

SERIES 3

VIOLENCE AGAINST CHILDREN IN NEPAL

**Health Practitioners' Knowledge, Attitude, and Practice
on Child Abuse and Sexual Abuse in Nepal**

unicef 

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Acronyms

CBO	Community-based organizations	KU	Kathmandu University
CCWB	Central Child Welfare Board	PHC	Public Health Care
CDD	Control of Diarrhoeal Diseases	MBBS	Bachelor of Medicine and Bachelor of Surgery
CDO	Chief District Officer	MCH	Maternal Child Health
CRC	Convention on the Rights of the Child	MoH	Ministry of Health
CTEVT	Council for Technical Education and Vocational Training	MoWCSW	Ministry of Women, Children and Social Welfare
CWIN	Child Workers in Nepal Concern Centre	NGO	Non-Governmental Organizations
DHO	District Health Office	SOP	Standard Operating Procedure
DWD	Division of Women Development	TUTH	Tribhuvan University Teaching Hospital
EPI	Expanded Program of Immunization		
FCHV	Female Community Health Volunteers		
FGD	Focus Group Discussion		
FP	Family Planning		
KAP	Knowledge/Attitudes/Practice		

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Foreword

Child abuse can have serious implications for children's development, in both the short term and the long term. It can affect children's health, their ability to learn and even their willingness to go to school at all. It may also lead children to run away from home, exposing them to further risks. Yet violence against children in Nepal remains a largely hidden problem, since much of it occurs within the privacy of the family or institutions such as schools and children's homes.

The existing studies on child abuse and sexual abuse suggest that the number of reported cases of abuse in Nepal is very low and reflects only a limited picture of what is happening in children's lives. The legal framework still allows some level of tolerance of violence against children.

Some communities continue harmful practices, such as child marriage, and are reluctant to take initiatives to challenge long-established attitudes or norms that may be detrimental to children's healthy development. Also, in the present conflict, children continue to suffer violence, abuse and exploitation. The prolonged armed conflict has resulted in the breakdown of family and social structures, a culture of violence, weak governance and lack of access to basic social services.

Although we recognise the importance of multi-sectoral efforts for effective prevention and responses to child abuse, in this present study we have focused specifically on the role of health practitioners. Experience from other countries shows that early detection of child abuse by trained health practitioners can minimise the consequences for the child and help to launch the necessary services as quickly as possible. Similarly, global experience suggests that the use of standard protocols and guidelines for the clinical management of abuse cases can significantly improve the quality of treatment and psychological support for victims, as well as the evidence that is collected.

The present study highlights the need for such protocols and guidelines, and for specific training of health practitioners. The study underlines the strong role to be played by health practitioners in providing immediate protection and support for victims of child abuse. We hope that it will contribute to the development of guidelines and training programmes that can provide health practitioners with greater knowledge and awareness of child abuse, and better equip them to detect and handle cases of abuse in a sensitive but timely and effective manner.

Dr. Suomi Sakai
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Executive Summary

Only in the past few decades have practitioners and academicians recognized child abuse as a serious social problem, one that can hinder a child's social, intellectual, physical and emotional growth. The available studies and media reports clearly suggest that children are physically and sexually abused in their homes and workplaces in Nepal, leading to psychological and physical injury with long-term consequences.

Health professionals who come into contact with these victims of abuse have a vital role in providing assistance: suspecting the abuse, establishing the diagnosis, treating injuries, addressing safety issues, reporting to appropriate child protection agencies and law enforcement bodies, documenting findings, and recommending follow-up treatment. This research was undertaken as an exploratory study to build a knowledge base in Nepal and to develop an appropriate response system. Its objectives also included an assessment of the capacity of existing health service providers and the responsiveness of the existing support mechanism(s) in addressing child abuse.

The study gathered both quantitative and qualitative data from primary and secondary sources. The secondary information sources consisted mainly of reports and docu-

ments published by different government and non-government organizations, and of data from various internet websites. The primary information was collected from interviews with relevant staff of health institutions at different levels, and from children themselves and key informants within the communities through focus group discussions in 12 districts.

The findings and conclusions of the study are as follows:

Technical Courses and Training of Health Practitioners

The medical courses taught in Nepal focus mainly on the clinical diagnosis and treatment of patients. The curriculums have some courses on community/family health, violence and social problems, but detection and treatment of child abuse has not been incorporated. Thus, medical practitioners lack the knowledge and skills to deal with child abuse. There is unanimous agreement among health practitioners that this is a very important subject and that immediate steps should be taken to include it in the syllabus of medical professionals.

Knowledge of Children regarding Child Abuse

Children saw deprivation of educational opportunities, slapping and scolding by elders, heavy workloads, early marriage, and discrimination between sons and daughters as

child abuse. Verbal and physical abuse were considered the most common forms of child abuse in the community.

Over 50 percent of the total 1,041 child respondents reported that they had knowledge of children being abused in their community and said they believed that more than half the victims of abuse were female. Likewise, children consider their homes to be the place where abuse most commonly takes place, and over 73 percent of the children believed that abusers were people who were familiar to them. However, 37 percent of the children reported that they do not disclose child abuse incidents.

Knowledge of Key Informants regarding Child Abuse

Key informants' perceptions of child abuse were very similar to those of the children. The key informants reported that child abuse included diverse issues, such as deprivation of educational opportunities, early marriage, unreasonable workloads, gender discrimination, adverse effects of the present conflict, and forced entry into strenuous work to supplement family livelihood on account of social custom and culture. Deprivation in various forms, such as lack of childhood entertainment and leisure time, parental love and care, and adequate and wholesome food, were also listed as types of child abuse common in rural areas of Nepal. Corporal punishment, trafficking, rape and severe physical punishment in work places were also perceived as child abuse.

Only 30 percent of the total 465 key informant respondents reported that they believed that family and commu-

nity have adequate knowledge of child abuse. A large minority of the key informants (more than 41 percent) reported that verbal abuse was most common, followed by physical abuse, psychological abuse and sexual abuse. Again, 79 percent of the respondents reported that the victims were generally females. Likewise, 30 percent of them believed that child abuse usually took place at home and over 84 percent of the respondents identified 'familiar people' as the abusers. About 36 percent of the respondents stated that the children do not disclose these incidents to anyone. Only 18 percent of the respondents reported that they had adequate health service facilities in the community to deal with cases of child abuse.

Key informants expressed the view that they wanted to see health practitioners playing a role in the prosecution of child abusers. Similarly, more than 34 percent of the key informants stated that school teachers do try to identify cases of child abuse. In less developed regions such as Mid/Far Western regions, where the education and awareness levels of parents are lower, teachers were reported to take the initiative in identifying child abuse cases. However, key informants suggested that the community itself should come forward to address this problem by establishing a reporting mechanism at the community level. It was recommended that this could be achieved with the active participation of all community-based organizations (CBOs). Key informants also suggested that only when the problem was very serious or could not be solved at community or VDC level should it be reported to the police, the Chief District Officer (CDO) or the district court, in coordination with community leaders, CBOs and child welfare organizations.

The key informants reported that the reasons for not reporting child abuse cases were lack of awareness, lack of financial support, caste and gender discrimination, fear of reprisal, lack of local governance on account of the present conflict and society's inclination to take the issue lightly.

Knowledge of Health Practitioners regarding Child Abuse

Investigation into the knowledge of health practitioners regarding child abuse revealed that very few of the total 264 health practitioner respondents knew what 'Battered Baby Syndrome' meant. Again, health practitioners had limited knowledge regarding evidence related to sexual abuse, such as blood, semen, saliva and hair. This evidence is vital for identifying and prosecuting the perpetrator of the crime.

It was also found that only a limited number of health practitioners had dealt with child abuse cases in their past practice. A large majority (more than 81 percent) of the health practitioners agreed that this was because child abuse was kept hidden and not reported. An overwhelming majority of the respondents agreed that abusers were people familiar to their victims.

The majority of the respondents (90 percent) said they thought the current health system in Nepal could not cope adequately with issues of child abuse because of a lack of training and education, and poor investigative labs and examination infrastructure in health facilities and health posts. Some respondents reported that the concept of child abuse itself was not clear and a better understanding was

required. Some also said that time was a constraint since the health practitioners were too busy with day-to-day obligations, making it impossible to add the responsibility of addressing child abuse cases as well.

Additionally, 80 percent of the health practitioners agreed that better infrastructure was required for handling cases of child abuse cases and over 73 percent of the respondents agreed that a standard operating procedure (SOP) should be developed for management of child abuse cases.

Health practitioners across the country confided that they lacked confidence in dealing with child abuse cases. They reported that the penal code system did not have adequate laws to deal with child abuse cases and even when laws existed they were not effectively implemented. Nearly half of the respondents agreed that NGOs played a positive role in dealing with child abuse. Additionally, the health practitioners believed that child abuse cases required a multi-sectoral approach.

More than 99 percent of the health practitioners were of the opinion that the subject of child abuse should be incorporated in the syllabus of all medical campuses. Respondents also agreed that child abuse is a new field and it is therefore necessary to have more training on the subject.

Attitudes of Health Practitioners towards Child Abuse

About 80 percent of the 264 health practitioner respondents said they believed they had an important role in the prevention of child abuse. However, only about half of

the respondents felt comfortable administering care to children who had been physically abused. The comfort levels of the health practitioners decreased even further when dealing with children who had been sexually abused. When it came to handling cases of psychological abuse of children, the comfort levels expressed by the health practitioners were as low as in dealing with cases of sexual abuse.

The majority of the health practitioners agreed that they played a key role because it was on the basis of their reports that the police and court could take action. By contrast, there were a few respondents who felt that health practitioners should not play a role in helping the victim to get justice, either because they did not want to get involved with the legal system, or because they felt powerless, it was too time-consuming or there were more pressing matters.

The majority of the health practitioners also said corporal punishment of children by anyone, including parents and teachers, was unjustifiable as it was not only physically harmful but also mentally harmful.

Practice of Health Practitioners regarding Child Abuse

Very few of the 264 health practitioners reported actually dealing with child abuse cases. About 83 percent of the respondents reported that there were no special forms for recording cases. The respondents also explained that the main reason for not filling out the reporting forms was that the victim wanted to keep the abuse hidden and secret. The customs and culture were difficult to bypass,

and with stringent laws it was sometimes difficult for medical personnel to report cases. Many health professionals responded that it was not their responsibility to report child abuse cases, and that their duty was to provide treatment only.

The provision of photographic recording and forensic investigation facilities is important for enabling health practitioners to determine and establish abuse cases so that the abuser may be prosecuted. However, such facilities were found to be lacking. Again, access to the 'rape kit' (used for collecting evidence of rape) was almost negligible.

Out of 82 health practitioners who responded about the actual actions they undertook when dealing with child abuse cases, about 17 percent reported that they treated only physical injuries, while about 45 percent provided guidance and counseling. More than 24 percent of them informed the authorities of cases of abuse and about 13 percent were present in the court to give evidence in the cases. More than half (over 58 percent) of the respondents reported that they did not have a referral system in place to deal with child abuse cases.

It was found that over 73 percent of the respondents had done some counseling work. It is important to note that the nature or scope of 'counseling' was not defined in the question. Therefore, the counseling provided could be of clinical nature or just simple advice.

