports in accordance with international conventions, monitoring the implementation of child- related programs at all levels of government, strengthening the capabilities of stakeholders involved in child protection efforts, and conducting campaigns to raise awareness about children rights and issues affecting them.

One-stop Crisis Management Center (OCMC):

It has been established in many central level and provincial and basic hospitals for the management of Gender Based Violence. If your hospital has one such center, and if the child protection issue in consideration also happens to be a case of gender- based violence, it has to be handled as per OCMC guidelines by incorporating the sensitivities of child protection into the actions.

Other important agencies are:

I. Police

The Police play an integral role in safeguarding children's rights through investigation, community engagement, specialized services, and public education. They take immediate measures to safeguard children when necessary and investigate criminal offences against children and gather evidences. They liaise with child protection officers, and other agencies, including NGOs working in the area when it is necessary to safeguard children. They manage the risks posed by dangerous offenders. Police contribute to the child protection plan with available information including intelligence.
In each district police office there is a provision of a separate site / room for dealing with cases of women and children. Many of the district police offices have a separate child friendly room for dealing with child protection issues.

The number 104 can be dialed from any telephone, which will be received in the respective district police office.

In Kathmandu, there is a dedicated child rescue and co-ordination center. It is commanded by a DSP of Nepal Police and also includes social service officers and counsellors.

104 can be called by any health personnel coming across a child protection issue where the involvement of police is deemed necessary.

II. Child welfare officer (Local Level)

- In developed countries, social services have the ultimate responsibility of child protection by liaisoning with other relevant agencies.
- Child protection officers receive referrals from hospitals, schools, or police, and other organizations regarding concerns about child protection. In countries with well-established social services, these officers are responsible for obtaining a court order to remove children from unsafe environments and make emergency decisions when necessary. Each case requires a tailored child protection plan, which the office is responsible for creating and implementing.
- Social workers are an integral part of any hospital, especially hospitals where children are treated. However, Nepal has yet to develop a similar integrated system.

Traditionally, child welfare was managed by Women and Children Officers in the District Women and Children Office. The delegation of authority to local levels is anticipated to enhance child protection efforts.

- In Nepal, in federal restructuring, the Act Relating to Children 2075 (2018) establishes the framework for child protection at the local government level. This legislation empowers local authorities to create procedures for protecting and promoting child rights, set up child funds, form Child Rights Committees (CRCs), and appoint Child Welfare Officers (CWOs). The CWOs is crucial for the protection and promotion of child rights at the local level. As of early 2023, only 246 out of 753 local levels have appointed CWOs, and just 238 have established CRCs.

Conventionally, child welfare issues used to be dealt by 'Women and Children officers' in "District Women and Children Office". Delegation of authority and services to lower level is expected to facilitate child protection activities.

After implementation of this proposal, child protection activities may be further facilitated. There is a provision of Women and Child Welfare Council (महिला विकास तथा बाल कल्याण परिषद्) in local as well as central level. Perhaps this will involve into full-fledged authority on coordination and enforcement of child protection activities.

III. Child Helpline Operations

- The Child Helpline was established in 1998 by the Child Workers Concerned Centre (CWIN), an NGO dedicated to child welfare, to provide emergency rescue, relief, and psychosocial counseling services for children. It became a formalized service with the launch of the toll-free number 1098 in 2007. Currently, the Ministry of Women, Children, and Social Welfare directs the functioning of a Child Helpline. The CWIN operates 18 child helplines across Nepal, with 7 of those directly managed by CWIN. The remaining helplines function through partnerships with local organizations.

Key Locations are Kathmandu, Morang, Makwanpur, Kaski, Rupandahi, Banke, and Kailali. Partnerships extend to organizations like Aasman Nepal in Dhanusa and Aawaz Nepal in Surkhet, enhancing the reach and effectiveness of the helpline services.

Child helplines have mandate and requirement to work for emergency rescue, relief, medical and legal assistance; and shelter as well as reintegration in coordination with relevant government authorities such as police and women and children offices.

Child helpline operation working procedure delineates basic requirements and detailed process of running a child helpline.

In Kathmandu, CWIN operates the child helpline located in Thankot. The helpline is equipped to respond to calls from health personnel and community members who encounter child protection issues.

Upon receiving a call, the helpline is required to address the situation and coordinate necessary actions with relevant authorities. Health personnel may call 10-9-8 when they come across child protection issues. Helpline is required to address the call and then do necessary co-ordination.

IV. School Nurse or Designated School Teacher

Every school is expected to have a School Nurse or designated teacher who is specially trained in child protection. School nurses play a vital role in child protection, serving as frontline professionals who can identify, report, and support children at risk of maltreatment. Their unique position within the school environment allows them to interact regularly with students, making them well-suited to recognize signs of abuse or neglect.

School nurses should be trained to recognize early signs of child maltreatment, including physical, emotional, and sexual abuse as well as neglect. They are responsible for reporting any suspicions to the appropriate authorities, such as Child Protective Services (CPS). They must be familiar with local laws and procedures for reporting child maltreatment to ensure compliance and effective intervention.

In Nepal, the school Health Nurse Program (SHNP), particularly the initiative known as “One School One Nurse” to place a nurse in every public school across Nepal, aims to enhance the health and well-being of the students within educational settings. The program was first launched in Province 3 in December 2018. Following its success, the program has been extended to other provinces as well. School Nurses (SN)provide healthcare services to students, addressing both acute and chronic issues. They conduct health screening, monitor immunization records, and develop individual health plan for students with specific needs.

Similarly, another significant focus of SN is on mental health, especially given the concern around adolescent mental health in Nepal. Recent initiatives have included training for school nurses to equip them with skills necessary for managing behavioral and psychological health interventions. In 2022, 116 school nurses received training in Bagmati Province as part of this effort.

They are also involved in child protection efforts. However, studies indicate that many lack adequate training in this area.

Designated school teachers serve as key figures in identifying and addressing child protection issues.

They are often the first point of contact for children facing risks such as abuse or neglect. He/she is also expected to contribute to a child protection plan. The effectiveness of these teachers is enhanced by collaboration with school nurses, creating a supportive environment for children.

