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My No.) FHB/CCDU/NCPA/01/2021

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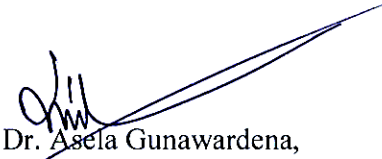
General Circular:01-32/2023.....

Deputy Director Generals National Hospitals, Colombo and Kandy,
Directors of National, Teaching, Provincial, District General, Special Hospitals and Health Campaigns,
All Provincial Directors of Health Services,
All Regional Directors of Health Services,
Medical Superintendent of Base Hospitals and All the heads of Institutions

**Standard Operational Procedure (SOP) to be used in Sri Lankan Government
Hospitals for the Management of Children who have Faced Violence**

In the year 2022, more than 10,000 child abuse cases were reported to the National Child Protection Authority. Prompt multi-disciplinary and multi-sectoral management promotes the successful re-integration of children who have faced violence, to society while supporting their mental health and education.

According to the National Guideline, the Ministry of Health has a significant role in the multi-sectoral management of children who face violence. Every healthcare staff should be aware and follow the standard procedures when managing a child who has faced violence, in the hospital setting. This SOP is developed to fulfil the above requirement and guide all the relevant health personnel attached to government hospitals in Sri Lanka when they encounter a child who has faced violence. You are instructed to share this among your institutions and teams and follow the SOP in relevant circumstances.


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DDG – PHS I & II
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Gynaecologists/Sri Lanka College of Forensic Pathologists/ Sri Lanka College of Psychiatrists/Sri
Lanka College of Child and Adolescent Psychiatrists/College of Community Physicians of Sri
Lanka/ College of Surgeons Sri Lanka/Sri Lanka College of Medical Administrators/
Sri Lanka Medical Association

Standard Operational Procedure (SOP) to be used in Sri Lankan Government Hospitals for the Management of Children who have Faced Violence

1. Introduction & the Purpose of the Standard Operational Procedure

The Ministry of Health has a primary role to play in preventing violence against children and protecting children who have faced violence. This Standard Operational Procedure (SOP) that should be followed by health personnel attached to Sri Lankan hospitals once they encounter a child who has faced or are suspected of having faced violence.

This SOP is intended to be followed in Teaching Hospitals, Provincial General, District General, and Base Hospitals, where the key specialties (Judicial medical officer, Paediatrician, Adult/Child & Adolescent Psychiatrist, and Gynaecologists) are available. In all other situations, the child should be transferred to the nearest Teaching Hospitals, Provincial General, District General, and Base Hospitals.

This SOP can be exempted in the following two situations:

- 1. Public Health care workers attached to the Medical Officer of Health offices (MOH).**
- 2. Matters related to the cohabitation of adolescents under 16 years, where the general Circular No. 01-25/2015 "providing sexual and reproductive health services for adolescents" is in operation.**

2. Violence against Children (VAC)

Violence against Children includes all forms of violence against children (0-17) years and may be perpetrated by parents or other caregivers, peers, romantic partners, or strangers. Violence can affect children even before they are born. Intimate partner violence during pregnancy, defined as physical, sexual, or psychological harm by an intimate partner (husband/partner) during pregnancy, is known to cause higher rates of intrauterine growth retardation, poor brain growth, premature deliveries, and behavioural problems in childhood.

The World Health Organization identifies six (6) Categories of VAC: child abuse and neglect, bullying (including cyberbullying), youth violence, intimate partner violence/dating violence, sexual violence, and emotional or psychological violence.

This SOP mainly manages children who have faced child abuse and neglect. However, the principles of management of other forms of VAC are similar.

3 Child abuse and neglect (also known as child maltreatment)

The World Health Organization defines Child abuse as *all forms of physical and/or emotional ill-treatment, sexual abuse, or commercial or other exploitation, resulting in actual or potential harm to the child's health, survival, development or dignity in a context of a relationship of responsibility, trust or power.*

All health professionals are obligated by law to exercise their duties to the fullest extent so that they ensure the best interest of the child who has been affected.

Maintaining a high degree of suspicion by health personnel can result in the prompt recognition of child abuse.