The authorities very seldom called upon health practitioners to testify in child abuse cases, although many health

practitioners believed that they could play a significant role in addressing child abuse, including contributing to prevention.

Recommendations

The assessment clearly suggests that health practitioners at all levels can play a significant role in addressing more effectively the issue of child abuse in Nepal. The recommendations related to the Ministry of Health (MoH) include:

- drafting 'medical record forms' for cases of child abuse
- identifying regional pools of counselors to refer child abuse cases to in each region
- developing a 'standard operating procedure' (SOP)
- conducting short-term training on child abuse for health workers and partners involved in this field
- identifying organizations working to address child abuse at regional level and developing better regional networks

- identifying laboratory(s) to which forensic materials could be sent in each region
- identifying one central lab and providing 'rape kits' to zonal hospitals at all times

Other recommendations include:

- including the subject of child abuse in the courses of all levels of health workers and in the school health program
- identifying the specific tasks of the health workers, police and legal authorities in handling child abuse cases and developing a protocol to develop awareness of how to better handle cases of child abuse
- massive awareness programs to bring about awareness among the public by using the different media available
- a mandatory reporting system to appropriate authorities
- strong coordination and effective teamwork between medical practitioners and law enforcement personnel.

Introduction

1.1 Background

Child abuse and neglect is a new term for an old problem, one that has been with us for thousands of years. It has only been in the past few decades that the issue of child abuse and neglect has attracted serious attention from practitioners and academicians, and the issue has been recognized as a serious social problem that can hinder the social, intellectual, physical and emotional growth of a child. Studies indicate that every day a significant number of children are exposed to serious maltreatment and neglect leading to physical and psychological injury and serious long-term consequences. Increasing evidence also suggests that, in addition to the immediate negative effects on children, maltreatment is associated with a host of problems manifested in adolescence and adulthood.

Definition of Child Abuse

The Convention on the Rights of the Child (CRC), article 19, sets out binding obligations on state parties to protect children from 'all forms of physical and mental violence'

while in the care of parents or others. It asserts children's right to respect for their dignity and physical and personal integrity. As a principle, it is linked to the right to life and to maximum survival and development .

The term child abuse and its definition in policy and practice differ greatly from country to country and culture to culture. In many places, numerous forms of violence which are harmful to children lie outside the common definition of child abuse . The definitions of child abuse are based on the laws of each land. The general definition of child abuse that has emerged in conjunction with these statutes emphasizes the presence of non-accidental injuries as a result of acts of commission (physical assault) or omission (failure to protect) by care takers .

Types of Abuse

Within the broad definition of child abuse and maltreatment, five sub-types can be distinguished. Their definitions represent the existing pattern of child abuse all over the world .

- **Physical abuse** of a child is an act which results in actual or potential physical harm from contact or lack of contact, and which is reasonably within the con-

trol of a parent or person in a position of responsibility, power or trust. This refers to the beating or battering of a child and includes poisoning, burning, hitting, kicking, biting, shaking, throwing, choking or any other harmful force or restraint, although physically abusive behavior is often justified in the name of discipline.

- **Child sexual abuse** is the involvement of a child in sexual activity that he or she does not fully comprehend or is unable to give informed consent to, or that violates the laws or social norms of society. Child sexual abuse can occur between a child and an adult, or between a child and another child. The key to defining an act as abusive is the difference in age and power between the victim and perpetrator.
- **Neglect and negligent treatment** is inattentiveness or the omission on the part of the caregiver to provide for the development of the child. This includes the failure to properly supervise and protect children from harm as much as possible. Examples of neglect include not providing appropriate food, clothing and/or shelter for a child, consistently ignoring his or her concerns and needs, and not providing developmentally appropriate levels of supervision. Neglect may have more devastating effects on children than other forms of maltreatment because it often remains undetected and is an ongoing pattern of parenting.
- **Emotional abuse** includes the failure to provide an appropriate development and supportive environment, so that the child can develop a full and stable range of emotional and social competencies appropriate to her or his personal potential. Like neglect,

emotional abuse is difficult to define and detect. Emotional abuse does not occur in a single episode, but rather is a form of repeated and sustained 'mental violence'. Behaviors such as rejecting, degrading, terrorizing, isolating, corrupting, exploiting and withholding positive emotional responses are considered forms of emotional abuse.

- **Commercial or other exploitation of a child** refers to use of the child in work or other activities for the benefit of others. These activities are to the detriment of the child's physical or mental health, education, or moral or social-emotional development.

Child Abuse Situation in Nepal

The available studies and media reports clearly suggest that children are physically and sexually abused in their homes and workplaces in Nepal. Nepal's tolerance of violence in school and at home seems to reflect that of the larger society. In the highly hierarchical Nepali society, unequal power relations based on gender, caste, class, and ethnic origin prevail, and are manifested in the form of oppression and violence against weaker groups.

Though limited in number, there have been efforts to investigate the scope and nature of sexual abuse of children in Nepal. It is believed that, as a result of societal taboos, reported cases of child sexual abuse represent only a very small proportion of sexual offences against children in Nepal. According to CWIN, of 223 recorded cases of rapes of women and children in 2002, 78 percent were of children below 16 years of age. These included the rape of children less than 10 years old, and of both girls and boys .

Intra-family violence, including sexual abuse, is often a factor contributing to children leaving home to fend for themselves in the streets, where their vulnerability increases. Domestic violence is prevalent in many forms in Nepal. It ranges from physical and sexual abuse to deprivation of food, and to verbal and emotional abuse. According to one study of domestic violence, 77 percent of the perpetrators of violence against women in Nepal are family members; 58 percent of the victims complained of daily abuse. Violence against more marginalized children is also alarming. A study among street children in Kathmandu shows that 73 percent of the respondents reported that they had faced physical, sexual or mental abuse by their family members.

1.2 Methodology

Objectives of the Study

Health professionals, who are often the first to come into contact with victims of abuse, have a vital role in all aspects of the provision of assistance to those victims. These include suspecting the abuse, establishing the diagnosis, treating injuries, addressing safety issues, reporting to appropriate child protection agencies and law enforcement bodies, documenting findings, and recommending follow-up treatment.

As the first step to building a knowledge base on child abuse and appropriate response systems, Samanata Institute for Social and Gender Equality has undertaken this study. Its aim is to assess the capacity of the existing health service providers and the responsiveness of the existing support mechanism(s) in addressing child

abuse. Good local information is essential for the development of proper awareness of child abuse and neglect, and of expertise in addressing the problem within the health care, legal and social service professions. The assessment will be followed by the development of guidelines, protocols and training packages.

Desk Review

The study used both quantitative and qualitative data collected from primary and secondary sources. The secondary information was extracted mostly from a review of reports, or documents published by different government and non-government organizations, and from internet searches of various websites.

Review of existing professional training programs

- School Curriculum (medical school, nursing school, etc)
- Pre-/in-service training (government/private training programs)

Review of existing practices

- Guidelines/Protocols (hospital, health centre, health post, sub health post)
- Knowledge/Attitudes/Practice (KAP) of Service Providers
- Knowledge of health practitioners regarding child abuse (hospital, health centre, health post, sub health post)
- Attitudes of health practitioners regarding child abuse (hospital, health centre, health post, sub health post)
- Practices of health practitioners regarding child abuse (hospital, health centre, health post, sub health post)

- Reporting mechanisms
- Protocols on reporting
- Inter-disciplinary collaboration between the health sector and other relevant sectors such as justice, law and order, and social welfare/family services
- Follow-up mechanisms

Sampling

The primary information was collected from direct interviews with heads or relevant staff of health institutions at different levels, and from children themselves and key informants from communities through focus group discussions.

For the purpose of spreading the sample across all regions, the country was first stratified by five development regions and further stratified by three ecological regions. This provided 15 strata. However, the mid-western and far-western regions are thinly populated and similar in many respects, so these two regions were combined to make one region for sampling purposes. This stratification provided 12 eco-development regions. Table 1 presents the districts selected for the study (also refer Map 1).

Table 1: Districts selected for the study, by development and ecological regions

Region	Mountain	Hill	Terai
Mid/Far Western	Humla	Dadeldhura	Kanchanpur
Western	Mustang	Palpa	Rupandehi
Central	Sindhupalchowk	Kavre	Dhanusha
Eastern	Sankhuwasabhi	Dhankuta	Sunsari
Sub Total	4	4	4
Grand Total	12		

Information was collected from sample districts regarding knowledge, attitudes, and practices of health service providers and practitioners working in hospitals, health centres, health posts, sub health posts, and from community health workers, regarding child abuse and violence against children and the care provided. Individual interviews of health service providers/practitioners with semi-structured questionnaires were conducted in each sample district. Two medical doctors were involved in conducting interviews of the medical doctors in the hospitals in all 12 districts.

The number of interviews conducted, broken down by institution type, is set out in Table 2.

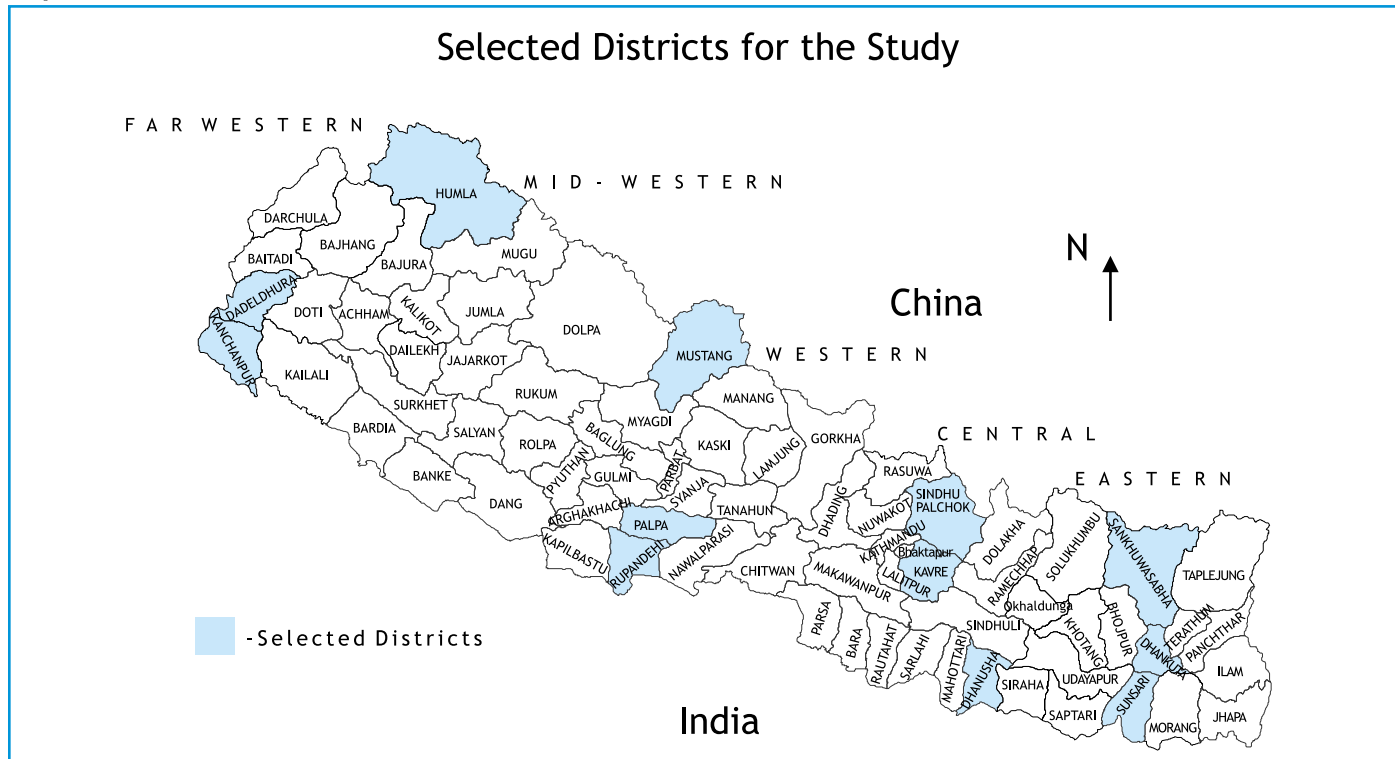
Table 2: Number of interviews conducted in each of the 12 sample districts, by institution type

Institution Type	Hospital / Health Centre	Health Post	SubHealth Post	Community
# of institutions	1	2	4	2
# of districts	12	12	12	12
# of individuals	4	2	1	6
Sub Total	48 (24)	48 (48)	48 (48)	144 (114)
Grand Total	288 (264)			

Note: The column under Community represents the Community Health Workers working in the villages.