V. Non-Governmental Organizations (NGOs)

- The role of NGOs is more important in a country like ours where the government's systems are not fully established and adequate facilities are not available.
- NGOs may help in running a child helpline.
- They may assist in the immediate rescue and shelter of a child requiring protection. NGOs may facilitate foster care.
- NGOs may also assist in finances in matters of child protection as well as for child protection campaigns and trainings.
- NGOs may perform advocacy to influence national policies and public awareness. NGOs in Nepal actively engage with governmental bodies to influence policies, conducting training, empowering local communities related to child rights, abuse and protection.

Some Key NGOs and their contributions are:

1. National Child Protection Alliance (NCPA): It was established in 2010, NCPA is a network of over 50 NGOs focused on combating violence, abuse, and discrimination against children across Nepal. They work to promote a child-protective environment through advocacy and awareness campaigns at local, national, and international levels.
2. Child Nepal: It was founded in 2003, Child Nepal aims to foster a child-friendly culture by promoting children's rights as outlined in the UN Convention on the Rights of the Child. The organization engages in policy advocacy and implements programs that address child trafficking, labor, and sexual violence through community training initiatives.
3. Child NGO Federation Nepal (CNFN): It was established in 1994, CNFN serves as an umbrella organization for various NGOs working in child development. It promotes the principles of the UN Convention on the Rights of the Child and facilitates collaboration among member organizations to enhance child welfare across the nation.
4. Save the Children: This is active since 1976, and focuses on improving childrens lives through health, education, and protection programs. They address pressing issues such as child labor and malnutrition while advocating for policies that safeguard children's rights.
5. Child Protection Centers and Services (CPCS): CPCS works specifically with street children and aims to reintegrate them into society through social rehabilitation programs. They provide shelter, informal education, and youth empowerment initiatives to support vulnerable children.
6. UNICEF and Plan International: are also contributing for legislative advocacy, capacity building related to child protection.

Anyone involved in the child's everyday care.

Anyone involved in child's everyday care can contribute a lot in identifying and planning appropriate intervention for a child requiring safeguarding.

Summary

Child protection cannot be done by a single person or agency. We should consult someone with expertise in this area and we should get the appropriate agencies involved. It is important to know our role and the role of other agencies and professionals so as to effectively and efficiently execute a child protection work by avoiding duplication of efforts

and/or inadequate efforts. We as health professionals have a very important task – of identifying a child protection. We are required to be competent with the skills and with the local mechanism of executing a child protection work. Child protection, by law, is one of our duties.

Exercise

Let's imagine that while working in a busy OPD in your hospital you come across a 12 months old boy with cough. He also has bruises over the cheek and buttock. The mother seems worried and says it happened after he fell off from the bed few days ago. There is no other significant medical history. The family of three with the parents and child X lives in a 1 room rented accommodation. The father is a labourer and would drink daily. Mum denied any domestic violence and baby X had no other carers except his parents. On further interrogation you conclude that this is a child protection issue. You try calling the police on duty in your hospital; he is on leave today and not reachable by phone. What do you do next?

- Possible child protection issue: the same case as outlined above.
- Consult a senior or a colleague with expertise (Second participant).
- Decide that it is an issue needing immediate protection. Because of possibility of physical offence call 104.
- Police officer (Third participant) decides that the case needs intervention. The father is taken into custody.
- Police informs local Women and Children officer (4th participant) and also calls a NGO working on rescue of children (5th participant) for immediate logistic management.
- Women and Children officer decides to proceed with prosecution of the father and protection of the mother and child, speaks with police officer for collection of evidences and building of case, and asks the NGO (5th participant) for coordinating the treatment, finances and psychological counseling.
- Child's preliminary assessment reveals no intracranial injury. Health personnel (1st and 2nd participant) decide to discharge the child.
- NGO representative (5th participant) takes the mother and child to rescue center after informing the police and women and children officer. They would now facilitate reintegration.

- The father pleaded guilty and was sorry for his way of dealing with the family. He has given up drinking and is back to home.
- The team decides to have some rounds of talk between the mother and the father and if they arrive in an agreement, to send the mother and child back to home.

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21. https://ncn.org.np/

Chapter 7

Confidential Medical Report and Court Handling

A. Confidential Medical Report: Safeguarding concerns

Participant Exercise Based on the case scenario given in the Annex E,
Complete the proforma on procedural response to suspected child abuse - Patient details, history, examination, investigations, conclusion and discharge plans. Use body maps to illustrate your examination findings as bruises and swelling.

1. Reflect on the important points of this scenario that prompts consideration of non-accidental injuries and details necessary to elicit during history taking and examination. Changing history not fitting with examination findings.
2. Importance of seeking details on the mechanism of injury such as height and surface of fall.
3. Patterned injuries
4. Site of injuries as over soft tissues, ear
5. Varied color bruises- bright red, purple, brown, fading yellow- implying injuries sustained at different times (however, injuries cannot be dated accurately based on their color)
6. Need for detailed examination, palpation of bones and joints as detection of fracture in the arm could have been overlooked
7. Typical radiology features suggestive of a non-accidental fracture - seek formal reports from the consultant radiologist
8. Delay/ not seeking medical attention when child is injured (Do consider measures parents have taken at home as use of medications/bandages, seeking advice from others, transport/economic constraints)
9. Importance of recognition and response by the junior doctor in a busy OPD
10. Discharge address from the hospital and name of the responsible adult (Parent/child protection officer/NGO representative) should be clearly documented in the notes (1-10) and if any others??

Report writing

Child X, Male, DOB 12/5/2023 Hospital ID 506327

My name is Dr Ram Pradhan/ name code - - I am a paediatric registrar working at Kanti Children's hospital since the past three years. My qualifications are MBBS, DCH and MD Paediatrics. I have eight years of work experience in paediatrics. The lead consultant for this case is Dr Mahendra Baral.