4. Aims of Management

The aims of the management of child maltreatment:

1. Provide immediate medical/medico legal care in a secure environment
2. Reduce re-traumatization
3. Ensure access to psycho-social rehabilitation and reintegration
4. Work towards holistic recovery
5. Apply a multi sectoral approach to prevent further abuse
6. Assist legal processes to facilitate judicial proceedings
7. Verify whether there are other children in the family or institution who may be at risk and take necessary action.

The Child Protection Procedure, the management of children who have faced violence.

4.1. The initial management

The important first step in management of a child who has faced violence or is likely to face such adversity is initial recognition. Healthcare professionals and other individuals working with children should have a high degree of suspicion to identify such children.

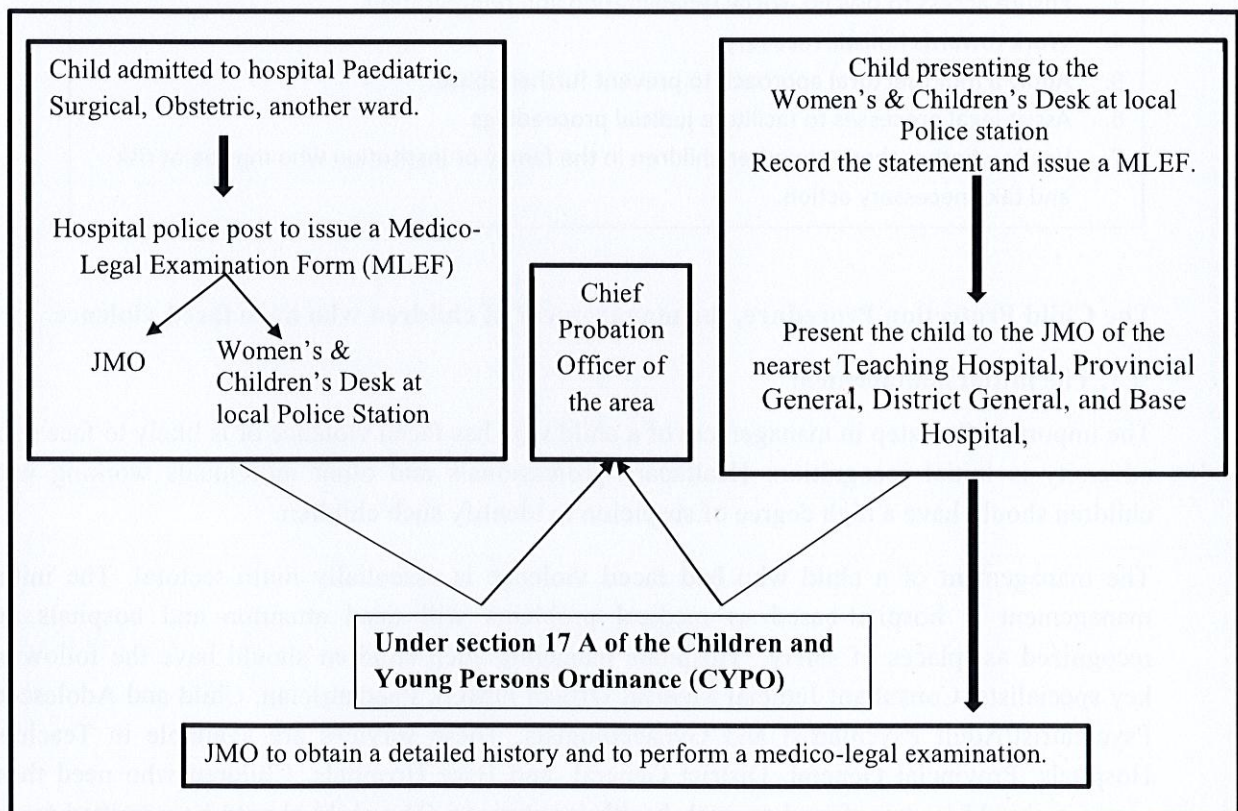
The management of a child who had faced violence is essentially multi-sectoral. The initial management is hospital-based as medical problems will need attention and hospitals are recognized as 'places of safety.' Hospitals managing such children should have the following key specialists: Consultant Judicial Medical Officer (JMO), Paediatrician, Child and Adolescent Psychiatrist/Adult Psychiatrist and Gynaecologists. These services are available in Teaching Hospitals, Provincial General, District General, and Base Hospitals. Children who need these services should be transferred to such health institutions. The child should be admitted to the pediatric ward for further management. If the child is pregnant she should be admitted to the obstetric ward. Initial admission is preferred to the surgical wards if surgical interventions are needed.