The required equal numbers of respondents in all districts at officer positions were not found because of various reasons, such as a lack of human resources posted at the district hospital and health post and the absence of the staff during the field visit. Hence, the number of respondents in the health practitioners category varied from

Map 1: NEPAL



the total expected number of 288. In all only 264 health practitioners were found at their various duty stations and available for interview. The required four officers were present in only two districts namely Dhanusha and Rupandehi. In case of the remaining 10 districts: two health practitioners were available in Dhankuta, Kavre, Sindhupalchowk, Dadeldhura and Kanchanpur district, whereas only one can be found in Humla, Palpa, Mustang and Sankhuwasabha district. The figures in brackets in the table 2 show the actual number of health practitioners found in facilities and communities.

Two focus group discussions were conducted with key informants comprising school teachers, parents, youth leaders and members of community-based organizations (CBO) and Non-governmental organizations (NGO) at two sites in each district. Additionally, two focus group discussions, one with children aged between 8 and 14 and one with children aged between 15 and 18, were conducted at each of two sites in each district to obtain first-hand information and assess the children's perceptions. A total of 144 focus group discussions with different groups of informants were conducted (Table 3).

Table 3: Number of focus group discussions (FGD) conducted

	Key informants	Children (8-14 years)	Children (15-18 years)
# of districts	12	12	12
# of sites	2	2	2
# of FGDs	2	2	2
Sub Total	48	48	48
Grand Total	144		

Survey Team Information

Three teams of four researchers (two male and two female in each team) were formed for data collection. Each team collected information from four districts. Each team visited the district hospital, health centre, two health posts, and four sub health posts to collect information. Each team focused their review on existing practices, guidelines and protocols in the four institutions, and knowledge, attitudes and practices (KAP) of service providers of the four levels of health institutions mentioned above. As well as the 12 field researchers, one research officer and a researcher/co-coordinator, two senior researchers and a pediatrician undertook the research.

Tools and Techniques

Preparations for field visit included the entire team attending the orientation and training organized at Samanata by the consultants to the study. A pre-test with all the research team members was also undertaken in Dhulikhel in Kavre District. All the tools and techniques were tested together. Discussions were undertaken in Kathmandu to clarify

doubts. Suggestions were made and incorporated in the finalized questionnaire and checklists.

At the central level, information was generated with the assistance of a checklist to interview key persons. The list of persons interviewed is presented in Annex I. Interviews were transcribed later.

At the rural community level, information was generated through focus group discussions with local children and key informants with the guidance of a checklist, while questionnaires were administered to the health care providers.

In the field, the team first visited the District Health Office (DHO) and selected health service institutions and sites with DHO assistance and guidance. The Department of Health in Kathmandu was extremely supportive of the study team and showed keen interest, as they understood the value and importance of the study. The Department provided the team members with letters instructing the DHO to provide necessary assistance, guidance and cooperation, which made the work of the team members less problematic than anticipated.

The Team Leader/Senior Social Development Specialist, Senior Socio-Economist/Statistician, Pediatricians, Research Coordinator and Research Officer were involved in spot checking of the interviews in the different development regions and ecological regions.

Review of Technical Courses and Training of Health Practitioners

This chapter presents the findings on the existing professional training programs, including the curriculum of medical schools, nursing schools, and government/private programs providing pre-service training and in-service training regarding child abuse. The chapter continues with findings regarding the activities undertaken regarding child abuse by the various ministries and civil society organizations. Information was gathered from published documents and informal interviews. (A list of persons interviewed is presented in Annex 1).

2.1 Academic Curriculum

The curriculums of the Tribhuvan University Teaching Hospital (TUTH), one of the major medical institutions of the country, Kathmandu University and the Council for Technical Education and Vocational Training (CTEVT) were reviewed.

Bachelor of Medicine and Bachelor of Surgery

The Bachelor of Medicine and Bachelor of Surgery includes a course entitled Community Medicine II, under which there is a topic sub-titled Family Health. The course is designed to increase knowledge and competency of students in developing family health services. The course includes family planning (FP), maternal and child health (MCH), nutrition, public health care (PHC), and rehabilitation covering all issues of family health.

The introduction to this course describes the family system of the country, the effect of dysfunctional families on the health of the family, the existing health care system, problems of addictive behavior in the family, the concept of responsible parenthood and the problem of teen-age marriage/pregnancy, women and child trafficking, child labor, orphans, the single-parent family, displaced persons and refugees. However, clinical management of child abuse is not incorporated in the course.

Certificate of Nursing

The curriculum for the certificate course on nursing has a subject entitled 'Nursing Care for Children' covering a total of 70 credit hours. Students are taught to provide nursing care in order to assist child to the optimum level of good health and to assist families in reducing or coping with their own health problems. No specific subject covering the issue of child abuse is included.

Bachelor of Nursing

The curriculum for the Bachelor of Nursing has a community health subject in both the first and second years. This course reviews the concept and principle of community health nursing, primary health care and the use of the nursing process in family and health care. Emphasis is placed on the Maternal Child Health (MCH) service in Nepal, such as nutrition, control of diarrhoeal diseases (CDD), expanded program of immunization (EPI), school health and family planning. No specific subject covering the issue of clinical management of child abuse is included.

Bachelor/Master of Public Health

The Bachelor of Public Health curriculum has a 120 credit-hour subject entitled 'Applied Family and Reproductive Health' for third-year students. This course imparts advance-level knowledge of parenthood, women's health, violence and problems of aging. The course addresses some socio-cultural issues which can affect family health, such as responsible parenthood, gender and health, violence and family health, and gerontology. Likewise the Master of Public Health curriculum includes the subject

Family Health. This subject covers emerging family health issues and their impact, such as environment degradation, gender issues, population/urbanization, ageing, street children/working children, girl trafficking, HIV/AIDS, community mental health, substance abuse and special care for vulnerable groups. However, child abuse is not specifically addressed.

Diploma of Nursing

The Lalitpur Nursing Campus, located in Shanta Bhawan, provides a diploma-level nursing course. Since this institution is affiliated to the Tribhuvan University Teaching Hospital (TUTH), it is using the same curriculum applicable to all institutions under the TUTH. The one-month community-based residential training in the second-year program, which focuses on socio-cultural practices and their effect on public health, imparts some basic knowledge of the causes and effect of child abuse in the community. Though this type of residential training has helped to make the medical trainees involved aware of various forms of child abuses in the community, it does not specifically address technical matters related to identification, treatment and reporting of child abuse cases.

Bachelor of Medicine and Bachelor of Surgery under Kathmandu University

The curriculum of the Kathmandu University (KU) affiliated Nepal Medical Collage, which produces 100 Bachelor of Medicine and Bachelor of Surgery (MBBS) graduates every year, is also similar to the one applicable in TUTH. The KU curriculum does not include a specific subject for the treatment and prevention of child abuse cases.

Council for Technical Education and Vocational Training (CTEVT)

The Council for Technical Education and Vocational Training (CTEVT) is a major institution for technical education in Nepal. Hundreds of smaller training institutions affiliated with the CTEVT follow the curriculum provided by CTEVT. The curriculum for the nursing course is similar to the TUTH curriculum.

In summary, from the review of the curriculums in various academic institutions, it is clear that medical courses in Nepal focus on the clinical diagnosis and treatment of patients. The curriculums have incorporated some courses on community/family health, violence and social problems. These subjects, to some extent, delve into the causes and effects of abuse. However, a separate subject specifically related to technical information on detection and treatment of child abuse has not been incorporated.

2.2 Training and Courses Attended by Health Practitioners

Interviews with health practitioners revealed that out of 127 respondents in the Eastern and Central regions, all (100%) received no knowledge of this subject in their basic course in academic institutions (Table 4). Of those who replied that they were given some knowledge about child abuse, none had been offered information on child abuse as a subject matter on its own. The few respondents with positive answers were those who had already done their post-graduate studies in pediatrics or obstetrics/gynecology and had some lessons regarding child abuse in

their respective courses. Only two of them had received some knowledge of child abuse in the subject of forensic medicine when it was taught in the training conducted by the Ministry of Health before being deployed to their respective postings.

Table 4: Teaching of child abuse in academic courses reported by practitioners, by region

	Eastern region	Central region	Western region	Mid/Far Western regions
Yes (8) (3%)	-	-	4 (5.6%)	4 (6.2%)
No (256) (97%)	64 (100%)	63 (100%)	68 (94.4%)	61 (93.8%)
Sub Total	64	63	72	65
Grand Total	264			

Medical professionals' knowledge of child abuse appears to be very poor. They had no lessons on the subject during their basic course in academic institutions and they had no further on-the-job training or courses (Table 5). This strongly suggests a large lacuna in the knowledge of medical professionals in terms of clinical management of child abuse. The number of medical doctors who had received some in-service training or courses was almost negligible.

Table 5: Attendance at trainings on child abuse after academic courses, by region

	Eastern region	Central region	Western region	Mid/Far Western regions
Yes (5) (1.9%)	1 (1.6%)	-	-	4 (6.2%)
No (259) (98.1%)	63 (98.4%)	63 (100%)	72 (100%)	61 (93.8%)
Sub Total	64	63	72	65
Grand Total	264			

According to the respondents, even those training courses were of limited nature and scope, such as a short training program or non-specific awareness seminars on child abuse.

2.3 Activities Undertaken regarding Child Abuse by the Various Ministries and Civil Society Organizations

Ministry of Health (MoH)

The Health Service Division has developed a protocol for reproductive health, yet a similar type of protocol or guidelines for management of child abuse has not been formulated. Since the primary focus of the MoH in child health is prevention of communicable disease and immunization, health problems related to violence and child abuse have so far been overlooked. Since there is no specific guideline or protocol on child abuse regarding further investigation or reporting, cases are usually treated clinically, as if they were any other health problem.

