National Guideline For The Management Of Child Abuse And Neglect In Health Facilities

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Department of Public Health
Ministry of Health

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FOREWORD

Children deserve to grow up in environments that are safe, nurturing, and free from harm. However, the findings from Bhutan's national studies reveal a significant number of children continue to experience various forms of violence, often within the very spaces meant to protect them. Such experiences have profound and lasting impacts on their physical, mental, and emotional well-being.

Recognizing the critical role of the health sector in identifying and responding to child abuse, the Ministry of Health and the Department of Forensic Medicine and Toxicology at Jigme Dorji Wangchuck National Referral Hospital (JDWNRH) (One Stop Crisis Centre), in collaboration with UNICEF Bhutan, have developed this National Guideline for the Management of Child Abuse and Neglect in Health Facilities. This document is a vital step towards strengthening Bhutan's health system response to child protection, ensuring that health professionals are equipped with the knowledge, tools, and sensitivity required to provide appropriate care to child victims.

The guideline is grounded in Bhutan's legal and policy frameworks, including the Convention on the Rights of the Child and the Child Care and Protection Act, and reflect international best practices. It aims to bridge the gap between policy and practice, empowering health professionals to respond effectively and refer cases appropriately.

We commend the efforts of all stakeholders involved in the development of this important resource and reaffirm our commitment to working together to protect the rights and well-being of every child in Bhutan.

Secretary
Ministry of Health

Representative
UNICEF

ACKNOWLEDGEMENT

The National Guideline for the Management of Child Abuse and Neglect in Health Facilities 2025 is an outcome of collaborative efforts between the Ministry of Health (MoH), the Department of Forensic and Toxicology, JDWNRH, and UNICEF Bhutan. The initiative was technically spearheaded by the Department of Forensic and Toxicology, with financial support from UNICEF.

The MoH extends its deepest gratitude and appreciation to the members of the Technical Working Group (TWG), comprising officials from the Department of Forensic and Toxicology, JDWNRH, district hospitals, Primary Health Centers, and UNICEF for their invaluable commitment, expertise, and time. Their collective efforts were instrumental in developing this guideline to support medical and health professionals in ensuring delivery of comprehensive and quality health care services to victims of child abuse and neglect.

We also extend our sincere gratitude to the diverse stakeholders, including civil society organizations (CSOs) and government agencies, for their active participation, valuable contributions, and guidance in shaping the guideline. Their insights ensured that the guideline aligns with existing systems and practices related to providing services to child victims of abuse and neglect.

Our special appreciation goes to UNICEF for the financial support and technical guidance in integrating both national and global perspectives into the guideline, ensuring coherence with international and national health goals. In addition, UNICEF's financial support was instrumental in facilitating a series of consultative meetings and workshops in validating and refining the guideline.

Contents

List of Abbreviation

AIDS	Acquired Immunodeficiency Syndrome
CC	Clinical Counsellor
CCPA	Child Care and Protection Act
CO	Clinical Officer
CMO	Chief Medical Officer
CRC	Convention on the Rights of the Child
CSO	Civil Society Organization
CRRH	Central Regional Referral Hospital
CT	Computed Tomography
DNA	Deoxyribonucleic Acid
EC	Emergency Contraception
EISR	Early Identification and Safe Referral
ERRH	Eastern Regional Referral Hospital
GBV	Gender-based Violence
GDMO	General Duty Medical Officer
HA	Health Assistant
HIV	Human immunodeficiency Virus
IPV	Intimate Partner Violence
LMP	Last Menstrual Period
MoH	Ministry of Health
MLR	Medicolegal report
NCWC	National Commission for Women and Children
NGO	Non-governmental organization
OAG	Office of the Attorney General
NHS	National Health Survey
OPD	Out-patient Department
PCB	Penal Code of Bhutan
PEP	Post-exposure Prophylaxis
PHC	Primary Health Center
PTSD	Post-traumatic Stress Disorder
RBP	Royal Bhutan Police
STI	Sexually Transmitted Infection
UN	United Nations
UNICEF	United Nation Children's Fund
USG	Ultrasonography
VAC	Violence against Children.
WHO	World Health Organization
SOP	Standard Operating Procedure

1. Introduction

According to the 2016 National Study on Violence Against Children, nearly half of all children (47.4%) reported having experienced emotional violence, 12.8% reported having experienced at least one instance of sexual violence, and 64% reported having experienced at least one instance of physical violence.[1] Additionally, the National Health Survey (NHS) 2023 reported over 82.2% of children aged 1 to 14 were subjected to some form of violent discipline in the previous month. 18.3 percent of the 60.1% of children experienced physical punishment. Almost 30% of mothers and caregivers believe that physical punishment is necessary for disciplining a child.[2]

Child victims of abuse and neglect can experience severe (though nonfatal) short- and long-term physical, sexual, and mental health consequences. Physical health consequences include injuries, disabilities, and gastro-intestinal disorders, while sexual and reproductive health consequences include sexually transmitted infections (STIs). Adolescent girls may face additional health issues, including gynecological disorders and unwanted pregnancies.

Research indicates that children who experience abuse tend to use healthcare services more frequently than their peers. Yet, reported incidents of child abuse and neglect within Bhutanese health facilities are notably scarce. This gap is likely due to several key challenges. First, frontline medical and health professionals might have failed to recognize signs of abuse during clinical assessments due to a lack of knowledge and skills. Second, child victims might not have sought medical care due to unfriendly or unwelcoming services. In addition, there were no standardized national clinical guidelines to assist medical and health professionals in providing appropriate care.

Despite the absence of a national guideline, numerous healthcare facilities assist in identifying and treating children who are victims of violence. A majority of these cases are encountered in outpatient departments (OPD), where children are either present for medical evaluation on their own or are brought by caregivers following an incident of abuse. In some instances, children may seek treatment related to pregnancies resulting from sexual assault. The Department of Forensic Medicine and Toxicology at JDWNRH has reported a significant increase in physical and sexual child abuse cases, as well as teenage pregnancies, rising from 45 in 2019 to 87 in 2024.

The Convention on the Rights of the Child (CRC), the Child Care and Protection Act of Bhutan (CCPA), 2011 and the Child Care and Protection Rules and Regulations of Bhutan 2015 provide a foundational basis for this guideline.

1 Study on Violence against Children 2016, National Commission for Women and Children.

2 National Health Survey, 2023, Ministry of Health.

2. Purpose of the guideline

The purpose of this guideline is to improve the quality of care to victims of child abuse and neglect by establishing a standardized framework for identifying, assessing, documenting, treating, reporting, and referral of cases of child abuse and neglect.
This guideline will be used by medical and health professionals working in health facilities in Bhutan.

3. Objectives of the guideline

This guideline aims to:

1. Provide standardized, comprehensive healthcare services for victims of child abuse and neglect.
2. Establish uniform data collection, documentation, reporting and referral protocols in healthcare settings.
3. Strengthen multidisciplinary collaboration among medical and health professionals, child protection agencies and the justice sector.

4. Guiding principles

Medical and health professionals will be guided by these principles when dealing with victims of child abuse and neglect:

4.1 Best Interest of the Child

This guideline adheres to the principle of best interest of the child as articulated in the Section 243 (a) of CCPA, 2011 and Article 3 of the CRC as follows:

- Section 243 (a) of CCPA, 2011:
  - » The totality of the circumstances and conditions which are most congenial to the survival, protection and feelings of security of the child and most encouraging to the child's physical, psychological and emotional development. It also includes the least detrimental available alternative for safeguarding the growth and development of the child.

- Article 3 of the CRC:
  - » In all actions concerning children, whether undertaken by public or private social welfare institutions, courts of law, administrative authorities or legislative bodies, the best interests of the child shall be a primary consideration.
  - » States Parties undertake to ensure the child such protection and care as is necessary for his or her well-being, taking into account the rights and duties of his or her parents, legal guardians, or other individuals legally responsible for him or her, and, to this end, shall take all appropriate legislative and administrative measures.

» States Parties shall ensure that the institutions, services and facilities responsible for the care or protection of children shall conform with the standards established by competent authorities, particularly in the areas of safety, health, in the number and suitability of their staff, as well as competent supervision.

» The best interest principle at a health facility should be determined by a committee comprising the health facility in charge and one or more additional members.

4.2 The principle of non-discrimination

WHO's Responding to Child Maltreatment: A Clinical Handbook for Health Professionals, principle of non-discrimination, states:

"All children and adolescents have a right to quality care, regardless of their sex, race, ethnicity, religion, sexual orientation, gender identity, disability or socioeconomic status. Some children – for example, adolescent girls from poor communities, children or adolescents with disabilities, children or adolescents that are part of ethnic minorities and indigenous groups, and other groups facing discrimination or exclusion – can be at higher risk of child maltreatment or might face additional barriers to accessing services. It is important to pay attention to the specific needs of groups made vulnerable by structural inequalities, and ensure that services are equally accessible to all children in these parts of the community. This can include alternative ways of communication or working with a translator, if necessary. Use language consistent with children's and adolescents' cultural, religious, gender, ethnic, and ability identities."

4.3 The principle of participation

WHO's "Responding to Child Maltreatment: A Clinical Handbook for Health Professionals, principle of participation, states:

"Children and adolescents have a right to participate in decisions that have implications for their lives, in accordance with their developing capacities. In practice, this means they should be asked what they think, have their opinions respected and taken into account when decisions are being made in relation to their clinical care. This can, for example, be done by asking them about where they prefer examinations to take place, and who should be present in the room. Because the act of abuse is a disempowering situation, you can contribute to restoring that power in every interaction, no matter how small. For example, you can ask: Would you like to sit in this chair or that chair? What color pen do you prefer?"

4.4 The principle of evolving capacities of the child

WHO's Responding to Child Maltreatment: A Clinical Handbook for Health Professionals, principle of evolving capacities of the child, states:

"Children's and adolescents' capacity to make informed choices evolves with their age and developmental stage. Addressing this principle involves:

- Providing information according to the child's age and developmental stage and capacity;
- Always seeking informed consent or assent, even from young children."

5. Informed consent and assent

Informed consent refers to the outcome of an open communication process between a patient and their medical and health professional, during which the patient is entitled to receive relevant health information and ask questions before undergoing any procedure or treatment. This exchange typically results in the patient giving permission for care or services. In case of child abuse, informed consent may be obtained from the guardian or caregiver.

Procedure for obtaining informed consent from caregiver includes the following:

- Provide information on range of services and choices available to the child and their family
- Explain possible advantages and risks associated with those services
- Explain methods of information collection and its usage
- Inform the scope and boundaries of confidentiality

Informed assent is a child's expressed willingness to engage in services, especially vital in cases of sexual abuse, where children may lack the legal or developmental ability to provide informed consent. Beyond its legal importance, informed assent also plays a therapeutic role, helping rebuild the child's sense of power. This requires developmentally appropriate, child-centered communication to support understanding and voluntary participation, even if children cannot grasp all service details.

Procedure for obtaining informed assent, medical and health professionals must:

- Offer complete and understandable information in multiple formats
- Clarify data sharing, storage, and confidentiality parameters
- Explain expected procedures and their benefits and risks
- Reinforce the child and caregiver's right to decline any service
- Children, including those who are very young and may not fully comprehend all procedures and their implications, shall be allowed to participate in certain decisions, such as selecting the location of the examination or determining who may be present in the room.

Code of Conduct, Ethics and Etiquette for Medical and Health Professionals (2021)
Duties towards patient:

Section 5.15 Respect patients' rights to privacy, and maintain confidentiality of information;

Section 5.21 Obtain informed consent to give treatment

In healthcare facilities, the requirements for informed consent and assent are as follows:

Situation 1 - Case referred through the justice sector (RBP/Court/OAG)

If the case is referred to through the justice sector, informed assent of the child is required. In case of refusal of assent by the child, it should be documented and reported to the justice sector. In case assent for partial examination is provided, proceed with the examination and submit the report to the justice sector accordingly.

Situation 2 - Case referred by other service providers (CSO/The PEMA Secretariat /Schools, etc.)

If the child is referred by other service providers, the assent of the child and informed consent of the parents/guardians/caregivers are required. In case of refusal of either assent or consent, inform the referring party accordingly and refer back. However, if the child is 16 years or above and gives assent, the medical and health professional may proceed with examination even without the consent of the guardian (Principle of mature-minor).

Situation 3 - Case first identified in a healthcare facility

If the child is first identified in a healthcare facility as a potential victim of abuse, assent of the child and consent of the parents/guardians/caregivers are required for further evaluation. In the best interest of the child, the medical and health professional may report to The Pema Secretariat or RBP if further assessment is refused.

Note:

- In all of the above situations/cases, consent of the parents/guardians/caregivers is not required if they are the implicated perpetrators in the case.
- In cases of emergency, treatment may override the protocol of obtaining informed consent from the caregiver to save lives.
- If the child is 16 years or above and gives assent, the medical and health professional may proceed with examination even without the consent of the guardian (Principle of mature-minor).

6. Definitions:

6.1 Child

A person below the age of 18 years shall be treated as a child, evidenced by an official record maintained by the government, birth certificate or any other document proving the age of the child (CCPA, 2011).

6.2 Child abuse:

Child abuse is an act of ill treatment or an omission that can harm or is likely to cause harm to a child's safety, well-being, dignity, and development. For child abuse, the intent of the action does not matter; it is the actual harm that comes to the child that is important (EISR Manual, NCWC).

Child maltreatment/abuse includes the perpetration of physical, sexual, and psychological/emotional violence, and neglect of infants, children, and adolescents aged 0–17 years by parents/guardians/caregivers and other authority figures, most often in the home but also in settings such as schools and orphanages (WHO).

6.2.1 Physical abuse

- Involves the use of physical force to cause actual or likely physical injury or suffering to a child.
- Examples include: hitting, shaking or torture of a child.

6.2.2 Sexual abuse

- Refers to any involvement of a child in sexual activity into which he or she has been forced, manipulated or deceived, which they may or may not understand is wrong, and about which they may or may not be afraid to report.