On 18 th May 2024, I got a call from my junior colleague Dr Ramesh Sharma regarding a12 month old infant Baby X who was seen at the outpatient department of this hospital, The baby was accompanied by his mother Mrs Sita Lama. Dr Sharma was concerned about multiple bruises that did not fit with the history provided by his mother as fall from the bed and therefore, referred the case to me for further evaluation.

I examined Baby X the same day, in the presence of Dr Sharma, on duty staff nurse Miss Rama Jha and the mother.

History provided by Mum: Child X had been coughing for a few days and the doctor at the OPD had reassured her that this was a viral infection and child was well. She was told child had some marks which needed blood tests. She mentioned she wasn't concerned about it as "children often have falls and bruises". This had happened a few days ago in her presence when he fell off the low bed on a floor mattress (height approximately 1 foot)
During examination, she appeared nervous and changed her story saying child had fallen off the stairs in her absence. On detailed questioning, she then mentioned that there was only a single step in the room, by the door.

The child was otherwise well. He was born full term in a hospital and was developing well for age. He could walk a few steps unaided and crawl. Past medical history was unremarkable. The child was not on any routine medications. The family of three, resided in a one bedroom rented accommodation at 13 Ka Dharamarg, Maharajgunj and child X has no other carers. Parents Ram lama (42 years) and Sita lama (22 years) were well with no family history of any illness including bleeding problems. Mum is a housewife and father is a daily wage labourer who drinks regularly.
On examination: baby X appeared generally well and looked clean. He weighed 8 kgs (c), length. cm (c). Head circumference 50cm (c) His general and systemic examinations were all normal. He appeared bright and interactive.

On examination of the skin, there were multiple bruises on the face and body. With mother'sconsent, photographs of these were taken for hospital records.

1. On the right cheek- well defined, 3 linear, purple slanting bruises interspaced by 1cm,measuring 4cm,6cm and 4 cm - the imprint appeared to be like a slap mark
2. On the left ear pinna - bright red bruises in the front and back of upper end of pinna(helix) which could be explained as pinch marks
3. On the right mid arm- 10 cm, yellow- brown, fading linear bruise as imprint from a linearhard object
4. On the left buttock- Ill defined, bright red bruise measuring about 2 cm
5. Left lower arm - slightly swollen and tender - possible underlying bony injury

Investigations:

1. Full blood count & clotting profile normal
2. X-ray of the Left elbow joint - Reported as metaphyseal fracture of lower lateral condyle of the humerus with some callus formation.

   These images were reviewed by the consultant radiologist, Dr Mira Shrestha who agreed with the report adding these images as a healing fracture in the left arm which was highly suspicious of a non-accidental injury.
3. Skeletal survey - normal
4. CT scan of the head - no bony or intracranial injuries
5. Ophthalmology- no retinal hemorrhage

In view of the distribution of various patterned injuries which appeared to have occurred at different times and the provided history of the mechanisms not fitting with the examination findings, the child underwent more detailed investigations outlined above (points 3,4 &5) as per the hospital policy.

The child was treated by the hospital- based orthopedic department with a plaster cast and pain relief medicine.

Conclusion:

12-month old Child X with multiple injuries sustained from blunt trauma to the body including fracture of left arm secondary to a non-accidental cause.

Strategy meeting was held on - 19/5/24 in my presence with
1. Consultant Paediatrician Dr Mahendra Baral
2. Police Inspector Badri Subedi, Maharajgunj Chakrapath brita, mobile 980333444
3. Child protection officer, Mr Navraj Subedi KMC wada-2, Maharajgunj, mobile 980444222
4. NGO representative Ms Geeta Thapa, mobile 980222333

Following confession of the assaults, father Ram lama was taken into police custody and child X was discharged with his mother to a shelter placement under the care of NGO personnel Ms. Geeta Thapa
Discharge address: Kopila Kendra, Baluwatar, Kathmandu
Mother was cautioned for appropriate childcare.

Discharge plan:
1. Paediatric OPD in 6 weeks to monitor growth, well-being and vaccination status
2. Orthopedic OPD, same day for review of his arm.

Copies of the letter has been provided to the Police, Child protection officer and the NGO for their records.

Name of discharging doctor: Dr Ram Pradhan
Signature:

Designation: Paediatric registrar, Kanti children's hospital, Maharajgunj 4-422333
NMC registration - 2098
Date: 19/5/2024 Time: 16:00

B. Court Handling

Objectives

By the end of this session, participants will be able to:
- Prepare to face Court:
  - The process that he/she might have to fulfill before presenting to the court- preparing for the visit to the court Thorough case preparation that has been called for in the court.
- Present in the court:
  - Things to be done & things not to be done in the court about the case.
  - Explanation of the Witness Statement (बक पत्र)

Court

A court is any person or institution, often as a government institution, with the authority to adjudicate legal disputes between parties and carry out the administration of justice in civil, criminal, and administrative matters in accordance with the rule of law.

When a doctor is involved in the child protection issues, he/she has to prepare the report and the details of the reports are to be kept for the reference. When the court needs then they might call the doctor who was involved in the child protection issues to the courses. The doctor will be called to clarify the confusions and the findings that have been documented. This will help in providing the justice to the child. The cases related to the child protection are seen by "सरकारी वकिल" so they are "सरकारीवादी मुद्दा".

There will be some procedural things for any doctors to be called by court. Anyone cannot bypass the court and the court has to be faced if one is asked for clarification. There are a series of the events that should be done before facing the court which are explained below.

Administrative part

The court will issue a letter which will be submitted to the administration office and the travel order to the concern doctor will be issued by the institution. This travel order has to be carried by the doctor while presenting in the court.

Preparation for the case

The case file has to be studied thoroughly and the examination details as well as findings are to be studied. In the court the questions will be asked on basis of the findings and the clarification of any points needed from the report will be asked. The clear and straight answers to the asked questions are mandatory. This will reduce the fear and stress in court.

Presentation to the court

The doctor or the person who has been called in the court will have to face the court in the designated date and time in the court. The doctor has to be face the lawyers and have to answer the questions which are made via both the sides. The clarification has to be given to the questions arouse. The questions asked will be written and the responses from the doctors has to be documented by the person and will be read by the doctor. Once the things are documented then the final copy is read by doctor and signed. This is the witness letter.