According to the key informants, medical practitioners realize they can play a vital role in detection, treatment and prevention of child abuse. Medical practitioners of the MoH also point out that child abuse cases are often suppressed, as the abusers are usually people who are familiar with the child and his/her family. Many argued that social and familial factors have much influence over whether an abused child will be referred for support services or not.

Ministry of Women, Children and Social Welfare (MoWCSW)

The Ministry of Women, Children and Social Welfare has a separate division for child development, which is working in coordination with Central Child Welfare Board (CCWB) based in the Division of Women Development (DWD) and with many other organizations that work for children. There is no specific training or orientation program on the issue of child abuse available for the relevant officials of the MoWCSW.

Women & Children Service Centres of Nepal Police

Women & Children Service Centres of Nepal Police have been dealing with a substantial number of child abuse cases. They stressed the importance of establishing an official coordination procedure or protocol for all the agencies involved in the effort against child abuse. The subject of violence against women and children is covered in their regular training programs.

Non-Governmental Organizations (NGOs)

Child rights organizations have been addressing the physical and psychological abuse of children. Prevention programs (that is, awareness programs) conducted by various NGOs are largely related to drug abuse, child trafficking and child labor. Some NGOs provide direct support to victimized children and have trained staff to support children who are victims of physical and psychological violence.

Knowledge of Children regarding Child Abuse

This chapter presents the perceptions and knowledge of children regarding child abuse. Slightly more than a thousand (1,041) children aged from 8 to 18 were asked about their knowledge of child abuse occurring within or outside their communities. These children, representing different development regions of Nepal, were divided into two age groups: 8 to 14 years old, and 15 to 18 years old. In the tables presented below, not all the children responded to the questions asked, hence the total numbers of respondents vary.

3.1 Knowledge of Child Abuse

Children's Perceptions

Children of all age groups offered similar perceptions of the meaning of child abuse. These perceptions relate primarily to deprivation of educational opportunities, slapping and scolding by elders, heavy workloads, discrimination between sons and daughters, and early marriage. The majority of the children in the districts of the moun-

tainous region mentioned heavy workloads as the most prevalent form of child abuse, while in the case of children from Kavre, Sindhupalchowk, Sunsari, Dhankuta, Kanchanpur, Rupandehi and Dhanusha districts, the perceptions of abuse related mostly to trafficking and sexual abuse. Children also stated that discriminatory behavior of teachers towards intelligent students is a prominent type of abuse in school. Children from Humla district said that discrimination against the girl child was a prominent form of child abuse in their district, while those from Dadeldhura district said that scarcity of food and proper clothing was also a form of child abuse.

Beside the above-mentioned perceptions, some distinct differences in the opinions of children in different age groups emerged. Children in the 8 to 14 years age group generally said that child neglect, along with the deprivation of their playtime due to household and labor for their livelihoods, was also a kind of abuse. On the other hand, children in the 15 to 18 years age group said corruption related to the use of scholarship budgets, involvement of children in political conflict, lack of entertainment oppor-

tunities, injustice due to the absence of juvenile justice system, mental torture and psychological pressure were other forms of child abuse in society.

Children from all the districts and of both age groups had similar perceptions regarding the effect of abuse on their lives. They responded that abuse can be the cause of numerous physical problems such as injuries, fractures, diseases, impairment, and deficient physical development. Likewise, they said incidents of abuse in childhood could cause mental and psychological problems, by reducing mental growth, destroying self-confidence and respect, and causing slow learning capacity. It was also stated that abuse has been responsible for suicidal tendencies at an early age.

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Knowledge of Child Abuse Occurring within or outside their Community

Of the total sample children, more than half reported that they had knowledge of children being abused in their community (Table 6). Examining the knowledge of child abuse by age groups of children across the regions, no systematic pattern was observed. Children from the Mid/Far Western regions appear to

be more aware of child abuse happening around them than children in other regions. The fact that the Mid/Far Western regions are the areas hardest hit by the on-going armed conflict may account for children's perceptiveness about child abuse.

Altogether, 1,029 children answered the question regarding knowledge of child abuse outside their community. Table 7 shows that a much larger percentage of children are aware of child abuse cases outside their community than of cases within their community. The disparity between Table 6 and Table 7 may arise because children are more easily able to access information about child abuse cases outside the community through radio, television or newspaper, whereas the cases within their own community may be hidden and unreported due to stigma, shame and other social restrictions.

When asked about victims of abuse, more than half (58.9 percent) of the children reported that they believe that the victims of abuse were female. Only 29.7 percent of them reported that the victims could be both female and male. There still remains a gap in children's understanding of who is at risk of child abuse.

Table 6: Knowledge of child abuse within the community

	Eastern region		Central region		Western region		Mid/Far Western regions	
	8-14 yrs	15-18 yrs	8-14 yrs	15-18 yrs	8-14 yrs	15-18 yrs	8-14 yrs	15-18 yrs
Yes	84	57	52	98	83	52	74	91
591 (56.8%)	141 (48.0%)		150 (55.8%)		135 (51.3%)		165 (76.7%)	
No	78	75	78	41	55	73	39	11
450 (43.2%)	153 (52.0%)		119 (44.2%)		128 (48.7%)		50 (23.3%)	
Sub Total	294		269		263		215	
Grand Total	1,041							

Table 7: Knowledge of child abuse outside the community

	Eastern region		Central region		Western region		Mid/Far Western regions	
	8-14 yrs	15-18 yrs	8-14 yrs	15-18 yrs	8-14 yrs	15-18 yrs	8-14 yrs	15-18 yrs
Yes	90	107	103	113	135	114	77	101
840 (81.6%)	197 (73.2%)		216 (79.7%)		249 (93.6%)		178 (79.8%)	
No	47	25	29	26	3	14	36	9
190 (18.4%)	72 (26.8%)		55 (20.3%)		17 (6.4%)		45 (20.2%)	
Sub Total	269		271		266		223	
Grand Total	1,029							

Verbal and physical abuse were considered the most common forms of child abuse by the children (Table 8). No consistent relationship was found between the age group and the type of abuse.

When asked about frequency of child abuse, 49.1 percent of the respondents said they believed that child abuse occurred only occasionally and another 41.6 percent believed that it occurred rarely. Only 9.3 percent of them believed that child abuse occurred frequently. However,

Table 9 shows that children in all regions except the Mid/Far Western regions consider their home to be the place where child abuse most commonly occurs. Children seem to feel more vulnerable to abuse in familiar places such as home and school: in all regions except the Mid/Far Western regions, over half of the respondents nominated those two places as the 'place where abuse takes place'. Children in the Mid/Far Western regions consider that child abuse is more likely to occur in community and other places than at home and at school. It is also interesting to

Table 8: Types of abuse in the community

	Eastern region		Central region		Western region		Mid/Far Western regions	
	8-14 yrs	15-18 yrs	8-14 yrs	15-18 yrs	8-14 yrs	15-18 yrs	8-14 yrs	15-18 yrs
Physical	102	80	81	79	97	58	76	90
663 (33.9%)	182 (34.1%)		160 (36.4%)		155 (30.8%)		166 (34.4%)	
Psychological	24	14	37	55	39	19	61	43
292 (14.9%)	38 (7.1%)		92 (20.9%)		58 (11.5%)		104 (21.6%)	
Sexual	49	39	27	26	31	43	38	28
281 (14.4%)	88 (16.5%)		53 (12.0%)		74 (14.7%)		66 (13.7%)	
Verbal	140	85	78	57	100	116	72	74
722 (36.9%)	225 (42.2%)		135 (30.7%)		216 (42.9%)		146 (30.3%)	
Sub Total	533		440		503		482	
Grand Total	1,958*							

*Multiple responses, hence the total is higher than 1,041.

note that these two regions are considered the most affected by the on-going armed conflict.

Altogether, 1,031 children answered the question as to whether child abusers were usually strangers or people familiar to them. It was found that 73.1 percent of the children believed that abusers were familiar people,

whereas only 26.9 percent said that abusers were strangers (Table 10). The findings correspond with those above: children generally consider familiar places such as home and school to be the places where they are more prone to child abuse. No consistent relationship was found between the age group and the types of abusers.

Table 9: Places where abuse occurred as reported by different age group of children

	Eastern region		Central region		Western region		Mid/Far Western regions	
	8-14 yrs	15-18 yrs	8-14 yrs	15-18 yrs	8-14 yrs	15-18 yrs	8-14 yrs	15-18 yrs
Home	57	62	61	47	20	33	46	69
395 (31.5%)	119 (34.0%)		108 (28.3%)		53 (41.7%)		115 (29.0%)	
Community	45	50	61	17	19	18	74	72
356 (28.4%)	95 (27.1%)		78 (20.5%)		37 (29.1%)		146 (36.8%)	
School	43	46	55	38	13	16	20	11
242 (19.3%)	89 (25.4%)		93 (24.4%)		29 (22.8%)		31 (7.8%)	
Other places	23	24	83	19	0	8	44	61
262 (20.9%)	47 (13.4%)		102 (26.8%)		8 (6.3%)		105 (26.4%)	
Sub Total	350		381		127		397	
Grand Total	1,255*							

**Multiple responses, hence the total is higher than 1,041*

Table 10: Types of abusers

	Eastern region		Central region		Western region		Mid/Far Western regions	
	8-14 yrs	15-18 yrs	8-14 yrs	15-18 yrs	8-14 yrs	15-18 yrs	8-14 yrs	15-18 yrs
Strangers	39	44	36	26	12	30	47	43
277 (26.9%)	83 (27.6%)		62 (24.9%)		42 (16.3%)		90 (40.4%)	
Familiar people	111	107	89	98	114	102	66	67
754 (73.1%)	218 (72.4%)		187 (75.1%)		216 (83.7%)		133 (59.6%)	
Sub Total	301		249		258		223	
Grand Total	1,255*							

**Multiple responses, hence the total is higher than 1,041*

With regard to whether children disclose incidents of abuse, 51 percent of the total respondents who answered this question answered in the affirmative, while 37 percent said that they did not disclose incidents (Table 11). The data also shows that children of younger age groups

are more likely to confide in others about incidents of abuse. However, the study did not explore any relationships between the nature of abuse and children's willingness to disclose the information.

Table 11: Disclosure of incidents of abuse

	Eastern region		Central region		Western region		Mid/Far Western regions	
	8-14 yrs	15-18 yrs	8-14 yrs	15-18 yrs	8-14 yrs	15-18 yrs	8-14 yrs	15-18 yrs
Yes	76	31	93	78	55	44	73	63
513 (51.0%)	107 (38.8%)		171 (63.1%)		99 (40.4%)		136 (65.7%)	
No	51	74	32	51	35	62	28	36
369 (37.0%)	125 (45.3%)		83 (30.6%)		97 (39.6%)		64 (30.9%)	
School	43	46	55	38	13	16	20	11
242 (19.3%)	89 (25.4%)		93 (24.4%)		29 (22.8%)		31 (7.8%)	
Don't know	23	21	7	10	36	13	4	3
117 (12.0%)	44 (15.9%)		17 (6.3%)		49 (20.0%)		7 (3.4%)	
Sub Total	276		271		245		207	
Grand Total	999							

Knowledge of Key Informants regarding Child Abuse

This chapter presents the findings from focus group discussions (FGDs) and structured questionnaires with key informants comprising school teachers, parents, youth leaders, and members of community-based organizations (CBOs) and NGOs. A total of 48 focus group discussions (FGDs) with key informants were conducted in two different localities of the 12 selected districts. The number of participants in each FGD ranged from eight to 12. In all, 465 key informants participated. Parents, teachers, youth leaders, members of CBOs and NGOs, representatives of political parties and teachers participated in the FGDs and answered structured questionnaires.