It includes (but not limited):

- Non-contact sexual abuse (e.g. sexual threats, verbal sexual harassment, sexual solicitation, indecent exposure, exposing the child to pornography);
- Contact sexual abuse (e.g. sexual intercourse with a child or child molestation); and,
- Child marriage.

6.2.3 Emotional/psychological abuse

- Any humiliating or degrading treatment against a child
- Examples include: Name calling, constant criticism, shaming or isolation.

6.2.4 Neglect (physical, medical, educational, emotional)

- Deliberately or negligently failing to provide for a child, their rights to safety and development. Failure of parents/guardians/caregivers to provide for the well-being and development of the child (where the parents/caregivers is in a position to do so) with respect to:
  - » Health
  - » Education
  - » Emotional support
  - » Nutrition
  - » Shelter and safe living conditions.

6.3 Guardian

"Guardian" in relation to a child, includes any person who in the opinion of the competent authority, having cognizance of any proceeding in relation to the child, has, for the time being, the actual charge of, or control over, that child. (243(f), Child Care and Protection Act of Bhutan 2011).

6.4 Caregiver

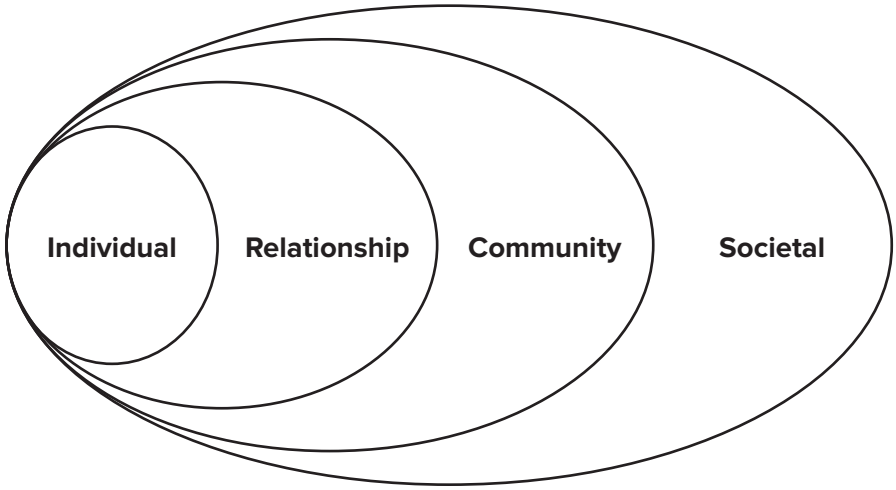
A caregiver is someone who provides daily care, protection and supervision of a child. This does not necessarily imply legal responsibility and therefore goes beyond only parents. It also includes customary parents/guardians/caregivers. A customary caregiver is someone that the community has accepted, either by tradition or common practice, to provide the daily care, protection and supervision of a child.

6.5 Trusted adult

A trusted adult is chosen by the young person as a safe figure that listens without judgment, agenda or expectation, but with the sole purpose of supporting and encouraging positivity within a young person's life.

7. Ecological theory of risk factors associated with child abuse and neglect:

This theory highlights the complex, multidimensional causes of abuse, demonstrating its dynamic nature. According to the WHO, the Ecological Theory distinguishes four interrelated levels that might, either separately or in combination, be the cause of child abuse and neglect. Therefore, during the assessment, it is important to look for these risk factors. The four ecological levels of risk factors are described as below:



Source: WHO, The VPA Approach

7.1. Individual Risk Factors

7.1.1 Individual Risk Factors (Child)

- Age: Younger children, especially those under 4 years old, are at higher risk due to their dependency and vulnerability.
- Disabilities: Children with physical, intellectual, or developmental disabilities are more likely to experience abuse due to increased caregiving demands and communication barriers.
- Behavioral Issues: Children with challenging behaviors (e.g., hyperactivity, aggression) may be at higher risk of abuse.
- Chronic Illness: Children with long-term health conditions may face neglect or abuse due to caregiver stress.

7.1.2 Individual Risk Factors (Caregiver)

- Mental Health Issues: Parents/guardians/caregivers with untreated mental health conditions (e.g., depression, anxiety, or personality disorders) are more likely to engage in abusive behaviors.
- Substance Abuse: Alcohol or drug abuse by parents/guardians/caregivers increases the risk of neglect and abuse.
- History of Abuse: Parents who experienced abuse or neglect in their own childhood are more likely to perpetuate abusive behaviors.
- Poor Parenting Skills: Lack of knowledge about child development or ineffective discipline strategies can lead to abusive practices.
- Young or Single Parents: Inexperience or lack of support can increase the risk of abuse.

7.2 Relational Risk Factors:

- Weak emotional bonds between children and parents/guardians/caregivers
- Poor parenting practices
- Family dysfunction or separation
- Witnessing domestic violence
- Early or forced marriage

7.3 Community Level:

- Poverty
- High population density
- Low social cohesion and mobile population
- Easy access to alcohol and drugs

7.4 Societal Level:

- Harmful social and gender norms that normalize violence (e.g., cultural beliefs)
- Policies perpetuating economic, gender, or social inequalities
- Weak or absent social protection systems
- Post-conflict or disaster settings
- Weak governance and poor law enforcement

8. Identification of Child Abuse and Neglect at Health Facilities

Victims of child abuse and neglect often withhold disclosure of abuse due to stigma, mistrust, shame, or fear of repercussions. Disclosure is even rarer when parents/guardians/caregivers are involved in abuse and neglect. For infants and very young children, disclosure may not be possible at all. Therefore, it is the essential responsibility of medical and health professionals to recognize the signs, symptoms, and behaviors of the child, as well as their interactions with parents/guardian/caregivers that may indicate abuse and neglect. In addition, various forms of abuse can coexist, and while some signs may indicate abuse, they are not always definitive. The key to managing child abuse is being vigilant and promptly identifying warning signs and symptoms. The different signs and symptoms of child abuse and neglect are described below:

8.1 Warning signs in history:

8.1.1 Nature of presentation

a) Delayed presentation for medical treatment.

b) History is inconsistent with examination findings or the child's developmental age.

c) Changing history from time to time.

8.1.2 Somatic symptom pattern:

a) Vaginal discharge especially if blood stained or purulent.

b) Assumed menarche without secondary sexual characteristics.

c) Painful defecation with or without bleeding per rectum.

d) Skin lesions in the perineum and or peri-anal region.

e) Somatization phenomena such as headache, abdominal pain, pseudo-seizures, etc.

8.1.3 Behavioral/psychological pattern:

a) Deteriorating school performance or school refusal.

b) Sudden onset of unusual behaviors.

c) Attempted suicide or deliberate self-harm.

d) Sexualized behavior.

e) Avoiding certain places or persons.

f) Sexually inappropriate behaviors, e.g., being unusually friendly with certain adults.

8.1.4 Social issues:

a) Dysfunctional home environment, e.g., fractured families, parent/s employed abroad, or substance abuse among family members.

b) Minors without adult supervision, abuse may occur among children of different ages, especially when older children take advantage of power imbalances to harm younger ones.

8.1.5 Parents/guardians/caregivers' behavior and potentially harmful interactions with child:

1. Emotional unavailability and unresponsiveness towards a child, particularly an infant.
2. Negativity, hostility, rejection or scapegoating of the child.
3. Using the child to fulfill the adult's needs (e.g., in disputes between parents/ guardians/caregivers).

8.2 Warning signs in the examination (physical, psychological, behavioral indicators):

8.2.1 Physical:

A - Soft tissue injuries

i) Any serious or unusual injury with an absent or unsuitable explanation.

ii) Lacerations, abrasions or scars with explanations that are inconsistent.

iii) Multiple injuries of different stages of healing.

iv) Unexplained bruising or petechiae (pinpoint red/purple spots) that cannot be attributed to medical conditions (e.g., coagulation disorders) and where the provided explanation is inconsistent with the injury pattern.

Examples include:

» Bruising in a non-ambulatory child;

» Multiple bruises or bruises in clusters; bruises of a similar shape and size;

» On any non-bony part of the body or face, including the eyes, ears, and buttocks;

v. Burn or scald injuries if the explanation is absent or unsuitable, particularly in non-ambulatory child, on a soft tissue area not likely to come into contact with a hot object in an accident, or in the shape of an implement (e.g., a cigarette tip or iron).

vi. Reports or appearance of a human bite mark that is thought unlikely to have been caused by themselves.

B - Skeletal injuries

a. One or more fractures in the absence of a bone fragility condition (such as osteogenesis imperfecta, rickets, or osteopenia of prematurity), accompanied by either no reasonable explanation or a contradictory account.

b. Unusual skeletal injuries:

I. Long bone fractures in infants (spiral fractures are very suspicious);

II. Metaphyseal fractures – chip and bucket handle fracture; and

III. Posterior rib fractures.

C - Genital injuries

1. Presence of injuries (e.g., tear/laceration of posterior fourchette)

2. Multiple anal fissures or patulous anus in females/males.

D - Other findings

- » Presence of foul smelling per vaginal discharges, anogenital warts/ulcers.
- » Presence of foreign bodies in vagina/anus.
- » Pregnancy in a child. (However, in some cases, teenage pregnancy may not necessarily indicate maltreatment, as consensual sexual activity between two minors can occur.)

8.2.2 Evidence of neglect (e.g. Poor grooming, unkempt, poor weight gain, malnutrition, etc.) - Persistent failure or the deliberate denial to provide a child with basic needs.

a. Consistently poor hygiene which is becoming a health concern (e.g. baby being left in soiled diapers for long periods of time despite access to diapers and adequate resources).

b. Inappropriately dressed for the weather.

c. Lack of care for medical needs, wound care, and medication.

8.2.3 Psychological & behavioral:

1. Psychological:
   - » Emotional dysregulation/disorders.
   - » Low self-esteem.
   - » Attachment and relationship issues.
   - » Developmental delays.
   - » Identity and self-concept problems.
   - » Distorted self-image, shame, and guilt.

2. Behavioral:
   - » Social withdrawal.
   - » Aggression and conduct problems - sexualized behavior in a prepubertal child, such as inappropriate sexual talk, actions mimicking sexual activity, or attempts at sexual contact with others or objects.
   - » Risky or self-destructive behavior.
   - » Problems with authority or law.
   - » Regressive behavior- e.g., bet wetting.
   - » Decreased academic performance or increased absenteeism from school.

If the medical and health professional identifies signs and symptoms suggestive of child abuse and neglect, it is usually necessary to obtain further information. The medical and health professional may seek explanation for the observed signs and symptoms. If there is suitable explanation for the signs and symptoms, the child abuse or neglect may be ruled out, and appropriate treatment should be provided. If there is/are no suitable explanation, the child abuse and neglect may be suspected and proceed with appropriate response and management. (Definitions of "suitable" and "unsuitable" explanations are provided in the appendix).

9. Response and management in health facilities

When a probable case of child abuse and neglect is identified at a health facility or referred by other service providers, a thorough clinical assessment is essential. The clinical evaluation should be undertaken in a safe setting by a trained medical and health professional. Informed assent from the child and informed consent from the guardian should be obtained as appropriate. The key components of a clinical evaluation include:

1. Safe setting
    - » Conduct all interviews and examinations in a private and secure location.

2. Informed consent/assent
    - » Obtain informed assent and informed consent from the child victim and parents/guardians/caregivers respectively.
    - » If informed consent/assent is not given, it is advisable to document the refusal and inform relevant parties.

3. Clinical evaluation and documentation
    - » Use data collection form to gather information and documentation.
    - » Apply the LIV of LIVES CC approach (refer appendix).
    - » Record verbatim statements using quotation marks
    - » Undertake thorough assessment.
    - » Document physical findings with diagrams/photography (use data collection forms, refer appendix).
    - » Note behavioral observations and developmental appropriateness

4. Management
    - » The initial management for all cases of child abuse and neglect involves providing first-line support services using the LIVES CC model.

» Subsequent management is tailored to the individual's needs and may include referrals to specialists, other relevant external agencies, and medicolegal services.

» It is essential that a child's safety, security, self-esteem and overall well-being are taken into consideration.

5. Data privacy
   » Secure all records with restricted access.
   » Follow reporting requirements while maintaining confidentiality (where relevant); restrict in ePIS (but may allow for courts/RBP/personal rights).

10. Clinical assessment protocol for suspected child abuse

The following are the salient features to be taken into consideration when undertaking clinical assessment of suspected victims of child abuse and neglect:

10.1 Consent and assent procedures

- Obtain informed consent from parents/guardians/caregivers (if appropriate) and assent from the child (considering age/developmental level - use the consent/ assent form. If consent is denied:
  » Prioritize the child's safety and best interests.
  » Report to the relevant agencies as appropriate.

The child should be interviewed alone, unless they expressly ask for the caregiver to be present, as having the caregiver in the room may discourage open disclosure for reasons such as:

- Fear of retaliation.
- Feelings of guilt or shame.
- Influence from the perpetrator (particularly if the caregiver is involved).

10.2 Clinical evaluation-history taking, physical examination and investigation

The components of the clinical evaluation are as follows:

10.2.1 History taking

» Presenting history.
» Previous report/s of abuse, or disclosure of abuse.
» Medical history (history of previous physical and mental health issues including chronic illness and disabilities)
» Gynecology and Obstetrics history (menarche, Last menstrual period (LMP), miscarriages, contraceptive, etc.)

» Social history (education, peer relationships, parental support and income, parental use of drugs and alcohol, marital disharmony/family dynamic, living conditions)

10.2.2 Physical examination

» General (appearance, anthropometry, and any obvious physical deformity, etc.).

» Mental state examination.

» Non-genital physical injury.

» Ano-genital (injury, discharges, bleeding, ulcers, blisters, growths, foreign bodies) - In case of suspected sexual abuse.

» Tanner staging (breast and pubic hair)- if relevant.

» Speculum examination (If required).