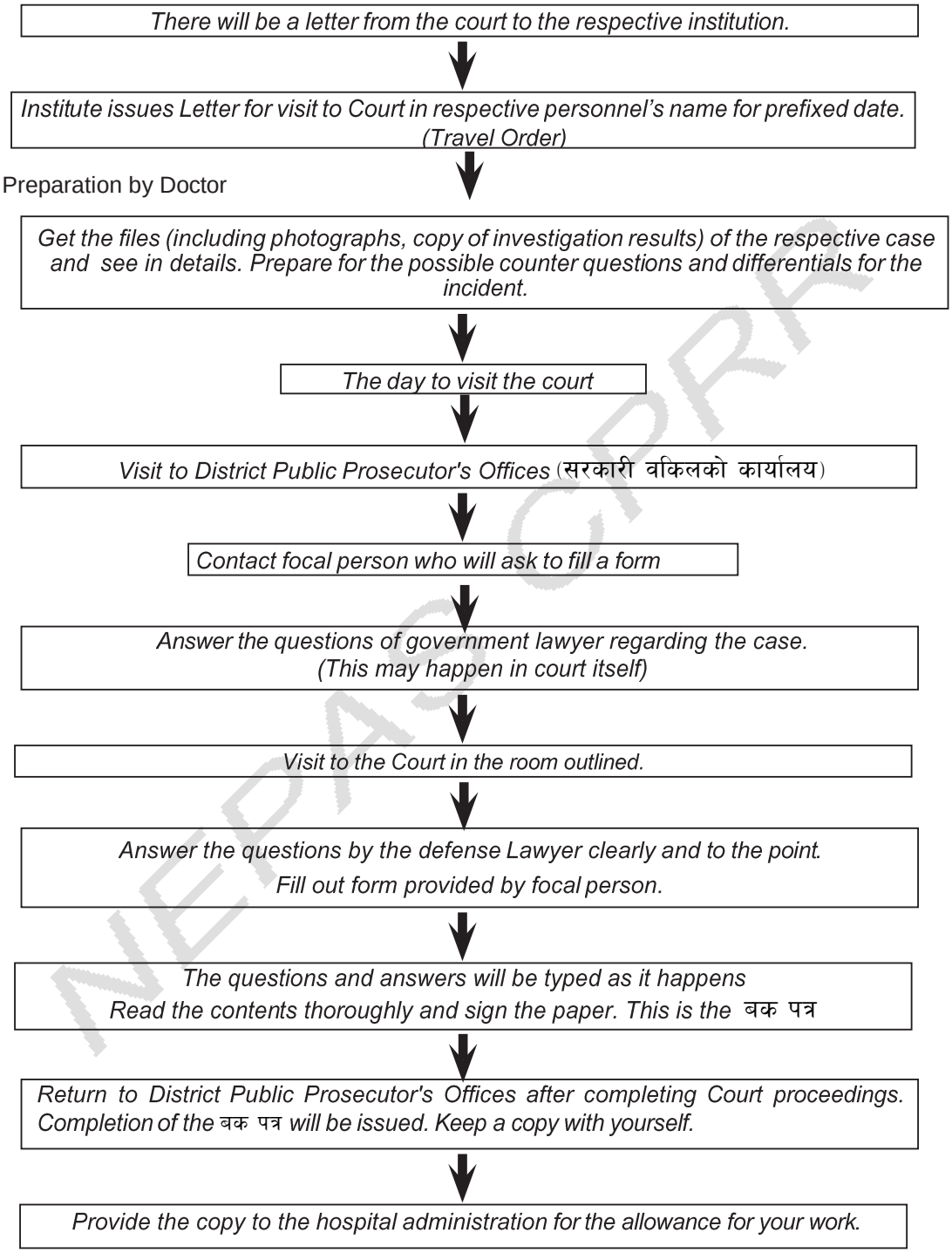
How to handle Court?

This flow chart is the simplified form of the steps and procedures to be done while presenting to court. The administrative part to the preparation to face court has to be followed so that there will not be any confusion while visiting the court. This will help to express oneself in explaining the questions asked in the court.

References:

1. एकद्वार संकट व्यवस्थापन केन्द्र र संघीय नेपालको महिला तथा बालकालिका सम्बन्धी सुरक्षा राष्ट्रिय महिला आयोग **www.nwc.gov.np**
2. OCMC_Program_Implementation.pdf (fwd.gov.np)

Administrative part



Pre/Post Test Questionnaire

1. Child protection is the protection of children from
   a. Violence and exploitation,
   b. abuse
   c. neglect.
   d. All of the above

2. Nepal Demographic and Health Survey, 2022,
   a. 25 percent of children under 5 are stunted, 19 percent are under weight (weight for age), and 8 percent are wasted
   b. 20 percent of children under 5 are stunted, 18 percent are under weight (weight forage), and 8 percent are wasted
   c. 25 percent of children under10 are stunted, 15 percent are under weight (weight forage), and 8 percent are wasted
   d. 30 percent of children under 8 are stunted, 20 percent are under weight (weight for age), and 8 percent are wasted

3. Child Neglect is defined as
   a. Failure to provide for the shelter, safety, supervision and nutritional needs of the child.
   b. Failure to provide education to child.
   c. Failure to provide enough food to child.
   d. Failure to treat during his/her illness.

4. Any health care profession who finds the suspected child abuse
   a. Should report to the concerned authority
   b. Should inform to his/her senior.
   c. Should report to guardians
   d. Should not inform any one for child's confidenciality.

5. Which of the following is a risk factor for child abuse?
   a. Single child
   b. Single parent
   c. Elderly maternal age
   d. Elderly paternal age

6. Which is true regarding recognition of child abuse?
   a. History is very clear
   b. No delay in seeking care
   c. Multiple or patterned injuries
   d. Bruises in knee

7. In children younger than one year, of fractures are abusive.
   a. 25%
   b. 50%
   c. 75%
   d. 100%

8. Which burns suggest forced immersion?
   a. Asymmetric
   b. Non-uniform in depth
   c. Splash burns
   d. Spare skin creases

9. Which is not considered long term effect of physical abuse in children?
   a. Criminal behavior
   b. Eating disorders
   c. Behaviour issues
   d. Malnutrition

10. When you are called for the “witness of statement” by the court which of the following you should be doing first?
   a. Visit to the court directly
   b. Prepare for the case that you have been called.
   c. Inform other hospital members
   d. Do not bother about this.