4.2 Presentation at the hospital

Hospital personnel may come across three categories of children in relation to child maltreatment:

1. Children who have faced maltreatment and have been brought directly to the hospital by parents, guardians.
2. Children being seen in the hospital for other ailments and the attending health personnel suspects of potential child maltreatment.
3. Children brought by the Police with a Medico-Legal Examination form (MLEF) to the Judicial Medical Officer of the hospital.

Flow chart of initial management



4.3 Admission, referral and informing authorities.

The procedures to be followed will differ by the initial place of presentation of the child. The initial presentation may be at:

1. The Out-Patient Department of a Divisional Hospital (OPD)
2. OPD of Secondary / Tertiary care hospitals
3. The JMO's Office

4.3.1 Action to be taken in the Outpatient Department – (OPD)

4.3.1.1. Children presenting to Divisional hospitals:

The Children who have faced maltreatment and have been brought to a Divisional hospital by parents, guardians, or law enforcement authorities should be admitted and transferred to a Teaching Hospital, Provincial General, District General, and Base Hospital, where specialist services (Paediatrics, Gynecology, Psychiatry, and Forensic) are available. The reason for transfer should be mentioned as “Transferred due to child protection concerns”. Prior to transfer telephone communications should take place with the on-call Judicial Medical Officer and the Paediatrician of the hospital to where the child is being transferred.

4.3.1.2 Children presenting to secondary & tertiary care hospitals:

Both reported and suspected incidents of child maltreatment may present in these institutions.

Reported cases: Children referred from Divisional Hospitals (as transferred for child protection concerns), children brought by parents or guardians, or children brought by the police.

Suspected cases: Children identified as suspected of having faced potential child maltreatment by attending medical officers at the OPD and medical teams in the wards.

Procedure to be followed at the OPD of the Teaching Hospital, Provincial General, District General, and Base Hospitals.

1. The attending medical officer should counsel the parents/guardian about the need for admission and obtain their consent to admit the child for further care.
2. When parents or guardians refuse admission, the medical officer should inform the hospital administrator to initiate child protection measures. These measures include informing the Child Rights Promotion Officers and the National Child Protection Authority (NCPA) officers of the child's area of residence. Alternatively, a call should have been given to the NCPA hotline in 1929 with the name and address of the child.
3. At the OPD, the admitting officer should speak very gently to the child and ask about their health-related complaints if any. However, at this stage, they **SHOULD NOT** ask the child about any details of the abuse incident.

4. The admitting officer should document details of the incident regarding the date and the time of occurrence with a brief description from the police and/or the guardian, preferably in a safe and private place. It is important that no other member of the staff should speak to the child regarding the problem. The MO OPD should take all possible precautions to ensure that all parties concerned are not embarrassed, criticized, or accused.
5. The MO OPD should undertake a brief examination including the vital signs to establish that the child is clinically stable. If any serious or life-threatening situations are suspected, relevant specialists should be immediately informed over the phone and all other necessary actions taken for any other OPD admission (ETU care etc.).
6. Documentation at the OPD must be kept confidential. The date and time of the incident should be recorded, and the cause of admission should be stated as "admitted due to child protection concerns" without mentioning the details of the abuse (i.e., sexual abuse, rape etc.)

4.3.1.3 Action to be taken in the respective ward.

Once the child is admitted to the ward, the ward staff in charge should inform the police post of the hospital. The police will issue a medico-legal examination form (MLEF).

The following standard procedures are recommended after admission.