10.3 Investigations

» Radiological/skeletal survey where relevant (X-ray, USG, CT-scan, etc.).

» Laboratory (pregnancy test, viral markers, others).

» Forensic (sperm microscopy, DNA, Toxicology, etc.).

10.4 Keep a record (include photo-documentation)

» Record exactly:

◊ What is observed;

◊ Who said what, and when;

◊ Why this is of concern.

» Fill in the data collection form

11. Management

11.1. Medical management

The child victim should be given comprehensive medical care that may range from initial resuscitation and stabilization to advanced care. For stable child victims, start the service with first line support services following LIVES CC protocol.

Basic medical care involves wound management such as cleaning, suturing, dressing, updating tetanus toxoid and diphtheria (Td) injection, administering analgesics and antibiotics as well as treatment of other medical conditions (e.g., chronic illnesses). If the medical services are not available at the given health facility, arrangements for referral to a higher health facility should be undertaken after consultation with the child victim and parents/guardians/caregivers.

In case of child sexual abuse, consider following:

- **Emergency contraception:** It is recommended for use within 5 days (120 hours) but is more effective the sooner they are used after the sexual act has occurred. Provide emergency contraception as per the "National family Planning standard, 2018".
- **Prevention and treatment for STIs:** Provide treatment as per the "National Guidelines for the Management of Sexually Transmitted Infections in Bhutan 2006".
- **HIV post exposure prophylaxis** (where relevant, within 72 hours): As per the "National guideline on treatment and management of HIV and AIDS, revised version 2024".
- In cases of child pregnancy, ensure provision of routine Antenatal care and other services such as Medical Termination of pregnancy if requested and available.

Child abuse and neglect can cause serious mental health problems, such as depression, anxiety, and post-traumatic stress disorder (PTSD), etc. Such conditions should be identified at the earliest opportunity and managed appropriately. Therefore, it is recommended that cases of child abuse and neglect be comprehensively assessed, including referral to psychiatrist and other experts, if necessary.

11.2 Medico-legal management

Cases of child abuse and neglect are considered criminal and may face prosecution in court of law for administration of justice. Therefore, it is essential that medical and health professionals gather complete information and document them properly. These findings can be used in court of law as medical evidence. The medical and health professional may be asked to submit a medico-legal report and may also be asked to provide oral evidence in court at a later date. The following best practices in the medico-legal field need to be observed:

1. Proper Identification and Documentation: Accurately record injuries and findings.
2. Fact-Based Opinion: Base conclusions on examination, investigation, and referral. Avoid presumption or hearsay.
3. Objective Reporting: State whether signs suggest abuse (e.g., genital penetration in sexual abuse), not definitive abuse.
4. Injury Details: Note healing stages and likely age/duration of injuries. Explain possible causes (e.g., battery, restraint, self-harm).
5. Sexual Abuse Indicators: Genital injuries, STIs, foreign bodies, or seminal fluid may indicate abuse, but their absence doesn't rule it out. Need to corroborate with other circumstantial evidence.
6. Facilitate Paternity testing upon the directives of the Court of law

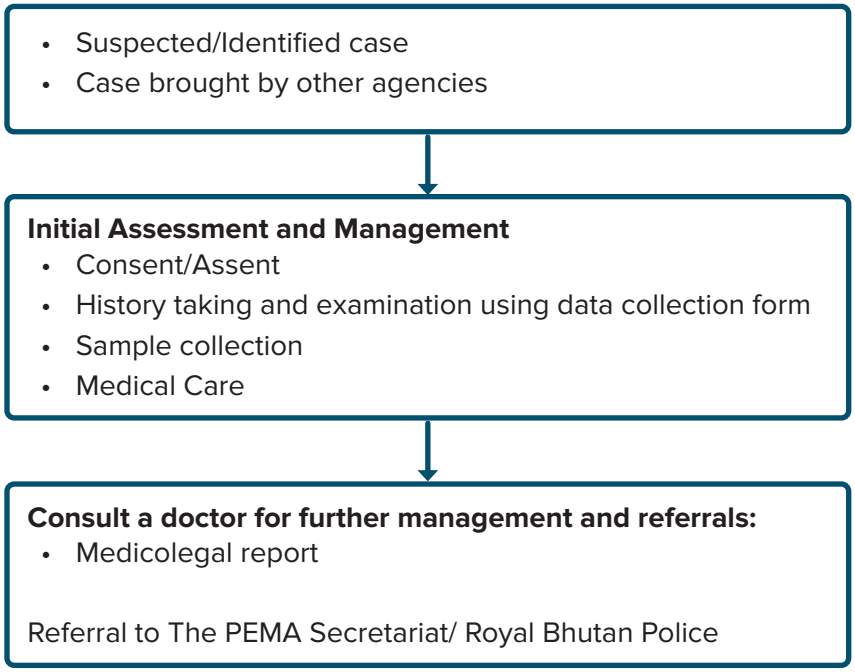
11.3 Psycho-social management

In addition to first-line support services, all survivors of child abuse or neglect should be assessed for psychosocial support need, which can help them recover emotionally and prevent further violence. Such needs may include change of residence, school, guardian, among others. Therefore, it is essential that every case of child abuse and neglect are referred to a case manager for evaluation and provision of psycho-social needs after obtaining due informed consent and assent. Currently, the following agencies provide case management services for victims of child abuse and neglect:

1. The PEMA Secretariat
2. RENEW
3. Nazhoen Lamtoen

12. Procedure for health facility care and referral pathway

12.1 At Health Assistant (HA)/Forensic focal level

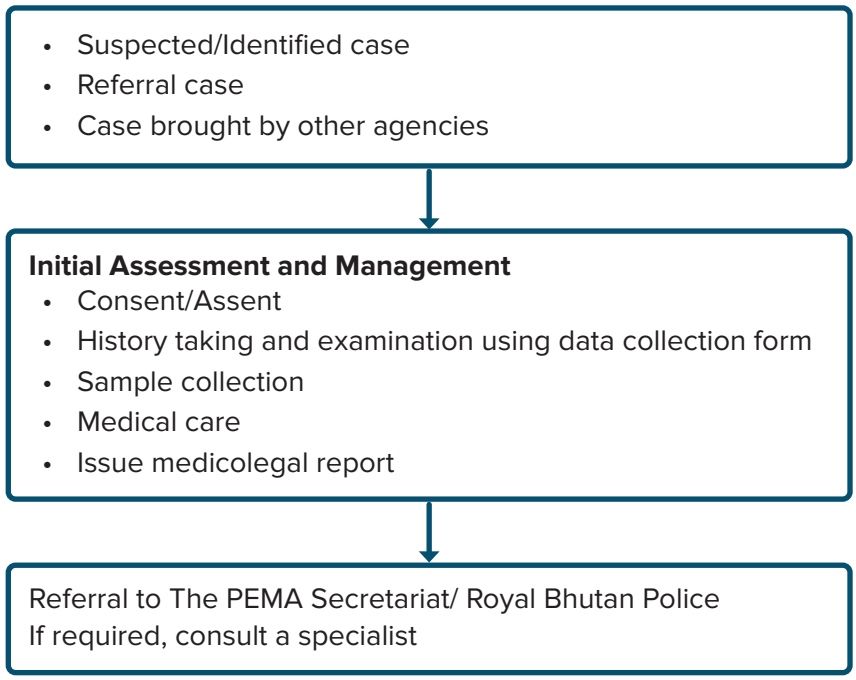


- In cases reported by other agencies (e.g., RBP, The PEMA Secretariat, RENEW, etc.) or identified at a health facility, initial assessment and management should be undertaken to stabilize the child victims.
- Once the child victim is stabilized, obtain informed consent and assent as appropriate.
- Undertake clinical evaluation and record the findings using the appropriate data collection form.
- Consult the medical officer concerned for further course of action regarding management and referrals.

Note: In consultation with the medical officer concerned:

- HA may collect forensic samples, especially in cases of sexual abuse to avoid delay.
- HA may issue medico-legal report.
- Refer/report the case to The PEMA Secretariat/ RBP.
- Referral to The PEMA Secretariat
  - » Emergency cases requiring immediate protection should be referred via 1098.
  - » Moderate or non-urgent cases (e.g., older cases) can be referred via email.

12.2 Medical officer level



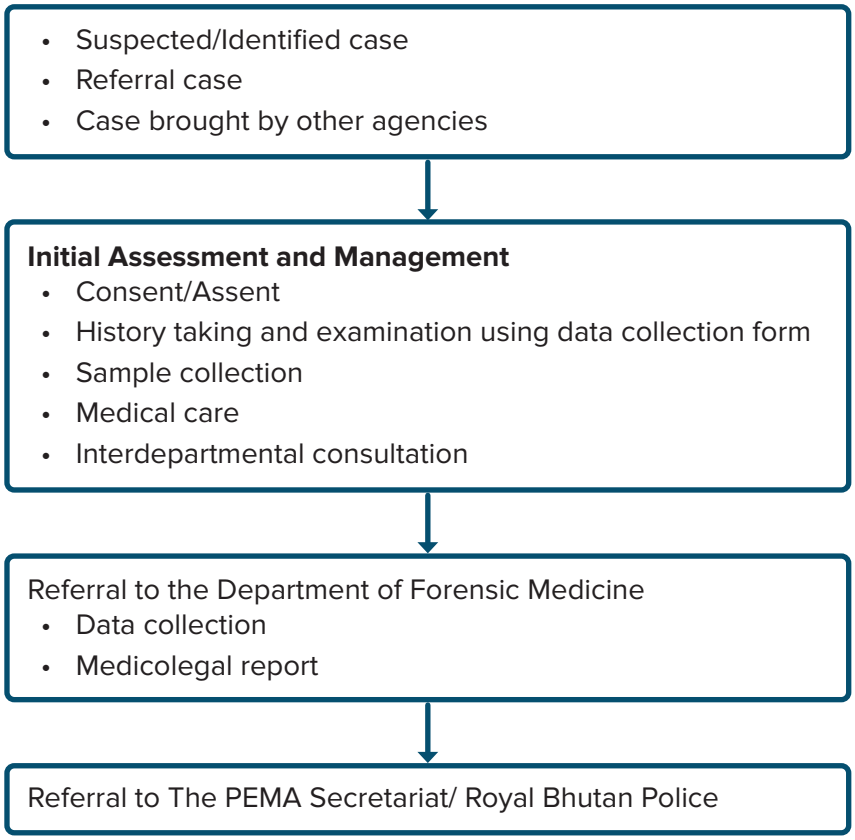
- In cases reported by other agencies (e.g., RBP, The PEMA Secretariat, RENEW, etc.) or referred by HA/Forensic focal, the child victim must first receive immediate first aid and be clinically stabilized.
- Once the child victim is stabilized, obtain informed consent and assent as appropriate.
- Undertake clinical evaluation and record the findings using the appropriate data collection form.
- Provide comprehensive medical services as needed. In cases of sexual abuse, consider emergency contraceptives, post exposure prophylaxis, forensic sample collection.
- Issue medico-legal report.
- Cases identified at health facilities should be referred to The PEMA Secretariat/ RBP.

Referral to The PEMA Secretariat

- Emergency cases requiring immediate protection should be referred via 1098.
- Moderate or non-urgent cases (e.g., older cases) can be referred via email.

Note: The medical officers concerned will be equally accountable for the cases consulted by the HA.

12.3 Specialist level



- In cases reported by external agencies (e.g., RBP, The PEMA, RENEW, Nazhoen Lamtoen, etc.) or where abuse is suspected or referred by medical doctors, the patient must first receive immediate first aid and be stabilized.
- Provide comprehensive medical services needed. In cases of sexual abuse, consider emergency contraceptives, post exposure prophylaxis, forensic sample collection.
- Undertake clinical evaluation and record the findings using the appropriate data collection form.
- Those requiring inter-departmental consultation must be done without delay.
- All relevant medical samples, including those needed for medicolegal purposes must be collected promptly by the treating physician.
- Refer to the Department of Forensic Medicine, if necessary.

- Cases identified at health facilities should be referred to The PEMA Secretariat/ RBP.

Referral to The PEMA Secretariat

- Emergency cases requiring immediate protection should be referred via 1098.
- Moderate or non-urgent cases (e.g., older cases) can be referred via email.

13. Follow up of child abuse victims

The medical and health professional may follow-up child abuse victims based on their medical needs. For child victims of sexual abuse, follow up services for STI and pregnancy may be indicated. Information for the need for follow up may be conveyed to the case manager for necessary support.

Case managers from The PEMA Secretariat/RENEW/Nazhoen Lamtoen will follow up and conduct social evaluations as per the SOP on Child Protection Case Management. They will also aid legal assistance, and family interventions as needed. Coordination with child protection services is crucial to ensure the child's safety and long-term rehabilitation.

APPENDIX

Appendix 1: INFORMED CONSENT FORM FOR CLINICAL EVALUATION AND MANAGEMENT OF CHILD ABUSE VICTIMS (From Parents/Guardians/ Caregivers)

Child's Name:_____ Date of Birth:_____
Parents/Guardians/Caregivers' Name: _____
Relationship to Child _____

Purpose of Evaluation:
This evaluation aims to assess and document any physical, emotional, or psychological harm to your child due to suspected abuse. The process includes medical examinations, forensic interviews, and necessary investigations to ensure your child's safety and well-being.

Confidentiality and Reporting

- Findings will be kept confidential but may be shared with child protection services, law enforcement, or other mandated agencies if abuse is confirmed or safety concerns exist.
- Anonymous data may be used for medical or epidemiological research.

I have been informed verbally about the procedures, benefits and associated risk. I understand the findings will be shared with relevant agencies to protect my child.

I consent to the above procedures and evaluation performed by Dr./Mr./Ms. _____.

Guardian's Rights

- You may withdraw consent at any time, except where legally mandated.
- You may request clarification about any part of the evaluation.

Guardian's Signature/Thumbprint: _____

Date & Time: _____

Provider's Statement:
"I have explained the purpose, procedures, and potential outcomes of this evaluation in language the guardian understands."