11. The defense layer asks you about any condition of the incident, what you should do?
   a. Explain all the probable causes of the incident.
   b. Do not tell anything about the incident.
   c. Response to him/her with what is being asked.
   d. Do not cooperate to the lawyer.

12. You have visited the court and the witness of statement has been completed. Now what will you do?
   a. Go back to home straightly after the witness of statement.
   b. Take the letter of attending the witness of statement in court.
   c. Ask for the travel allowance in the court.
   d. Do not bother for anything more.

13. After the questionnaire during the statement of witness what will you have to do?
   a. Leave the room once you finished the answer.
   b. Sign the witness of statement report directly.
   c. Do not sign the witness of statement letter.
   d. Read thorough and sign the witness of statement letter.

14. The report during examination is to be prepared by the senior and kept in home. Which of the statement is true?
   a. The report is to be prepared by the junior most staff though senior doctor has seen the case.
   b. The report is to be prepared by the senior most doctor.
   c. The report is to be prepared by police and the doctor together.
   d. The doctor who has examined the case should prepare the report.

15. What is the legal age of children?
    a. 14 years
    b. 22 years
    c. 18 years
    d. Not defined

16. Where do you need to report the child abuse case?
    a. No need to report
    b. Report to parents
    c. Report to Child Welfare officer
    d. Report to Police

17. Which of the following is not related to child help line?
    a. 104
    b. 100
    c. 1089
    d. None of the above

18. Which article of Constituency of Nepal mainly sees for Child right?
    a. Article 5
    b. Article 39
    c. Article 2
    d. There is no provision

19. Female Genital Mutualism (FGM) is mostly carried out on
    a. old woman
    b. adolescent girls
    c. Infancy to 15 years female.
    d. Yong boys

20. A child or young person experiencing abuse online
    a. can have many friends
    b. very happy and good moods
    c. have habit of talking more and discussion on home.
    d. seem distant, upset, or angry after using the internet or texting.

ANNEXES

A. SEXUAL OFFENCE OF A FEMALE CHILD

अनुसूची: ११

(नियम २४ को उपनियम (१) को खण्ड (क) सँग सम्बन्धित)

योनजन्य अपराध सम्बन्धी शारीरिक परिषण प्रतिवेदनको ढाँचा

(महिलाको हकमा)

REPORT OF MEDICAL EXAMINATION IN SEXUAL OFFENCE
(FEMALE SUBJECT)

1. Case Registration No.:
2. Name of the Office referred for examination (with letter reference No. and Date)
3. Name of the accompanying Police Personnel:

DETAIL ABOUT THE EXAMINEE

1. Name/ Code Name (To maintain confidentiality): e. g. 3060800471-2080-12-27-055 (394-6)
2. Age and Sex:
3,. Address:
4. Marital status:
5. Guardian's Name and relation:
6. Date and time of examination:
7. Attendants Name / address:
8. Identification marks:
9. Consent for examination: I am fully aware about the process and possible consequences of the examination; I hereby give my full consent for medical examination without any compulsion. (Consent should be taken in the form of signature / thumb print.) For minors Consent should be taken from guardians.

Child Protection Recognition and Response
Participants Training Module

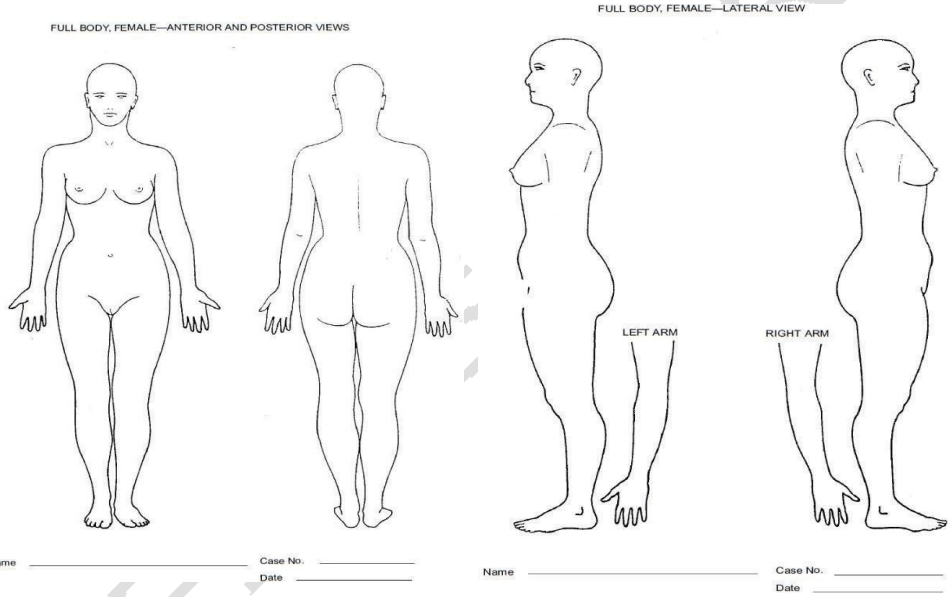
10. Brief History of the incident, as stated by examinee or guardian (How, When, Where and what had happened?):
11. Medical history (Emotional, Medical and Psychological history including past medical history):

12. Clothes changed or not after incident:
13. Whether clothes and body parts washed or not after the incident:
14. Description of the examination of clothes (Any tear, scratches, stain and foreign materials:

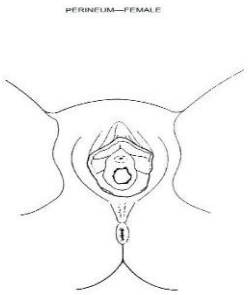
EXAMINATION

1. **General physique and vitals: -**
   Height: Weight: Pulse: B.P: Temperature:
   Respiratory rate: Degree of consciousness:
   Any disability:

