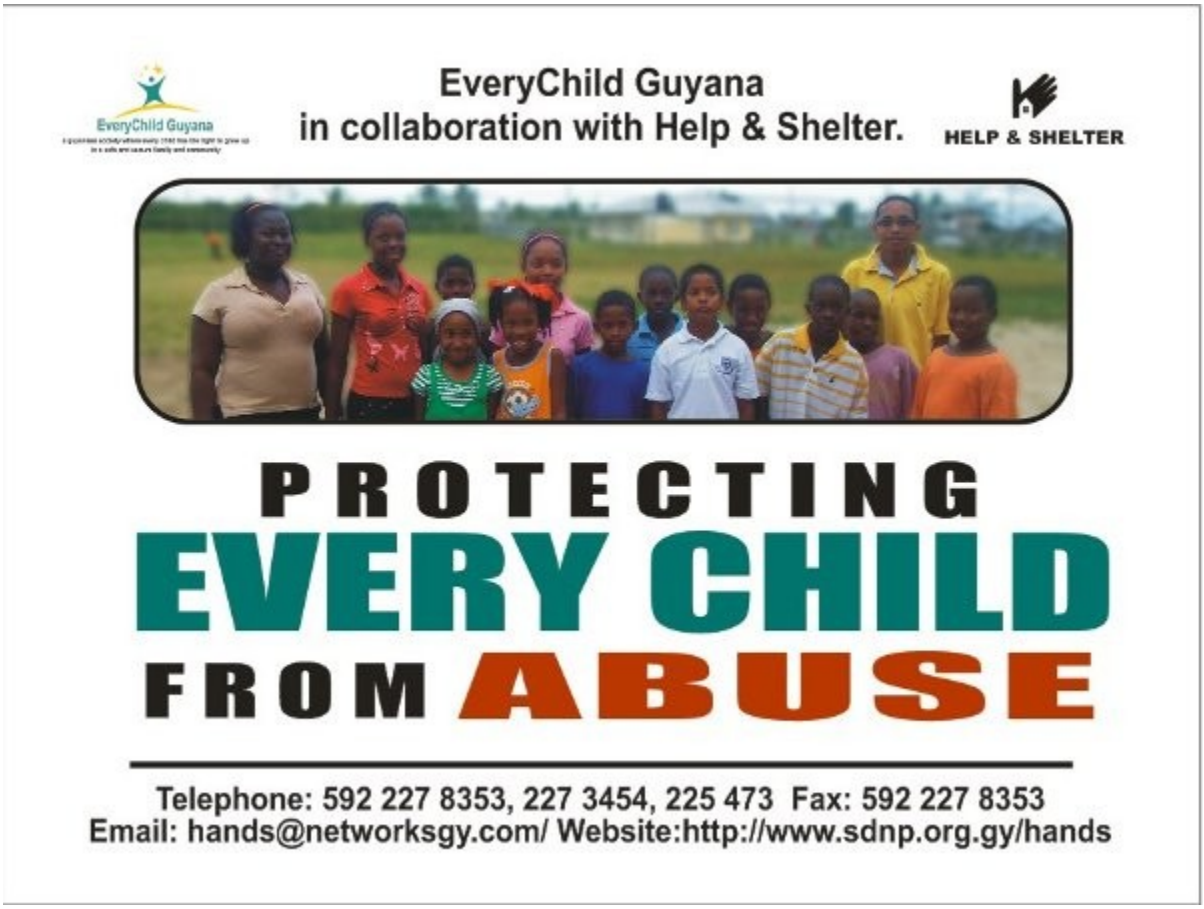
Facilitator Resource Kit : Training of Health Care Workers in Child Protection



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INTRODUCTION

1. Purpose of this Resource Kit

The purpose of this kit is to provide facilitators with resources to train nurses and other health care workers to make appropriate interventions when they discover that the children in their care have been abused.

The resource kit provides notes, activities and handouts. It contains a schedule of four sessions to be conducted in periods of two to two and half hours each. The facilitators and participants could work on the scheduling of the workshop if there is a different time allocated and arrange the topics according the learning needs.

This kit was prepared and tested with a workshop organised by the General Nursing Council of Guyana. Thanks must be expressed to the following people :-

- General Nursing Council
- Guyana Nurses' Association
- Mr Michael Gillis who was the pilot facilitator
- Dr Janice Jackson who helped with proofreading and organising the manual
- Ms Golda Gaskin who worked on proofreading and corrections during the pilot phase

2. Philosophy of learning

This kit assumes that the facilitators will be using a constructivist approach to learning in which the nurses and health care workers would be active participants in the learning. At the same time, there will be appropriate interventions to share facts and other information which may be new to the nurses and health care workers.

3. The Learning Objectives

The learning objectives are as follows :-
By the end of the Session 1, the participants should be able to:

- Define child abuse.
- Explain their role in preventing child abuse.
- Recognise cultural and personal factors which may hinder appropriate interventions in cases of child abuse.

By the end of the Session 2, the participants should be able to:

- Identify physical and behavioural indicators of child abuse.
- State the risk factors contributing to child abuse.
- Describe the effects of child abuse.

By the end of the Session 3, the participants should be able to:

- Link the stages of children development with the appropriate interventions.
- Identify helping strategies for children who have been abused.
- Identify techniques to probe suspicions of child abuse.

By the end of the Session 4, the participants should be able to:

- List situations in which health workers must report suspected cases of maltreatment.
- Demonstrate their capacity to take action in protecting a child by filing a child abuse report and using other strategies.
- Describe the legal framework for reporting child abuse.

Other learning objectives
Facilitators are encouraged to let participants also state their own learning objectives. They should encourage the participants to identify other strategies for addressing questions which they still have during the final evaluation.

4. Notes about Facilitation and being a Facilitator

4.1 What is a Facilitator?

A facilitator is one who uses methods of interaction with other people to enhance learning. A facilitator uses techniques which encourage discussion, dialogue, introspection and sharing of experiences.

4.2 Qualities of a facilitator

A facilitator has the following qualities:-

- Trusts other people and their abilities.
- Respects other people's ideas and experiences.
- Is willing to listen and has good listening skills.
- Has confidence and is humble.
- Is friendly, interested in people and their development and sensitive to their needs and feelings.
- Is creative, flexible and dynamic.
- Is open to feedback and willing to adjust or change accordingly.
- Is aware of their strengths and weaknesses, and is willing to learn more.
- Is alive, active and has a good sense of humour.
- Gets things done.
- Is mentally and physically organised and has a sense of order and system.
- Is skilled in participatory processes.
- Works well with a team or group.
- Is creative.
- Speaks clearly and uses simple words and short sentences.

Developing Facilitation Skills

There are several important skills that a facilitator can develop and use to create a safe and dynamic learning environment. Some of these skills are listed below with tips on their use.

a) Develop a relationship of trust with the participants.

- Be respectful, honest, open and friendly before, during and after the process.
- Conduct group work while sitting in a circle, whenever possible, the way people do in informal discussions. Sitting behind desks or tables may intimidate some participants and create a competitive setting for others.
- Encourage and value all the participants' contributions.
- Establish an informal and comfortable atmosphere using your words and actions.
- Emphasise that you are learning and growing through the process as well; avoid presenting yourself as the expert.
- Share the objectives of the process openly and address the expectations that the participants may have.

b) Structure the learning process in an understandable and meaningful way.

- Think and plan ahead about how to facilitate each activity so that the participants can feel that you are a reliable and credible person.
- Keep time and negotiate any major schedule changes with the participants.
- Share the timetable. Explain the flow of the process and obtain agreement. Be willing to modify the schedule if the group suggests alternatives.

c) Enable the participants to share their experiences meaningfully.

- Develop ground rules with participants at the beginning of the process to share responsibility for the outcome of your work together.
- Create a safe way for participants to introduce themselves to the group at the beginning of the process and thus help them feel that they are members of the group. A fun activity often works well.
- Protect shy and vulnerable participants from being forced into silence or revealing personal information inappropriately.
- Delegate some of the 'disciplinarian' roles to nominated members such as time keeping and monitoring whether the objectives are being met.
- Ask open-ended questions that help participants expand on what they are sharing and that help the group broaden their discussions.
- Emphasise in words and actions that all contributions are valid. Build on and make links between participants' contributions instead of searching for 'right answers'.
- Avoid pressuring participants or singling them out to share their views (e.g., calling on participants, when they are not ready, putting people on the spot). This may inhibit the participants and make them anxious about getting it wrong.
- Clarify what participants contribute using gentle probing questions and by repeating what you think is being said.
- Invite elaboration without embarrassing participants by using neutral questions such as“Can you

say more?"

- Extract meaning from a set of contributions by summarising them and linking them to form a collective understanding.

d) Intervene if you feel the group's objectives are being compromised.

- Seek contributions from different participants if one or two of them are dominating the group.
- Have a private word with a participant if s/he is promoting an agenda for personal instead of collective learning or one that opposes the group's learning objectives.
- Focus the discussion if it is becoming diffuse and straying from the objective of the workshop.
- Boost the energy of the group by introducing a game or a physical activity, especially if energy is low during a demanding discussion or the heat of the afternoon.

e) Ensure that the work remains a learning process.

- Summarise frequently, and always summarise at the end of each activity to highlight the collective learning that has occurred.
- End each session with an overview of the discussions and, if appropriate, questions for reflection until the next session.
- Begin each new session with an overview of the previous session's work and with an opportunity for participants to contribute reflections.
- Conduct an oral evaluation of the process and a written evaluation if appropriate. This allows the participants to come to a collective emotional understanding of the process.
- Ensure, whenever possible, that participants have had an opportunity to think about what they will do practically with what they have learned.
- Discuss, if appropriate, what support the participants will need, and who from, to apply what they have learned.

Every time you facilitate a learning process, the participants are placing their trust in you and therefore placing on you the responsibility to be as effective as you can be. Becoming an effective facilitator is primarily about having respect for the participants with whom you are working.

If you begin with that, then the rest will come with experience and practice. It is also important to believe in your ability to make a meaningful contribution to the development of the participants.

Keep learning from each process you facilitate and, above all, make it fun!

Facilitating a Training Session for nurses and healthcare workers

The modules are geared toward encouraging discussion, dialogue and introspection about issues of child abuse. In order to increase good open communication with participants, think of the following:-

- Remember to ask open-ended questions. This is a good way to start and continue a discussion. Open-ended questions start with: How, Why, When and What (e.g., "How does this affect you?", Why is this so?", What can we do to help/change this situation").

- Listen and acknowledge different opinions. If a participant introduces a controversial point, try to separate what is fact from opinion. **Should a disagreement occur, encourage participants to challenge the ideas, not the participant/participants.**

- Encourage lively discussions but avoid arguments. Because the issues in this manual are emotional topics for many, especially in the area of child abuse, people usually have strong convictions and discussions can become heated. If this happens you can call a time out and get participants to reflect on why this is happening (e.g., it could be a defence mechanism for someone who may be abusive or who may have suffered abuse but is in denial, or defending a parenting style that has been passed on to them.)

- Stay focused. When discussions seem to get off track, try to reintroduce the original issue being addressed.

- Listen. Ask everyone to listen to and respect each person's point of view before responding. It is important not only to understand what a person is trying to say, but also to allow her/him an opportunity to express herself/himself.

- Recognize that there are many views on any topic. The whole purpose of discussion is to share ideas/information –it is not about winning a discussion or being right.

- Do not feel you have to be an expert on all issues. If you do not know something, admit it. If a participant raises a difficult question, ask if anyone knows the answer. Or, if the question is important, state, "My understanding is that..., but I'll have to look into it further."

- State clearly from the beginning that abusive behaviour is not acceptable at any time including during this session. In discussions, differences will be respected but not abusive or insulting behaviour. Language that poisons the environment - words and ideas that are sexist, racist, or biased against particular groups of people (based on their nationality, age, sexual orientation, religion, or physical abilities) should be challenged. Discussion is great; hurtful words are not.

Your Role as Facilitator in Creating a Safe Environment

The modules in this training, especially those which deal with abuse, can be very emotionally charged and personal in nature. As a facilitator you need to create as safe a space as possible for participants to honestly discuss their experiences, opinions and feelings. The following points are suggested as ways to help create a safe environment.

<u>Respect</u>

As a facilitator you have to lead by example and make sure you demonstrate respectful behaviour yourself at all times. It is of vital importance to be sensitive and aware of differences or different perspectives being expressed by participants. At the same time, you need to be sensitive and aware of embarrassment, discomfort or emotional reactions that participants may be experiencing during the discussion of an topic.

Judgement
Be careful not to be judgemental in your opinions. Keep focused on the facts.

Safety and Ground Rules
At the very start of the workshop to encourage open discussion establish safety and ground rules. Ask participants what they need from you and each other in order to feel safe talking about issues, Some such rules may be

- Confidentiality.
- Respect for other opinions and views expressed.
- Avoidance of abusive language, labelling, name calling, insults or discrimination.

Another way to create safety for participants is to set up a 'question box' in which participants can anonymously ask questions that might be difficult to raise in front of other participants. As facilitator, you can then read aloud and answer these questions without reference to an individual.

Dealing with Disclosure

The issue of abuse may affect participants in a very personal way. In discussing sensitive topics and issues some participants may disclose previous or current abuse or assault. The following points may help when dealing with disclosure:

Find a Safe/Quiet Space
If possible talk with the participant in a quiet, safe atmosphere, where he/she will not be disturbed. Do not under any circumstances break the confidentiality of a participant unless the participant is at risk to herself/himself or others. If in doubt, refer the matter to Help & Shelter or a trained counsellor.

Listen
This may be the first time the participant has ever spoken about her/his experience. She/he may just need a willing ear and not require any action on your part.

Believe
It is very important that the participant feels understood and believed. Your demeanour should communicate that you believe what is being said.

Reassure
Reassure the participant that the abuse/assault is not her/his fault.

From the outset, do not make promises you cannot keep. Avoid making statements such as I'll take care of it"or I won't tell anybody." Make sure the participants understand what information can and cannot be kept confidential.

Preparation for the Session

- Ensure that you have made all arrangements and that the venue is confirmed. If it is possible, you might want to visit the selected venue for the sessions to familiarise yourself beforehand. Alternatively, you could plan to arrive about 20 minutes earlier than the scheduled start of your session so that you could ensure that the surroundings and room arrangement are comfortable and appropriate.
- Ensure that you have the materials you will need. Check the following:-
  Handouts
  Flip chart paper/News print, Tape, Markers Scissors
  Equipment

Ensure that you have your outline of the activities for the session with the participants.