Provider's Signature: _____ Date & Time: _____

Attach Child's Assent Form (if age-appropriate)

Appendix 2: INFORMED ASSENT FORM FOR CLINICAL EVALUATION AND MANAGEMENT OF CHILD ABUSE VICTIMS

Assessment and Examination of victims of Child Abuse

This form explains the assessment/examination to you (the child) in simple terms. We want to make sure you are safe and healthy. Doctors/counselors need to check how you are feeling and ask questions to help you.

What Will Happen?

1. A doctor or counselor will talk to you privately.
2. They may ask questions about your body, feelings, or things that happened.
3. A gentle physical and genital examination might be done (only if needed).
4. Photos may be taken of injuries (if needed).
5. Forensic samples (blood/urine/swab, etc.) might be taken for investigation (only if needed).

Your Rights:

- You can say “stop” or “I’m not comfortable” at any time.
- You can ask for a trusted adult to be with you.
- Your answers will be kept private unless someone’s safety is at risk.

Who Will Know?

Only people who need to help you (medical and health professionals, justice sector, and child protection officers/case managers) will see your information.

Assent:

I, _____ (child’s name), understand this procedure is to help me. I agree to participate, but I know I can change my mind at any point of the process.

Child’s Signature/Thumbprint:_____

Date & Time:_____

Parent/Guardian/Caregiver’s Consent: A separate consent form will be signed by your parent/guardian/caregiver

Appendix 3: NON-SEXUAL PHYSICAL ABUSE - CHILD VICTIMS DATA COLLECTION FORM

Patient information

- Name
- CID
- Age/Sex
- Contact No
- Guardian Name
- Guardian CID
- Relation
- Facility Department
- Consulting Health Professional
- Informed Consent/Assent Taken: Yes/No
- Date and Time of Examination:

History

- History of the incident given by the child victims/guardian
  - » Date & Time of the Incident
  - » Place of Incident - Home/Work Place/Others (Please Specify)
  - » How many Assailant/s
  - » Relationship with the Assailant
  - » Nature of Violent Acts (e.g., Punch, Slap, Push, Kick, Hair pull, Bite, etc.)
  - » Brief Description of Violent Acts .....

Obstetrics and Gynecological History (for Female Patients):

- Age at menarche
- Date of last menstrual period
- Current pregnancy status: Yes/No/Unsure

Medical and Surgical History

- Do you have any medical conditions? - If yes, Please Specify.
- Do you have any disability? - If yes, Please Specify.
- Did you have any surgical intervention/s in the past? - If yes, please specify.

Psychiatric History

- Have you ever experienced any of the following:
  - » Feeling very sad or worried for a long time,

» Having trouble sleeping or eating,

» Hearing or seeing things that others do not, or,

» Feeling that you want to harm yourself?

Social History

- Education Level
- Current occupation
- Current relationship status - Single/Living together/Separated/others (Please specify)
- Type of Residence (e.g., Living with parents/step-parents/relatives, boarding school/monastic/others - please specify)
- Personal Habit - Tobacco/alcohol/illicit substances.

Family history

- Parental status: Living together/separated/disharmony/others
- Parental age: Father's age/mother's age
- Parental educational level: No formal education/monastic/primary/secondary/tertiary
- Parental occupation: One employed/both employed/both unemployed
- Parental habits: Alcohol/drugs/gambling

Examination

General Examination

- Height/Weight/BMI
- Appearance: Normal/fearful/withdrawn/overly compliant/Distracted/Agitated/Restless/Anxious/Crying/Sad/Intoxicated
- Hygiene: Good Hygiene/Poor hygiene (Unpleasant body odor/unkempt hair/poor oral care/visible lack of bathing)
- Clothing: Appropriately dressed/Inappropriately dressed/Torn/Stained with soil/blood/others
- Speech (not applicable/speaking clearly/speaking with difficulty/silent)
- Gross deformity: Head/Face/Spine/Limbs/others/Nil
- Significant impairment of Vision/Hearing/Speech/Walking/Memory - If others, please specify.
- Stigmata of Chronic Illness.
- Developmental milestones if appropriate*
- Other Significant Findings.

*Assess only in children below five years of age and if relevant

Vital Signs (if applicable)

- Temperature
- Pulse rate
- Respiratory rate
- Blood pressure

Physical Injuries (Use Body Diagram or Attach Separate Sheet)

	Nature of injury	Location	Remarks (Describe the No. & aging of the injuries)
1	Abrasion	Head/Face/Neck/Upper limb/Chest/ Abdomen/Back/Buttock/Lower Limb/ Genital/Others- specify	
2	Contusion	Head/Face/Neck/Upper limb/Chest/ Abdomen/Back/Buttock/Lower Limb/ Genital/Others - specify	
3	Laceration	Head/Face/Neck/Upper limb/Chest/ Abdomen/Back/Buttock/Lower Limb/ Genital/Others - specify	
4	Fracture	Skull/Facial/Spine/Upper limb/Ribs/ Sternum/Pelvis/Lower Limb/Others - specify	
5	Cut or incised wound	Head/Face/Neck/Upper limb/Chest/ Abdomen/Back/Buttock/Lower Limb/ Genital/Others - specify	
6	Stab	Head/Face/Neck/Upper limb/Chest/ Abdomen/Back/Buttock/Lower Limb/ Genital/Others - specify	
7	Bite marks	Head/Face/Neck/Upper limb/Chest/ Abdomen/Back/Buttock/Lower Limb/ Genital/Others - specify	
8	Burns	Head/Face/Neck/Upper limb/Chest/ Abdomen/Back/Buttock/Lower Limb/ Genital/Others - specify	
9	Others (specify)	Head/Face/Neck/Upper limb/Chest/ Abdomen/Back/Buttock/Lower Limb/ Genital/Others - specify	

Tanner Staging (If Relevant - use annexure)

- Breast
- Pubic Hairs

Investigations

Investigation type	Purpose
X-ray	Detection of fracture/Dislocation/Disease/Age/Others
Ultrasound	Detection of injury/Disease/Pregnancy/Others
CT-scan	Detection of fracture/Dislocation/Disease/Age/Others
Blood	Detection of STI/Disease/Pregnancy/Drugs/Poison/Others
Urine	Detention of disease/Pregnancy/Drugs/Poison/Others
Others	Please specify

Management of the Case

Provide details on the case management:

Type of management	Yes	No	Comments
Wound treatment			
Other treatment			
Psychological treatment			
Referral to specialists			
Referral to other agencies			
Reporting to Police			
Medico-legal report			

Examiner Details

- Name and Professional Title of the Examiner:
- Registration Number:
- Date and Time of Examination completed:

Appendix 4: CHILD VICTIMS SEXUAL ABUSE DATA COLLECTION FORM

Patient Information:

- Name
- CID
- Age/Sex
- Contact No
- Guardian Name
- Guardian CID
- Relation
- Facility Department
- Consulting Health Professional
- Informed Consent/Assent Taken: Yes/No
- Date and Time of Examination:

History

- History of the Incident Given by the child victim/guardian
  - » Date & Time of the Incident
  - » Place of Incident - Home/Work Place/Others (Please Specify)
  - » How many Assailant/s
  - » Relationship with the Assailant
  - » Nature of Sexual Act:
- Penetration of vagina —(Penis/finger/object/others)
- Penetration of anus — (Penis/finger/object/others)
- Penetration of oral cavity — (Penis/finger/object/others)
- Other acts, such as licking, kissing, biting, touching, or others- specify

Additional details:

- Was force used to restrain you? If yes, please describe.
- Did you attempt to resist the assault? If yes, explain how.
- Was a weapon used to threaten you? If yes, describe the weapon.
- Did you consume alcohol or drugs before the incident? If yes, specify whether voluntary or involuntary.
- Did ejaculation occur? If yes, did it occur inside?
- Was a condom used? If yes, indicate its condition (intact, torn, or slipped).
- Did you use any contraceptive methods? If yes, specify.
- Did you take a shower after the incident?
- Did you wash or dispose of your clothes/undergarments? If yes, please describe.

- Did you experience any genital discharge, painful urination, ulcers, or other symptoms?
- Any violent act - (Describe e.g., punch, slap, push, kick, hair pull, bite, etc.)

Obstetrics and Gynecological History (for applicable female Patients):

- Age at menarche
- Date of last menstrual period
- Current pregnancy status: Yes/No/Unsure
- Gestational age (if pregnant)
- Estimated due date (DD/MM/YYYY)
- Previous pregnancies: Outcomes (miscarriages, still birth, live birth, etc.)

Medical and Surgical History

- Do you have any medical conditions? If yes, please specify
- Do you have any disability? If yes, please specify
- Did you have any surgical intervention/s in the past? If yes, please specify.

Psychiatric History

- Have you ever experienced any of the following:
  - » Feeling very sad or worried for a long time,
  - » Having trouble sleeping or eating,
  - » Hearing or seeing things that others do not, or,
  - » Feeling that you want to harm yourself?

Social History

- Education Level
- Current occupation
- Current relationship status - Single/Living together/Separated/Others (Please specify)
- Type of Residence (e.g., Living with parents/step-parents/relatives, boarding school/monastic/others - please specify)
- Personal Habit - Tobacco/Alcohol/Illicit Substances

Family History

- Parental status: Living together/separated/disharmony/others
- Parental age: Father's age/mother's age
- Parental educational level: No formal education/Monastic/primary/secondary/tertiary

- Parental occupation: One employed/both employed/both unemployed
- Parental habits: Alcohol/drugs/gambling

Examination

General examination

- Height/Weight/BMI
- Appearance: Normal/fearful/withdrawn/overly compliant/Distracted/Agitated/ Restless/Anxious/Crying/Sad/Intoxicated
- Hygiene: Good Hygiene/ Poor hygiene (Unpleasant body odor/unkempt hair/poor oral care/visible lack of bathing)
- Clothing: Appropriately dressed/Inappropriately dressed/Torn/Stained with soil/ blood/others
- Speech (not applicable/speaking clearly/speaking with difficulty/silent)
- Gross deformity: Head/Face/Spine/Limbs/Nil
- Significant impairment of Vision/Hearing/Speech/Walking/Memory. If others, please specify.
- Stigmata of Chronic Illness.
- Developmental milestones if appropriate.
- Other Significant Findings.

*Assess only in children below five years of age and if relevant.

Vital Signs (If applicable)

- Temperature
- Pulse rate
- Respiratory rate
- Blood pressure

Physical Injuries (Use Body Diagram or Attach Separate Sheet)

Nature of injury	Location	Remarks (Describe the No. & aging of the injuries)
Abrasion	Head/Face/Neck/Upper limb/Chest/ Abdomen/Back/Buttock/Lower Limb/ Genital/Others - specify	
Contusion	Head/Face/Neck/Upper limb/Chest/ Abdomen/Back/Buttock/Lower Limb/ Genital/Others - specify	
Laceration	Head/Face/Neck/Upper limb/Chest/ Abdomen/Back/Buttock/Lower Limb/ Genital/Others - specify	

Nature of injury	Location	Remarks (Describe the No. & aging of the injuries)
Fracture	Skull/Facial/Spine/Upper limb/Ribs/ Sternum/Pelvis/Lower Limb/Others - specify	
Cut or incised wound	Head/Face/Neck/Upper limb/Chest/ Abdomen/Back/Buttock/Lower Limb/ Genital/Others - specify	
Stab	Head/Face/Neck/Upper limb/Chest/ Abdomen/Back/Buttock/Lower Limb/ Genital/Others - specify	
Bite marks	Head/Face/Neck/Upper limb/Chest/ Abdomen/Back/Buttock/Lower Limb/ Genital/Others - specify	
Burns	Head/Face/Neck/Upper limb/Chest/ Abdomen/Back/Buttock/Lower Limb/ Genital/Others - specify	
Others (specify)	Head/Face/Neck/Upper limb/Chest/ Abdomen/Back/Buttock/Lower Limb/ Genital/Others - specify	

Genitalia Examination

Note any abnormalities observed in the following areas, including signs such as redness, abrasion, contusion, laceration, cut, stab, burn, or other findings:

Location	Nature of Injuries	Remarks
Inner thighs	Redness/Abrasion/Contusion/Laceration/ Cut/Stab/Burn/Others/Nil	
Perineum	Redness/Abrasion/Contusion/Laceration/ Cut/Stab/Burn/Others/Nil	
Labia majora	Redness/Abrasion/Contusion/Laceration/ Cut/Stab/Burn/Others/Nil	
Labia minora	Redness/Abrasion/Contusion/Laceration/ Cut/Stab/Burn/Others/Nil	
Clitoris	Redness/Abrasion/Contusion/Laceration/ Cut/Stab/Burn/Others/Nil	
Periurethral area	Redness/Abrasion/Contusion/Laceration/ Cut/Stab/Burn/Others/Nil	
Posterior fourchette	Redness/Abrasion/Contusion/Laceration/ Cut/Stab/Burn/Others/Nil	
Fossa Navicularis	Redness/Abrasion/Contusion/Laceration/ Cut/Stab/Burn/Others/Nil	

Vaginal Examination (If relevant):

Note the following during the vaginal examination (if applicable):

	Findings	Remarks
Injury	Abrasion/Redness/Swelling/Laceration/Cut/Stab/nil	
Discharge	Whitish/Yellowish/Blood stained/Nil	
Foreign objects	Yes/No. If yes, specify	
Others	Yes/No. If yes, specify	

Hymenal Examination

Conduct Hymenal Examination and document the following:

	Findings	Remarks
Type of Hymen	Annular/Crescentic/Fimbriate/Imperforate/ Cribriform/Attenuated/Absent/Others	
Nature of injury	Redness/Abrasion/Swelling/Contusion/ Laceration/Tenderness/Nil	
Position of the injury if present	1,2,3,4,5,6,7,8,9,10,11,12 'O' clock position	
Position of old injury/tear if any	1,2,3,4,5,6,7,8,9,10,11,12 'O' clock position	

Ano-Rectal Examination (If Relevant):

Document the following during the ano-rectal examination (if applicable):

	Findings	Remarks
Injury	Redness/Contusion/Bleeding/Laceration/ Others -specify	
Position of the injury if present	1,2,3,4,5,6,7,8,9,10,11,12 'O' clock position	
Position of old injury/tear if any	1,2,3,4,5,6,7,8,9,10,11,12 'O' clock position	
Discharge	Whitish/Yellowish/Blood-stained/Nil	
Others	Gaping, Foreign body detected, etc.	