1. A senior experienced medical staff member should gently speak to the child at the time of admission. The interview should adopt child-friendly approaches and be conducted in a non-threatening environment that maintains extreme confidentiality and privacy. No one else should be allowed to ask the child about the incident. The interviewing, approach the child with **extreme sensitivity, recognizing and understanding their vulnerability and establishing a rapport**. The affected child should not be questioned about the incident at this stage. This is the duty of the medico-legal team.
2. A relevant history should be obtained from the Guardian or the Police by interviewing medical staff member in the ward.
3. A relevant Pediatric examination should be carried out to manage the immediate medical concerns.
4. Once a child with a history of child maltreatment is admitted to the ward, the house officer /SHO should immediately inform the Paediatrician/ Gynecologist about the child, irrespective of the time of day. The Pediatrician/ Gynecologist should then visit the hospital to attend to the child as soon as possible.
5. If the case is an acute abuse (brought within 72 hours of the incident), the forensic medicine personnel (Consultant, Senior Registrar, Registrar, Postgraduate trainee, MO-Medico-legal on call) should be informed over the telephone, irrespective of the time of day to conduct a medico-legal examination (MLE) (except in the cases where the child is already examined by the JMO). The Paediatrician or Gynecologist /senior member of the Paediatric/

Gynecology team should explain details regarding the Forensic Medicine examination to the child, whilst providing comfort and reassurance.

6. Pages of the BHT should be numbered as it is an important legal document, and each entry should carry the date, time, name, and full signature of the person making the documentation. The recordings in the BHT should be legible and reflect the management of the case in chronological order. The BHT should be kept under lock & key to be taken out as and when necessary. This should be the responsibility of the Nursing Sister, -in -Charge of the ward.
7. If the history changes from time to time (as the child may change the history as he/she gradually recovers from the mental trauma and may recall more details), the different versions should be documented separately on the BHT & the new information should be exchanged with other relevant specialists.
8. The essential needs of the child should be met. e.g. when clothes are taken for medico-legal purposes, the child may be in need of new clothes. The Sister /Nurse-in-Charge should take the necessary steps to provide the essentials to the caregivers in special cases as well.

Under **no circumstances** should any other visitors, especially the perpetrator of the crime or his/her representatives of media personnel, be allowed to have access to the child or interview the child. The ward staff should inform security and the hospital police post to deal with such intruders.

The investigations required for the clinical management of the child will be at the discretion of attending medical personnel 4.3.1.4 The Multi-disciplinary Management in the health sector

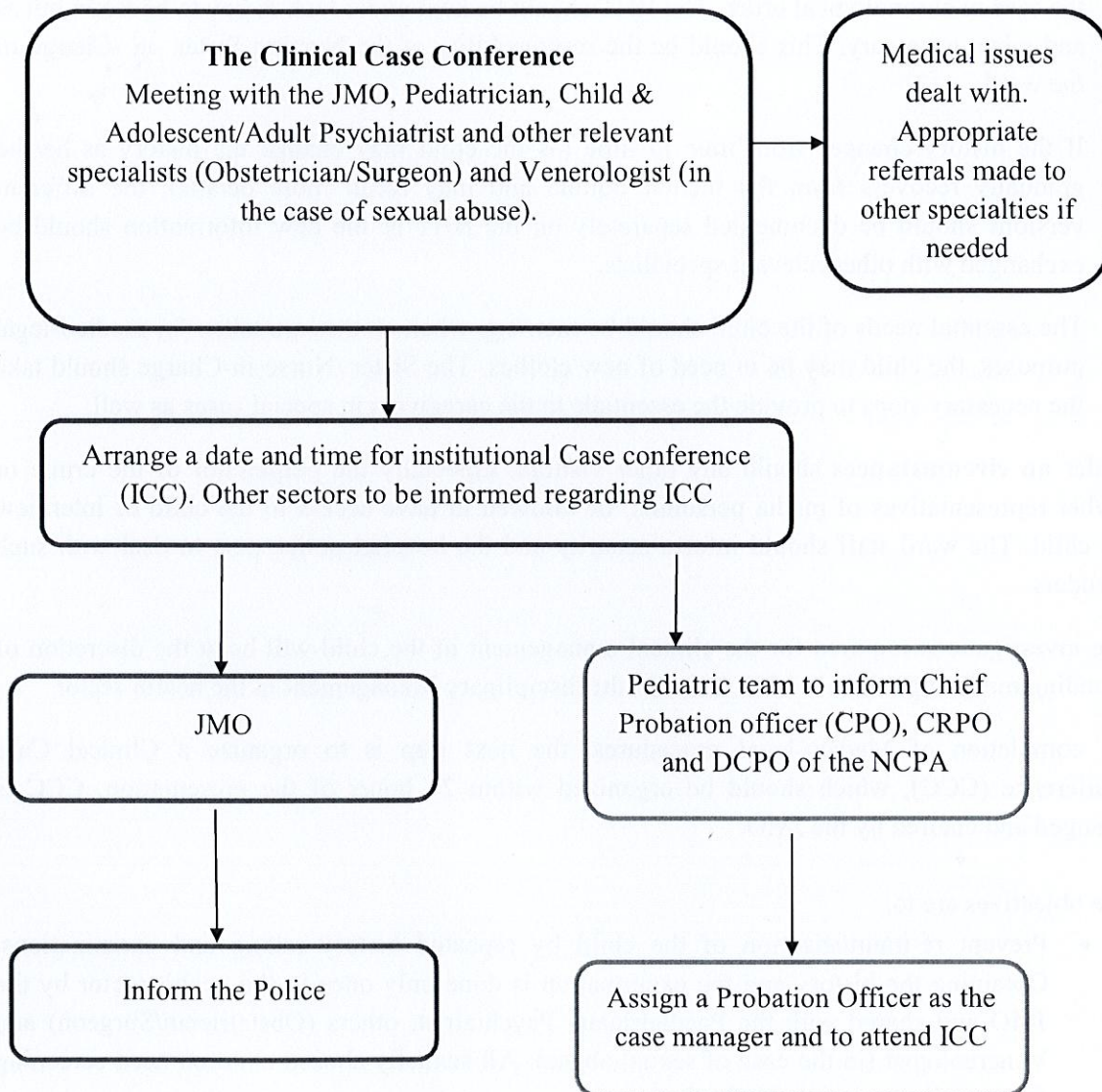
On completion of Medico-legal procedures, the next step is to organize a Clinical Case Conference (CCC), which should be organized within 24 hours of the presentation. CCC is arranged and chaired by the JMO.