2. Injuries on the bodies (Name, Size, Site, Color, Surrounding area, sign of treatment, Bleeding Marks, Sign of Healings, any Imprints etc.) Please use the figure provided to depict the injuries as best as possible:



3. Genital injuries (Name, Size, Site, Color, Surrounding area, Sign of treatment, Bleeding Marks, Sign of Healings, Imprints, any content, stain and discharge etc.) Please use the figure provided to depict the injuries as best as possible: -
   a. Perineum:
   b. Vulva:
   c. Vagina:
   d. Hymen:
   e. Perianal area and anal orifice:
   f. Oral cavity:



4. Conditions of pubic hair (Matted, stained, any foreign hairs:
5. Bite marks: - (enclose photos if possible) :
6. Specimen preserved for further analysis:-
   a. Blood:

b. Urine:
c. Swab from stains:
d. Vaginal swab:
e. Foreign hairs/debris:
f. Hair from the examinee:
g. Nail scrapings:
h. Others:

7. Investigation and reports: -
8. Treatment (including prevention of pregnancy, vaccination and sexually transmitted diseases):
9. Referral (Where and Why?):-
10. Follow up visits suggested on:-
11. Psychiatric evaluation and psychosocial counseling:-
12. Condition of teeth (Type of dentition and Number of teeth) :-
    8 7 6 5 4 3 2 1/1 2 3 4 5 6 7 8
    …….. = / (Total teeth =)
    8 7 6 5 4 3 2 1/1 2 3 4 5 6 7 8

Opinion of the expert:

a. Opinion about mental status of the examinee:
b. Opinion about the Injuries on the body:
c. Opinion about the condition of genital regions:
d. Age estimation:
e. Other opinion, if any: -

Name of the Examiner:- _____

Signature:- Qualification:-

NMC Reg. No. :- Office/Hospital/Health Centre:-

Date:- Seal of the Hospital/Health Centre:-

Note

- परिक्षण कार्य सम्भव भएसम्म Forensic विषयको विशेषज्ञता, सो नभएमा तालिम प्राप्त चिकित्सककर्मीले गर्नुपर्दछ ।
- परिक्षण गर्ने चिकित्सककर्मीले नै प्रतिवेदन तयार गर्नुपर्दछ ।
- सम्भव भएसम्म कम्प्युटर टाईप गरी प्रतिवेदन तयार गर्नुपर्नेछ, सो नभएसम्म स्पष्ट बुझिने गरी उल्लेख गर्नुपर्ने हुन्छ । साथै परिक्षण प्रतिवेदनको सक्कल प्रति नै संलग्न गर्नुपर्नेछ ।
- निर्धारित स्थानमा विवरण उल्लेख गर्न नपुग भएमा छुट्टै कागज प्रयोग गर्नुपर्नेछ ।

B. SEXUAL OFFENCES OF MALE CHILD

अनुसूची: १२

(नियम २४ को उपनियम (१) को खण्ड (क) सँग सम्बन्धित)

योनजन्य अपराध सम्बन्धी शारीरिक परिषण प्रतिवेदनको ढाँचा

(पुरुषको हकमा)

REPORT OF MEDICAL EXAMINATION OF MALE SUBJECT IN SEXUAL OFFENCES

1. Case Registration No.:
2. Name of the Office referred for examination (with letter reference No. and Date)
3. Name of the Accompanying Police Personnel:

DETAIL ABOUT THE EXAMINEE

1. Name/ Code Name (To maintain confidentiality):
2. Age and Sex:
3. Address:
4. Marital Status:
5. Guardian's Name and Relation:
6. Date and Time of Examination:
7. Attendants Name/Address:
8. Identification Marks:
9. Consent for examination: I am fully aware about the process and possible consequences of the examination; I hereby give my full consent for medical examination without any compulsion. (Consent taken in the form of signature/ thumb print.) For minors Consent taken from guardians.
10. Brief History of the incident (How, When, Where and what had happened?):
11. Medical History (Emotional, Medical and Psychological history including past medical history):
12. Clothes changed or not after incident:
13. Whether clothes and body parts washed or not after the incident: No
14. Description of the examination of clothes (Any tear, scratches, stain and foreign materials

EXAMINATION

1. General Physique and vitals:-
   Height: Weight: Pulse: B.P:
   Temperature: Respiratory Rate: Consciousness:

Any disability:

2. Injuries on the bodies (Name, Size, Site, color, Surrounding area, Sign of treatment, bleeding Marks, Sign of Healings, any Imprints etc.) :-
3. Genital injuries (Name, Size, Site, color, Surrounding area, Sign of treatment, Bleeding Marks, Sign of Healings, imprints, any stain and discharge etc.) :-
   a. Perineum:
   b. Penis :
   c. Scrotum:
   d. Perianal area and anal orifice:
   e. Oral cavity :

4. Conditions of pubic hair (Matted, Stained, Any foreign hairs):-
5. Bite Marks:-
6. Specimen Preserved for further analysis:-
    a. Blood:
    b. Urine:
    c. Swab from stains.:
    d. Swab from penis:
    e. Foreign hairs/debris:
    f. Hair from the Examinee:
    g. Nail scrapings:
    h. Others (including oral sexual activities):
7. Investigation and reports: -
8. Treatment (including sexually transmitted diseases): -
9. Referral (Where and Why?): -
10. Follow up (if necessary): -
11. Psychiatric evaluation and psychosocial counseling: -
12. Condition of teeth (Type of dentition and Number of teeth to assess age of examinee)

    8 7 6 5 4 3 2 1/1 2 3 4 5 6 7 8

    …… = / (Total teeth):

    8 7 6 5 4 3 2 1/1 2 3 4 5 6 7 8
13. Opinion of the expert:
    a. Opinion about injuries on body: -
    b. Opinion about condition of genital organs: -
    c. Opinion about the age of the examinee: -
    d. Other opinion; if any: -

    Name of the Examiner: -_____
    NMC Reg. No.: -
    Office/Hospital/Health Centre: -
    Date: -
    Seal of the Hospital/Health Centre: -