Peno-Scrotal Examination

Record the following findings during the peno-scrotal examination:

Location	Findings	Remarks
Penis	Injuries/Stains/Discharges/Foreign body/Others	
Scrotum	Injuries/Stains/Discharges/Foreign body/Others	
Perineum	Injuries/Stains/Discharges/Foreign body/Others	
Others	Gaping, Foreign body detected, etc.	

Tanner Staging (If Relevant- use tanner staging guide in appendix)

- Breast
- Pubic Hairs

Sample Collections

Indicate and describe any sample collections obtained:

Purpose of sample	Nature of sample
Detection of seminal fluid/ Spermatozoa	Secretions or stains collected from vulva, vagina, cervix, anorectal area, oral cavity, or other specified sites
DNA analysis	Secretions or stains from vulva, vagina, cervix, bite marks, clothing, anorectal area, oral cavity, or other relevant sources
Toxicology Screening	Blood/urine/other biological specimens
STI/HIV/Hepatitis B/C testing	Vaginal swab/blood/anorectal/ oral specimens
Pregnancy testing	Blood/urine samples

Forensic and Other Investigations and Results:

Document findings from forensic and additional laboratory investigations, as applicable:

Type of Investigation	Result of Investigation
Sperm cells in vaginal/anal swabs	Present/Absent/Not done
Acid phosphatase in vaginal/anal swabs	Present/Absent/Not done
Alcohol, drugs, or poison in blood/urine	Present/Absent/Not done
Gonococcal bacteria in vaginal/anal/penile swabs	Present/Absent/Not done
HIV/Hep B/Hep C/Syphilis in blood/urine	Present/Absent/Not done
Beta-HCG in blood/urine	Present/Absent/Not done
Additional investigations (please specify)	Present/Absent/Not done

Management of the Case:

Provide details on the case management:

Type of management	Yes	No	Comments
Wound treatment			
Tetanus prophylaxis			
STI treatment			
HIV PEP			
Hepatitis B vaccination			
Emergency contraception			
Psychological treatment			
Referral to specialists			
Referral to other agencies			
Reporting to police			
Medico-legal report			
Other treatment			

Examiner Details

- Name and title of the Examiner:
- Registration Number:
- Date and Time of Examination completed:

Appendix 5: DETAILS OF SUITABLE AND UNSUITABLE EXPLANATION

Seek an explanation

If, during history taking, you observe signs or symptoms that may indicate child maltreatment, seek an explanation. Collect additional details about the sign or symptom using open-ended questions. For instance, if you notice a bruise, you might ask in a neutral and non-judgmental way: “I see this bruise on your thigh. Can you tell me how it happened?”

Suitable explanations

A suitable explanation is one where a physical sign is linked to a clearly described injury, and the symptom corresponds with the timing and nature of that injury. Children’s behavior may also have other explanations, such as the loss of a family member, parental divorce, relocating to a new home, or changing schools - events that can all cause stress.

Unsuitable explanations

Explanations are considered unsuitable if they are implausible, inadequate, or inconsistent with factors such as the child’s presentation, usual activities, medical condition (if any), age, or the reported account of how the signs or symptoms occurred, whether provided by parents/guardians/caregivers, differing between parents/guardians/caregivers, or changing over time. Explanations are also unsuitable if they rely on cultural practices or the parents/guardians/caregivers’ own childhood experiences of being beaten, which may be wrongly used to justify harming a child.

Appendix 6: GENERAL EXAMINATION CHECKLIST

Growth

Measure and record the height/length and weight of children under five on a standardized growth chart. If the child is younger than two, measure their head circumference as well. Use age-appropriate BMI charts to determine and document the BMI of children five years of age and up. If the child's growth is concerning or not age-appropriate, refer them for additional evaluation.

Appearance

Assess the child's general appearance and emotional state before, during, and after interactions. Be alert for signs of trauma, which may include appearing emotionally withdrawn, fearful, overly compliant, distracted, agitated, restless, anxious, tearful, sad, or intoxicated. Clearly document all observations. However, a child's normal appearance does not rule out the possibility of abuse.

Hygiene

Assess the child's hygiene status, noting whether it appears good or poor; indicators of poor hygiene may include unpleasant body odor, unkempt hair, poor oral care (such as visible dental caries or foul breath), and signs of inadequate bathing (like persistent dirt accumulation or skin irritation).

Clothing

Evaluate the child's clothing for appropriateness, condition, and cleanliness. Note whether attire is suitable for the child's age, weather, and social context. Document any concerns such as torn or ill-fitting garments, or stains (e.g., dirt, blood, food, or bodily fluids) that may indicate neglect, inadequate care, or potential exposure to harmful environments. Persistent inappropriate dress, such as summer clothing in winter or visibly soiled items- warrants further investigation.

Speech

Examine a child's communication skills in light of their developmental stage while evaluating their speech. Take note of any issues like slurring, stuttering, or delayed language development, as well as if speech is clear and age-appropriate. Determine whether a child's silence is normal (as in the case of very young or children with specific neurodevelopmental disorders) or if there may be a problem that needs more investigation. Any decline in previously learned speech patterns or oddities like echolalia should be noted since they could be signs of underlying neurological or psychiatric problems.

Gross Deformity

Examine the child for any visible deformities affecting the head, face, spine, or limbs. In the head and face, look for abnormalities such as microcephaly, macrocephaly, or facial asymmetry, which may suggest congenital conditions or past trauma. Spinal inspection should include checking for scoliosis, kyphosis, or signs of spina bifida, while limb assessment involves noting malformations like clubfoot, contractures, or evidence of fractures. Document whether these deformities are congenital or acquired, and consider their functional impact on the child's daily activities and mobility.

Significant Impairment

Evaluate the child for any notable impairments in vision, hearing, speech, walking, or memory. For vision, observe whether the child can track objects or if they squint frequently, which might indicate refractive errors. Hearing assessment should note responsiveness to sounds or the need for repeated instructions. Speech difficulties should be cross-referenced with the earlier speech evaluation. Observe the child's gait for abnormalities like limping or ataxia, and in older children, assess memory by asking about recent events. Always document whether these impairments are corrected with aids like glasses or hearing devices and explore potential causes, whether congenital, developmental, or injury-related.

Stigmata of Chronic Illness

Identify physical signs that may indicate chronic illness, such as poor growth, cachexia, or edema suggesting malnutrition. Skin findings like pallor, jaundice, or hyperpigmentation can point to hematologic, hepatic, or endocrine disorders. Respiratory or cardiac conditions may manifest as clubbing or cyanosis, while endocrine abnormalities could present with hirsutism or striae. Correlate these signs with the child's medical history, such as the presence of medical devices (e.g., insulin pumps) or known diagnoses, to provide context for ongoing care or further investigation.

Developmental Milestones

For children under five years, assess whether they are meeting expected developmental milestones across motor, language, and social domains. Motor skills to evaluate include sitting, crawling, and walking, while language milestones range from babbling to forming sentences. Social milestones involve behaviors like eye contact, response to their name, and engagement in pretend play. Note any delays or regressions, as these may signal developmental disorders or neurological issues and warrant early intervention or specialist referral.

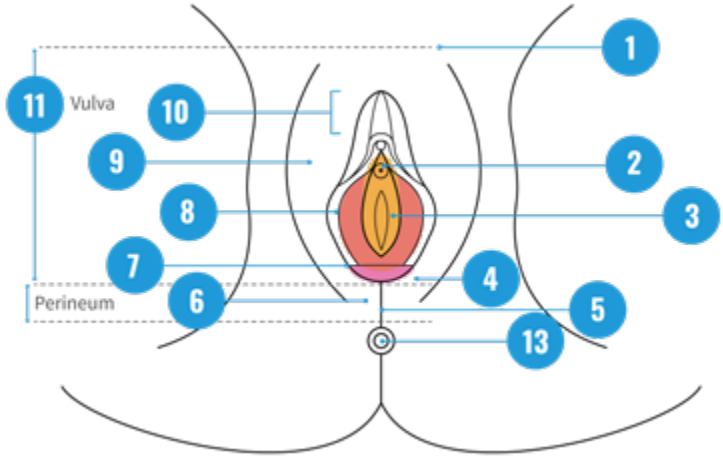
Other Significant Findings

Document any additional observations that could be clinically relevant, such as unexplained bruises, burns, or scars that may suggest abuse or neglect. Behavioral signs like hypervigilance, self-injury, or extreme withdrawal should also be recorded, as they may indicate psychological trauma. Environmental clues, such as poor hygiene or untreated medical conditions, can provide further context about the child's living situation. Always include specific details about the location, severity, and consistency of these findings with the child's history to guide appropriate follow-up actions.

Appendix 7: GENITO-ANAL EXAMINATION IN CASES OF SUSPECTED SEXUAL ABUSE OF FEMALE CHILD

The genital examination of a female child, particularly in the context of suspected abuse, is a highly sensitive procedure that must be approached with utmost care, respect, and professionalism. The examination should be conducted in a child-friendly and private setting, with sensitivity to the child's emotional and physical well-being. The genito-anal exam is essential to detect injuries, document evidence for legal purposes, identify infections, and guide treatment.

Anatomy of Female genitalia



Source: https://iris.who.int/server/api/core/bitstreams/87944065-4f4f-45d2-9bd8-abab73320e4f/content

1. Mons pubis: The area where the labia majora meet in front, covered with hair after puberty.
2. Urethral opening: The opening of the urethra to the external environment, allowing urine to be expelled.
3. Hymen: A membrane at the vaginal opening, almost always with a visible opening.
4. Posterior fourchette: The area where the labia minora meet at the back in the midline.
5. Perineal raphe: The visible line running from the genitalia to the anus.
6. Perineum: The region between the thighs, bounded by the vulva in the front and the anus at the back.
7. Fossa navicularis: The concave area between the back of the vaginal wall and the posterior fourchette.
8. Labia minora: Skin folds that cover or partially cover the hymen and vagina.
9. Labia majora: Broad skin folds that surround the labia minora, covered with hair after puberty.

10. Clitoris: Erectile tissue that expands when stimulated.
11. Vulva: All components of the external genitalia, including the mons pubis.
12. Vagina (not displayed): A tubular canal between the cervix and the hymen.
13. Anus: The outlet for feces.

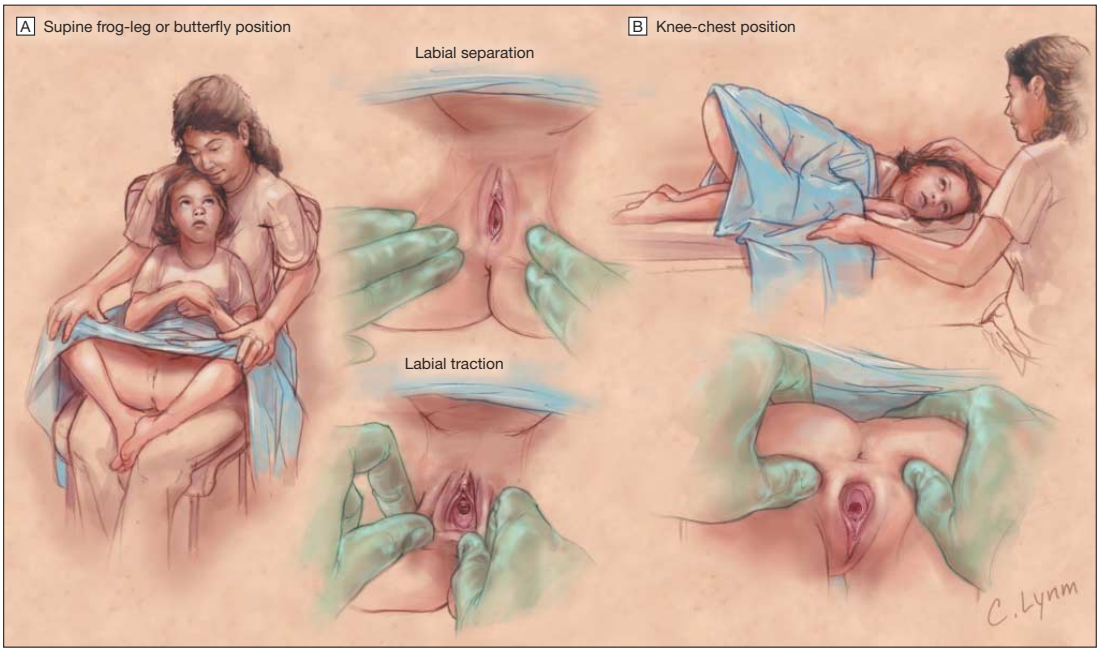
Positioning

Preadolescent children - supine position is most commonly used in genital exams. Younger children - can be placed on the lap of the non-offending caregiver, if this is comfortable for them.

Older girls - can be examined in the supine position with knees flexed, hip flexed and slightly abducted, and at the edge of the bed.

Perineal and anal examinations - The prone knee chest position is most commonly used.