Before the Session Begins

- Arrange the participants in a formation that allows you to see every participant.
- Outline the learning objectives for the particular session.

During the Session

- Refer to the session's topics and objectives.
- Check that quiet participants also get a chance to participate.
- Keep an eye on time management, allocate participatory activities with discussions and briefing points.

After the Session

- Conduct an evaluation of the session, and get feedback from the participants.
- Prepare a report which you can use for further learning.
- Check in with the organisers if necessary to make plans for follow-up sessions.

5. How to Use This Kit

This kit been provided as a resource for use by facilitators who would like to work with nurses and other health care workers.

- Before you begin a session, read through the manual and plan how you will facilitate the session.
- Look through the introduction to make sure you have all the materials ready prior to conducting the session.
- You may choose to facilitate the activity as described or adapt it for your group.
- Once you are familiar with the steps and the intent of the session, allow your creativity to flow.
- Ensure that the core knowledge, attitudes and skills are transferred within the allotted time period.
- Feel free to organise your own plan based on the objectives of the group. Some groups might want details on some areas. The sessions can be reorganised according to the needs of the group.

Session 1 : Defining Child Abuse and the role of health care workers in preventing child abuse

A. Learning Objectives:

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

- Define child abuse and identify forms of child abuse
- Understand the role of health care workers in preventing child abuse.
- Recognise cultural and personal factors which will hinder appropriate interventions in child abuse.

B. Materials

Flipchart paper, markers
Handouts
Post-it notes (or small squares of flip chart paper)
Sheets of letter size printing paper

C. Proposed Schedule

1. Introductions/Icebreaker
2. Setting group contract
3. Discussing participant expectations and learning objectives
4. Briefing on the role of the health care worker in preventing child abuse
5. Brainstorming exercise to define child abuse
6. Group activity on cultural factors which will hinder appropriate interventions in child abuse
7. Individual activity to look at personal factors
8. Evaluation of Session 1

C.1 Introductions/Icebreaker (10 minutes)

Facilitator Notes: Use an appropriate icebreaker for introductions. Some ideas are:

a) Ask each person to introduce herself/himself and to place an adjective before their name which starts with the first letter of their name.
b) Ask persons to pair up with someone they know the least. Ask them to introduce each other. Encourage them to share more than demographic information.
c) Ask people to move around the room until they find people who have a similar characteristic with them e.g., like the same food or the same TV show or have the same birth month. Let them introduce each other.

C.2 Setting Group Contract (5 minutes)

Facilitator Notes: Use this time to brainstorm some items for the training contract for the four sessions. This may include:-

- Punctuality.
- One person speaking at a time.

- Confidentiality if there are disclosures.
- Keeping time for exercises.
- Cell phones on vibrate or turned off.

Note that this contract is not limited and that it could be changed over the four sessions. Place it on a permanent space on the wall.

C.3 Review of Participant Expectations and Learning Objectives (5 minutes)

Facilitator Notes: Ask participants to write their expectations on post-it notes or on small squares of flipchart paper. Stick these up on the wall, reading out each one, grouping them according to theme if possible. Keep a record of these for the evaluation of this session and the other sessions. Match the participant expectations with the learning objectives, if possible. (Use the post-it notes and organise them according to the objectives.) Keep these handy since in every session, you can use them as part of the evaluation process.

Briefing Notes: This training programme is divided into four sessions. The objectives of the sessions are outlined in the programme printed for you. In addition, we hope to also answer some of the questions and find ways to meet your expectations before the end of the four sessions.

C.4 Why a training programme with nurses and healthcare workers? (3 minutes)

Briefing Notes: Any organization whose staff interacts with children, irrespective of class, ethnicity or economic strata, should ensure that the staff have an in-depth understanding of child abuse and strategies for its prevention. In the nursing profession, it is extremely important.

Nurses and healthcare workers are in a unique position as they may be among the first to identify incidents of child abuse, especially those that are severely physical. Several social, physical and other structures that exist to serve the populace make little provision for child protection.

Nurses and other healthcare workers have access to children, and in many instances, the nurse would be the only person to witness a survivor of child abuse, especially if the parents or guardians do not want to report the abuse.

The kind of intervention which a nurse or other health care worker makes will have an impact on the ability of the child to recover from the abuse.

The Protection of the Child Bill will also makes it mandatory for health care workers to report child abuse.

C.5 Defining Child Abuse (10 to 15 minutes minimum)

Facilitator Notes: Brainstorm some key points which will emerge in the definition of child abuse. Encourage the group to think of the physical, sexual, emotional, negligent and exploitative forms of abuse.

Briefing Notes: In Guyana, there are various definitions of the age of majority for different contexts. The Convention on the Rights of the Child considers any person up to 18 years of age a child. In Guyana, the age of consent for sex is 16 years.

Child Abuse consists of any action or omission of action which will impact negatively on the well being of a child. There are many definitions of child abuse. For our purposes, we will consider the World Health Organisation definition. In Guyana, the Protection of the Children legislation defines when a child is in need of protective intervention. This is discussed in Session 4.

We must note that poverty is not neglect. The definition of neglect is when resources are available and the adults do not access the resources for the best interests of the child.

Facilitator Notes: Share *Handout 1: World Health Organisation Definition of Abuse*. Check with participants as they review this definition whether they have any questions or comments about it.

C.6 Cultural Factors which Impact on the Prevention of Child Abuse (40 minutes)

Briefing Notes: Historically, children were seen as possessions and not as bodies with individual rights. Children were bought and sold in slavery sometimes by parents. In some cultures, girl children were killed, or twins were left to die. In many cultures, beating children persists as a form of discipline. Children were sacrificed as offerings to God. Sexual abuse of children was accepted in some cultures, while in others, there was a pretence that such abuse did not exist. Guyana's cultural history has some similarities. Many of us recognise now that child abuse is generally wrong. What are our cultural perceptions and how will this impact on our ability to intervene when we witness child abuse?

Facilitator Notes: Split the group into four. Share *Worksheet 1: Opinion Statements*, one per group. Ask the group to take five minutes to discuss how much they agree or disagree with the statement in question.

Bring the session back to plenary. Let each group present the statement and their view on the statement. The notes which are appended present some talking points to focus on the dilemmas involved in treating with children who are abused.

Facilitator Notes on Opinion Statements

"It is okay for parents and teachers to beat children as a form of discipline."
Use the discussion time to explain that our culture has tolerated the beating of children as a form of discipline. This has often resulted in injuries and even death of some children in Guyana. As we evolve as a country, we should be learning that the goal of discipline should be to teach and reinforce appropriate behaviours rather than use violence and pain.
Corporal punishment of children in schools is legal in Guyana. In some countries, corporal punishment is outlawed in schools. Some beatings have resulted in injuries. Parents and teachers are rarely punished for the physical violence inflicted on children.
What is happening in your homes? How will this impact your ability to intervene when you see a child who has been beaten and left with brands? What will you do if the parent is a friend of yours?

"The way some young teenage girls dress and behave, they looking to get rape."
There are perceptions that the way victims dress determines whether they would be raped or not. One of the difficulties in supporting rape victims is that many people seek to blame the victim – the way they were dressed, the places they walked, the fact they did not scream or that they were in some place they should not have been are used as excuses to blame. The perpetrators need to face the consequences, while victims should get the necessary support to recover from this exploitation.

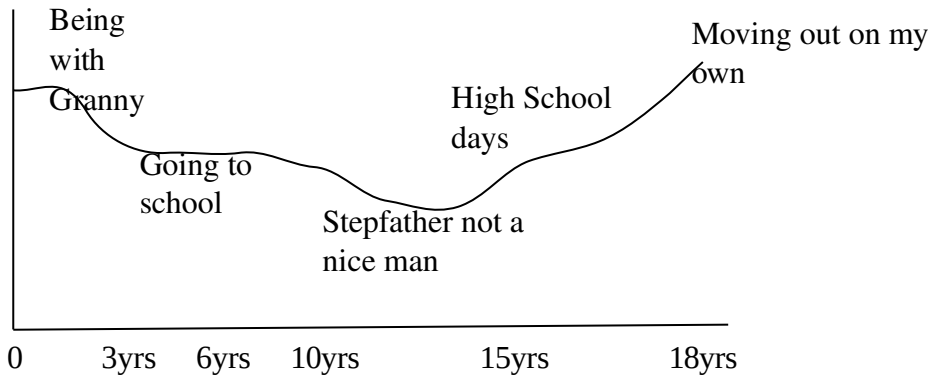
"Boys who are sexually molested or buggered should keep quiet."
Some statistical reviews in other countries suggest that boys and girls are sexually molested at the same rate. In Guyana, the sexual abuse of boys is rarely reported, unless the boys are in toddler or pre-teen ages. The prevailing homophobia in the country prevents the reporting of abuse. Many of the boys are ashamed and the abusers reinforce the shame, saying that people are not going to believe them. Why do people laugh when they hear of a boy being buggered? What is the first reaction which goes through people's heads? What impact would that have on a boy who has survived rape or sexual assault?

"Children should honour and obey their parents."
Our society has taught children to be obedient to their parents and other adults. This has resulted in many children being confused as to when to report abuse and in hiding abuse because they feel they have to protect their parents. Some children believe that they have to do what their parents tell them, even if they feel bad doing it. Some children in some families might feel that they should not report abuse so as to protect the family.

C.7 Lifeline Exercise – Individual Experiences of Childhood (45 minutes)

Briefing Notes: Let us reflect a bit and draw a graph. The horizontal axis represents different stages of our life, starting at age 0 to now. The vertical axis represents the ups and downs in our lives. Let us draw this graph and show the high points and low points of our lives on it. High points would be times when we had great happiness. Low points would be the time when me might recall pain. Start with our earliest memory. An example of a lifeline is on the next page.

An example of a lifeline would be as shown here.



Facilitator Notes: Discuss the lifeline. Ask each person to share her/his lifeline with the larger group. The purpose of the discussion is to reflect on how happy experiences are remembered, how adults remember sad experiences and how they survive.

This exercise can be modified and a few participants rather than all participants can share their lifeline experiences. Encourage participants to focus on any experiences of child abuse.

C8. Evaluation of the Session

Do a quick round to get any thoughts or experiences orally before the session ends. After oral comments are received, share out the evaluation form and ask persons to complete them. Remind participants that their names should not be written on the forms.

Handout 1.1 : Definition of Child Abuse[1]

General Definition

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

Physical abuse

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

Emotional abuse

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

Neglect and negligent treatment

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

Sexual Abuse

Child sexual abuse is the involvement of a child in sexual activity that he or she does not fully comprehend, is unable to give informed consent to, or for which the child is not developmentally prepared and cannot give consent, or that violate the laws or social taboos of society. Child sexual abuse is evidenced by this activity between a child and an adult or another child who by age or development is in a relationship of responsibility, trust or power, the activity being intended to gratify or satisfy the needs of the other person. This may include but is not limited to:

- The inducement or coercion of a child to engage in any unlawful sexual activity.
- The exploitative use of child in prostitution or other unlawful sexual practices.
- The exploitative use of children in pornographic performances and materials.

Exploitation

Commercial or other exploitation of a child refers to use of the child in work or other activities for the benefit of others. This includes, but is not limited to, child labour and child prostitution. These activities are to the detriment of the child's physical or mental health, education, or spiritual, moral or social-emotional development.

1 Taken from the World Health Organisation , *Report of the Consultation on Child Abuse Prevention, Geneva, 29-31 March 1999, World Health Organization, Social Change and Mental Health, Violence and Injury Prevention pp. 13-17.*

Worksheet 1 : Opinion Statements on Child Abuse[2]

“It is okay for parents and teachers to beat children as a form of discipline.”
“The way some young teenage girls dress and behave, they looking to get rape.”
“Boys who are sexually molested or buggered should keep quiet.”
“Children should honour and obey their parents.”

2 Print and cut out these statements so that they could be shared for the groups.

Evaluation Form: Session 1

Date :
Please complete this form and submit to the facilitator before you leave. You are not required to put your name on the form.

Please tick your answer to questions in the boxes to the left.			
	Yes, Definitely	**Somewhat**	**No, Not at All**
Did you understand the information presented?			
Did you learn new ideas or skills?			
Do you understand your role in preventing child abuse?			
Can you define child abuse?			
Do you understand the cultural factors which affect the prevention of child abuse?			
Do you feel comfortable talking about your own experience with child abuse?			
Did you like the way the workshop was facilitated?			

What was your favourite part of this session? ……..

…….

What did you not like about the session? ……..

……

How could the session be improved? ……..

……

How will you use the knowledge you have gained?.....

.....

…….

What would help to prepare you better to use the knowledge you have gained?
……

….....…

How useful are the handouts or leaflets that you received?.....

Session 2 : Effects of Child Abuse

{This session has some more 'lecture' type presentations since there is some theory to share}

A. Learning Objectives

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

- State the risk factors contributing to child abuse.
- Describe the effects of child abuse.
- Identify physical and behavioural indicators of child abuse.

B. Materials

- Flipchart, markers, masking tape
- Handouts to distribute
- Case Study slips

C. Proposed Schedule

1. Greetings
2. Recap of Session 1
   a. Review of contract
   b. Review of learning objectives for Session 1
   c. Participant expectations and overall learning objectives for the session
   d. The role of the nurse in child protection
   e. The definition of child abuse and the forms of abuse
   f. Cultural factors which affect nurses' and health care workers' response to child abuse
   g. Personal factors which affect nurses' and health care workers' ability to intervene in child abuse
3. Learning objectives for Session 2
4. Risk factors contributing to child abuse
5. Identifying physical and behavioural indicators of abuse
   a. Physical abuse
   b. Emotional/psychological abuse
   c. Neglect
   d. Sexual abuse
6. Evaluation of Session 2

C.1 Greetings (5 minutes)

Facilitator Notes: Greetings are used to reintroduce participants to each other and to ground the participants so that they can focus on the session.

a) Suggestion for Introductions (If not done before): Ask each participant to introduce themselves, using an adjective which begins with the first letter of their name, e.g.: Pretty Paula, Romantic Ramesh.

b) Seek from the group any thoughts or reflections on incidents related to what they have learnt during Session 1. These could include any cases they have seen, or reactions to any stories in the news.