Note

- परिक्षण कार्य सम्भव भएसम्म Forensic विषयको विशेषज्ञता, सो नभएमा तालिम प्राप्त चिकित्सककर्मीले गर्नुपर्दछ ।
- परिक्षण गर्ने चिकित्सककर्मीले नै प्रतिवेदन तयार गर्नुपर्दछ ।
- सम्भव भएसम्म कम्प्युटर टाईप गरी प्रतिवेदन तयार गर्नुपर्नेछ, सो नभएसम्म स्पष्ट बुझिने गरी उल्लेख गर्नुपर्ने हुन्छ । साथै परिक्षण प्रतिवेदनको सक्कल प्रति नै संलग्न गर्नुपर्नेछ ।
- निर्धारित स्थानमा विवरण उल्लेख गर्न नपुग भएमा छुट्टै कागज प्रयोग गर्नुपर्नेछ ।

C: INJURY REPORT FORM

अनुसूची १६

(दफा २२ को उपदफा (१) सँग सम्बन्धित)

घाउ जाँचको फारामको ढाँचा

INJURY EXAMINATION REPORT

(IT IS USED IN CASE OF EXAMINATION OF DETAINEE ALSO)

1. Case Registration No.:
2. Name of the Office referred for injury examination (with letter ref. No. and Date):
3. Name, Age, Date of birth and Sex of the injured person:
4. Address:
5. Name of the accompanying Police Personnel:
6. Name of the Hospital/Health center:
7. Date, time and place of examination:
8. Identification mark of the examinee:
9. Consent for examination taken from:
   Injured person Family member or others
10. Brief history about the incident (how and when the injuries were produced?):
11. Medical history of the examinee:
12. General Physique and vitals :
    Height: Weight: Pulse: B.P:
    Temperature: Respiratory Rate: Consciousness:
13. Injuries (Name, Size, Site, Color, Surrounding area, signs of treatment, Bleeding Marks, Sign of Healings, any Imprints and content etc.):
    A. Type of injury
    a. Simple:
    b. Angabhanga (Grievous):
    c. Severe:
    d. Other remarks:

    B. Type of weapon/object used:
    a. Blunt force
    b. Sharpe force
    c. Pointed objects
    d. Projectile
    e. Heat
    f. Chemical
    g. Others (Specify)

C. Condition of the patient at the time of examination :
D. Severity (Explain the severity in terms of existing condition and possible complication):
E. Investigation and reports (for example X-ray, USG, Blood, Urine etc) :
F. Treatment provided (briefly) :
G. Referral (Where and Why?):
H. Follow up (if necessary) :
I. Re- Examination (Whether case needs information about grade of disability) :

Opinion: (Condition of examinee, severity of the injury, age of the injury and possible causative objects should be considered to frame opinion)

Name of the Examiner: Signature:
Qualification: - Medical Council / NHPC
Reg. No.: Office/Hospital/Health Centre: Date:
Seal of the Hospital/Health Centre:

द्रष्टव्य:

- परिक्षण कार्य सम्भव भएसम्म Forensic विषयको विशेषज्ञता, सो नभएमा तालिम प्राप्त चिकित्सककर्मीले गर्नुपर्दछ ।
- परिक्षण गर्ने चिकित्सककर्मीले नै प्रतिवेदन तयार गर्नुपर्दछ ।
- सम्भव भएसम्म कम्प्युटर टाईप गरी प्रतिवेदन तयार गर्नुपर्नेछ, सो नभएसम्म स्पष्ट बुझिने गरी उल्लेख गर्नुपर्ने हुन्छ । साथै परिक्षण प्रतिवेदनको सक्कल प्रति नै संलग्न गर्नुपर्नेछ ।
- निर्धारित स्थानमा विवरण उल्लेख गर्न नपुग भएमा छुट्टै कागज प्रयोग गर्नुपर्नेछ ।

D. Procedural response to physical abuse in Children

Patient identification Altered Name Code: ……
Name: …… Age: …… DOB: …… Sex: …….
Address: …….
Hospital ID number: ……..
Parents' details
Father –Name: ……., Age: ….., address: ……., contact number: …….
Mother- Name: ……., Age: …, address: ……, contact number: ……
(if different)
Details of person accompanying child, if different- with contact number
Name of School: ……., Class: ……
Referred by- Health Professionals/ Police/ School / Others- specify
Initial concern at presentation/ Background history-
Date and time of examination:
Place of examination:
Examining doctor:
Accompanying nurse: others present:
Name of lead consultant for the case Notified
History from the Parent/ guardian/ adult accompanying the child

History from the Child (where applicable)
Birth history
Developmental history
Any delayed development/ learning difficulty Y/ N
Immunization
Past medical history/ Medications
Family history (including name, age of all siblings)
Social history- alcohol, smoking, substance abuse. History of domestic violence, previous police involvements/ charges for offence

Consent for

1. Medical examination
2. Clinical photographs done by hospital medical photography/ Police
3. Medical/ Surgical procedures if required
4. Storage of samples, if required

General appearance
Child's interaction with parent's/ adults present
Growth- height weight head circumference (below 2 years age)
Scalp/ face/ mouth/ frenulum
Eyes/ ENT/ teeth
Central nervous system (fundi if indicated)
Respiratory
Cardiovascular
Abdominal (including external genitalia)
Skin- detail any scars, marks, bruises with description, measurement,
Use body maps
(Body map covering all views of external examination)

E. SCENARIO

A 12-month old boy (child x) was brought into the OPD by his mother Sita Lama for cough. He was seen by the junior doctor, Ramesh Sharma. The child was noted to have a few bruises on the cheek. Further examination revealed several bruises on the arm and buttock. Mother stated that the bruises occurred when the child fell off the bed few days ago. As doctor Sharma wasn't convinced, he decided to consult the senior registrar Dr. Ram Pradhan.