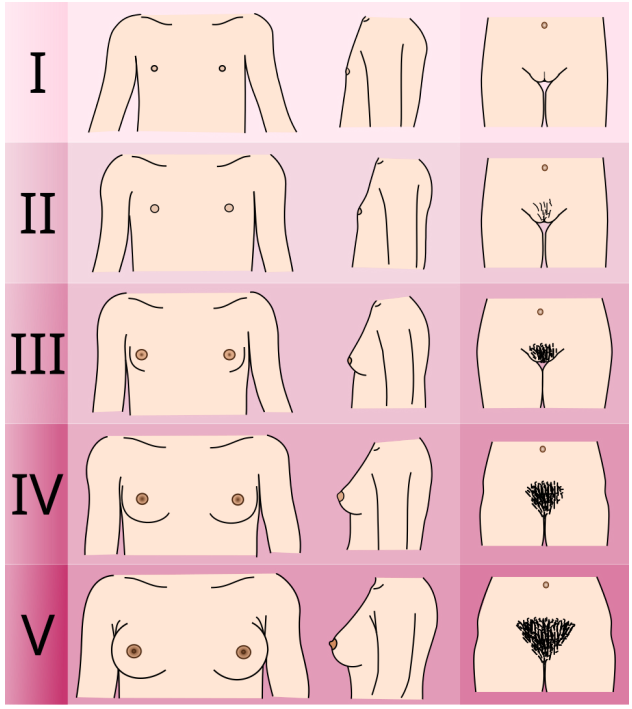
- Be aware that these positions may cause embarrassment for some child victims or bring back memories of prior abuse.
- Always ensure that the child is in control of the positioning and provide constant reassurance.



Source: https://ahchmedicallibrary.wordpress.com/wp-content/uploads/2011/01/berkoff_has-this-prepubertal-girl-been-sexually-abused_2008.pdf

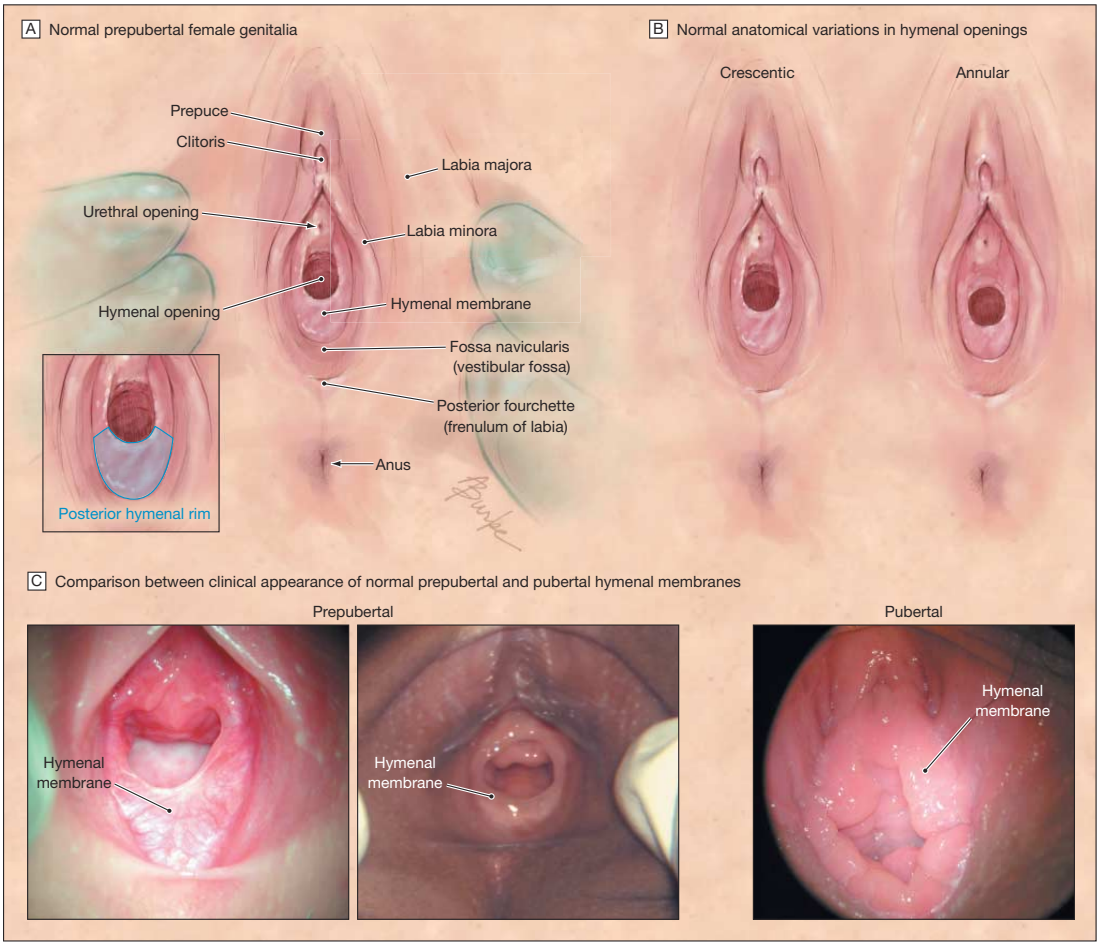
What to assess in female genito-anal examination:

- Pubic hair development - Note tanner stage; presence of loose hair/foreign bodies/ stains/discharges, etc.
- Thigh - Note dried or moist secretions, grab marks, bite marks, or evidence of other injuries. Note any healed scars, or other abnormal findings.
- Perineum - Note fresh or healed injuries, foreign bodies, stains or discharges, or other unusual findings.
- Posterior fourchette and fossa navicularis - Note fresh/healed injuries, STI lesions.
- Labia majora and minora - Note fresh/healed injuries, STI lesions, or other unusual findings.
- Clitoris - Note unusual size or changes of the clitoris or hood.
- Urethral meatus - Assess for any discharge, noting its amount, color, and odor. Note signs of inflammation, edema, or other lesions of the periurethral tissue.
- Hymen - Assess the presence or absence of the hymen and document its type. Document normal variants (notches if any). Look for fresh hymenal injuries- redness, bruises, hemorrhages, abrasions, tears and healed injuries such as attenuated and healed.
- Vaginal orifice & walls - Examine for injuries, discharges, foreign bodies and any other lesions.
- Cervix- Note bleeding, injuries, discharges, foreign bodies or other lesions.



Tanner Stages – Female (Breast & Pubic Hair Development)

Source: https://en.wikipedia.org/wiki/Tanner_scale

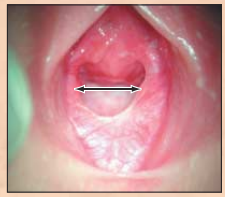


A, Inset, The region defined as the posterior hymenal rim, between 4 and 8 o'clock, is shaded blue. B, There is a range of normal anatomical variations in hymenal openings. Crescentic and annular are 2 of the most common shapes. C, The photographs illustrate the range of normal prepubertal hymenal membranes. In most children, the hymen becomes thicker and more redundant during puberty.

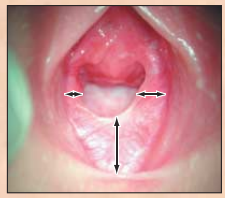
Source: https://ahchmedicallibrary.wordpress.com/wp-content/uploads/2011/01/berkoff_has-this-prepubertal-girl-been-sexually-abused_2008.pdf

Measurements[28]

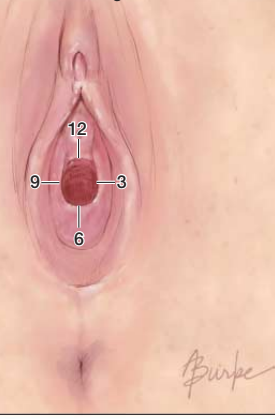
Horizontal diameter of hymenal opening



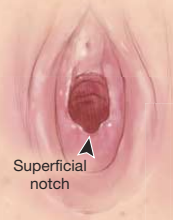
Width of hymenal tissue from edge of the hymen to the muscular portion of the vaginal introitus at 3, 6, and 9 o'clock.



Clock-face diagram



Clinical signs	Definition
Notch	Indentation on the edge of the hymenal membrane. A notch may be angular (v-shaped) or curved (u-shaped).
Superficial	Notch extending <50% of width of hymen
Deep	Notch extending >50% of width of hymen



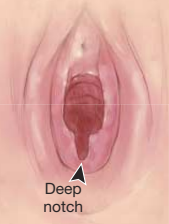
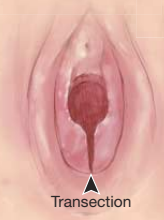
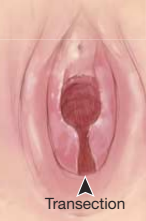
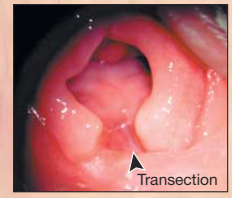


Photo obtained in knee-chest position

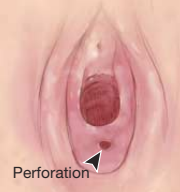
Transection	A tear (separation or interruption) through the entire width of the hymenal membrane extending to or through its attachment to the vaginal wall







Perforation[a]	A hole or opening in the hymenal membrane that is separate from the hymenal opening



Source: https://ahchmedicallibrary.wordpress.com/wp-content/uploads/2011/01/berkoff_has-this-prepubertal-girl-been-sexually-abused_2008.pdf

Techniques of female genital examination:

1. **Labial separation technique:**
   a. The patient is kept in supine position with knees flexed and hips externally rotated.
   b. The labia minora are gently separated with the thumb and index finger of the left hand in case of children, but both hands are usually used in older children.
   c. The hymen is exposed and examined

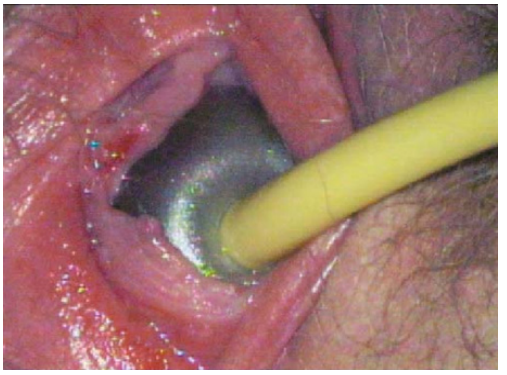
2. **Labial traction technique:**
   a. The patient is kept in supine position with knees flexed and hips externally rotated.
   b. The labia minora are separated using both the hands
   c. Some traction is applied
   d. It will enable better viewing of the hymen but may cause mild pain or discomfort.

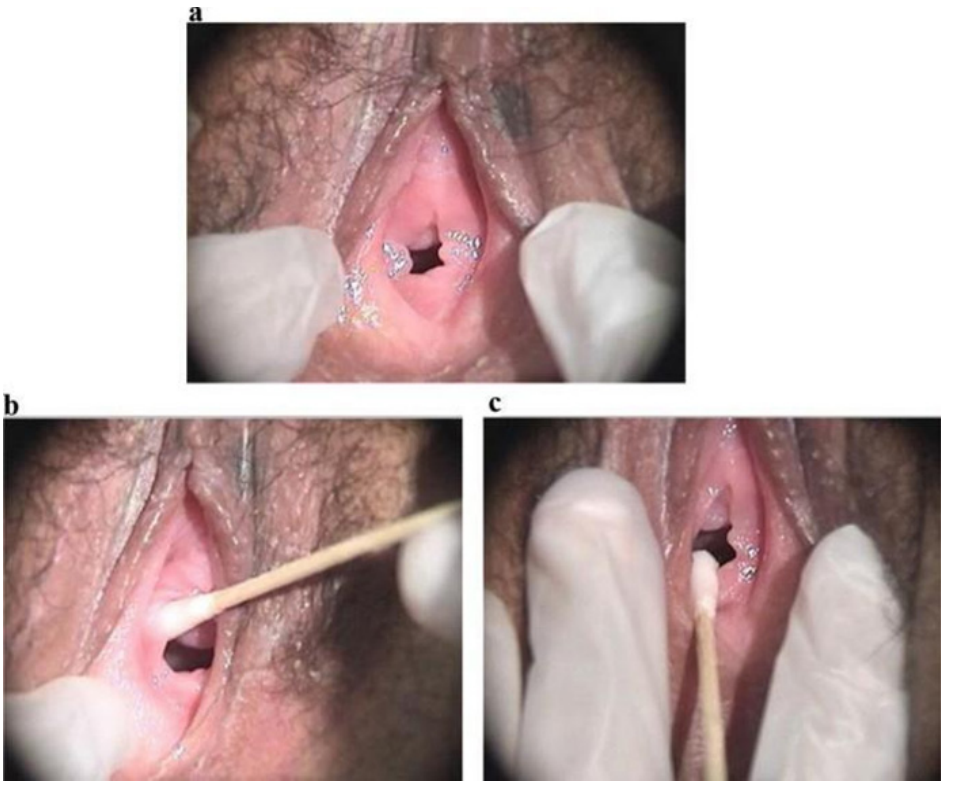
3. **Foley catheter technique:**
   a. The Folly catheter is gently inserted into the vaginal canal.
   b. The catheter bulb is gently filled with water.
   c. Then the catheter is gently retracted back till it hits the hymenal rim.
   d. The exposed hymenal rim is observed for any injuries or defects.
   e. It is usually used in adolescent

4. **Cotton bud technique:**
   a. Use a small, moistened cotton-tipped swab (avoid dry swabs to prevent discomfort).
   b. Gently separate the labia majora with one hand (labial separation technique).
   c. Hold the swab like a pen and lightly touch the inferior hymenal edge (near 6 o'clock position).
   d. Roll the swab downward (toward the perineum) to stretch the hymen slightly, exposing the vaginal opening.
   e. Avoid excessive force to prevent artifactual tearing.
   f. Observe hymenal morphology (e.g., annular, crescentic), integrity, and any signs of trauma (e.g., notches, clefts, or transections).
   g. Note findings objectively (e.g., "hymen smooth and uninterrupted at 6 o'clock; no acute lacerations").

Note:

- Speculums or proctoscope and bimanual examinations of the vagina or rectum of a prepubertal child are not routinely required.
- Do not carry out a digital examination to assess vaginal orifice size or anal sphincter tone.
- A speculum should be used only when there is suspicion of penetrating vaginal injury, internal bleeding, or the presence of a foreign body. If required, the smallest appropriate speculum size should be used to minimize discomfort.