C.2 Recap of Session 1 (10 minutes)

Facilitator Notes: This recap can be done by the facilitator alone going through the materials, or by asking the participants to review what they have learnt. Other methods include asking specific groups of people to prepare the recap session and to use any creative ways of doing the recap for the next session (e.g. through song, skit, dance).

1 Review of contract

Facilitators Notes : Review the training contract with the participants and check to see if there is anything which should be added or removed. This is a good time to remind about putting the Cell Phones in vibrate mode.

2. Participant expectations and overall learning objectives for the session

Facilitator Notes: Review the objectives and the participant expectations for the course which were listed in Session 1

3. The content of Session 1

Facilitator Notes: Review these topics, referring to the handouts and the discussions from Session 1

- The role of nurses and health care workers in child protection
- The definition of child abuse and the forms of abuse
- Cultural factors which affect nurses and health care workers' response to child abuse
- Personal factors which affect nurses and healthc are workers' ability to intervene in child abuse

C.3. Learning Objectives for Session 2 (5 minutes)

Facilitator Notes: Reflect on the learning objectives for this session.

C.4. Risk factors contributing to child abuse (25 minutes)

Facilitator Notes: The purpose of this session is to draw attention of participants to the factors which contribute to child abuse. This session can be done as a brainstorming/discussion session. The facilitator should be able to draw on the briefing notes below.

Handout 1: Risk Factors

Briefing Notes: There are different factors which contribute to the abuse of children. Some of these factors may occur alone while more than one may be present at any given them. Recognition of these factors could assist with the prevention of abuse. Abuse can happen in institutional settings such as schools , orphanages and other child care facilities. All of the contributory factors are not known, but research and anecdotal evidence suggests the following:-

COMMUNITY FACTORS

There are some child-rearing practices which are abusive and public education is needed to change these. Other community factors include lack of access to social and other services and limited access to resources to support child protection education. Communities with high levels of violence and tolerance for violence are likely to provide an environment in which child abuse is not detected or identified as such. Some communities might have religious or other cultural practices which are abusive to children.

PARENT FACTORS

History of child abuse. Unfortunately, the patterns we learn in childhood are often what we use as parents. Without treatment and insight, sadly, the cycle of child abuse often continues. As a result, many parents abuse children thinking that this is the normal way to rear children

Poor parenting skills. Parenting can be a very time intensive, difficult job. Parents caring for children without support from family, friends or the community can be under a lot of stress. Teen parents often struggle with the maturity and patience needed to be a parent. Caring for a child with a disability, special needs or difficult behaviours is also a challenge. Caregivers who are under financial or relationship stress are at risk as well. Poor parent-child interaction, negative attitudes and attributions about a child's behaviour and inaccurate knowledge and expectations about child development are other contributing factors.

Alcohol or drug abuse. Alcohol and drug abuse lead to serious lapses in judgment. They can interfere with impulse control making emotional and physical abuse more likely. Due to impairment caused by being intoxicated, alcohol and drug abuse frequently lead to child neglect and other forms of abuse.

Domestic violence. Witnessing domestic violence in the home as well as the chaos and instability that is likely to result is emotional abuse to a child. Frequently, domestic violence will escalate to physical violence against the child as well.[3]

Poverty and neglect.

Poverty means the lack of access to resources and in many cases, parents and caregivers who live in poverty go to all lengths to ensure that their children's needs are met. When considering issues of neglect, we should consider whether the parents and caregivers have made any effort to access the resources to ensure that the child's needs are met.

Corporal punishment and discipline.

The beating of children as a form of discipline has been an accepted cultural practice in many families in Guyana. There have been some severe cases of injuries, both physically and emotionally to the children. Some points to remember about discipline are:-

3 Modified from http://www.helpguide.org/mental/child_abuse_physical_emotional_sexual_neglect.htm [does this refer to dv, up to dv or the whole section on parent factors?]

DISCIPLINE helps a child learn a lesson that will carry over and positively affect future behaviour. ABUSE affects the future in a negative way, leading to anger, hatred and more deviant behaviour.

DISCIPLINE enhances the child's sense of self worth, helping the child learn self-control and thus becoming comfortable within the family and in society. ABUSE robs the child of self-worth and causes him/her to feel like an outcast and resentful.

DISCIPLINE is not shame or guilt. ABUSE is shame or guilt which satisfies the needs of the parents at the moment and undermines the self-image of the child.

DISCIPLINE is taught by example. But so is abuse!

- Discipline is a learning process; the goal is to teach appropriate behaviour.
- Abuse is not a learning process; the goal is to stop behaviour through infliction of physical and/or psychological pain.
- Abuse teaches avoidance of pain rather than alternative, acceptable behaviours.
- Abuse teaches resolution of conflicts with violence rather than with reason.

FACTORS WHICH INCREASE CHILDREN'S VULNERABILITY TO ABUSE

Age of children

The rate of documented maltreatment is highest for children between birth and 3 years of age. It declines as age increases.

Infants and young children, due to their small physical size, early developmental status and need for constant care, can be particularly vulnerable to certain forms of maltreatment, such as Shaken Baby Syndrome and physical neglect.[4]

Children and adolescents with disabilities:

Children with physical, cognitive, and emotional disabilities are 1.7 times more likely to be maltreated than children without disabilities.

Children who are perceived by their parents as "different" or those with special needs, chronic illnesses, or difficult temperaments may be at greater risk of maltreatment. The demands of caring for these children may overwhelm their parents. Disruptions may occur in bonding or attachment processes, particularly if children are unresponsive to affection or separated from parents by frequent hospitalization.[5]

In addition to the common risk factors for all children and adolescents, the following apply to children and adolescents with disabilities:

4 Http://www.childwelfare.gov
5 Http://www.childwelfare.gov

- May have developmental or communication difficulties that make disclosure of abuse difficult or impossible.
- May lack correct information or education about abuse prevention, sexuality and self-protection strategies (e.g., the right to say "no").
- May not understand the difference between a hygienic touch, an affectionate touch or an abusive touch.
- May have physical disabilities that prevent them from defending themselves or getting away.
- May depend on others to meet even their most basic needs (bathing, toileting, feeding) which creates an extreme imbalance of power.
- May have a desire to please or may have cognitive difficulties that make them overly trusting and easier to trick.[6]

C.5. Identifying Physical and Behavioural Indicators of Abuse (35 minutes)

Facilitator Notes: This session requires some discussions and brainstorming since there is a lot of theory to bring to the attention of the participants. This might be a good point in the discussion to do an energiser activity.

Activity: Divide the participants into four groups. Assign a different form of abuse – Physical abuse, Emotional abuse, Sexual abuse and Neglect – to each of the groups. Give each group a sheet of flipchart paper. Ask each group to draw a symbol representing a child in the middle of the paper (e.g., a stick drawing). Tell participants to write the signs of the relevant abuse on the paper.
In plenary, ask each group to mount its flipchart paper on the wall/board and the participants to walk around the room to see what the other groups have written. Then the facilitator can use the Briefing Notes to guide the discussion, summarizing key points and clarification groups responses, as necessary.

Handout 2: Signs of Physical Abuse
Handout 3: Shaken Baby Syndrome
Handout 4: Indicators of Emotional Abuse, Sexual Abuse and Neglect

Briefing Notes: Often we use the term “indicators” to refer to those specific behaviours, conditions or consequences that support suspicion of maltreatment. For example, certain types of bruises on a child might be an indicator of abuse. If a child is afraid to go home, or expresses fear of a parent, this might also be an indicator of abuse. However, remember that an indicator of abuse only indicates that abuse **may** have occurred.

1. Indicators of Physical Abuse

Physical Indicators (physical injuries)

6 http://childabusemd.com/disabilities/risk-factors.shtml

Nurses and health care workers are likely to see the after-effects: injuries that suggest abusive parental/caregiver behaviour. Injuries that have the following characteristics may indicate abuse has occurred:

Questionable bruises and welts or other injuries which are:

* On the face, lips, mouth
* On the torso, back, buttocks, thighs
* In various stages of healing
* Clustered
* Forming regular patterns
* Reflecting the shape of the object used to inflict the injury (electric cord, belt buckle)
* On several different body surface areas
* Regularly appearing after an absence, weekend, or vacation
* Consistent with human bite marks

Questionable burns

- Cigar or cigarette burns, especially on soles, palms, back or buttocks
- Immersion burns (sock-like or glove-like burns on feet or hands, or doughnut-shaped burns on buttocks or genitalia)
- Burns patterned like electric stove burner, iron, etc.
- Rope burns on arms, legs, neck or torso

Questionable fractures

* To the skull, nose, facial structure
* In various stages of healing
* Multiple or spiral (twisting) fractures

Questionable cuts and scrapes

* To the mouth, lips, gums, eyes
* To external genitalia

Remember, in all cases, consider the context. Look for a combination or pattern of indicators. Consider indicators along with the child's explanation of the injury, the child's developmental and physical capabilities and any behavioural changes you notice in the child.

All children get bumps and bruises. Recognizing when those bumps and bruises may be indicative of physical abuse is part of your task.

Inflicted physical injury most often represents severe corporal punishment. This usually happens when

the parent is frustrated or angry and strikes, shakes or throws the child. Physical abuse may also be an intentional, deliberate assault, such as burning, biting, cutting, and the twisting of limbs.

Remember, in all cases, consider the context. Look for a combination or pattern of indicators. Consider indicators along with the child's explanation of the injury, the child's developmental and physical capabilities, and any behavioural changes you notice in the child.

Behavioural Indicators
(refer to the flipchart exercise)
Physical abuse is frequently accompanied by certain child behaviours. These may include:

* Being uncomfortable with physical contact.
* Being wary of adult contact.
* Being apprehensive when other children cry.
* Showing behavioural extremes—aggression or withdrawal.
* Being frightened of parents.
* Being afraid to go home.
* Arriving at school early or staying late, as if afraid to be at home.
* Reporting being hurt by a parent.
* Complaining of soreness or moving uncomfortably.
* Wearing clothing inappropriate to the weather to cover the body.
* Chronically running away from home (adolescents).

How do you tell the difference between abuse and accidental injury?

Abuse and accidental injury can look similar, but there are important differences:

* Cuts and bruises caused from accidents normally occur in bony areas of the body (elbows, knees, etc.). Accidental injuries to soft tissue areas (stomach, buttocks) are less likely.
* If an injury happens often, it is less likely to be an accident.
* If multiple injuries are present, especially if they are in different stages of healing, it is less likely to be an accident.

If a series of injuries appear in a pattern or resemble an object (electrical cord, wooden spoon, etc.) the injury may have been inflicted. If the child's or caregiver's explanation for the injury is inconsistent with the facts, the injury would be suspect.
Shaken Baby Syndrome : Refer to the handout

a. Indicators of Emotional/Psychological Abuse

Physical Indicators
Emotionally maltreated children often show:

- Non-organic failure to thrive (infants)

- Speech disorders
- Developmental delays

Behavioural Indicators

The range of possible behavioural indicators of emotional maltreatment include:

- Habit disorders (sucking, biting, rocking)
- Conduct disorders (antisocial, destructive)
- Neurotic traits (sleep disorders, inhibition of play)
- Behavioural extremes (compliant, passive, undemanding, aggressive, demanding, raging)
- Overly adaptive behaviour (inappropriately adult, inappropriately infantile and needy)
- Self-destructive behaviour and suicide attempts
- Cruelty; seemingly taking pleasure in hurting other people or animals
- Delinquent behaviour

3. Indicators of Neglect

Physical Indicators

- Looks undernourished and is usually hungry
- Is often lethargic, as if the child has not slept well
- Has untreated injuries or maladies, like a badly infected cut or a toothache
- Chronically has injuries that you can attribute to a lack of supervision, including being harmed by others

Behaviours often associated with neglect :-

* Begging for or stealing food because of persistent hunger
* Noticeably poor hygiene
* Inappropriate dress for the weather
* Accidents and injuries
* Risky adolescent behaviour
* Promiscuity, drugs, and delinquency
* Being shunned by peers
* Clinging behaviour
* Poor ability to relate to others

Emotional consequences of neglect :-

* Poor self-esteem
* Attachment difficulties
* Emotional neediness
* Social problems; reduced pro-social behaviors

* Difficulty setting personal boundaries
* Inability to say “no” to inappropriate requests (related to neediness for attention)
* Impaired initiative

3. Sexual Abuse

Physical Indicators

Most physical indicators of child sexual abuse would be found on physical exam by a medical practitioner. Other professionals rely more upon behavioural, emotional, and cognitive/academic indicators in determining whether to suspect sexual abuse.

Behavioural Indicators

The range of behavioural indicators of child sexual abuse include:

* Expressions of age-inappropriate knowledge of sex and sexually “pseudo-mature” behaviours
* Sexually explicit drawings
* Highly sexualized play
* Expressions of unexplained fear of a person or place
* Avoiding or attempting to avoid a familiar adult
* Signs of post-traumatic stress disorder
* Nightmares
* Sleep interruptions
* Withdrawal
* A child’s statement

One of the strongest indicators of sexual abuse is a child’s report. When a child says that he/ she has been sexually abused, take the statement seriously. Resolve doubt in favour of the child and err on the side of protection.

Emotional Indicators

Sexual abuse is often a devastating breach of trust for a child. Furthermore, the adult usually tries to manipulate the child into collusion or silence (“this is our little secret”) with real or implied threats. This manipulation is far beyond the child’s ability to understand. Not surprisingly, the child may experience a range of emotional responses, including:

* Self-image problems
* Low self-confidence
* Guilt (“my fault”)

* Shame
* Depression
* Anxiety
* Mood swings

Other Effects of Child Abuse

Different children have different levels of resilience and ability to recover from traumatic events such as abuse. Other children may find coping mechanisms. Adult survivors of child abuse sometimes have flashbacks and some health related and psychological complications in adulthood.

Facilitator Notes: Activity Case Study Analysis (25minutes)

Divide the participants into groups. Share out the case studies for discussion – 10 minutes per group. Some notes for the discussion are included here.

1. Susan

Susan is a 5-year old child who presents with bruises on her cheek, her upper arm and on her torso. Her mother said she fell down on the stairs, that she is a tomboy and she is always falling down. What do you think?