4.1 Knowledge of Child Abuse Perceptions of Key Informants

It is interesting to note that the data reveals that the key informants' perceptions and the children's perceptions

regarding child abuse were very similar. The key informants reported that child abuse comprised a range of diverse issues, such as deprivation of educational opportunities, early marriage, unreasonable workloads, gender discrimination, adverse effects of the present political conflict and forced entry into strenuous work to supplement family livelihood on account of social custom and culture. Deprivation of childhood entertainment and leisure time, deprivation of parental love and care, and deprivation of adequate and wholesome food were also listed as common types of child abuse occurring in rural areas. Corporal punishment, trafficking, rape and severe physical punishment in work places were also perceived as child abuse.

Of the total 465 key informants, 139 (30 percent) said they believed that families and the community have adequate knowledge of child abuse, while the rest believed otherwise (Table 12). More than 80 percent of key informants from the Mid/Far Western regions said they believed that family and community-level awareness of child abuse was limited.

Table 12: Knowledge of child abuse

	Eastern region	Central region	Western region	Mid/Far Western regions
Have knowledge	34	44	39	22
139 (30.0%)	(29.6%)	(37.3%)	(36.8%)	(17.5%)
No knowledge	81	74	67	104
326 (70.0%)	(70.4%)	(62.7%)	(63.2%)	(82.5%)
Sub Total	115	118	106	126
Grand Total	465			

Knowledge of Key Informants

Table 13 shows that 265 (57 percent) of the total 465 key informants had knowledge of child abuse cases within their community, whereas the remaining 43 percent did not have such knowledge. It is interesting to note that key informants from Mid/Far Western regions appeared to be most aware of child abuse cases within their communities, but the same informants said that families and communities in their regions generally lacked knowledge of child abuse.

Table 13: Knowledge of child abuse within the community

	Eastern region	Central region	Western region	Mid/Far Western regions
Have knowledge	57	51	62	95
265 (57.0%)	(49.6%)	(43.2%)	(58.5%)	(75.4%)
No knowledge	58	67	44	31
200 (43.0%)	(50.4%)	(56.8%)	(41.5%)	(24.6%)
Sub Total	115	118	106	126
Grand Total	465			

When the key informants were asked about their perceptions concerning the sex of usual victims, 79 percent of the respondents reported that the victims were females, 6.1 percent of informants said the victim could be male while only 14.9 percent believed that the victim could be

both male and female. This is very similar to the report given by the children.

Table 14 shows key informants' perceptions concerning the types of abuses usually found in the community. It was reported that the form of abuse most commonly observed is verbal abuse (41.1 percent), followed by physical abuse (32.3 percent), psychological abuse (15.2 percent), and sexual abuse (11.4 percent). It is interesting to note that regional differences shown in the key informants' perceptions are not seen in children's responses to the same question.

Table 14: Types of abuse

	Eastern region	Central region	Western region	Mid/Far Western regions
Physical	44	31	44	42
161 (32.3%)	(29.6%)	(55.4%)	(29.5%)	(29.0%)
Psychological	20	-	10	46
76 (15.2%)	(13.4%)	-	(6.7%)	(31.7%)
Sexual	27	6	10	14
57 (11.4%)	(18.1%)	(10.7%)	(6.7%)	(9.7%)
Verbal	58	19	85	43
205 (41.1%)	(38.9%)	(33.9%)	(57.1%)	(29.6%)
Sub Total	149	56	149	145
Grand Total	499*			

**Multiple responses, hence the total is higher than 465*

When key informants were asked about the places where child abuse usually occurs, about 30 percent said they believe that child abuse usually takes place at home, while another 28 percent said they believe that child abuse usually takes place within the community and at other non-specified places (Table 15). The perceptions of key informants on this issue did not show the regional consistency observed in the children's answers to the same question.

Table 15: Places where child abuse occurs

	Eastern region	Central region	Western region	Mid/Far Western regions
Home	12	12	10	10
44 (29.7%)	(30.0%)	(28.6%)	(27.8%)	(33.3%)
Community	10	10	11	10
41 (27.7%)	(25.0%)	(23.8%)	(30.5%)	(33.3%)
School	8	6	5	3
22 (14.9%)	(20.0%)	(14.3%)	(13.9%)	(10.0%)
Other places	10	14	10	7
41 (27.7%)	(25.0%)	(33.3%)	(27.8%)	(23.4%)
Sub Total	40	42	36	30
Grand Total	148*			

**Many did not know or did not have personal experience regarding this matter*

Table 16 shows that 84.4 percent of the respondents identified 'familiar people' as abusers as oppose to 'strangers'. The findings from the key informants are consistent with the perceptions of children concerning the types of abusers.

Table 16: Types of abusers

	Eastern region	Central region	Western region	Mid/Far Western regions
Stranger	34	7	23	34
98 (15.6%)	(19.9%)	(5.5%)	(14.6%)	(19.8)
Familiar people	137	121	135	138
531 (84.4%)	(80.1%)	(94.5%)	(85.4%)	(80.2%)
Sub Total	171	128	158	172
Grand Total	629*			

**Multiple responses, hence the total is higher than 465.*

With regard to the perceptions of key informants about whether children disclose incidents of abuse, 53 percent of the total respondents answered in the affirmative, while 36 percent said that the children did not disclose these incidents and 11 percent reported that they did not know whether children confide in others or not.

Table 17: Disclosure of abuse incident

	Eastern region	Central region	Western region	Mid/Far Western regions
Yes	50	78	35	83
246 (53%)	(20%)	(32%)	(14%)	(34%)
No	44	36	43	43
166 (36%)	(26%)	(22%)	(26%)	(26%)
Don't know	21	4	28	-
53 (11%)	(42%)	(7%)	(51%)	-
Sub Total	115	118	106	126
Grand Total	465			

During the FGDs, respondents said that there might be many reasons for children's reluctance to disclose such incidents. If the abuser was an employer, the child might fear losing their job and thereby being deprived of the opportunity to earn income for themselves and their family. In the case of more common practices, such as scolding and beatings by their elders and teachers, children might be more inclined to take it in their stride, as if it was their normal fate.

Some pointed out that children did not speak about the incidents because they were afraid of the abuser, did not have the self-confidence to face the consequences, or felt that their parents were simply helpless in dealing with the abuse cases. Sexual abuse was also hidden because of the associated social stigma, whereby not only the abuser but also the victims lose face.

Key informants said that if the abuser was an outsider (that is, a stranger), children would confide in their parents. However, in instances when the abuser was a family member, children usually confided in their friends. A

few respondents stated that in some cases children confided in their siblings, relatives or teachers.

Key informants were further asked about the types of responses that might be made by the person in whom the child confided. Key informants said they believed that the type of response would depend upon the seriousness of the incident and the socio-economic background and capability of the person. In most cases, key informants believed that the person who received the information about the abuse case would just keep quiet. Some respondents said that the parents and guardians of the abused child also took action against the abuser in cases where the child was seriously injured. This usually happened in the case of sexual abuse.

4.2 Health Care System Response

Medical Care for Abused Children

In addition to the perceptions and knowledge of child abuse among the key informants, the study looked at the responses of the medical and health care system to child abuse. When key informants were asked whether children needed medical help due to physical, psychological or sexual abuse, 22.5 percent of the 453 of the respondents that responded said there was a need for medical help (Table 18).

Table 18: Requirement of medical care for abused children

	Eastern region	Central region	Western region	Mid/Far Western regions
Yes	36	21	11	34
102 (22.5%)	(31.3%)	(19.8%)	(10.4%)	(27%)
No	79	85	95	92
351 (77.5%)	(68.7%)	(80.2%)	(89.6%)	(63%)
Sub Total	115	106	106	126
Grand Total	453			

Distance to Health Facilities

To assess whether health facilities were easily accessible or not, key informants were asked about the distance of such facilities from their community. Only 44 key informants responded to this query because the non-responders did not perceive reporting of cases of abuse to a health facility as something they would normally do, and did not think it necessary to answer this query. The data shows that about 61 percent could reach the health facility in less than 30 minutes (Table 19).

Table 19: Distance to the health facility

	Eastern region	Central region	Western region	Mid/Far Western regions
Less than 15 minutes walk	1	5	6	5
17 (38.6%)	(11.1%)	(62.5%)	(50%)	(33.3%)
15 to 30 minutes walk	3	1	5	1
10 (22.7%)	(33.3%)	(12.5)	(41.7%)	(6.7%)
Half an hour walk	0	2	1	3
6 (13.9%)	(0.0%)	(25%)	(8.3%)	(20.0%)
More than one hour	5	0	0	6
11 (25.0%)	(55.6%)	(0.0%)	(0.0%)	(40.0%)
Sub Total	9	8	12	15
Grand Total	44			

Behaviors of Health Practitioners

During the FGDs, key informants were asked about the behaviors of health care providers towards victims of abuse. Only those key informants who had taken a child victim to a health care provider responded to the question, thus the total number of respondents is only 23. With

regard to this query, 14 respondents (60.9 percent) said that health care providers were sympathetic and kind, while four respondents said their attitude was indifferent and three respondents found health care providers to be rude to the victim (Table 20). More than twice as many key informants (12 persons) had taken a child victim to a health facility people in the Mid/Far Western regions as in any other region.

Table 20: Health care providers' behavior

	Eastern region	Central region	Western region	Mid/Far Western regions
Sympathetic and kind	1	4	4	5
14 (60.9%)	(7.1%)	(28.6%)	(28.6%)	(35.7%)
Rude	-	-	-	3
3 (13.1%)	-	-	-	(100%)
Indifferent	-	1	-	3
4 (17.4%)	-	(25%)	-	(75%)
Others	1	-	-	1
2 (8.7%)	(50%)	-	-	(50%)
Sub Total	2	5	4	12
Grand Total	23			

Adequacy of Health Service Facilities

Table 21 shows that only 18 percent of the 460 respondents that responded reported that they had adequate health service facilities in their communities. The remaining 82 percent said that the community did not have adequate health service facilities. A major regional variation was found in the key informants' opinions about the availability of adequate health service facilities. Table 21 shows that the Mid/Far Western regions have the highest percentage of the respondents agreeing that they have adequate health

service facilities in their communities. This was followed by the Central region (28.9 percent). It is interesting to note that the general situation of basic services is often perceived to be less developed in these two regions, compared to the rest of the country. As shown in Table 4 and Table 5, the sample health practitioners in the Mid/Far Western regions were seen as being better trained, which may indicate that services provided are more adequate.