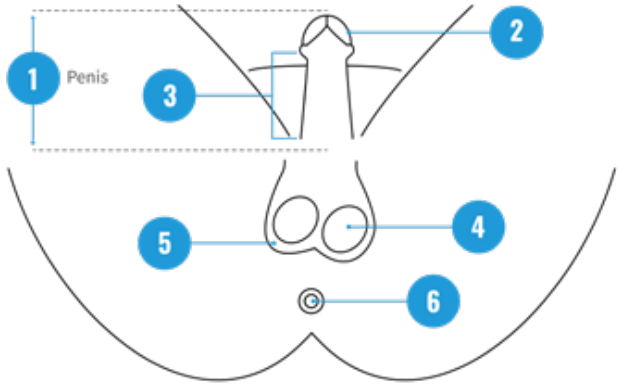




Source: Jones et al (2003)

What to assess in a genito-anal examination, Males

Anatomy of Male Genitalia

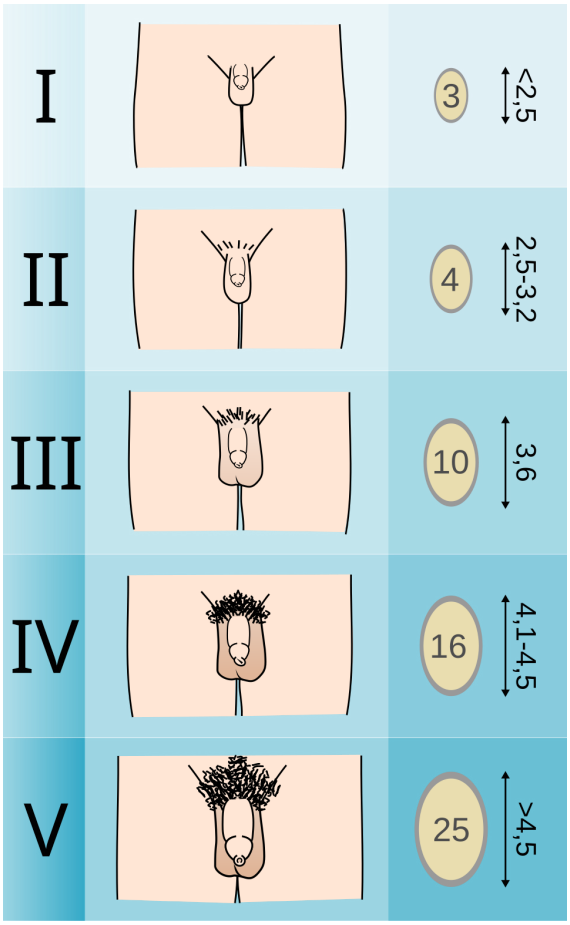


Source: https://iris.who.int/server/api/core/bitstreams/87944065-4f4f-45d2-9bd8-abab73320e4f/content

1. Penis: Male organ of copulation and urinary excretion.
2. Glans (head): The expanded head of the penis.
3. Shaft: The cylinder of tissue between the body and the head of the penis.
4. Testicle: The egg-shaped glands housed within the scrotum.
5. Scrotum: The pouch of skin containing the male reproductive glands (testes).
6. Anus: Outlet for feces.

What to assess in male genito-anal examination:

- Pubic hair development - Note tanner stage; presence of loose hair/foreign bodies/ stains/discharges, etc.
- Glans penis - Check for abrasions, contusions, oedema, hematomas, bite marks, lacerations, dried secretions, or discharges.
- Urethral meatus - Look for discharges, bleeding, or scars.
- Penile shaft - Look for injuries, stains, discharges, foreign bodies, and scars.
- Scrotum - Examine for injuries, stains, discharges, foreign bodies, and scars.
- Testes - Verify presence of descended testes or other abnormalities.
- Buttocks - Examine for fresh or healed lesions, secretions, bruises, rashes, handprints, or fingerprints.
- Perianal skin - Check for inflammation, dried secretions, bruising, fissures, tears, or lacerations.
- Anal verge/folds/rugae - Look for injuries, stains/discharges, foreign bodies or other abnormalities.
- Anal laxity - Look for gapping/reflex dilatation.
    - » Look for signs of sexually transmitted infections such as condyloma acuminata, condyloma lata, herpes, and primary syphilitic lesions.



Source: https://en.wikipedia.org/wiki/Tanner_scale

Tanner Stage	Genital Development	Pubic Hair	Testicular Volume
Stage I	Prepubertal; no enlargement	None or vellus hair like on abdomen	<4 mL
Stage II	Enlargement of scrotum and testes; scrotal skin reddens and thins	Sparse, long, slightly pigmented hair at base of penis	4–8 mL
Stage III	Penis begins to enlarge, especially in length; further growth of testes	Darker, coarser, curlier hair spreading over pubis	9–12 mL
Stage IV	Penis grows in length and breadth; glans develops; scrotal skin darkens	Adult-type hair, but limited in area (not on thighs)	13–15 mL
Stage V	Adult genitalia in size and shape	Adult in quantity and distribution (medial thigh spread)	>15 mL

Appendix 8: SEXUAL VIOLENCE FORENSIC SAMPLE/ EVIDENCE COLLECTION PROCEDURE

Forensic validity and legal admissibility require that samples be collected aseptically, labeled accurately, stored properly and transferred with documented custody. If feasible, sample must be collected promptly using sterile techniques to prevent degradation and contamination, preserving the integrity of the samples while respecting the dignity of the examinee of sexual assault.

Correct sampling, appropriate storage and transportation of any forensic sample is critical for maintaining sample integrity to assure high quality test results.

Pre-requisites

Consumables

- SAEC Kit: Annexure 1
- Consent form
- Chain of Custody form
- Toxicology Test Requisition Form
- Semen analysis request form

Sexual Assault Evidence Collection Kit (SAECK)

Sl No	Name of Items
1	Powder free latex gloves
2	Mask
3	Plastic gown
4	2 ml, 5ml and 10 ml Syringes
5	Pasteur Pipette
6	Vaginal Speculum
7	Pair of comb
8	Nail cutter
9	Toothpicks
10	Sterile cotton swabs with write on Tube
11	Distilled water
12	Sterilized Gauge pack
13	Whatmann filter paper/ FTA cards
14	EDTA vacutainer (purple top)
15	Sodium Fluoride vacutainer (Grey top)
16	Plain vacutainer (Red top)
17	Sterile Uricol container

Sl No	Name of Items
18	Frosted Glass slides
19	Pregnancy detection kit
20	Catch Paper
21	Evidence paper bags/Clothing bags
22	Evidence envelopes
23	Hand disinfectant
24	Cello tape
25	Parafilm tape
26	Cotton
27	Tourniquet
28	OHP Pen
29	Diamond pencil
30	Evidence label
31	Butterfly needle set of different sizes
32	Pencil
32	Cover slip
33	DSL camera
34	UV lamp
35	Disposable tweezer
36	Sterile Forceps
37	Scissors

Procedure

1 Consent

- Obtain verbal informed consent and explain the procedure at every step of sampling. Respect withdrawal and record refusal with reasons.
- If possible, conduct examinations respecting the preference of the gender of the examiner.

2 Preparation

- The examination should be done in a private place.
- Provide a gown to the examinee.
- While sampling, follow basic universal safety precautions and wear powder-free latex gloves.

3 Sampling collection

1. Foreign Material/Debris on Body clothing

» Record if the examinee has not changed clothes or bathed before sampling.

» Have the examinee stand on a clean white paper sheet (preferably 1x1 metre) and gather any foreign material/debris on body and clothing that might fall on the paper.

» Fold the paper and place it into a paper envelope labeled with the examinee's details, sample type, date and time of collection and case number if available and seal with cello tape.

NB: Avoid plastic bags to prevent moisture accumulation and damage to evidence.

2. Clothing

» Provide privacy to the examinee for undressing. A curtain may be used to protect privacy.

» Ask the examinee to undress herself while standing on a clean white paper sheet.

» A Wood's Lamp (UV) may be used to locate potential secretions (semen, blood, saliva) and marks on clothing and body surface that are not visible under normal light conditions.

» Record the detail of the clothing retrieved from the examinee and hand them over to the Police with proper packaging.

NB: Clothing with forensic importance will be retrieved in consultation with the examinee.

3. Oral swabs

- Collect oral swabs if requested by the Police.
- Use a sterile cotton swab to collect the oral swab.
- Collect two oral swab
- Swab the upper and lower buccal mucosa and gum lines by rotating gently.
- Place the swab in the swab tube and hand it over to the Police.

4. Fingernail clipping and scraping

- Use sterile nail clippers for clipping nails,
- Use sterile toothpicks for scraping under nails.
- Nail clipping and scrapping should be done on a clean paper.
- Fold the paper containing the nail slipping and scrapping and place it in an envelope and seal it with cello tape.
- Label the envelope with sample details.

NB: Collect samples only if history or suspicion of scratching exists.

5. Pubic hairs

- Collect any loose pubic hair by. Combing may be done to collect them by placing a white paper under the examinee's buttock.
- If areas of matted pubic hair are noted, collect them by using sterile scissors
- Fold the paper containing pubic hair and place it in an envelope.
- Label the envelope with sample details.

6. Genital samples collection

- Use three sterile cotton swabs to collect genital samples as follows.

1. Vulva swab:

1. Separate the labia majora carefully with the left hand.
2. Swab around the inner surface of the labia minora and fosa naviculars.
3. Make smear on the labeled slide
4. Air dry the swab and pack it.

2. Low vaginal swab:

1. Take swabs from the low/mid anterior and posterior vaginal walls.
2. Make smear on the labeled slide
3. Air dry the swab and pack it

3. High Vaginal swab/Cervical swab:

1. Take a swab from the cervical orifice/vaginal fornices.
2. Make smear on the labeled slide
3. Air dry the swab and pack it.

The High vaginal swab sample may be sent to the Clinical Laboratory for the following test.

1. Culture and Gram staining for Neisseria gonorrhoeae
2. Microscopy for Trichomonas vaginalis.

7. Bite Marks

1. Collect two numbers of swabs, if appropriate
2. Label the swabs
3. Collect a wet swab from the bite mark by moistening the swab with distilled water.
4. Collect a dry swab.
5. Place the swab in the respective swab tube.

NB: If indicated clinically, additional tests may be done.

8. Anal sample collection

- Use moistened swabs for peri-anal area; dry swabs for anal canal and rectum.
- Apply gentle lateral traction for a few minutes to relax anal sphincter when inserting a rectal swab.
- Place the swab in the swab tube
- Label the tube with sample details

9. Penile swab

- Moisten swab with distilled water
- Roll along the tip of the penis including sulcus and urethral meatus.
- Swab inside foreskin as well.
- Place the swab in the swab tube
- Label the tube with sample details

10. Condom

- Swab inner and outer surfaces of condom with sterile cotton swabs.
- Air dry swabs prior to packing.
- Preserve condoms in sterile urine containers.

11. Urine and blood sample for toxicological analysis

1. **Blood**
    - » Clean the venipuncture site with spirit and then distilled water.
    - » Collect approximately 6 ml of blood samples.
    - » Transfer 2 ml in each of the following blood tubes:
    - » Sodium fluoride (grey top) blood tube
    - » Plain (red top) blood tube
    - » Label tubes with relevant patient details.
    - » Refrigerate samples at (2–8°C).

2. **Urine**
    - » Collect 10–30 ml urine in a sterile plastic container.
    - » Label container clearly and refrigerate until analysis.

12. Blood sample collection for paternity testing

- Collect venous blood from the mother, the child and the alleged father in EDTA vial or on filter paper.
- Place 5-7 drops blood on a filter paper, labeled with client information
- Air dry for about 1 hour at room temperature or until fully dried in an enclosed environment.
- Preserve 2 ml whole blood in EDTA vial.
- Change gloves after every collection and packaging of blood in filer paper.
- Collection requires court authorization letter and presence of a client party witness during the procedure.

Storage

1. Maintain the cold chain (2-8°C) immediately after collection of samples.
2. Specimens may be retained and stored at 2-8°C for about one week if immediate shipment is not possible.
3. Avoid freezing samples.

Shipment to Department of Forensic Medicine & Toxicology, JDWNRH

1. Wrap the sample with gauze or cotton and place it in a leak-proof container.
2. Ship the sample in a medicine container, cold chain box, vaccine carrier, or cardboard box of appropriate size, based on availability with dry ice packs to avoid breakage of sample containers or tubes and leakage of samples.
3. Ensure all documents (Chain of Custody forms, TRF) accompany the samples.
4. If the sample is transported from the District Healthcare Centers, the relevant healthcare professionals will hand it over to the driver, and both parties must sign the CoC form.
5. If direct transport to DFMT, JDWNRH is not possible, the relevant healthcare professionals may contact the relevant healthcare professionals of the Regional Referral Hospitals or Referral Centers to facilitate shipment of samples to DFMT, JDWNRH for test analysis.
6. Upon arrival at DFMT, JDWNRH, the driver will hand over the sample to Laboratory/ DFMT staff, and both the driver and receiver must sign the Chain of Custody form after proper verification.
7. Samples will be received at DFMT, JDWNRH from 9:00 AM to 3:00 PM.
8. Samples arriving after 3:00 PM may be received by the forensic staff on call duty

Sample Receipt and Verification at Department of Forensic Medicine & Toxicology, JDWNRH

1. Staff receiving the sample will verify and crosscheck the sample condition, labeling, amount and documents.
2. Verify and confirm the patient information and test requested in EPIS if the tests are advised or with forwarding letters and other documents sent as hard copy.
3. Generate and paste barcode on the specimen container
4. Refrigerate the specimen at 2-8°C until analysis.