Discussion: Research has shown that children who fall down stairs rarely have these kinds of injuries, and are likely to show these if they are carried by an adult who might trip. The location of the bruises on the soft parts of the body and the frequency indicate that some abusive behaviour is happening.

2. Craig

Craig has arrived at the clinic with bruises on his elbows and a bad scrape on his knee. When you ask what happened, he tells you that he was riding his bike on a busy street where his father had told him not to, he swerved to avoid a car, and he fell off. When you ask how he got hurt, he says it was in the fall. What do you think?

Discussion: The bruises are consistent with the explanation of a fall from the bike. They are on the bony parts of this body and not the soft parts.

3. Annie

Annie is a 5-year old child and is always dirty. She seems otherwise healthy and is happy around her parents. Is this neglect?

Discussion : Some children as part of play will get dirty quickly. If it is a problem of hygiene and an obvious lack of care, the parents of the child should be counselled on how to improve care and hygiene.

4. Josie

Josie's mother has brought her in after she fell down the steps. Josie's mother says cannot afford the spectacles for her child. Is this neglect?

Discussion: Neglect refers to situations when parents and caregivers do not use available resources to provide the health care for their children. It is likely that the parent may be unaware of places where she can get spectacles for her child.

5. Baby

One of your patients, Baby, is an alcoholic and you know that she has two children aged 8 and 9 years. They are not going to school, but seem otherwise healthy and well cared for and concerned about their mother. Is this neglect?

Discussion: Children of parents who are substance abusers are endangered since there could be periods of care. There are many reasons in Guyana why children do not go to school. An intervention could be done with the parent to ensure that the children are registered for school. While the parent might not intend to endanger the children, the caregivers can be concerned if the children are not cared for properly.

6. John

You observe some nursery-aged school children playing. One of them, John pulls down his pants to show his privates. He then asks the others to show their parts. When they say no, John insists and starts fighting with them. What do you think? What questions should you ask? Why?

Discussion: Young children will be curious about their body parts. However, the play is a cause of concern if the child is forcing other children to participate.

7. Nicky

A 15-year-old girl drinks poison and is She tells you that she does not want to live with her mother. What do you think? What questions should you ask? Why?

Discussion: The attempt at suicide and the revelation are signs that the relationship between the child and her mother are not going well. An intervention can be made to improve the parent-child relationship.

8. Mama

There is a mother with two children in your maternity clinic. The children are playing and the mother keeps shouting at them to stop. She also tells the children that they are no good and she is fed up with them. The children continue playing and laughing. What do you think? What would you do? What questions would you ask to find out?

Discussion: Some children are resilient and have coped with all sorts of abusive language from their parents. If the children are not obviously affected by their mother's words, then it would be important to counsel the mother on her parenting skills.

C.6 Evaluation and Closing of Session 2 (10 minutes)

Facilitator Notes: Conduct an oral evaluation of the session. Share out the evaluation form and ask the participants to complete them. Remind participants that their names should not be written on the forms.

Inform the participants of the time of and venue for Session 3. Share the objectives for Session 3.

Handout 2.1: Risk Factors for Child Abuse

Community Factors

There are some child-rearing practices which are abusive and public education is needed to change these. Other community factors include lack of access to social and other services, and limited access to resources to support child protection education. Communities with high levels of violence and tolerance for violence are likely to provide an environment in which child abuse is not detected or identified as such. Some communities might have religious or other cultural practices which are abusive to children.

Parent Factors

History of child abuse. Unfortunately, the patterns we learn in childhood are often what we use as parents. Without treatment and insight, sadly, the cycle of child abuse often continues. As a result, many parents abuse children thinking that this is the normal way to rear children

Poor parenting skills. Parenting can be a very time intensive, difficult job. Parents caring for children without support from family, friends or the community can be under a lot of stress. Teen parents often struggle with the maturity and patience needed to be a parent. Caring for a child with a disability, special needs or difficult behaviours is also a challenge. Caregivers who are under financial or relationship stress are at risk as well. Poor parent-child interaction, negative attitudes and attributions about a child's behaviour and inaccurate knowledge and expectations about child development are other contributing factors.

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Poverty and neglect.

Poverty means the lack of access to resources and in many cases, parents and caregivers who live in poverty go to all lengths to ensure that their children's needs are met. When considering issues of neglect, we should consider whether the parents and caregivers have made any effort to access the resources to ensure that the child's needs are met.

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DISCIPLINE helps a child learn a lesson that will carry over and positively affect future behaviour.
ABUSE affects the future in a negative way, leading to anger, hatred and more deviant behaviour.

7 Modified from http://www.helpguide.org/mental/child_abuse_physical_emotional_sexual_neglect.htm

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DISCIPLINE is taught by example. But so is abuse!

Factors which increase children's vulnerability to abuse

Age of children

The rate of documented maltreatment is highest for children between birth and 3 years of age. It declines as age increases. Infants and young children, due to their small physical size, early developmental status, and need for constant care, can be particularly vulnerable to certain forms of maltreatment, such as Shaken Baby Syndrome and physical neglect.[8]

Children and adolescents with disabilities:

Children with physical, cognitive, and emotional disabilities are 1.7 times more likely to be maltreated than children without disabilities.

Children who are perceived by their parents as "different" or those with special needs, chronic illnesses, or difficult temperaments may be at greater risk of maltreatment. The demands of caring for these children may overwhelm their parents. Disruptions may occur in bonding or attachment processes, particularly if children are unresponsive to affection or separated from parents by frequent hospitalizations.[9]

In addition to the common risk factors for all children and adolescents, those with disabilities are vulnerable because they:

- May have developmental or communication difficulties that make disclosure of abuse difficult or impossible
- May lack correct information or education about abuse prevention, sexuality, and self-protection strategies (e.g., the right to say "no")
- May not understand the difference between a hygienic touch, an affectionate touch, or an abusive touch
- May have physical disabilities that prevent them from defending themselves or getting away
- May depend on others to meet even their most basic needs (bathing, toileting, feeding) which creates an extreme imbalance of power
- May have a desire to please or may have cognitive difficulties that make them overly trusting and easier to trick [10]

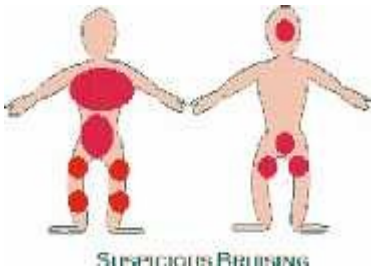
8 http://www.childwelfare.gov
9 http://www.childwelfare.gov
10 http://childabusemd.com/disabilities/risk-factors.shtml

Handout 2.2: Indicators of Physical Abuse[11]

Signs of physical abuse #1: Bruising

Bruising is the most common of abuse injuries. There are four factors to take into account when determining whether or not the bruising is suspicious: location, size, colour and frequency.

Normal Bruising


Suspicious Bruising

Normal bruising can be found on the knees, shins, elbows and the forehead. Toddlers are especially vulnerable to forehead bruising, as they frequently bump into furniture, counters, anything that is at their head level. But the size of the bruise(s), the colour, and the frequency in which bruising occurs can turn even normal bruising into suspicious bruising.

Suspicious bruising can be found on the face, head, chest, back, arms, genitalia, thighs, back of the legs and buttocks.

Size The size of the bruise(s) can tell us what object or body part the child was struck and/or harmed with. See under Beatings and Choking for more details on size of bruising.

Colour The colour of the bruise(s) can tell us how fresh the bruise is and the force with which the child was struck. The bruise can take on a red, purple, black or blue appearance on lighter coloured skin depending on the force of the blow. As the bruise heals it will turn green, then become a jaundice yellow before fading away completely.

Frequency The more frequent the bruising incidents occur, the more likelihood of physical child abuse. The child may have a legitimate reason for the bruising, but if there are too many incidences, then the red flags of suspicion should go up.

Signs of physical abuse #2: Beatings

The pattern of bruising and/or abrasions will resemble the shape of the object or body part used. The most common are belts, sticks, bats, bottles, and fists, but children are could also be attacked with firearms and knives.

11 http://www.child-abuse-effects.com/signs-of-physical-abuse.html

If a belt is used, there will be welts that are the width of the belt. There may also be bruising, and/or bleeding. The length of the welt depends on how much of the belt came in contact with the skin. Typically, caregivers who use a belt will strike the buttocks, the back and the backs of the legs.

If a child is beaten with a fist, the shape of the bruise(s) can be that of a whole fist or the bruising can show up as a cluster of lines (the imprint of the fingers of the fist). If the knuckles were used, bruising will be a line of roundish discolorations that are about the size of a five dollar coin, depending on the size of the fist. Caregivers who use their fists generally give blows to the face, head, chest, stomach and arms. Injuries are often to the face and head: black eyes, bloody and/or broken nose, fat and split lips, swelling of the eyes, cheeks or jaw, bruising and abrasions to the side of the head. Broken ribs and internal injuries can also result with severe blows to the chest and stomach.

Signs of physical abuse #3: Burning

Burning is the third most frequent cause of death in children from 1 - 14 years of age, and the fourth most frequent in children under one year of age (Feldman, 1987, p. 1972). 70 - 90% of childhood burns occur in the home during the winter months, early morning and late afternoons being the most vulnerable times (Feldman, 1987, p. 1983).

There are several kinds of burns: chemical, cigarette, electrical, heat and water burns. Each presents its own unique signs of physical abuse.

With chemical burns on the skin's surface, depending on the chemical used, there can be a rash, blistering, and/or open sores that have pus and/or bleeding. When caustic substances such as lye or acid are thrown, they are typically aimed at the child's face. If a child is forced to ingest chemicals, there will likely be nausea, vomiting, cramping, chest and abdominal pain, distension, and possibly unconsciousness.

Cigarette burns will be the size and shape of the cigarette tip. Typically, caregivers who burn children/youth with cigarettes, do so on the backs of the arms, the buttocks, and the backs of the legs.

Electrical burns appear as black marks at the site of the burn, and can extend beyond, depending on the electrical appliance used, and the volts of electricity the child is exposed to. Size and shape are also determined by these latter two factors.

Heat burns such as that from a flame and/or flammable liquid can encompass any part of the body. If clothing is ignited, the whole body can be burned. Victims of this type of burning are often older children.

It is important to note here that not all water burns constitute signs of physical abuse. Accidental water burns generally appear as a splatter of splash burns. With non-accidental water burns, excessive splash marks will appear above the site of the primary impact, on body parts where accidental burning is

unlikely. A child who is held under flowing hot water or immersed in scalding water will learn that the pain is lessened if they keep perfectly still. What results is what the medical profession calls the red sock or red glove. There will be a clear margin of colourations which are different from the colour of the skin starting where the water line was and continue to all parts of the body that were immersed, typically, the buttocks, legs, feet and hands. Eventually, there will be peeling of skin layers.

Signs of physical abuse #4: Choking and Hanging
With these signs of physical abuse, a child who is choked will have bruising around the front and back of the neck that will resemble the fingers and thumb of the caregiver doing the choking. The bruising can also take the shape of a red band, depending on the pressure used, the length of time the pressure was exerted, and how much of the hand came in contact with the skin. If the caregiver is facing the child, the bruises at the front of the neck will be two thumb imprints, while the bruising at the back of the neck will be a tier of finger marks. This will be reversed (finger marks at the front, thumb marks at the back of the neck) if the caregiver is behind the child when doing the choking.

Bruising and possibly 'rope burns' around the neck will be evident when a child is hanged. The bruising will take on the imprint of the rope or material used to hang the child.

With these two signs of physical abuse, the child may be hoarse and/or have a cough, especially immediately and shortly after the choking or hanging incident. Damage to the larynx can occur in more severe cases. In extreme incidences, the neck may be broken.

Signs of physical abuse #5: Smothering and Drowning
During smothering, a child's breathing may be compromised, but other than this immediate effect, there may not be any noticeable physical abuse evidence. There can be bruising around the face, especially the nose and eyes and upper chest area, depending on the item used to do the smothering and the force exerted to asphyxiate the child. With drowning, there may be hand or finger bruising at the back or side of the neck or at the shoulders where the child was held under water with force. The child's breathing may be jeopardized on a more long-term basis when these two signs of physical abuse are done regularly. If the child's breathing is raspy or the child has difficulty catching his/her breath, this may be a sign of smothering or drowning.

Signs of physical abuse #6: Poisoning
Poisoning may be difficult to detect because quantity is what determines the ill effects. Children can be poisoned with drugs, dish liquid, gas (i.e., combination of ammonia and bleach) and other noxious substances. A child who has been poisoned may suffer from nausea, vomiting, abdominal cramping, diarrhea, lethargy, sleepiness, light-headedness, dizziness and, in more severe cases, unconsciousness. When noxious substances are force-fed to a child, depending on the substance, signs of physical abuse are: redness, chemical burns or bleeding in and around the mouth. If a child is forced to ingest dish liquid, the child will not be able to control his/her bowels and a rash may be present around the mouth and lips.

Signs of physical abuse #7: Hair-pulling
Thinning hair and bald patches on the scalp may be present with severe hair-pulling. The child may experience headaches, and may also exhibit neck pain if the hair-pulling incidents are accompanied with jerking or snapping of the child's head.

Signs of physical abuse #8: Pushed from Heights
Bruising and broken bones are the most common abuse injuries when a child is pushed from heights. If a child is pushed down a flight of stairs, bruising may be present anywhere and everywhere on the child's body.

Signs of physical abuse #9: Shaken Baby Syndrome
(See separate handout)

Signs of physical abuse #10: Munchausen Syndrome by Proxy
Munchausen Syndrome by Proxy (MSBP), also known as *fictitious disorder,* is defined as "the deliberate production or feigning of physical or psychological signs or symptoms in another person who is under the individual's care, motivated by a psychological need to assume the sick role by proxy" (Barnett, Ola, et al., 1997, p. 449). Generally, the victim is under the age of five and the perpetrator of the physical child abuse is most often the child's mother. Perpetrators may use the following to cause the victims' illness, resulting in a variety of signs of physical abuse:

- Administering laxatives, causing severe diarrhea and dehydration.
- Applying substances to the skin that cause burns or rashes.
- Altering lab test results.
- Withholding required medication or over/under medicating.
- Administering barbiturates, anti-depressants and/or poisonous substances.
- Contaminating the child's urine sample with blood, faeces or other substances.