Table 21: Adequacy of health service facilities

	Eastern region	Central region	Western region	Mid/Far Western regions
Have adequate facilities	3	24	3	53
83 (18%)	(2.6%)	(20.3%)	(3%)	(42.1%)
Do not have adequate facilities	112	94	98	73
377 (82%)	(97.4%)	(79.7%)	(97%)	(57.9%)
Sub Total	115	118	101	126
Grand Total	460			

Role of Health Practitioners

Key informants were asked what they thought of the roles of health practitioners in addressing child abuse. Many informants did not respond to this question because they had never thought that child abuse was important and hence they were not familiar with the concept that health practitioners had a role in this field. The key informants described various roles of health practitioners for preventing child abuse. Table 22 presents the percentages of respondents. The table shows that among various roles mentioned by the key informants, the highest percentage (28 percent) went to the role to treat injuries of the victims, thus

more curative response to child abuse. This was followed by 19.5 percent of the respondents who opined that detecting suspect abuse cases is also the responsibility of the health care providers. Similarly, 16.1 percent of the respondents had also pointed out that addressing safety issues was also the concern of health practitioners. The findings show that key informants wish to see health practitioners taking a more 'pro-active' role in addressing (and especially preventing) child abuse through early detection of cases and awareness-raising about safety concerns.

Some informants also want to see health care practitioners' contributing to bringing perpetrators to justice. Table 22 shows that 10.1 percent of the respondents said re-

Table 22: Views on health practitioners' roles

	Eastern region	Central region	Western region	Mid/Far Western regions
Suspecting abuse	5	7	4	7
23 (19.5%)	(21.8%)	(30.4%)	(17.4%)	(30.4%)
Treating injuries	11	9	10	3
33 (28%)	(33.3%)	(27.3%)	(30.3%)	(9.1%)
Addressing safety issues	1	5	7	6
19 (16.1%)	(5.3%)	(26.3%)	(36.8%)	(31.6%)
Documenting the findings	1	3	1	5
10 (8.5%)	(10%)	(30%)	(10%)	(50%)
Reporting to the appropriate child protection agencies and law enforcement	1	4	4	3
12 (10.1%)	(8.4%)	(33.3%)	(33.3%)	(25%)
Providing expert testimony	1	2	1	-
4 (3.4%)	(25%)	(50%)	(25%)	-
Others	4	6	3	4
17 (14.4%)	(23.5%)	(35.3%)	(17.7%)	(23.5%)
Sub Total	24	36	30	28
Grand Total	118*			

*Multiple responses

porting the abuse cases to appropriate child protecting agency was also the role of health care providers. Likewise, 8.5 percent of the respondents said documenting the findings of abuse cases was the role of health care providers. Interestingly, only 3.4 percent of the respondents said that providing expert testimony was the role of health practitioners. This may suggest that community's limited knowledge about a significant role of health care practitioners and their expert testimony which often is critical in criminal prosecution of abuse cases.

4.3 Reporting on Cases of Child Abuse

When key informants were asked whether people reported child abuse cases or not, only a few responded to the question because many had no personal experience regarding this matter. Out of the total of 30 who responded, 22 were of the opinion that abuse cases were reported rarely and the remaining 8 said they were reported occasionally.

Reasons for Not Reporting Incidents of Abuse

Respondents gave the following reasons for not reporting the abuse cases:

- Lack of awareness
- Lack of financial support
- Caste and gender discrimination
- Fear of reprisal
- Lack of local governance on account of the present political conflict
- Society's tendency to treat abuse lightly

These reasons were common across all the development regions.

Different Places for Reporting Child Abuse Cases

Respondents in the Eastern, Central and Mid/Far Western regions mostly reported the abuse cases to better facility followed by reporting to police (Table 23). Very few in the Eastern and Mid/Far Western regions reported to the NGOs.

Table 23: Where child abuse cases were referred to

	Eastern region	Central region	Western region	Mid/Far Western regions
Better facility	14	17	40	9
80 (74.8%)	(63.6%)	(85.0%)	(87.0%)	(47.4%)
Police	6	2	5	9
22 (20.6%)	(27.3%)	(10.0%)	(10.9%)	(47.4%)
NGOs	2	-	-	1
3 (2.8%)	(9.1%)	-	-	(5.2%)
Others	-	1	1	-
2 (1.9%)	-	(5.0%)	(2.1%)	-
Sub Total	22	20	46	19
Grand Total	107*			

*Multiple responses

Teachers Reporting Child Abuse Cases

Key informants were asked what they thought the role of school teachers should be in identifying child abuse cases. Of the 434 respondents that responded Table 24 shows that 34.2 percent of the key informants said that school teachers do try to identify cases of child abuse. It is interesting to note regional differences here. Except for Mid/Far Western regions, the number of key informants reporting that teachers do not identify child abuse cases significantly outnumbered the number of key informants who reported more positively about teachers' roles in identifying child abuse. This implies that in less developed regions such as Mid/Far Western regions, where the education and awareness levels of parents are more limited, teachers may take a stronger initiative in identifying child abuse cases.

Table 24: Teachers' role in reporting abuse

	Eastern region	Central region	Western region	Mid/Far Western regions
Yes	16	34	13	93
156 (34.2%)	(10.3%)	(21.8%)	(8.3%)	(59.6%)
No	90	84	93	11
300 (65.8%)	(30%)	(28%)	(31%)	(57.9%)
Sub Total	106	118	106	104
Grand Total	434			

The key informants were also asked if they knew of any child abuse cases reported by school teachers. Out of the 21 who responded to the question, only nine reported that they knew of school teachers seeking medical treatment for the abused child. Eight respondents were of the opinion that school teachers were not playing a significant role.

Reporting Mechanisms

During the FGDs, key informants suggested that in most child abuse cases, the community itself should come forward to address the problems. It was suggested that the first step should be to ensure a reporting mechanism at the community level under which community leaders would be notified. FGDs further recommended that this could be achieved with the active participation of all community-based organizations (CBOs) encouraging community members to report such cases. Key informants also suggested that only when the problem was very serious or could not be solved at community or VDC level should it be reported to the police, CDO or the district court, in coordination with community leaders, CBOs and child welfare organizations.

According to the FGDs, the existing reporting of child abuse could be improved through the implementation of awareness

programs, a massive education drive and improvement of the socio-economic status of rural communities. Other areas identified for further improvement included special legislation related to child abuse, the establishment of a juvenile justice system, and coordination between CBOs, police and village and district level authorities. Key informants also suggested that an effective monitoring and reporting system must be in place at all levels if child abuse is to be prevented.

4.4 Effects of Child Abuse and Neglect

The FGDs suggested child abuse had a multitude of effects. The identified effects were of a physical, mental and social, as well as an economic, nature. For instance, the main physical effects identified were impairment, disability and underdevelopment. The main psychological effects nominated were loss of confidence, inability to perform to one's potential in work and education, loss of memory, trauma and fear, yearning for revenge, suicidal tendencies, frustration, loss of self-respect and high susceptibility to drug and alcohol abuse.

Similarly, the major social effects cited included societal and parental neglect, loss of education on account of dropping out of school, and displacement and separation from one's family and community. On the economic side, the main effects identified were the loss of income-earning capability of the abused child in the long run, on account of mental and physical injury resulting from abuse, and the expenses required for treatment.

4.5 Suggestions for Preventing Child Abuse

Many suggestions for helping to prevent child abuse were made during the FGDs. The key informants stressed the inclusion of child rights in the school syllabus, awareness programs for specific target groups at the community level, income generation programs, free education and meals for poor students, a peaceful solution to the current political conflict, the eradication of discrimination on the basis of gender, class and caste, and strong punitive measures against perpetrators of abuse.

Knowledge of Health Practitioners regarding Child Abuse

This chapter presents the health practitioners' general knowledge of the issue of child abuse. Data was also generated regarding the health practitioners' opinions of how the health system and other stakeholders addressed child abuse. Data was gathered from various health care institutions, such as hospital/health centers, health posts and sub health posts, and from personnel working in different positions in these institutions. Information was also generated from the community health workers who work at the village level. In total there were 264 respondents.

The data generated from health care practitioners at different levels reveals very few differences in their responses to queries regarding knowledge (this chapter) and attitudes and practices (the following two chapters). Hence, information is analyzed and presented by development regions only. In several tables the figures in the table do not add to 264 because the respondents did not answer the question, either because they did not know about the issue or had not experienced it personally.

5.1 Knowledge of Child Abuse

The issue of child abuse first received wider recognition and attention among the medical profession and the general public following the publication of 'The Battered Child Syndrome' in 1962. According to WHO, the battered child means a child 'showing repeated and devastating injury to the skin, skeletal system or nervous system. It includes children with multiple fractures of different ages, head trauma and severe visceral trauma, with evidence of repeated infliction.'

However, the data in Table 23 reveals that very few respondents knew what 'Battered Child Syndrome' meant. The majority of the health workers working in the hospitals, health posts or sub health posts reported that they had not even heard the term 'Battered Child Syndrome'. Since even professionals at the hospital level have not heard about this term, it is hard to believe that the people in the lower levels such as health posts and sub health posts will have heard of it. This shows that even basic knowledge about child abuse is lacking throughout the hierarchy of the health system. Moreover, the 10 out of 264 respondents who answered in the affirmative were medical doctors or specialists in their respective fields.

Table 25: Knowledge on 'Battered Child Syndrome'

	Eastern region	Central region	Western region	Mid/Far Western regions
Yes	1	2	6	1
10 (3.8%)	(1.6%)	(3.2%)	(8.3%)	(1.5%)
No	63	61	66	64
254 (96.2%)	(98.4%)	(96.8%)	(91.7%)	(98.5%)
Sub Total	64	63	72	65
Grand Total	264			

It is standard practice that any case reported to a health practitioner should be examined thoroughly. In a case of sexual abuse, the basic samples necessary for evidence are primarily blood, semen, saliva and hair. Medical personnel must look for these basic but very vital evidentiary materials when a victim arrives at a medical facility. This evidence is vital for identifying and prosecuting the perpetrator of the crime. Hence, health practitioners were asked they had knowledge about evidentiary material related to sexual abuse or not. Table 26 reveals that hair was the only material that 40 percent of the

Table 26: Evidentiary material in cases of sexual abuse

	Eastern region	Central region	Western region	Mid/Far Western regions
Hair	27	20	27	32
106 (40.2%)	(38%)	(30.8%)	(37.5%)	(57.1%)
Saliva and hair	29	24	27	9
89 (33.7%)	(40.8%)	(36.9%)	(37.5%)	(16.1%)
Semen, saliva and hair	10	9	9	7
35 (13.3%)	(14.1%)	(13.8%)	(12.5%)	(12.5%)
Blood, semen, saliva and hair	5	12	9	8
34 (12.8%)	(7.1%)	(18.5%)	(12.5%)	(14.3%)
Sub Total	71	65	72	56
Grand Total	264			

respondents could nominate as evidence of sexual abuse, while about 34 percent could identify hair and saliva. Very few (just over 13 percent) identified hair, saliva and semen as evidence of sexual abuse and even fewer respondents (less than 13 percent) identified hair, saliva, semen and blood as evidence of sexual abuse. These figures reveal that the health practitioners again had limited knowledge regarding evidentiary material related to sexual abuse.

Table 27 provides information about health practitioners' knowledge of the number of child abuse cases that they had come across in their practice to date. Since the data was generated simply based on individual respondents' recollections, it should be used with caution. Table 27 indicates that only a limited number of health practitioners had dealt with child abuse cases in their past practice. It also appears that the frequency of reporting of such cases is rather limited across the regions, except for Mid/Far Western regions where three health practitioners recalled dealing with child abuse cases on a daily basis.