Appendix 9: CHAIN OF CUSTODY FORM, TOXICOLOGY TEST REQUISITION FORM, SEMEN ANALYSIS TEST REQUISITION FORM

CHAIN OF CUSTODY RECORD

CID/UHID:

A. Details of Sample

Sample Type	Quantity	Date & Time of collection	Description of sample

B. Transfer Form

Name & Address of Transfer	Email ID & Contact No	Date & Time of Transfer	Sign & Seal

C. Details of Transportation

Name & Address of Sample Transporting Officer/Driver	Email ID & Contact No	Date & Time of Transfer	Sign & Seal

D. Transfer To

Name & Address of the Recipient	Email ID & Contact No	Date & Time of Received	Sign & Seal

TOXICOLOGY TEST REQUISITION FORM

Name		Age/Sex	
CID/UHID		Location	
Date of collection		Collected By	
Referring Dept/Hosp		Requested By	
Sample Type	Blood ☐ Urine ☐ Vomit ☐ Liver ☐ Stomach contents ☐ Other (Specify):		

Test Requested	**Test Name**	**Tick(✓)**	**Test Name**	**Tick(✓)**
	Amphetamine	☐	Nitrazepam	☐
	Morphine	☐	Oxazepam	☐
	Cocaine	☐	Temazepam	☐
	Heroin	☐	Alcohol content	☐
	Propoxyphene	☐	Aconitum Alkaloids	☐
	Tetrahydrocannabinol	☐	Zine phosphate	☐
	Methamphetamine	☐	Chlorpyrifos	☐
	MDMA	☐	Cypermethrin	☐
	Tramadol	☐	Captan	☐
	Ketamine	☐	Aldrin	☐
	Alprazolam	☐	Paraquat dichloride	☐
	Clonazepam	☐	Endosulfan	☐
	Diazepam	☐	Malathion	☐
	Flunitrazepam	☐	Diazinon-d10	☐
	Lorazepam	☐	Others (Specify)	☐

Type of analysis	Qualitative ☐ Quanlitative ☐
Storage Temperature	Referigerated ☐ Frozen ☐ Room Temperature ☐

Brief history of the case

Lab use only- Sample received by the lab on

Date..... Time.....

Requested By
(Name & Seal)

SEMEN ANALYSIS TEST REQUISITION FORM

Name		Age/Sex	
CID/UHID		Location	
Nature of Case		Requested By	
Referring Dept/Hosp		Date of collection	
Collected By		No of swabs collected	
Sample Type & Source	Vagina ☐ Vulva ☐ Cervical ☐ Oral ☐ Other(Specify):		

For Lab use only- Sample received by the lab on

Date..... Time.....

Microscopy Examination Report

Sl. No.	Repost Date	Results	Remark

Examined By **Verified By**

Appendix 10: LIVES CC APPROACH

CHAIN OF CUSTODY RECORD

1. **LISTEN-** Listen closely to the child's words and nonverbal cues, and observe their interaction with the caregiver. Watch for any physical, emotional, safety, economic, or social needs. Support non-offending parents/guardians/caregivers too, as they may feel shock, guilt, or fear, especially if they have also experienced violence or feel they failed to protect the child.

   DOs

   » Stay calm and patient; avoid pressuring the child to speak.

   » Show you are listening with nods or sounds like “hmm”.

   » Sit at the child's level and maintain open, non-threatening body language.

   » Acknowledge their feelings (e.g., “You seem upset”).

   » Let them talk at their own pace and express themselves in any way like, showing, drawing, or writing.

   » Speak slowly and clearly.

   » Use open-ended questions (e.g., “How do you feel about that?”).

   » Reflect their emotions and observe non-verbal cues.

   » Speak directly to the child and allow silence for thinking

   » Speak to the child or caregiver directly, not about them in third person.

   DON'Ts

   » Avoid judgment or criticism - Don’t say things like, “You shouldn’t feel that way”, “You should feel lucky you survived,” or “Poor you”.

   » Don’t dismiss or minimize their feelings.

   » Don’t assume you know what’s best for them.

   » Don’t share personal stories or others’ experiences.

2. **INQUIRE-** Inquire about the child's physical, emotional, social needs, and safety concerns. Tailor your approach to their age and situation. Use supportive techniques to help them express themselves and ensure you understand.

TIPS AND HINTS

- Ask inviting questions, like “How can I help today...?”
- Help the child express needs: “Is there anything you need or worry about?”
- Explore further: “Can you tell me more about...?”
- Clarify if unsure: “Can you explain that, please?”
- Repeat their words to confirm understanding.

3. **VALIDATE-** Validating a child's experience means:
    - » Showing you are listening and believe them without judgment.
    - » Letting them know their feelings are normal and safe to express.
    - » Affirming their right to live free from violence and fear.

Words you can use to show your understanding:

"I believe you."
"This is not your fault. You are not to blame", or "I am very glad you told me".
"It's ok to talk."
"I am sorry this happened to you."
"You are very brave for telling me."

Helping children cope with negative feelings	
Feeling	**Things you can say**
Hopelessness	*"Many children feel what you are feeling after such an experience. I'm here to help you and there are ways we can support you to help you feel better."*
Powerlessness and loss of control	*"I will explain to you how we proceed today. You can also make some choices by yourself."*
Guilt and shame	*"You are not to blame for what happened to you. You are not responsible for his/her/their behavior."*
Fear	*"Right now, you are in a safe place."*
Anger	*"It's ok to be angry." Acknowledge that this is a valid feeling.*

4. **ENHANCE SAFETY**

While health professionals can't guarantee a child's safety, they can:
- Empower the child by assessing immediate risks and strengths.
- Take key steps to enhance safety by:
    - » Evaluating safety at home or in their environment.
    - » Creating a protection plan with the child and safe caregiver to prevent further harm.

Immediate safety risks for children may include:
- Abuse by family members with access to the child.
- A caregiver unable/unwilling to protect the child from harm.
- Threats or fear of retaliation from a caregiver.
- Failure to meet basic needs (food, shelter, medical care, etc.).

- Caregiver's substance abuse impairs their ability to care for the child.
- Caregiver's mental health issues affecting supervision or protection.
- History of abuse or neglect.
- Domestic violence puts the child at imminent risk.

5. SUPPORT

Medical and health professionals and health professionals can connect the child and the caregiver with other resources for their health, safety, and social support. These might include referral to:

- Specialized health services (other clinics/departments)
- Mental health care
- Social welfare services
- Legal aid or advocacy services

6. CHILD FRIENDLY ENVIRONMENT

Barriers to Accessing Services for Abused Children

Children facing abuse often struggle to get help due to:

- Stigma
- Bureaucratic hurdles
- Unawareness of available services
- Transportation issues

How medical and health professional and health professionals can help:

1. Create a child-friendly environment
2. Be supportive and non-judgmental
3. Have the right skills to provide appropriate care.
4. Inform children about where and how to access services.

Child-Friendly Communication: DOs

- Use simple, clear language (no jargon).
- Explain with visuals (pictures, dolls, models).
- Let the child respond freely (their way, their pace).
- Provide toys/materials to help them relax and connect.
- Build rapport first—start with light, friendly questions.

Child Interaction: DON'Ts

- Avoid rushing into examinations.
- Never force responses– respect their comfort level.

- Skip distressing details – don't push if they are uneasy.
- No leading questions – let them share freely.
- Don't make them repeat– avoid redundancy.

7. CAREGIVER SUPPORT

In order for a child to recover from abuse, the role of non-offending parents/ guardians/caregivers is essential. Their ability to support the child and their emotional health are very important. The child's healing is strengthened when caregivers are strengthened.

Key Actions:

- Talk privately with the caregiver to assess their needs.
- Offer emotional support - they may be distressed or have past trauma.
- Assess safety - ask about risks at home for both child and caregiver.
- Connect them to mental health or psycho-social services if needed.
- Provide guidance on:
  - » The examination process and long-term abuse effects.
  - » Supporting the child (sleep issues, anger, regression).
  - » Follow-up care (symptoms to watch, medications).

Appendix 11: BRIEF DESCRIPTION OF SOME COMMON MECHANICAL INJURIES

Abrasion

Abrasions are defined as superficial injuries to the skin caused by the application of blunt force. They can be caused by tangential application of force or vertical application of force. They can be further subdivided into linear abrasions, imprint abrasions, and grazed abrasions. They do not leave permanent scars. Dating of abrasions can be helped by evolution surface scab.

Contusion/bruise

They are defined as an area of hemorrhage beneath the skin due to rupture of small blood vessels by application of blunt force. Acute bruises are usually red, blue, and purple or brown/black while the resolving bruises are usually green or yellow in color. It should be borne in mind that bruises may not reflect the site of impact or size of the weapon. Intradermal may contain the imprint of the causative agent.

Laceration

Lacerations are defined as ragged or irregular tears or splits in the skin, subcutaneous tissues or organs resulting from blunt force. Lacerated wounds have ragged, irregular or bruised margins with bridging underlying tissues like nerves, blood vessels, and other fibrous tissues.

Incised wound

Incised wounds are defined as injuries produced by sharp edged objects whose lengths are greater than the depths. Such wounds are produced by knife, razor blade, scalpel, sword, or glass fragment. Incised wounds have regular margins without bruising or abrasion. No bridging tissues will be present. On the head, sometimes scalp laceration can mimic incised wound with regular margins. However, the hair shaft will not be cut and the hair roots may be crushed. Moreover, underlying bridging tissues may be present.

Stab wound

Stab wounds are defined as incised wounds whose depths are greater than their lengths on the skin surface. The depth of the wound may correspond to the minimal length of the weapon and the surface length of the wound may reflect the width of the weapon. However, due to movement of the weapon during stabbing, great care should be taken during such interpretation.

Fracture: A fracture refers to the structural break or discontinuity in a bone caused by mechanical force exceeding its strength.

Chop wound: A chop wound is a deep, sharp-force injury caused by a heavy-edged weapon (e.g., axe, machete, cleaver, or sword) that combines sharp cutting and blunt force trauma.

Appendix 12: NOMENCLATURE FOR DESCRIBING HYMENAL FINDINGS

Cleft: An angular defect on the edge of the hymen whose edges are closely approximated. The defect may extend to the muscular attachment of the hymen.

Concavity: A curved or hollowed U-shaped depression of the edge of the hymenal membrane.

Notch: A V-shaped indentation or defect on the edge of the hymenal membrane that may extend to the muscular attachment of the hymen.

Hymenal tear/laceration: A defect/injury in the hymenal membrane caused by a blunt force that has ripped or pulled apart the hymenal tissue.

Superficial partial tear of the hymenal membrane: A laceration or tear of the hymenal membrane that extends less than half way through the width of the membrane.

Intermediate partial tear of the hymenal membrane: A laceration or tear of the hymenal membrane that extends halfway through the width of the membrane.

Deep partial tear of the hymenal membrane: A laceration or tear of the hymenal membrane that extends more than halfway through the width of the membrane.

Complete tear or transection of the hymen: A laceration or tear of the hymenal membrane that extends through the entire width of the membrane to its attachment.

Transection of the hymen with an extension: A laceration or tear of the hymenal membrane that extends through the attachment and into the surrounding tissues.

Appendix 13: SKELETAL INJURIES IN CHILD ABUSE

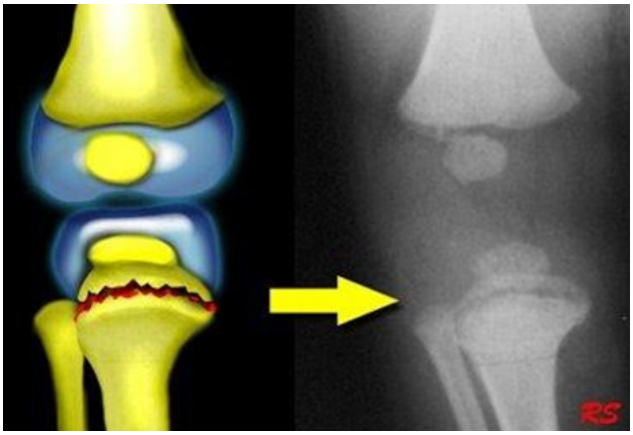


Fig. 1. Metaphyseal fractures – chip and bucket handle fracture

Source: https://www.orthobullets.com/pediatrics/4001/pediatric-abuse

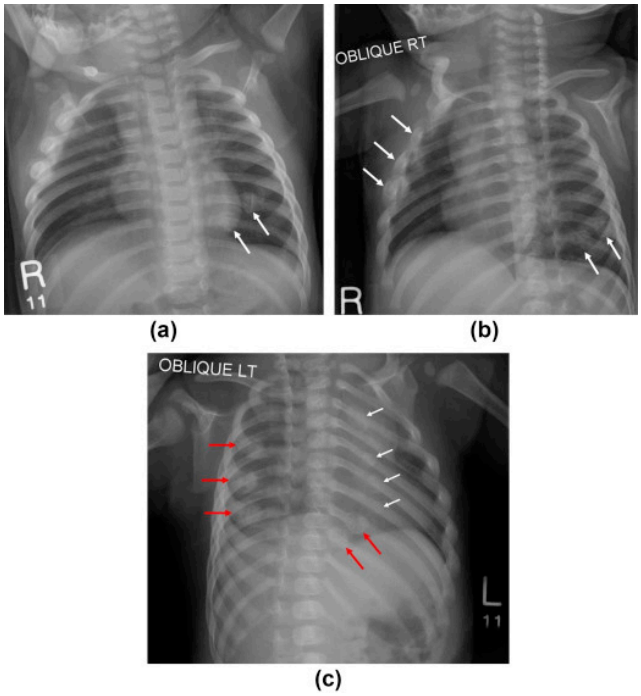


Fig. 2. Healing rib fractures in a 3-month-old female infant. (a) AP chest radiograph (arrows), (b) right oblique (arrows) and (c) left oblique (red arrows) show healing fractures of the posterior arcs of the left 8th and 9th ribs and anterior arcs of the right 2nd to 4th ribs. Do not mistake the sternal segments (white arrows) seen in (c) for the healing rib fractures (red arrows).

Source: Paddock, M. et al. Clinical Radiology, Volume 72, Issue 3, 189 - 201; https://www.clinicalradiologyonline.net/article/S0009-9260%2816%2930478-0/fulltext

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