Munchausen Syndrome by Proxy results in the child suffering from the caregiver's actions. The child is at risk for long-term psychological problems, physical illnesses as well as death. Health care professionals unknowingly become accomplices when they provide unnecessary and potentially dangerous testing procedures and therapies. MSBP is very difficult to prove, in part, because this form of physical child abuse is so difficult to believe. Often, it is only suspected after a child is repeatedly admitted to hospital for treatment. The red flag for MSBP is when the child exhibits no symptoms or illness when the caregiver is away from the child for an extended period of time.

Perpetrators of MSBP may be motivated by the support, sympathy and attention they receive from health care workers. Family and friends are often supportive of what seems to be a very loving, concerned and caring mother anxious to get help for a sick child. Some perpetrators have considerable experience and/or knowledge in health-related areas and may enjoy working with health care staff (Barnett, Ola, et al., 1997, p. 4410).

Handout 2.3: Abusive Head Trauma (Shaken Baby Syndrome)

Abusive head trauma/inflicted traumatic brain injury or AHT (also called shaken baby/shaken impact syndrome or SBS) is a form of inflicted head trauma.

AHT can be caused by direct blows to the head, dropping or throwing a child, or shaking a child. Head trauma is the leading cause of death in child abuse cases in the United States.

How These Injuries Happen

Unlike other forms of inflicted head trauma, abusive head trauma results from injuries caused by someone vigorously shaking a child. Because the anatomy of infants puts them at particular risk for injury from this kind of action, the vast majority of victims are infants younger than 1 year old. The average age of victims is between 3 and 8 months, although these injuries are occasionally seen in children up to 4 years old.

The perpetrators in these cases are most often parents or caregivers. Common triggers are frustration or stress when the child is crying. Unfortunately, the shaking may have the desired effect: although at first the baby cries more, he or she may stop crying as the brain is damaged.

When someone forcefully shakes a baby, the child's head rotates about the neck uncontrollably because infants' neck muscles aren't well developed and provide little support for their heads. This violent movement pitches the infant's brain back and forth within the skull, sometimes rupturing blood vessels and nerves throughout the brain and tearing the brain tissue. The brain may strike the inside of the skull, causing bruising and bleeding to the brain.

The damage can be even greater when a shaking episode ends with an impact (e.g., hitting a wall or a crib mattress), because the forces of acceleration and deceleration associated with an impact are so strong. After the shaking, swelling in the brain can cause enormous pressure within the skull, compressing blood vessels and increasing overall injury to its delicate structure.

Normal interaction with a child, like bouncing the baby on a knee, will **not** cause these injuries, although it's important to **never** shake a baby under **any** circumstances because gentle shaking can rapidly escalate.

What Are the Effects?

AHT often causes irreversible damage. In the worst cases, children die due to their injuries.

Children who survive may have:

- Partial or total blindness.
- Hearing loss.
- Seizures.
- Developmental delays.
- Impaired intellect.

- Speech and learning difficulties.
- Problems with memory and attention.
- Severe mental retardation.
- Cerebral palsy.

Even in milder cases, in which babies looks normal immediately after the shaking, they may eventually develop one or more of these problems. Sometimes the first sign of a problem isn't noticed until the child enters the school system and exhibits behavioural problems or learning difficulties. But by that time, it's more difficult to link these problems to a shaking incident from several years before.

Signs and Symptoms

In any abusive head trauma case, the duration and force of the shaking, the number of episodes and whether impact is involved all affect the severity of the infant's injuries. In the most violent cases, children may arrive at the emergency room unconscious, suffering seizures or in shock. But in many cases, infants may *never* be brought to medical attention if they don't exhibit such severe symptoms.

In less severe cases, a child who has been shaken may experience:

- Lethargy
- Irritability
- Vomiting
- Poor sucking or swallowing
- Decreased appetite
- Lack of smiling or vocalizing
- Rigidity
- Seizures
- Difficulty breathing
- Altered consciousness
- Unequal pupil size
- An inability to lift the head
- An inability to focus the eyes or track movement

Unfortunately, unless a doctor has reason to suspect child abuse, mild cases (in which the infant seems lethargic, fussy, or perhaps isn't feeding well) are often misdiagnosed as a viral illness or colic. Without a diagnosis of child abuse and any resulting intervention with the parents or caregivers, these children may be shaken again, worsening any brain injury or damage.

If shaken baby syndrome *is* suspected, health workers may look for:

- Hemorrhages in the retinas of the eyes.
- Skull fractures, Swelling of the brain.
- Subdural hematomas (blood collections pressing on the surface of the brain).
- Rib and long bone (bones in the arms and legs) fractures
- Bruises around the head, neck or chest.

Handout 2.4: Indicators of Neglect, Emotional Abuse and Sexual Abuse

Neglect

Some Signs of Neglect:

- Unkempt appearance
- Lack of medical or dental care
- Poor hygiene
- Abandonment
- Child unusually small for his/her age
- Child is very thin and always hungry
- Child is rifling through garbage for food

Some Behaviours of a Neglected Child:

- Begs for food
- Stealing
- Lack of interest
- Tired and listless
- Passive or aggressive
- Poor attendance at school
- Rocking
- Isolation
- Depression
- In infants, failure to thrive
- Difficulty concentrating
- Difficulty learning
- Low self-esteem

Some Signs of Emotional Abuse:

- Physical problems resulting from stress
- Poor performance at school
- Low self-esteem
- Low confidence
- Constantly putting self down

In boys

- Aggression
- Temper tantrums
- Fights with peers and siblings
- Bullying tactics
- Frustrates easily
- Disobedience
- Lying and cheating
- Destructive behaviours
- Impulsive behaviours
- Tease excessively
- Worry excessively
- Withdrawn

In girls

- Withdrawn
- Passive
- Approval-seeking
- Compliant
- Frustrates easily
- Infinite patience
- Clinging to adults
- Overly dependent
- Stubborn
- Tease excessively
- Worry excessively
- Somatic complaints

Sexual Abuse

Physical signs

- Physical trauma such as redness, rashes, and/or bleeding to oral, genital and/or anal areas
- Bruises on breasts, buttocks, lower abdomen, thighs, genital and/or rectal areas
- Complaints of pain or itching in genital or anal areas
- Difficulty walking or sitting
- Unusual or offensive body odours
- Difficulty in bladder or bowel control
- Constipation
- Pain or discomfort on urination
- Blood in urine
- Abnormal dilation of vaginal or rectal openings
- Foreign bodies in vaginal, rectal or urethral openings
- Sexually transmitted diseases found vaginally, rectally or orally
- Yeast or bacterial infections
- Frequent sore throats; difficulty swallowing; choking
- Sudden weight gain or extreme weight loss
- Severe psychosomatic complaints such as stomach aches and headaches

Some Behaviours of a Sexually-abused Child

- Promiscuous sexual behaviours
- Resist physical contact
- Obsession with private parts
- Fearful
- Self-destructive
- Suicidal
- Withdrawal
- Depression

Worksheet 2 : Case Studies on child abuse[12]

Facilitator Note: Print and cut out each case study to share for discussion.

1. Susan Susan is a 5-year old child who presents with bruises on her cheek, her upper arm and on her torso. Her mother said she fell down on the stairs, that she is a tomboy and she is always falling down. What do you think?
2. Craig Craig has arrived at the clinic with bruises on his elbows and a bad scrape on his knee. When you ask what happened, he tells you that he was riding his bike on a busy street where his father had told him not to, he swerved to avoid a car, and he fell off. When you ask how he got hurt, he says it was in the fall. What do you think?
3. Annie Annie is a 5-year old child and is always dirty. She seems otherwise healthy and is happy around her parents. Is this neglect?
4. Josie Josie's mother has brought her in after she fell down the steps. Josie's mother says cannot afford the spectacles for her child. Is this neglect?
5. Baby One of your patients, Baby, is an alcoholic and you know that she has two children aged 8 and 9 years. They are not going to school, but seem otherwise healthy and well cared for and concerned about their mother. Is this neglect?
6. John You observe some nursery-aged school children playing. One of them, John pulls down his pants to show his privates. He then asks the others to show their parts. When they say no, John insists and starts fighting with them. What do you think? What questions should you ask? Why?
7. Nicky A 15-year-old girl drinks poison and is She tells you that she does not want to live with her mother. What do you think? What questions should you ask? Why?
8. Mama There is a mother with two children in your maternity clinic. The children are playing and the mother keeps shouting at them to stop. She also tells the children that they are no good and she is fed up with them. The children continue playing and laughing. What do you think? What would you do? What questions would you ask to find out?

12 Extracted from http://www.vcu.edu/vissta/training/va_teachers/topic1_1.html

Evaluation Form: Session 2

Date:
Please complete this form and submit to the facilitator before you leave. You are not required to put your name on the form.

Please tick your answer to questions in the boxes to the left.			
	Yes, Definitely	**Somewhat**	**No, Not at All**
Did you understand the information presented?			
Did you learn new ideas or skills?			
Can you identify some risk factors of abuse?			
Can you recognise the signs of physical abuse?			
Can you identify the signs of emotional abuse?			
Can you recognise the signs of neglect?			
Can you identify the signs of sexual abuse?			
Did you like the way the session was facilitated?			

What was your favourite part of this session? ……..

…….

What did you not like about the session? ……..

……

How could the session be improved? ……..

……

How will you use the knowledge which you have gained?.....

.....

…….

What would help to prepare you better to use the knowledge you have gained? ……..

……
How useful are the handouts or leaflets that you received?.....

Session 3 : Helping Strategies

A. Learning Objectives

By the end of the Session 3, the participants would be able to:

- Link the stages of child development with the appropriate interventions
- Identify helping strategies for children who have been abused
- Identify techniques to probe suspicions of child abuse and practise them

B. Materials

1. Flipchart, markers, masking tape
2. Handouts to distribute
3. Flipchart sheets from Session 2 which could be used for recap session
4. Training contract flipchart
5. Participant Expectation flipchart
6. Work sheets
7. A pair of scissors
8. Name Tags

C. Proposed Schedule

1. Greetings
2. Recap of Session 2
   i. Review contract and evaluation of Session 2.
   ii. Review topics from Session 2.
   iii. State the risk factors contributing to child abuse.
   iv. Describe the effects of child abuse.
   v. Identify physical and behavioural indicators of child abuse.
3. Present learning objectives for Session 3.
4. Discuss the stages of a child's psychosocial development.
5. Identify and practise techniques to probe suspicions of child abuse.
6. Evaluation of Session 3

C.1 Greetings (5 minutes)

Facilitator Notes: The greeting session is used to reintroduce participants to each other and to ground the participants so that they can focus on the session.

Reflections

Seek from the group any thoughts or reflections on incidents related to what they have learnt since Session 2. These could include any cases they have seen or reactions to any stories in the news or any incidents which they have come into contact with.

Note any issues or questions which they would like answered if these are to be done during the session.

C.2 Recap of Session 2 (10 minutes)

1. Review of contract

Facilitator Notes: Review the training contract with the participants and check to see if there is anything which should be added or removed. This is a good time to remind participants about putting the cell phones in vibrate mode.

The training contract should be visible during all sessions.

2. The content of Session 2

Facilitator Notes: Review these topics, referring to the handouts and the discussions from Session 2. If you had asked a group of participants to do the recap activity, ask them now to present.

Ensure that the participants are reminded about these learning objectives during this recap session. The participants should be able to:

- State the risk factors contributing to child abuse
- Describe the effects of child abuse
- Identify physical and behavioural indicators of child abuse

If you wish, identify the group of participants who would work on the recap of the session which is to follow. If this method is chosen, you should rotate among participants.

C.3 Learning Objectives for Session 3 (5 minutes)

Facilitator Notes: State the learning objectives for this session, and any of the participant expectations which might be linked to them. These participant expectations would have been recorded in Session 1. The objectives should be written on flipchart paper.

Briefing Notes: By the end of the Session 3, it is expected that you the participants would be able to:

- Link the stages of child development with the appropriate interventions
- Identify helping strategies for children who have been abused
- Identify techniques to probe suspicions of child abuse and practise them

C.4 Stages of Psychosocial Development (40 minutes)

Facilitator Notes: The purpose of this session is to introduce the participants (or to remind them if they have known this before) of the stages of psychosocial development as posited by Erik Erikson, psychologist from the 20th century who theorised on social development. The proposed methodology is to use the Briefing Notes to explain the stages of development. If time does not permit, share the handout and highlight the importance of understanding child development. The activities will involve

participants determining the effects of child abuse on the development of the child and allow participants to start to think of the interventions needed for recovery.

Briefing Notes[13]: (10 minutes)

Erikson emphasized psychosocial development and theorized that:-

1. Human personality continues to develop throughout one's life.
2. Humans develop personalities by moving through a series of stages. He hypothesized 8 major stages of development, each of which contains a developmental task that presents to individuals a crisis that they must resolve.
3. Healthy personalities are the result of mastering life's tasks.
4. Personality development does not end at age 5, 6 or 7, rather for all of us, there are significant events that shape who we are throughout our lives.

The first five stages relate to child development.

[Share the handout 3.1 at this part of the session]

Psychosocial Stage 1 - Trust vs. Mistrust

The first stage of Erikson's theory of psychosocial development occurs between birth and one year of age and is the most fundamental stage in life.

Because an infant is utterly dependent, the development of trust is based on the dependability and quality of the child's caregivers.

If a child successfully develops trust, he/she will feel safe and secure in the world. Caregivers who are inconsistent, emotionally unavailable or rejecting contribute to feelings of mistrust in the children they care for. Failure to develop trust will result in fear and a belief that the world is inconsistent and unpredictable.

Psychosocial Stage 2 - Autonomy vs. Shame and Doubt

The second stage of Erikson's theory of psychosocial development takes place during early childhood and is focused on children developing a greater sense of personal control.

Erikson believes that learning to control one's body functions leads to a feeling of control and a sense of independence.

Other important events include gaining more control over food choices, toy preferences and clothing selection.

Children who successfully complete this stage feel secure and confident, while those who do not are left with a sense of inadequacy and self-doubt.