Table 27: Number of abuse cases dealt with

	Eastern region	Central region	Western region	Mid/Far Western regions
One case a day	-	-	-	3
3 (3.4%)	-	-	-	(12.5%)
One case a week	1	-	-	1
2 (2.3%)	(4.6%)	-	-	(4.2%)
A few cases a month	3	-	4	4
11 (12.5%)	(13.6%)	-	(21.1%)	(16.7%)
A few cases a year	18	23	15	16
72 (81.8%)	(81.8%)	(100%)	(78.9%)	(66.6%)
Sub Total	22	23	19	24
Grand Total	88			

The above findings correspond with the findings from the previous chapters: only half the children reported that information on abuse would be disclosed to others and nearly three-quarters of the key informants were of the opinion that child abuse cases were rarely reported.

Table 28 also shows health practitioners' views on whether child abuse cases are hidden or not. Across the regions, a large majority (81.6 percent) of the health practitioners agreed or strongly agreed that child abuse was kept hidden and not reported.

Table 28: Report on hiding cases of child abuse

	Eastern region	Central region	Western region	Mid/Far Western regions
Strongly agree	24	18	31	29
102 (39.1%)	(38.1%)	(29%)	(43.7%)	(44.6%)
Agree	31	36	22	22
111 (42.5%)	(49.2%)	(58.1%)	(31%)	(33.9%)
Disagree	3	2	12	2
19 (7.3%)	(4.8%)	(3.2%)	(16.9%)	(3.1%)
Strongly Disagree	-	-	-	1
1 (0.4%)	-	-	-	(1.5%)
Undecided	5	6	6	11
28 (10.7%)	(7.9%)	(9.7%)	(8.4%)	(16.9%)
Sub Total	63	62	71	65
Grand Total	261			

Health practitioners were also asked if they were aware of the effects of child abuse. The majority of the health practitioners across the regions were aware that child abuse could have long-term effects (Table 29). Only in the Mid/Far Western regions did a considerable proportion of the respondents report that they were not aware of the long-term effects of child abuse.

Table 29: Reporting on long-term effects of child abuse

	Eastern region	Central region	Western region	Mid/Far Western regions
Yes	56	58	58	44
216 (81.8%)	(87.5%)	(92.1%)	(80.6)	(67.7%)
No	8	5	14	21
48 (18.2%)	(12.5%)	(7.9%)	(19.4%)	(32.3%)
Sub Total	64	63	72	65
Grand Total	264			

Health practitioners were asked about their views on abusers. Table 30 shows that the overwhelming majority of the respondents agreed that abusers were those who were familiar with the abused child. There was no regional discrepancy in this regard. The findings are also consistent with views expressed by children and key informants in answer to the same question.

Table 30: Identification of abusers

	Eastern region	Central region	Western region	Mid/Far Western regions
Strangers	34	7	23	34
98 (20.7%)	(25.8%)	(7.3%)	(20%)	(26.2%)
Familiar people	98	89	92	96
375 (79.3%)	(74.2%)	(92.7%)	(80%)	(73.8%)
Sub Total	132	96	115	130
Grand Total	473*			

**Multiple responses*

5.2 Health Care System Response

Table 31 indicates that the majority of the respondents (90 percent) thought that the current health system in Nepal could not cope adequately with the issue of child abuse. Specifically, 95.3 percent in the Eastern, 87.3 percent in the Central, 97.3 percent in the Western and 80 percent in the Mid/Far Western regions reported that

the health system could not adequately cope with the issue of child abuse.

The majority of respondents from the Eastern region reported there was a lack of training and education on child abuse in the present health system. They also felt that health posts and health facilities were not equipped with proper facilities such as investigative labs and examination infrastructure. Some respondents reported that the issue of child abuse itself was not clear and had to be investigated further. Some also said that certain health facilities, especially sub health posts and health posts, were geared to managing other public health interventions related to prevention, such as immunization, nutrition and treatment of a few of the killer diseases. Hence, the issue of child abuse was a field quite alien to many health practitioners. Some also said that time was a problem as they were already too busy with carrying out other responsibilities related to their day-to-day obligations and it was simply impossible to add the responsibility of addressing child abuse cases.

Most of the respondents from the Central region cited the same reasons as their Eastern counterparts. In addition, some said that the health practitioners' job was just to treat patients, so other responsibilities related to child abuse cases were not quite within the scope of their work. Some also said the health system's ability to address child abuse might be negatively affected by the lack of an effective legal system, a lack of protocols, and in particular a lack of authority delegated to village health workers.

Respondents from the Western region mostly shared the views stated above. They added that a clear definition of

child abuse was lacking. Some also pointed out that only sexual abuse was considered as abuse in the community. Some also said inclusion of the subject of child abuse in the syllabus of all health workers should be considered.

Respondents from the Mid/Far West had similar opinions and added that the armed conflict in the country, and the lack of road and transportation facilities that would allow people to reach health facilities, were particularly problematic in the regions.

Table 31: Adequacy of health system to provide care to child abuse cases

	Eastern region	Central region	Western region	Mid/Far Western regions
Yes	3	8	2	13
26 (9.8%)	(4.7%)	(12.7%)	(2.8%)	(20.0%)
No	61	55	70	52
238 (90.2%)	(95.3%)	(87.3%)	(97.2%)	(80.0%)
Sub Total	64	63	72	65
Grand Total	264			

The limited confidence expressed by health practitioners across the regions in their ability to deal with child abuse cases is revealed in Table 32. The health practitioners who reported feeling competent were either child specialists or obstetrician/gynecologists. Many of the health practitioners at the hospital level reported that they did not feel comfortable treating cases of child abuse with their existing knowledge. This 'self-assessment' of competency among the health practitioners seems to correspond to their limited level of academic and job training on the subject of child abuse, as seen in the earlier chapter. Likewise, the respondents from health post and community level also reported that they did not feel competent to treat cases of child abuse.

Table 32: Competency to treat cases of child abuse

	Eastern region	Central region	Western region	Mid/Far Western regions
Yes	15	13	20	15
63 (23.9%)	(23.4%)	(20.6%)	(27.8%)	(23.1%)
No	49	50	52	50
201 (76.1%)	(76.6%)	(79.4%)	(72.2%)	(76.9%)
Sub Total	64	63	72	65
Grand Total	264			

5.3 Penal Code System

Health practitioners were asked about the effectiveness of the present penal code system in addressing child abuse. As seen in Table 33, very few respondents felt that the penal code system had adequate laws to deal with child abuse cases. Specifically, 93.1 percent of the respondents from the Western, 89.1 percent from the Eastern, 84.1 percent from the Central and 83.1 percent from the Mid/Far Western regions reported that the penal code system did not have adequate laws to deal with child abuse cases. Many also expressed the view that, even though laws exist, they may not have been sufficiently implemented for various reasons.

Table 33: Adequacy of the penal code system to deal with child abuse cases

	Eastern region	Central region	Western region	Mid/Far Western regions
Yes	7	10	5	11
33 (12.5%)	(10.9%)	(15.9%)	(6.9%)	(16.9%)
No	57	53	67	54
231 (87.6%)	(89.1%)	(84.1%)	(93.1%)	(83.1%)
Sub Total	64	63	72	65
Grand Total	264			

5.4 Role of Non-Governmental Organizations

Table 34 shows that there were different views among health practitioners on whether NGOs make it easier for the health practitioners to handle child abuse cases. Nearly half of the respondents agreed or strongly agreed that NGOs played a positive role in dealing with child abuse. A positive view on NGOs' role was expressed most in the Mid/Far Western regions, where 68.4 percent of the health practitioners agreed or strongly agreed that NGOs make it easier for health practitioners to handle cases of child abuse. By contrast, in the Central region, only 32.2 percent of the health practitioners agreed or strongly agreed that the role of NGOs was positive.

The health practitioners who believed that it was easier to handle cases of child abuse thanks to NGOs were of the opinion that the issue of child abuse required a multi-sectoral approach. They reported that NGOs were doing a good job in the preventive aspects of child abuse by

Table 34: Role of NGOs in dealing with child abuse

	Eastern region	Central region	Western region	Mid/Far Western regions
Strongly agree	9	6	7	16
38 (15.9%)	(15.5%)	(10.2%)	(12.3%)	(24.6%)
Agree	21	13	20	22
76 (31.8%)	(36.2%)	(22.0%)	(35.0%)	(33.8%)
Disagree	4	2	7	9
22 (9.2%)	(6.9%)	(3.4%)	(12.3%)	(13.8%)
Strongly disagree	1	-	5	4
10 (4.2%)	(1.7%)	(0.0%)	(8.8%)	(6.2%)
Undecided	23	38	18	14
93 (38.9%)	(39.7%)	(64.4%)	(31.6%)	(21.6%)
Sub Total	58	59	57	65
Grand Total	239			

creating awareness among communities. Some reported that NGOs also helped a few of the victims who came in contact with them. The respondents also said that many NGOs worked on the issue of girl trafficking in various districts and these anti-trafficking interventions directly or indirectly helped to address child abuse cases as well.

However, almost 39 percent of the respondents were undecided about the role of NGOs in addressing child abuse cases. Further discussions with health practitioners revealed that the 'undecideds' were mostly those who did not know about or were unaware of the activities of NGOs.

The health practitioners who responded negatively were of the opinion that NGOs had short-lived projects and, since these were not sustainable, they were not helpful in the long run. In many districts, the respondents reported that NGOs were not involved in the issue of child abuse, and thus had not made any impact. Many expressed that NGOs had not reached grass-roots level and were only concentrated in the urban areas. This was particularly the case with the respondents from Humla: the health practitioners reported that NGOs had been completely inactive for quite some time, due to the current political situation.

5.5 Suggestions for Addressing Child Abuse Incorporation of Child Abuse Subjects in the Syllabus

Table 35 shows that 99.2 percent of the health practitioners were of the opinion that the subject of child abuse needed to be incorporated in the syllabus of all the medical campuses. This clearly shows the need felt by the health practitioners from all over Nepal for knowledge on the issue. As mentioned earlier, the respondents ranged

from village health workers to specialists in hospitals with experience from a few years to 25-30 years. Yet they all seem to feel a dearth of knowledge regarding child abuse.

Table 35: Necessity of inclusion of child abuse in syllabus of all medical campuses

	Eastern region	Central region	Western region	Mid/Far Western regions
Strongly agree	43	44	40	42
169 (65.3%)	(68.3%)	(69.8%)	(58.8%)	(64.6%)
Agree	19	18	28	23
88 (34%)	(30.2%)	(28.6%)	(41.2%)	(35.4%)
Disagree	-	-	-	-
-	-	-	-	-
Strongly Disagree	-	-	-	-
-	-	-	-	-
Undecided	1	1	-	-
2 (0.7%)	(1.5%)	(1.6%)	-	-
Sub Total	63	63	68	65
Grand Total	259			

Among the myriad reasons why child abuse should be incorporated in the syllabus, the majority of the respondents from the Eastern region reported that child abuse was an important issue which was being reported more and more frequently, and when faced with such cases, health practitioners seemed to be caught off guard. If the subject were included in the syllabus, it would increase the health practitioners' knowledge and make it easier for them to deal with child abuse cases. Then health practitioners would also be able to provide the right type of service to the public. Some of the respondents also suggested that the subject of child abuse should be taught not only in medical schools, but also in schools and colleges, as health practitioners alone could not fight this huge social problem, and awareness about child abuse was just as important as treatment.