The objectives are to:

- Prevent re-traumatization of the child by repeated history taking and examinations. Obtaining the history and the examination is done only once in the health sector by the JMO and shared with the Paediatrician, Psychiatrist, others (Obstetrician/Surgeon) and Venereologist (in the case of sexual abuse). All sexually abused children need screening for sexually transmitted infections.
- Plan further medical and psychological management of the child

Flow chart of the CLINICAL CASE CONFERENCE

CLINICAL CASE CONFERENCE



The Multi-Sectoral Management

Successful rehabilitation and re-integration of a child who has faced violence need input from other sectors and in addition to health professionals.

Once medical management has commenced, the next step is to involve the other sectors. The Police should inform the chief Probation officer of the area. The Paediatric team should inform the CRPOs and the Divisional Child Protection Officer (DCPO) of the NCPA to attend the Institutional Case Conference (ICC). It is chaired by either the Paediatrician or the Child & Adolescent/Adult Psychiatrist.

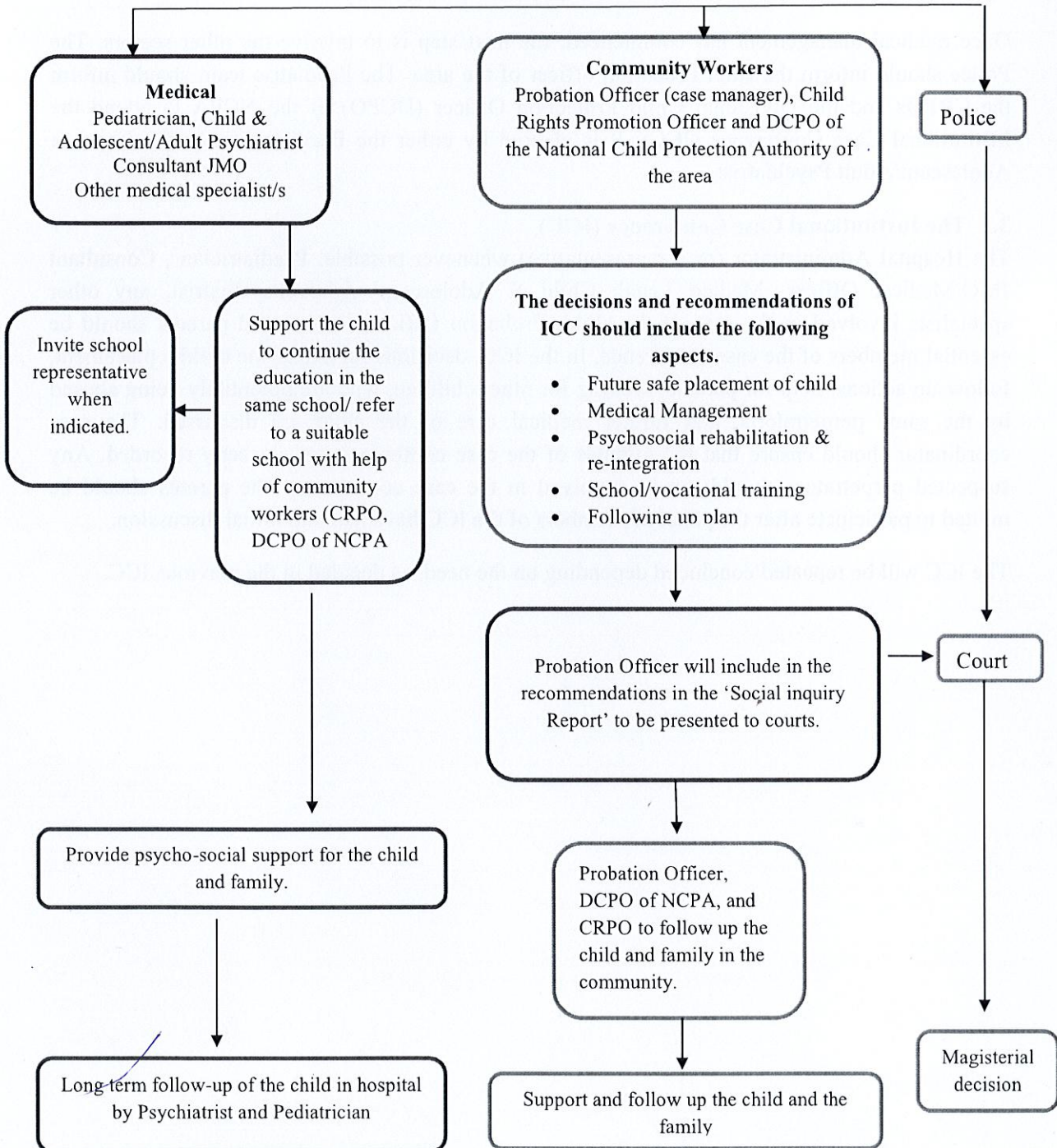
3.2 The Institutional Case Conference (ICC)

The Hospital Administrator (or a representative) whenever possible, Paediatrician , Consultant JMO/Medical Officer- Medico Legal, Child & Adolescent/ Adult Psychiatrist, any other specialists involved in the care of the child, Probation Officer, Police, and parents should be essential members of the case conference. In the ICC, decisions regarding the child's placement, follow-up actions, help for parents, looking for other children, who are potentially being abused by the same perpetrator/s, and further medical care of the child are discussed. The case coordinator should ensure that the minutes of the case conference are correctly recorded. Any suspected perpetrators should not be involved in the case conference. The parents should be invited to participate after the panel of members of the ICC have had an initial discussion.

The ICC will be repeated/concluded depending on the need, as decided in the previous ICC.

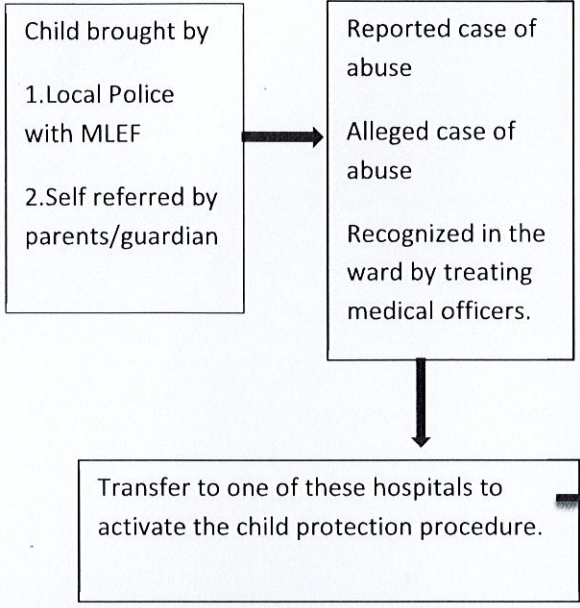
FLOW OF INSTITUTIONAL CASE CONFERENCE

INSTITUTIONAL CASE CONFERENCE(ICC)