13 Extracted from Training Manual for Childcare Counsellors prepared by Helen Braganza-Guillermo, for Everychild Guyana

Psychosocial Stage 3 - Initiative vs. Guilt
During the preschool years, children begin to assert their power and control over the world through directing play and other social interaction.

Children who are successful at this stage feel capable and able to lead others. Those who fail to acquire these skills are left with a sense of guilt, self-doubt and lack of initiative.

Psychosocial Stage 4 - Industry vs. Inferiority
This stage covers the early school years from approximately age 5 to 11.

Through social interactions, children begin to develop a sense of pride in their accomplishments and abilities. Children who are encouraged and commended by parents and teachers develop a feeling of competence and belief in their skills. Those who receive little or no encouragement from parents, teachers or peers will doubt their ability to be successful.

Psychosocial Stage 5 - Identity vs. Confusion
During adolescence, children are exploring their independence and developing a sense of self.
Those who receive proper encouragement and reinforcement through personal exploration will emerge from this stage with a strong sense of self and a feeling of independence and control. Those who remain unsure of their beliefs and desires will feel insecure and confused about themselves and the future.

The other stages relate to adulthood and are not discussed in detail. The information is shared for knowledge.

C.5 Questioning and Probing Techniques for Children who have been Maltreated (30 minutes)

Facilitator Notes: In this section some techniques are presented to the participants as to how to interview and question children who have been maltreated. The methodology is to present some information as briefing notes.

The participants then practise these skills in role plays which are meant to highlight the skills.

Briefing Notes:

The objectives of the interview with a child are to:-

- Build a trusting relationship where the child can communicate freely without fear of judgement.
- Establish what has happened to the child so as to provide effective care.
- Reduce the child's fear and distrust of other people.
- Reassure the child that they have done nothing wrong and are not to blame for the abuse if they feel that way.

Interviewing guidelines are presented on the handouts and organised in the following sections:-

- Basic principles when interviewing a child
- General interviewing skills
- Things to avoid when interviewing

Activity: Practising the skills in role play; Worksheet 3.1 has the role plays. (20 minutes)

Divide the participants into groups of three persons.
One person will play the role of nurse, another person the child patient and a third person will observe the interaction. Each person should be assigned a child role so that all persons get a chance to practise the skills.

Assign each scenario to the members of the group in rotation. Each person in a trio should have a chance to practise the interview skills.

After each round, debrief with the groups as follows:-

- Ensure that the person who was playing the child role has been able to come out of the role and is not affected by the role.
- Ask what interview skills were used.
- Identify any difficulties experienced by the persons playing the role of the nurse Do not focus on the role of the child.
- Clarify any questions or conflicts which might have arisen in the role play

C.6. Evaluation and Closing of Session 3 (10 minutes)
Facilitator Notes: Do a quick round to get any thoughts or experiences orally before the session ends. After oral comments are received, share out the evaluation form and ask persons to complete them. Remind participants that their names should not be written on the forms.

Remind the participants of the time and venue for Session 4. Share the objectives for session 4.

Handout 3.1 Summary Chart: Erikson's Psychosocial Stages[14]

Stage	Basic Conflict	Important Events	Outcome
Infancy (birth to 18 months)	Trust vs. Mistrust	Feeding	Children develop a sense of trust when caregivers provide reliability, care, and affection. A lack of this will lead to mistrust.
Early Childhood (2 to 3 years)	Autonomy vs. Shame and Doubt	Toilet Training	Children need to develop a sense of personal control over physical skills and a sense of independence. Success leads to feelings of autonomy, failure results in feelings of shame and doubt.
Preschool (3 to 5 years)	Initiative vs. Guilt	Exploration	Children need to begin asserting control and power over the environment. Success in this stage leads to a sense of purpose. Children who try to exert too much power experience disapproval, resulting in a sense of guilt.
School Age (6 to 11 years)	Industry vs. Inferiority	School	Children need to cope with new social and academic demands. Success leads to a sense of competence, while failure results in feelings of inferiority.
Adolescence (12 to 18 years)	Identity vs. Role Confusion	Social Relationships	Teens need to develop a sense of self and personal identity. Success leads to an ability to stay true to yourself, while failure leads to role confusion and a weak sense of self.
Young Adulthood (19 to 40 years)	Intimacy vs. Isolation	Relationships	Young adults need to form intimate, loving relationships with other people. Success leads to strong relationships, while failure results in loneliness and isolation.
Middle Adulthood (40 to 65 years)	Generativity vs. Stagnation	Work and Parenthood	Adults need to create or nurture things that will outlast them, often by having children or creating a positive change that benefits other people. Success leads to feelings of usefulness and accomplishment, while failure results in shallow involvement in the world.
Maturity (65 to death)	Ego Integrity vs. Despair	Reflection on Life	Older adults need to look back on life and feel a sense of fulfillment. Success at this stage leads to feelings of wisdom, while failure results in regret, bitterness, and despair.

14 Extracted from http://psychology.about.com/library/bl_psychosocial_summary.htm

Handout 3.2 Guidelines for Interviewing Children[15]

A. Basic principles when interviewing a child

- Ensure that you comfortable doing the interview. If you are not comfortable, seek support from colleagues who are willing to talk with the child.
- Ensure that the child is comfortable. Establish a feeling of permissiveness so that the child feels free to express his/her feelings.
- Be alert in recognising the feelings that the child is expressing.
- Understand the child's feelings, behaviour, needs and situations from the child's point of view and not your own point of view.
- Help the child recognise and be aware that he/she is not alone in resolving his/her present difficulty.
- Take the child seriously at all times, even though his/her story might seem strange, unreal and not meaningful. It might be his/her way of telling the story.
- Accept the child for who he/she is. The child might have different experiences from what you expect children to have.
- Explain that you need to know what happened so as to provide effective care.

B. General interviewing skills

- Establish rapport and trust.
  - Identify a topic of interest.
  - Share a toy.
  - Sit at eye level with the child.
  - Establish eye contact.
  - Pursue discussion of a topic that the child is interested in if time permits and is related to the goal of the session.
- Observe the child's behaviour and body language.
- Use simple language and the child's vocabulary.

e.g., Child says: "my dada touched my kuku".
Appropriate response : "How did your dada touch your kuku?"

- Clarify any questions or statements from the child.
- Some children might tell fanciful stories involving a third person. Note those stories are ways of telling their own story.
- Show the child that you are really listening by restating what he/she has said to check whether your understanding of what has been said by the child is consistent with his/her meaning.
- Be aware of the reasons why a child might not want to participate in an interview. A child might not want to participate in an interview for the following reasons:-
  - The abuser has coerced or threatened the child if the child speaks out.
  - The child feels that he/she has to protect the abuser, e.g., he/she does not want his/her parent to go to jail.

15 Some extracts from Training Manual for Community Facilitators , by Helen Braganza Guillermo for Everychild Guyana

- The child does not want to recount the experiences because they have been too traumatic
- The child might be scared of you or does not trust you.
- The child might feel responsible for the abuse and might feel guilty.

- Reassure the child that he/she did not do anything wrong in telling you and your colleagues.
- Ask the child where he/she would like to go to feel safe.
- Follow up with the necessary referrals.
- Pay attention to what the child is saying.
- Allow the child to speak freely.
- Be cautious about touching the child, especially one who has been physically or sexually abused.
- Allow the child to accept, reject or modify messages received.

C. Things to avoid when interviewing a child

- Do not correct the child's grammar or vocabulary.
- Do not be judgmental.
- Do not command or dictate to the child what he/she is supposed to do.
- Avoid warning or threatening the child.
- Do not give direct advice or provide solutions to their problems.
- Do not argue or persuade the child to do something which he/she may not like to do.
- Do not label the child negatively (*"You were a bad girl, that is why your mummy did that to you").*
- Do not ask leading questions which could put ideas into the child's head. The child could start telling you what they think you want to hear.
- Do not ask 'Why' questions for these may feel like accusation or rejection, often resulting in defensive or withdrawn responses from the child. For example, do not ask "Why did your daddy touch your kuku?"
- Never make promises or reassurances without knowing if these can be fulfilled.

Worksheet 3 : Role Plays to test helping strategies

Make enough (number of participants divided by 3) copies of this worksheet. Cut out the scenarios and distribute to the different groups. Give the cutouts for each role to the person playing the part.

Scenario 1

Information for Nurse Role: You have a case where you are treating a broken arm of a 5-year-old girl. You notice other suspicious bruises. You interview the child to find out what is happening.

Information for Child Role: You are a 5-year-old girl. You are in the hospital because your mother threw you down and you broke your arm. Your mother is sometimes angry with you for small things and she is nice at other times. You have been beaten and, afterwards, your mother hugs you and tells you sorry. Your mother is crying outside the room and she tells you not to tell anybody what happened. She tells you she would not do it again. You are feeling scared and do not know what to do. Your arm is hurting badly.

Scenario 2

Information for Nurse Role: You have a case where a 13-year-old girl is being treated for a miscarriage brought on by use of tablets.

Information for Child Role: You are a 13-year-old girl. Your stepfather has been having sex with you. Your mother found out and beat you and told you not to tell anyone. You told your mother you were feeling unwell and your mother found out you were pregnant. She then gave you some tablets to drink and told you to go into the latrine. You had noticed a lot of blood and felt a lot of pain and that the foetus had come out. Afterwards, you continued to bleed. Your mother brought you to the hospital, warning you not to say anything about who you were pregnant for.

Scenario 3

Information for Nurse Role: An 8-year-old boy whose hands have been burnt and scarred is brought to you by his teacher. You have noticed other marks on his hands and face.

Information for Child Role: You are an 8-year-old boy. Your mother threw hot water on your hands because you had not done what she had asked you to do. Your mother hits you and sometimes has used a wire and mop stick to beat you. Afterwards, she tells you that you make her do those things to you and she is fed up with you. Sometimes she is nice to you. Your teacher noticed the marks and forced you to come to the hospital. Your mother had put ointment on the marks. You do not like the hospital and you want to go home. You do not want your mother to get into trouble.

Evaluation Form: Session 3

Date:

Please complete this form and submit to the facilitator before you leave. You are not required to put your name on the form.

Please tick your answer to questions in the boxes to the left.			
	Yes, Definitely	**Somewhat**	**No, Not at All**
Did you understand the information presented?			
Did you learn new ideas or skills?			
Can you identify Erikson's stages of personality development?			
Can you identify ways you can help with a child's developmental needs?[what does this mean?]			
Can you identify ways you can work with parents to improve their capacity to parent? ????			
Can you identify ways to influence the family and environmental factors which enhance child protection? ???			
Do you understand the kind of interviewing skills which are necessary to work with children?			
Did you like the way the session was facilitated?			

What was your favourite part of this session? ……..

…….

What did you not like about the session? ……..

……

How could the session be improved? ……..

……

How will you use the knowledge you have gained?.....

.....
…….

What would help to prepare you better to use the knowledge you have gained?

……

How useful are the handouts or leaflets that you received?.....

Session 4 : Social and Legal Framework

A. Learning Objectives

By the end of the Session 4, the participants should be able to:-

- Summarize the actions that health workers may take to protect a child beyond filing a child abuse report.
- List situations in which health workers must report suspected cases of maltreatment.
- Describe the legal framework for reporting child abuse.

It would be good to invite a representative from the Child Care and Protection Agency to interact with the participants at this session.

B. Materials

1. Flipchart, markers , masking tape
2. Handouts to distribute
3. Flip charts from Session 3 which could be used for recap session
4. Training contract flip chart
5. Participant Expectations flip chart
6. Work sheets
7. Diagram from C.6 drawn up.
8. Case Studies to distribute for discussion

C. Proposed Schedule

1. Greetings
2. Recap of Session 3
   a. Review contract and evaluation of Session 3.
   b. Review topics from Session 3.
   c. Discuss the stages of a child's psychosocial development.
   d. Discuss helping strategies for children who have been abused.
   e. Identify and practise techniques to probe suspicions of child abuse.
3. Examine learning objectives for Session 4.
4. Demonstrate how to help a child, others than filing a report.
5. Present the legal framework.
6. Case Study analysis
7. Evaluation of Session 4

C.1 Greetings (5 minutes)

Facilitator Notes: The greeting session is used to reintroduce participants to each other and to ground the participants so that they can focus on the session. Use any of the exercises or activities in the Annex as the icebreaker.

Review of contract
Facilitator Notes: Review the training contract with the participants and check to see if there is anything which should be added or removed. This is a good time to remind about putting the cell phones in vibrate mode.

The training contract should be visible during all sessions.

Reflections
Seek from the group any thoughts or reflections on incidents related to what they have learnt since Session 3. These could include any cases they have seen, or reactions to any stories in the news or any incidents which they have come into contact with.

Note any issues or questions which they would like answered if these are to be done during the session.

C.2 Recap of Session 3 (10 minutes)
The content of Session 3

Facilitator Notes: Review these topics, referring to the handouts and the discussions from Session 3. If you had asked a group of participants to do the recap activity, ask them now to present.
Ensure that the participants are reminded about these learning objectives during this recap session. The participants should be able to:-

- Link the stages of children development with the appropriate interventions.
- Identify helping strategies for children who have been abused.
- Identify techniques to probe suspicions of child abuse.

C.3. Learning Objectives for Session 4 (5 minutes)
Facilitator Notes: Reflect on the learning objectives for this session and any of the participant expectations which might be linked to them. These participant expectations would have been recorded in Session 1.

Briefing Notes: By the end of the Session 4, it is expected that you the participants would be able to:-

- Summarize the actions that health workers may take to protect a child beyond filing a child abuse report.
- List situations in which health workers must report suspected cases of maltreatment.
- Describe the legal framework for reporting child abuse

C.4 Actions to Protect Children – the Assessment Framework for Child Protection (30 minutes)

Facilitator Notes: The base for this section is to consider the *Assessment Framework for Children in Need* which is a model in use by child protection services in different parts of the world. The proposed methodology is for the model to be presented to the class. The class is then divided into three groups. Each group will consider one domain of the assessment framework.

Replicate this diagram on one piece of flipchart paper.

Briefing Notes:

Emphasis:
The goal of a nurse's intervention is to ensure that the child receives the necessary health care AND that the child could be placed in a protective environment.