Dr Pradhan took a full history from the mother who kept changing her stories. She mentioned that the marks on the cheek and body were sustained by the child having fallen off the bed few days ago. This bed was low and child had fallen on a floor mattress. She did not seek medical attention as she thinks children often have falls and bruises. There was no other significant medical history. The family of three with the parents and child X lived in a 1 room rented accommodation. The father Ram Lama was a laborer and would drink daily. Mum denied any domestic violence and baby X had no other careers except his parents.

Doctor Pradhan examined the child in the presence of Dr. Ramesh Sharma, on duty staff nurse Rama Jha and the mother. On examination, child X appeared generally well. All his systemic examinations were unremarkable apart from him being underweight. On more detailed examination, the child had purple bruises on his right cheek which appeared well defined and linear. There were bruises on his left pinna and fading yellow- brown, linear bruise measuring 10 cm on the right arm. On the right buttock, there was an ill- defined bright red bruise measuring 2 cm. On lifting the child, he appeared to be in pain. Careful examination and palpation revealed the child had tenderness on the left lower arm.

Dr. Pradhan was suspicious and thought injuries were probably due to a non-accidental cause. The mother then changed her story and mentioned that the child may have crawled and fallen off the stairs when she had gone to collect water. On a more detailed questioning, she admitted they lived in the ground floor room and there was only a small single door step. Dr. Pradhan told the mother that he suspected these injuries were non-accidental. As per the hospital policy, he decided to carry out some investigations and make a referral to the relevant authorities. These included blood tests to rule out any underlying medical cause for easy bruising. He also ordered an X-ray of the arm. Mother provided a written consent to take photographs of all the bruises for the medical records. Father was asked to attend the hospital.

Blood reports were all normal. X-ray of the arm showed a metaphyseal fracture of the lower end of humerus with some callus formation. Dr Pradhan was now convinced that the injuries were as a result of abusive trauma. Child was referred to Orthopaedic department within the hospital. Paediatric consultant Dr Baral was requested to review and he was in agreement with all the findings as documented by Dr Pradhan. The information was shared with the local police Inspector, Mr Badri Subedi, social worker Ms Harimaya Gurung and the child protection officer from the wada (Bal kalyan Adhikrit) Mr Navraj Dhakal.

When the father Mr Ram Lama arrived, he appeared abusive but became quiet on seeing the security officer. The mother started crying and mentioned that the father used to often beat them both. Following this, the father made a confession saying he would get violent and assault the family after drinking heavily. He was soon taken into police custody. Child x was admitted to the medical ward to complete further investigations as per hospital protocol. A CT scan of the head, skeletal survey and ophthalmology test were arranged which were all reported as normal.

The following afternoon, a meeting was held in the presence of the child protection officer Mr Navraj Subedi , Dr Baral, Dr Pradhan, the police inspector, social worker and the NGO personnel Ms Thapa. Dr Pradhan updated the team about the progress and findings. The orthopedic team had put a plaster in the arm and prescribed a pain relief medication. Follow up was advised in six weeks coinciding with the medical OPD visit. Nutritional advice was provided.

Child X was discharged under the care of Ms Geeta Thapa along with his mother to a shelter home. Mother was cautioned regarding ongoing care. OPD follow up was advised to evaluate growth, ensure wellbeing and check on vaccination status.

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Tear from here

PRE TEST ANSWER SHEET FORM

Participants ID: ……
Please circle the best options below.

Question No. 1	a	B	c	D
Question No. 2	a	b	c	D
Question No. 3	a	b	c	D
Question No. 4	a	b	c	D
Question No. 5	a	b	c	D
Question No. 6	a	b	c	D
Question No. 7	a	b	c	D
Question No. 8	a	b	c	D
Question No. 9	a	b	c	d
Question No. 10	a	b	c	d
Question No. 11	a	b	c	d
Question No. 12	a	b	c	d
Question No. 13	a	b	c	d
Question No. 14	a	b	c	d
Question No. 15	a	b	c	d
Question No. 16	a	b	c	d
Question No.17	a	b	c	d
Question No. 18	a	b	c	d
Question No. 19	a	B	c	d
Question No. 20	a	B	c	d

Tear from here

Tear from here

POST TEST ANSWER SHEET FORM

Participants ID: ……
Please circle the best options below.

Question No. 1	a	B	c	D
Question No. 2	a	b	c	D
Question No. 3	a	b	c	D
Question No. 4	a	b	c	D
Question No. 5	a	b	c	D
Question No. 6	a	b	c	D
Question No. 7	a	b	c	D
Question No. 8	a	b	c	D
Question No. 9	a	b	c	d
Question No. 10	a	b	c	d
Question No. 11	a	b	c	d
Question No. 12	a	b	c	d
Question No. 13	a	b	c	d
Question No. 14	a	b	c	d
Question No. 15	a	b	c	d
Question No. 16	a	b	c	d
Question No.17	a	b	c	d
Question No. 18	a	b	c	d
Question No. 19	a	B	c	d
Question No. 20	a	B	c	d

Tear from here

Tear here from

Participants ID: ……

Course Evaluation Form

Child Protection Recognition and Response Training Course Evaluation

You are kindly requested to answer the following questions. Please comment on the Statements by using the tick in the appropriate column as follows.

1=Strongly disagree, 2= Disagree, 3=neutral option, 4= agree, 5= strongly agree

S.N.	Statements	1	2	3	4	5
1	The training was useful for my routine practice as a health professional					
2	The objectives of the training were clear.					
3	The topics/contents were relevant.					
4	The methods of teaching were relevant.					
5	The subject matter was understanble.					
6	The time allocation for different section was sufficient.					
7	My queries were adequately addressed.					
8	Facilitators had good facilitating skills.					
9	Please list 3 things that you liked about this training. 1. 2. 3.					
10	Please list 3 things that you would like to recommend for the improvement about this training. 1. 2. 3.					
11	How can you implement the concepts/methods emphasized in the training?					

NEPAL PAEDIATRIC SOCIETY
CHILD PROTECTION RECOGNITION AND RESPONSE TRAINING
SECOND EDITION CONSULTATIVE MEETING

Venue: NEPAS Office Baluwatar
Date: 27 Jan 2025 (14 Magh, 2081) Monday

Expert Participant

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