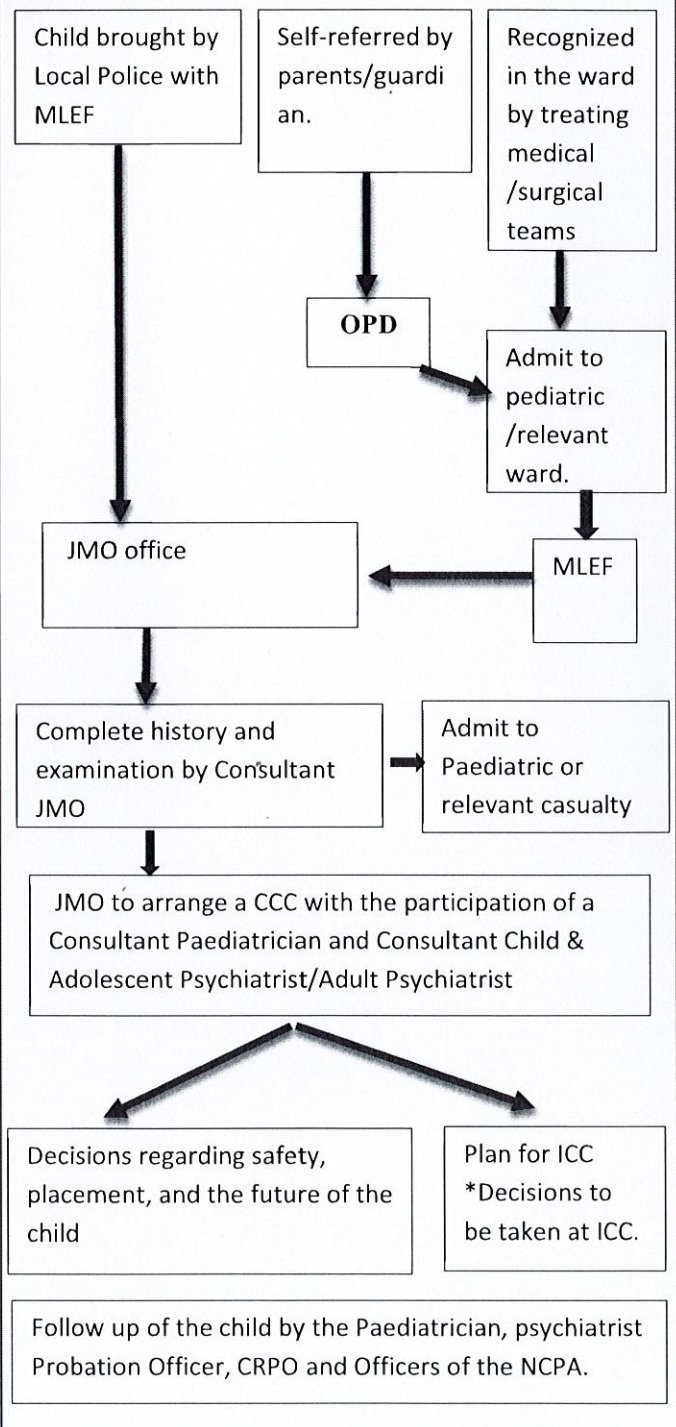
Divisional Hospital

(Consultant JMO, Paediatrician, Psychiatrist not available)



Base, District General, General, and Teaching hospitals

(Consultant JMO, Paediatrician, Child & Adolescent /Adult Psychiatrist available)



Special situations

In situations where there is uncertainty regarding the diagnosis of maltreatment the Paediatrician may discuss with the JMO and obtain his/her opinion. Based on this opinion a request to issue a MLEF can be made. Specialist in Forensic medicine before issuing an MLEF and depending on the probability can request to issue an MLEF.

- *
- Future safe placement of the child
 - Medical Management
 - Psychosocial rehabilitation & re-integration
 - School/vocational training
 - Following up plan

**Reference - National Guideline for the Management of Child Abuse and Neglect
A Multi-Sectoral Approach**