The Framework for the Assessment of Children in Need and their Families provides a systematic basis for collecting and analysing information to support professional judgments about how to help children and families in the best interests of the child. Practitioners should use the framework to gain an understanding of the following domains:

- a child's developmental needs;
- the capacity of parents or caregivers to respond appropriately to those needs, including their capacity to keep the child safe from harm; and
- the impact of wider family and environmental factors on the parents and child.

Developmental needs refer to Health, Education, Emotional and Behavioural Development, Identity, Family and Social Relationships, Social Presentation and Self-care Skills.

Parenting Capacity refers to Basic Care, Ensuring Safety, Emotional Warmth, Stimulation, Guidance, Boundaries and Stability.

Family and Environmental Factors refer to Availability of Community Resources, Family's Social Integration, Income, Employment, Housing (Water and Sanitation), Wider Family, Family History and Functioning.

Instructions for Self-study Activity: How can nurses and health care workers meet the needs of a child survivor of abuse?

Distribute Handout 4.1
Divide the group into three groups (or six groups if the class is larger). Each group will study one domain and present answers for each of the factors as to how nurses and health care workers can meet the needs of a child within each domain.

Each group will use flipchart paper. Each group will head up the flipchart with the domain title.

The factors will be listed and, under each factor, the group members will list actions which they believe nurses and other health care workers can take to protect children.

Suggested time for discussion is 15-20 minutes.

The groups then put up their flipchart sheets in shopping window style. The participants examine the different presentations and are allowed to add to them.

In Plenary, the facilitator highlights the different ways in which nurses and other health care workers can help to ensure that the needs of children can be met.

Point out that in some cases, these are in the professional domain, while in other cases it would be in the personal sphere.

C.5 Legal Framework and Reporting Mechanisms (15 minutes)
Facilitator Notes : The Protection of Children Act of 2009 explains the reporting responsibilities of health care workers when they suspect that children are in need of child protection.

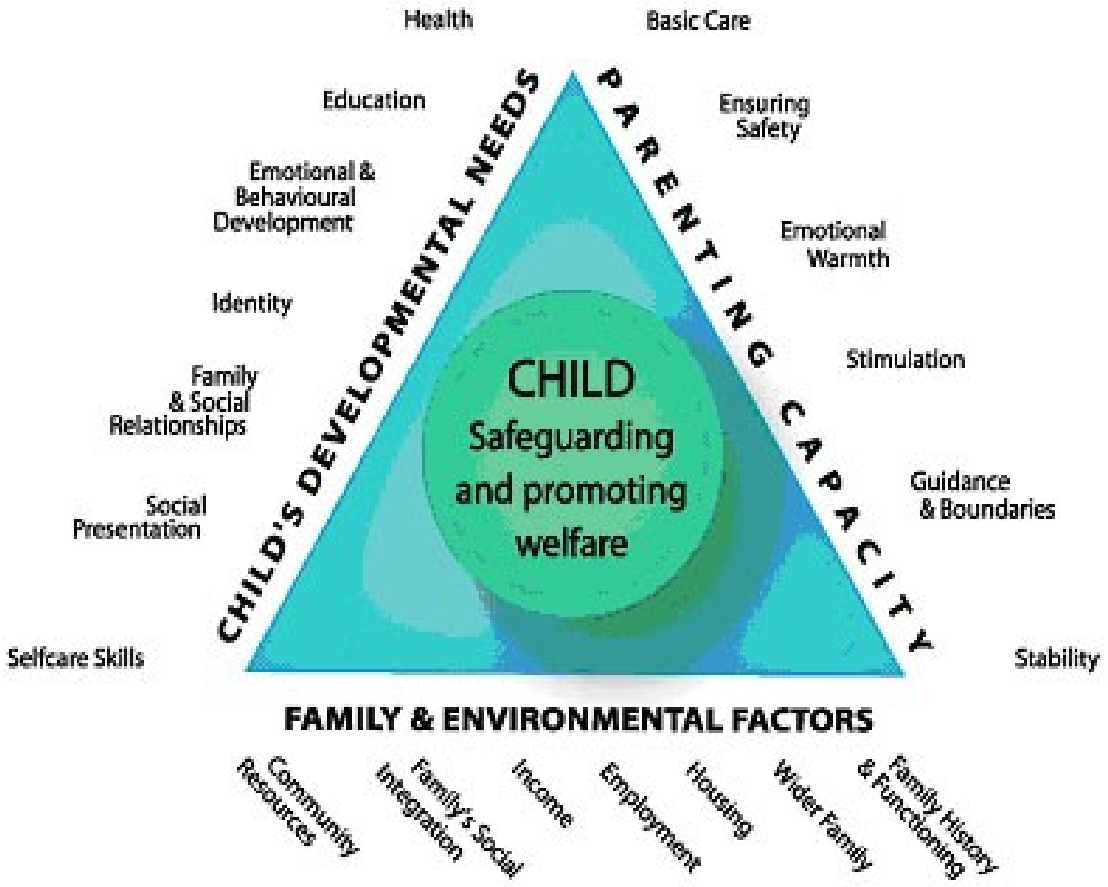
C.6 Case Study Analysis (30 minutes – 20 minutes plenary)

Facilitator Notes: The case studies give the participants an opportunity to reflect on the objectives of the four sessions. Participants are divided into groups of no more than four persons. Each group is given a case study to analyse. The results are presented in plenary.

C.7. Evaluation and Closing of Session 4 (10 minutes)
Facilitator Notes: Conduct an oral evaluation of the session.

Review the list of participant expectations which were compiled in Session 1 and see if they were completed.

Handout 4.1: Assessment Framework for Children in Need[16]



DIMENSIONS OF CHILD'S DEVELOPMENTAL NEEDS

Health

This includes growth and development as well as physical and mental well-being. The impact of genetic factors and any impairment needs to be considered. Involves receiving appropriate health care when ill, an adequate and nutritious diet, exercise, immunisations (where appropriate) and developmental checks, dental and optical care and, for older children, appropriate advice and information on issues that have an impact on health, including sex education and substance use and abuse.

Education

This covers all areas of a child's cognitive development which begins from birth. It includes

16 Adapted from http://cpp.shropshire.gov.uk/chapters/p_frame_ass_cin.html

opportunities:

1. for play and interaction with other children;
2. to have access to books;
3. to acquire a range of skills and interests;
4. to experience success and achievement;

It involves an adult interested in educational activities, progress and achievements, who takes account of the child's starting point and any special educational needs.

Emotional and Behavioural Development

Concerns the appropriateness of response demonstrated in feelings and actions by a child, initially to parents and caregivers and, as the child grows older, to others beyond the family. Includes nature and quality of early attachments, characteristics of temperament, adaptation to change, response to stress and degree of appropriate self-control

Identity

Concerns the child's growing sense of self as a separate and valued person. It includes the child's view of self and abilities, self-image and self-esteem, and having a positive sense of individuality. Race religion, age, gender, sexuality and disability may all contribute to this. Feelings of belonging and acceptance by family, peer group and wider society, including other cultural groups.

Family and Social Relationships

Development of empathy and the capacity to place self in someone else's shoes. It includes a stable and affectionate relationship with parents or caregivers, good relationships with siblings, increasing importance of age appropriate friendships with peers and other significant persons in the child's life and response of family to these relationships.

Social Presentation

Concerns child's growing understanding of the way in which appearance, behaviour, and any impairment are perceived by the outside world and the impression being created. It includes appropriateness of dress for age, gender, culture and religion; cleanliness and personal hygiene; and availability of advice from parents or caregivers about presentation in different settings.

Self Care Skills

Concerns the acquisition by a child of practical, emotional and communication competencies required for increasing independence. It includes early practical skills of dressing and feeding, opportunities to gain confidence and practical skills to undertake activities away from the family and independent living skills as older children. It also includes encouragement to acquire social problem solving approaches. Special attention should be given to the impact of a child's impairment and other vulnerabilities, and on social circumstances affecting these in the development of self care skills.

DIMENSIONS OF PARENTING CAPACITY

Basic Care

Providing for the child's physical needs, and appropriate medical and dental care. Includes provision of food, drink, warmth, shelter, clean and appropriate clothing and adequate personal hygiene.

Ensuring Safety

Ensuring the child is adequately protected from harm or danger. Includes protection from significant harm or danger and from contact with unsafe adults/other children and from self-harm. Recognition of hazards and danger both in the home and elsewhere.

Emotional Warmth

Ensuring the child's emotional needs are met giving the child a sense of being specially valued and a positive sense of own racial and cultural identity. Includes ensuring the child's requirements for secure, stable and affectionate relationships with significant adults, with appropriate sensitivity and responsiveness to the child's needs. Appropriate physical contact, comfort and cuddling sufficient to demonstrate warm regard, praise and encouragement.

Stimulation

Promoting child's learning and intellectual development through encouragement and cognitive stimulation and promoting social opportunities. Includes facilitating the child's cognitive development and potential through interaction, communication, talking and responding to the child's language and questions, encouraging and joining the child's play, and promoting educational opportunities. Enabling the child to experience success and ensuring school attendance or equivalent opportunity. Facilitating child to meet challenges of life.

Guidance and Boundaries

Enabling the child to regulate their own emotions and behaviour. The key parental tasks are demonstrating and modelling appropriate behaviour and control of emotions and interactions with others, and guidance which involves setting boundaries, so that the child is able to develop an internal model of moral values and conscience, and social behaviour appropriate for the society within which they will grow up. The aim is to enable the child to grow into an autonomous adult, holding their own values, and able to demonstrate appropriate behaviour with others rather than having to be dependent on rules outside themselves. This includes not over protecting children from exploratory and learning experiences. Includes social problem solving, anger management, consideration for others, and effective discipline and shaping of behaviour.

Stability

Providing a sufficiently stable family environment to enable a child to develop and maintain a secure attachment to the primary caregiver(s) in order to ensure optimal development. Includes ensuring secure attachments are not disrupted, providing consistency of emotional warmth over time and responding in a similar manner to the same behaviour. Parental responses change and develop according to child's developmental progress. In addition, ensuring children keep in contact with important family members and significant others.

FAMILY AND ENVIRONMENTAL FACTORS

Family History and Functioning

Family history includes both genetic and psycho-social factors. Family functioning is influenced by who is living in the household and how they are related to the child; significant changes in family/household composition; history of childhood experiences of parents; chronology of significant life events and their meaning to family members; nature of family functioning, including sibling relationships and its impact on the child; parental strengths and difficulties, including those of an absent parent; the relationship between separated parents.

Wider Family

Who are considered to be members of the wider family by the child and the parents? This includes related and non-related persons and absent wider family. What is their role and importance to the child and parents and in precisely what way?

Housing

Does the accommodation have basic amenities and facilities appropriate to the age and development of the child and other resident members? Is the housing accessible and suitable to the needs of disabled family members? Includes the interior and exterior of the accommodation and immediate surroundings. Basic amenities include water, heating, sanitation, cooking facilities, sleeping arrangements and cleanliness, hygiene and safety and their impact on the child's upbringing.

Employment

Who is working in the household, their pattern of work and any changes? What impact does this have on the child? How is work or absence of work viewed by family members? How does it affect their relationship with the child? Includes children's experience of work and its impact on them.

Income

Income available over a sustained period of time. Is the family in receipt of all its benefit entitlements? Sufficiency of income to meet the family's needs. The way resources available to the family are used. Are there financial difficulties which affect the child?

Family's Social Integration
Exploration of the wider context of the local neighbourhood and community and its impact on the child and parents. Includes the degree of the family's integration or isolation, their peer groups, friendship and social networks and the importance attached to them.

Community Resources
Describes all facilities and services in a neighbourhood, including universal services of primary health care, day care and schools, places of worship, transport, shops and leisure activities. Includes availability, accessibility and standard of resources and impact on the family, including disabled members.

Handout 4.2 Extracts from Protection of Children Bill of 2009

This handout has been prepared by Help & Shelter to use in the training of health care workers. Sections of the Protection of Children Bill are extracted here. It is expected that this Bill would come into law in 2009. The full text of the legislation is available from the Parliament Buildings or the website of the Parliament at http://www.parliament.gov.gy

An ACT to provide for the protection of children at risk, children in difficult circumstances and children in general and for related matters.

From Section (2) Part (1)

In this Act *(definitions)*

"child" means a person under the age of eighteen years, whether born in or out of wedlock, who has never been married, and includes -

a) a step child or child adopted by law; or
b) a child of the family

except that in the case where a person has special needs that person shall be a child under this Act regardless of his age

"mental impairment" means a state of arrested or incomplete development of mind which includes a significant impairment of intelligence and social functioning which results in that person having special needs;

"'physical impairment" means lacking part of or all of a limb, or having a defective limb, organ or mechanism of the body.

"parent" unless the context means otherwise implies means a person's mother or father or stepmother or stepfather and includes adoptive parents as well as a person who has been treated as a child of the family.

PART II GENERAL PRINCIPLES

3. This Act shall be interpreted and administered in accordance with the following principles and due consideration must be given to these principles by the court or any other body or entity that is charged with the administration of these provisions -

(a) the overriding and paramount consideration in any decision made under this Act shall be the best interests of the child;
(b) every child is entitled to be assured of personal safety , health and well-being;
(c) the family is the basic unit of society responsible for the safety , health and well being of the child;
(d) the members of a community have a responsibility to support the safety, health and well-being

of a child;

.....

(g) the cultural heritage of a child shall be respected

….....…

(h) in the absence of evidence to the contrary , there shall be a presumption that a child twelve years of age or over is capable of forming and expressing an opinion regarding his care and custody

….....

5. All relevant factors shall be considered in determining a child's best interests, including

a) the child's safety and health ….....

(i) any issues to be considered where a child is HIV positive or has special needs

Part III – Protective Intervention

6. A child is in need of protective intervention where the child -
   (a) is , or is at risk of, being physically or emotionally harmed by the action or lack of appropriate action by the child's parent, guardian, person in whose care the child is left or other persons living in or visiting the household;
   (b) is, or is at risk of, being sexually or emotional abused or exploited by the child's parent, guardian, person in whose care the child is left or other persons living or visiting the household;
   (c) is, or is at risk of, being physically harmed by a person and the child's parent, guardian or person in whose care the child is left, does not protect or seek protection for the child;
   (d) is, or is at risk of, being sexually abused or exploited by a person and the child's parent, guardian or person in whose care the child is left does not protect the child
   (e) is being emotionally harmed by a person.
   (f) is in the custody or *de facto* custody of a person who refuses or fails to obtain or permit essential medical, psychiatric, surgical or remedial care or treatment to be given to the child when recommended by a qualified health practitioner;
   (g) is abandoned
   (h) has no living parent or has a parent who is unavailable to care for him and who has not made adequate provisions for his care;
   (i) is living in a situation where there is violence;
   (j) has -
      (i) been left without adequate supervision
      (ii) allegedly killed or seriously injured another persons or has caused serious damage to another person's property; or
      (iii) on more than one occasion caused injury to another person or other living thing or threatened, either with or without weapons, to cause injury to another person or other living thing, either with the parent's encouragement or because the parent does not respond adequately to the situation; or
      (iv) is being exposed to drugs or obscene material or objects

Section 7 Duty to report

(1) Where a person has direct information that a child is or may be in need of protective intervention, the person shall immediately report the matter to the Director [of the Childcare and Protective Agency] , a probation officer appointed by the Public Service Commission or a police officer.
(2) Where a person makes a report under subsection (1), the person shall report all information in his possession
(3) Where a report is made to a police officer under subsection (1), the police officer shall immediately inform the Director of the said report, investigate the matter promptly , and inform the Director of the findings of the investigation
(4) this section applies, notwithstanding the provisions of any other law, to a person referred to in subsection (5) who, in the course of his professional duties, has reasonable grounds to suspect that a child is or maybe in need of protective intervention.
(5) Subsection (4) applies to every person who performs professional or official duties or is in a position of trust with respect to a child, including -
    (a) a health care professional;
    (b) a school principal, teacher, social worker, family counsellor, coach, religious leader, operator or employee of a child care service;
    (c) a police officer;
    (d) an attorney-at-law;
    (e) a member of a non-governmental organisation which provides special services for children;
    (f) a person who is entrusted with the care of children;
    (g) a mediator; and
    (h) a coroner

(6) A person pursuant to subsections (4) and (5) who is found to have had knowledge and failed to make a report commits an offence and shall be liable on summary conviction to a find of fifty thousand dollars.
(7) This section applies notwithstanding that the information is confidential or privileged, and an action does not lie against the informant unless the making of the report is done maliciously or without reasonable cause
(8) A persona shall not interfere with or harass a person who gives information under this section.
(9) A person who contravenes subsection (8) commits an offence and is liable on summary conviction to a fine of two hundred thousand dollars or to imprisonment for a term of twelve months
(10) Notwithstanding any other law, a complaint under subsection (10) shall be laid within three years from the day when the matter of the complaint arose.

EXPLANATORY MEMORANDUM

This Bill seeks to provide for the protection of children generally, children at risk and children in difficult circumstances.

Clause 3 sets out the general principles to be applied when interpreting and administering the provisions of the proposed legislation.

Clause 4 sets out the conditions to be applied when providing child and family services whether provided by the State, the Board or other persons or entities.

Clause 5 outlines all relevant factors to be considered in determining a child's best interests.

Clause 6 lays down the situations which give rise to a need for protective intervention.

Clause 7 compels a person who is aware that a child is in need of protective intervention to report the matter and sets out the reporting procedure.

Clause 8 provides that the Director and a social worker shall assess whether a child is in need of protective intervention when the information is received and sets out the duties of the Director or social worker after the assessment.

Clause 9 provides that the Director, social worker or a person appointed by the Director may visit or interview the child in private and for the Director or social worker to notify the parents of the interview.

Clause 10 states that the Director or social worker may apply ex parte to a Judge for an order where access to the child is denied and lists some of the orders that a Judge may make. It also provides for where the child is removed, the Director or social worker must return the child except where further action is taken by the Director or social worker and for the Police to assist in enforcing the Judge's order.

Clause 11 provides for not disclosing the location of child. Subclause (1) provides for a person who does not comply with the order under section 10 to be arrested and brought before the Judge for hearing into his non-compliance with the order. Subclauses (2) and (3) state that the Judge, after hearing the reasons for not complying with the order, may order that the person may be imprisoned or for the Judge to draw adverse inferences during the hearing of the matter.

Clause 12 provides for the Director or social worker to apply to the Court for an order that records may be produced and sets out the circumstances under which an application can be made to the Court. It allows for an ex parte application to be made.

Clause 13 allows for the Director or social worker to apply for an order that a child be protected from contact with another person and sets out the procedure to be followed by the applicant. It also outlines the orders that the Judge may make and provides for the Judge to take appropriate action where there is non-compliance with an order. It also allows for the persons affected by the order to apply to the Judge to vary, rescind or extend the order; and for a police officer to assist in enforcing an order.

Clause 14 allows the Director or social worker to apply to the Judge for the removal of a child who is in need of protective intervention and provides for the Judge to make an order authorising the

Director or social worker to remove a child by force if necessary. It also provides for a police officer to assist the Director or social worker to remove a child.

Clause 15 sets out the time-line to hear and decide matters referred to in section 14.

Clause 16 states that the Director or social worker shall provide counselling to a child.

Clause 17 provides for care of a child after removal and for the child to be medically examined. It also provides for medical care of a child where necessary.

Clause 18 sets out the procedure to be followed where a child is need of protective intervention but the child is not removed; it also provides for the Director or social worker to apply to a Judge with or without counsel for a protective intervention hearing and for a Judge to make appropriate orders under section 21.

Clause 19 empowers the Director or social worker to apply to Judge for an order where a child is in need of medical treatment but his or her parents refuse to obtain or permit this treatment and sets out procedure to be followed.

Clauses 20 and 21 sets out the procedure to be followed for a protective intervention hearing and the orders that a Judge may make.

Clause 22 provides for Judge to make an order that the parents of a child continue to financially support a child where a child is removed.

Clause 23 provides for a Judge to extend a temporary order under section 20 in exceptional circumstances and set out the procedure to be followed where an extension is applied for.

Clause 24 provides for the parties to arrive at a settlement by means of a pre-trial settlement conference, a family conference, mediation or other means of alternative dispute resolution and for any agreement reached to be make into a final Court order.

Clause 25 provides for the Director to make decisions regarding a child where the Director is granted a temporary order under section 20, except decisions relating to medical treatment or a decision under the Adoption of Children Act 2008.

Clause 26 provides for the Director to make decisions for placement of a child where an order for continuous custody is made; it also allows for the Director to approach the Court for directions as regards the future of a child.

Clause 27 sets out conditions which brings a final order to an end.

Clause 28 provides for rescission of a continuous order where the circumstances have change significantly form the date of a continuous order and procedure to be followed. It allows for the

Director to continue to monitor a child and for a child to continue to receive counselling where a continuous order is rescinded.

Clause 29 provides for discontinuance of a protective intervention hearing where a child is returned before the hearing.

Clause 30 states that hearing under this Act is of a civil nature and may be informal. It allows for the admission of evidence including video-taped oral statements.

Clause 31 provides for a Director or social worker to attend and have audience in Court in respect of a matter under this Act.

Clause 32 allows for a person who has custody or care of a child to be heard in Court.

Clause 33 allows for a child to be heard in Court.

Clause 34 empowers a Judge to vary the time for service of notices and also to dispense with notice.
Clause 35 allows for service of a copy of an original document and for personal service of documents to be proved by written or oral statements under oath.

Clause 36 provides for full disclosure of information relevant to the hearing; it prohibits the disclosure of the identity of the complainant except where the complainant agrees or where a Judge so orders.

Clause 37 provides that information obtained at a family conference, mediation or other means of alternative dispute resolution is confidential. It however allows for disclosure is certain circumstances, but creates an offence where the child in question is identified in the media.

Clause 38 provides for the making of a consent order.

Clause 39 allows for a hearing of proceedings under this Act and the Custody, Access, Guardianship and Maintenance Act to be done together.

Clause 40 allows for a variation of an order where circumstances have changed since the original order.

Clause 41 states the facts to be considered by the Director or social worker when placement of a child is done. It also allows for a child to be placed with the non-custodial parent or caregiver.

Clause 42 provides for the Director or social worker to make an agreement for service and final support or a child.

Clause 43 allows the Director or social worker to provide information concerning a child to the caregiver and parent of a child.

Clause 44 allows the Director or social worker to remove a child from the care of a caregiver without

notice.

Clause 45 states that a child who is removed under section 44 shall be entitled to counselling.

Clause 46 gives a person over twelve years and a person who has custody of a child right of access to certain information.

Clause 47 provides for denial of access to information to a person in certain situations.

Clause 48 allows for a Director to authorised disclosure of information without consent in certain situations.

Clause 49 creates a criminal offence against a person who contributes to a child being in need of protective intervention and sets out the penalty for that offence.

Clause 50 creates offences against a person who causes drugs or other obscene, materials to come into a child's possession, to be ingested by the child for the purposes of trafficking or where a child is forced to engaged in prostitution, and sets out the penalties for the offences.

Clause 51 provides that a person shall not remove or cause a child to leave the care or custody of the Director.

Clause 52 provides for the establishment of an advisory committee by the Minister and appointment of persons to that committee.

Clause 53 imposes a duty on the Minister to keep a list of individuals who are unsuitable to work with children and for removal of persons from that list.
Clause 54 provides for an individual who is or has been employed in a child care position and certain conditions are fulfilled to be included in the list.

Clause 55 provides for person included in the list to appeal against his inclusion in certain circumstance.

Clause 56 sets out the effect of inclusion on a person where he is on the list.

Clause 57 provides for the setting up of a Board and for the Minister to make provisions by regulations for the conduct of appeals by the Board.

Clause 58 empowers the Minister to make orders for removal of difficulties in giving effect to the provisions of the proposed legislation.

Clause 59 creates an offence against a person who contravenes the provisions of this Act and states the penalty for the offence.

Clause 60 provides for applications under this Act to be heard in camera.

Clause 61 states that appeals for the decision of a Judge shall be to the Court of Appeal.

Clause 62 provides for the Minister to make regulations to give effect to this Act.

Clause 63 provides for the Director and duly authorised officers who operate under this Act to be protected from personal liability.

Clause 64 provides for supervision and control of the Childcare and Protection Agency over all administrative authorities functioning under the proposed legislation.

Minister of Human Services and Social Security.

Worksheet 4 : Case Studies to assess child protection needs

Case Study : Clive
Age: 7 years old

Clive has been brought to you by his teacher.

Clive seems to literally be “carrying the world on his shoulders”. His handsome little face seemed to be pondering why an adult actually wants to talk with him. He resides with his sister, brother-in-law and their two children.
He appeared to be a very smart child and has some faded marks on his hands and legs, clear indications of beatings he had suffered over a period of time. He is unkempt. At seven years old Clive still wears pampers. His teacher indicated that he has problems retaining his faeces, which she speculated could be a result of abuse.
When asked questions about sharing any bad thing that he has ever experienced he readily responds “my big sister does beat me nearly every day. Day before yesterday I get licks on my belly and me foot. She does beat me with shoes, slippers, belt, whip anything. A time she pelt me with a big brick and burst me head then she put antibiotic on it. I does got to wash my clothes, clean de concrete, fetch water and sweep de yard.” “Everybody does beat me even me lil nephew, he is two. My mother does beat me too when she come. She burst me mouth already, and a time she black and blue me face. Me brother-in-law does beat me for everything. He does beat me with rope, wire and big wood. I ent like no body in my house; only my lil niece, she is five she don’t beat me, she does play with me and she does cry when anybody knock me.

1. What are the forms of abuse in this case?
2. What are the needs of Clive from the Assessment Framework which have to be addressed in this case?
3. For each need identified in 2 above, how would you seek to address the needs?

Case Study : Ram
Age : 14 years old

Ram drank poison and was found by his grandmother. He has been brought to your hospital for treatment. The antidote has been applied.

Ram's grandmother is 67 years old and she says that Ram lives with his mother and father. Ram's father drinks alcohol and when he is drunk, he beats Ram's mother. Ram has tried to stop his father from beating his mother. Ram's mother has been calling Ram a “no good” and tells him that he is like his father since Ram prefers not to go to school and to go out with his friends.

Ram does not like school because the teachers call him a dunce. He does not have money for clothes and sometimes he is hungry. His mother has two younger children and Ram. Ram says that his mother only looks after the younger children and not him.

Ram stays out of the house because he says 'I aint able wid no cuss up and fret up'.

Ram drank poison because his mother accused him of stealing some money. He says he did not steal the money and he might as well be dead.

1. What are the forms of abuse in this case?
2. What are the needs of Ram from the Assessment Framework which have to be addressed in this case?
3. For each need identified in 2 above, how would you seek to address the needs?

Case Study : Bianca
Age : 12 years old

Bianca is referred to you one night after she drank a tablet to have a miscarriage.

Bianca is 12 years old and lives with her stepfather, mother and several other people in the house. Bianca tells you that her stepfather has been climbing in her bed with her in the nights when her stepmother is at work. Her stepfather tells her that she makes him feel good and buys things for her. Her stepfather does not beat her, but her mother beats her a lot.

Bianca knows that something is wrong. Her mother found out she is pregnant and beat her and called her a whore several times. Her mother then told her to drink the tablet. Bianca drank the tablet and did not know why she was drinking it. When she started bleeding, she told her mother who then brought her to the hospital.

Her mother is standing outside of the room. Bianca does not want any more problems. She is suffering from pain. She also has exams to write soon. Bianca is not talking to the nurses and she does not want to see her mother. She does not want to go to the police.

1. What are the forms of abuse in this case?
2. What are the needs of Bianca from the Assessment Framework which have to be addressed in this case?
3. For each need identified in 2 above, how would you seek to address the needs?

Evaluation Form: Session 4

Date:

Please complete this form and submit to the facilitator before you leave..

Please tick your answer to questions in the boxes to the left.			
	Yes, Definitely	**Somewhat**	**No, Not at All**
Did you understand the information presented?			
Did you learn new ideas or skills?			
Do you understand the ways in which you can help children when they do not want to report the abuse?			
Do you understand the legal requirements in the intended child protection legislation?			
Did you like the way the session was facilitated?			

What was your favourite part of this session? ……..

…….

What did you not like about the session? ……..

……

How could the session be improved? ……..

……

How will you use the knowledge you have gained?.....

.....

…….

What would help to prepare you better to use the knowledge you have gained?
……

How useful are the handouts or leaflets that you received?.....

How did you find the entire series of sessions?.....