Additionally, the respondents from the Central region said it was health practitioners who were working at village or grass-roots level, hence they could create awareness within communities. Secondly, it was health practitioners who would most probably be the first to have contact with the victims of abuse and it was very important that they have knowledge about the issue. They also said that if all the medical campuses had the same syllabus, then the method of treatment would be the same and not vary from place to place.

Everyone in the Western region agreed with the importance of gaining knowledge and reiterated that child abuse was a growing problem which needed to be tackled head on. Another important reason for child abuse to be incorporated in school syllabus was that the children could then teach their parents and make them aware of it.

Respondents from the Mid/Far Western regions agreed with what has been said above. One respondent said that it would also help the health practitioners practice what they preach and it was important that they incorporate this learning into practice.

All the respondents seemed to agree that child abuse was a new field and the knowledge about it was very limited among health practitioners, so it was necessary to have more training on the subject. With training, skilled human resources could be developed who could tackle all aspects of child abuse - be they curative, preventive or rehabilitative. The trained human resources were seen to be of utmost importance, as they were the ones to come in

contact with the victims. Many respondents said that the basis for good service to the victims was skilled human resources and this could come through only with training of health professionals. Some even suggested that not only initial training, but also continuous up-grading and evaluation of such training, were necessary. As well, by developing local health practitioners, much time, money and effort could be saved, as the primary care could be given locally and immediately.

Basic Infrastructure

When asked about basic infrastructure of health facilities, nearly 80 percent of the health practitioners either agreed or strongly agreed that better infrastructure was required in order to handle cases of child abuse (Table 36). The main reasons cited by the respondents were the need for proper 'private areas' for treating child

Table 36: Requirement of health facilities for addressing child abuse

	Eastern region	Central region	Western region	Mid/Far Western regions
Strongly agree	28	28	25	39
120 (47.4%)	(44.4%)	(44.4%)	(41.0%)	(59.1%)
Agree	20	26	17	16
79 (31.2%)	(31.8%)	(41.3%)	(27.9%)	(24.2%)
Disagree	2	3	5	1
11 (4.4%)	(3.2%)	(4.8%)	(8.1%)	(1.5%)
Strongly Disagree	-	1	-	-
1 (0.4%)	-	(1.6%)	-	-
Undecided	13	5	14	10
42 (16.6%)	(20.6%)	(7.9%)	(23.0%)	(15.2%)
Sub Total	63	63	61	66
Grand Total	253			

abuse cases and maintaining the privacy of the child, and lab facilities for management of child abuse cases. Having good infrastructure would help in providing optimum services, whereas in the absence of such facilities compromises might have to be made. On the other hand, many health practitioners also felt the healthcare institutes or facilities were already overwhelmed with the different services they were required to provide; hence, another activity in these facilities would be an extra burden.

Necessity for a Standard Operating Procedure (SOP)

More than 73 percent of the respondents either agreed or strongly agreed that there should be a standard operating procedure (SOP) in health facilities for the management of child abuse cases (Table 37). Only one junior officer in the Central region responded that it was unnecessary to develop such a protocol.

Table 37: Necessity of Standard Operating Procedure (SOP)

	Eastern region	Central region	Western region	Mid/Far Western regions
Strongly agree	20	23	24	30
97 (44.3%)	(38.5%)	(37.7%)	(51.1%)	(50.9%)
Agree	14	26	7	17
64 (29.2%)	(26.9%)	(42.6%)	(14.9%)	(28.8%)
Disagree	-	1	-	-
1 (0.5%)	-	(1.6%)	-	-
Strongly Disagree	-	-	-	-
-	-	-	-	-
Undecided	18	11	16	12
57 (26%)	(34.6%)	(18.1%)	(34.0%)	(20.3%)
Sub Total	52	61	47	59
Grand Total	219			

In the present situation, many respondents agreed that an SOP was necessary as it would not only make it easier for health practitioners to carry out their duties, but also enhance the services provided by health practitioners at all levels. This would allow victims to receive better service from health practitioners. An SOP would not only make management of child abuse cases 'more straightforward' or 'simpler' for health practitioners, but would also help to streamline the whole process of examination and treatment of the victim. An SOP would also help to establish the same treatment and procedures for the management of child abuse across the regions. Last, it would also protect health practitioners from legal hassles, as they could confidently point out, if anything untoward happened, that the His Majesty's Government of Nepal's protocol had been followed.

Attitudes of Health Practitioners towards Child Abuse

This chapter presents the findings on the attitudes of health practitioners regarding child abuse. It discusses their attitudes related to physical, sexual and psychological abuse. This is followed by the views of the practitioners on the existing detection rate of child abuse by the health system.

6.1 Attitudes of Health Practitioners towards Child Abuse

Physical Abuse

The attitudes of medical practitioners while working with physically abused children are presented in Table 38. The data reveals that only about half of the respondents felt comfortable administering care to children who had been physically abused. The comfort level was particularly low (29.0 percent) in the Mid/Far Western regions. Overall, 37 percent of the health practitioners said they were still uneasy when handling cases related to child abuse. In addition, 12.5 percent reported that they 'just got on with the job' since it was their duty: among these there were even medical doctors from the zonal hospitals. If the medical doctors just had to get on with the job, one can imag-

ine how 'comfortable' other health practitioners must have felt with cases of child abuse. However, there was no significant difference in the responses given by various levels of health professionals.

Table 38: Comfort level when handling physically abused children

	Eastern region	Central region	Western region	Mid/Far Western regions
Comfortable	42	27	42	18
129 (50.4%)	(66.7%)	(42.9%)	(61.8%)	(29.0%)
Uncomfortable	11	28	20	36
95 (37.1%)	(17.5%)	(44.4%)	(29.4%)	(58.1%)
Just get on with the job	10	8	6	8
32 (12.5%)	(15.8%)	(12.7%)	(8.8%)	(12.9%)
Sub Total	63	63	68	62
Grand Total	256			

Those health practitioners who felt comfortable and competent in handling physical abuse of children responded that tending to the victims was part of their job, and that they treat cuts and wounds daily, thus treatment of physical abuse cases was not unusual. Yet there were many other health practitioners who said that child abuse was inhuman. They said they felt uncomfortable due to lack of knowledge, lack of medication in their facilities and lack

of proper diagnostic equipment. Some felt uncomfortable because it was mental torture for them to see small children suffer from abuse. Lastly, there were others who said they felt uncomfortable not because of the medical treatment but because of a lack of counseling services and lack of training for that. This suggests the need for orientation among health practitioners on victim support and care.

Sexual Abuse

Table 39 shows that the comfort levels of the health practitioners while working with children who have been sexually abused are even lower than when they are working with physically abused children. As with physical abuse, the comfort level was lowest (14.5 percent) among the health practitioners in the Mid/Far Western regions. Over 56 percent of the respondents said they felt uncomfortable while working with sexually abused children.

The respondents who replied that they felt comfortable were those who thought that it was part of their job responsibility and all they had to do was to give primary

Table 39: Comfort level when handling sexually abused children

	Eastern region	Central region	Western region	Mid/Far Western regions
Comfortable	23	22	34	9
88 (34.8%)	(37.1%)	(34.9%)	(51.5%)	(14.5%)
Uncomfortable	32	39	28	44
143 (56.5%)	(51.6%)	(61.9%)	(42.4%)	(71.0%)
Just get on with the job	7	2	4	9
22 (8.7%)	(11.3%)	(3.2%)	(6.1%)	(14.5%)
Sub Total	62	63	66	62
Grand Total	253			

care and refer the case to a better facility. These health practitioners were working in the medical field where they regularly saw people suffer, so they said that they did not feel particularly uncomfortable when cases of child abuse came to them.

On the other hand, the respondents who replied that they felt uncomfortable reasoned that they did so due to lack of specific knowledge, skills training and Standard Operating Procedures (SOP) on child abuse. They also felt uncomfortable because few cases of child abuse came to them and these were not the usual illnesses for which they provided services daily. They reported that they felt uneasy primarily because of the victims' condition, and that it was also very disturbing to see children becoming victims of sexual abuse. Another reason given for feeling uncomfortable was that it was very difficult to gather evidence to help in any prosecution of the abuser.

Psychological Abuse

When it came to handling cases of psychological abuse of children, the comfort levels expressed by the health practitioners across the regions were as low as with cases of child sexual abuse (Table 40). Thirty four percent of the respondents reported that they felt comfortable handling cases of child psychological abuse. Many of those who felt comfortable seemed to think that it was their regular duty, and that there was nothing to feel uncomfortable about it. They reported that they just gave advice and sent or referred the victim to a better care facility.

On the other hand, more than 55 percent of the respondents felt uncomfortable with psychological abuse cases,

because they thought that such cases were beyond their knowledge and skills. These health practitioners said that without knowledge it was difficult enough to identify the cases, let alone treat them. They also felt uncomfortable because of the long-term effects on child victims, and the realization that it takes a long to heal these mental problems. Some wondered about the availability of facilities to treat psychologically abused children, even in the better health centers of Nepal.

Table 40: Comfort level when handling psychologically abused children

	Eastern region	Central region	Western region	Mid/Far Western regions
Comfortable	22	21	25	14
82 (33.6%)	(36.1%)	(33.3%)	(43.9%)	(22.2%)
Uncomfortable	32	36	25	42
135 (55.3%)	(52.5%)	(57.2%)	(43.9%)	(66.7%)
Just get on with the job	7	6	7	7
20 (8.2%)	(11.4%)	(9.5%)	(12.2%)	(11.1%)
Sub Total	61	63	57	63
Grand Total	244			

6.2 Capacity to Detect Child Abuse

Table 41 shows that many of the respondents did not have the capacity to detect and distinguish between normal injuries and injuries related to child abuse. About 95 percent of the respondents said they did not know how to detect child abuse, or estimated their capacity at low or very low. This reveals the reality of the health services capacity of Nepal. It also emphasizes the genuine need to further upgrade capacity and establish in-service training for all health practitioners.

Table 41: Capacity to detect child abuse

	Eastern region	Central region	Western region	Mid/Far Western regions
Very high	-	-	-	3
3 (1.2%)				(5.3%)
High	-	4	1	6
11 (4.4%)		(6.4%)	(1.4%)	(10.5%)
Low	9	9	9	14
41 (16.2%)	(14.3%)	(14.5%)	(12.7%)	(24.5%)
Very low	13	20	17	12
62 (24.5%)	(20.6%)	(32.3%)	(23.9%)	(21.2%)
Don't know	41	29	44	22
136 (53.7%)	(65.1%)	(46.8%)	(62.0%)	(38.5%)
Sub Total	63	62	71	57
Grand Total	253			

6.3 Role of Medical Professionals in Prevention of Child Abuse

Table 42 reveals that over about 80 percent of the respondents said they believed that medical professionals have an important role in prevention of child abuse, while less than 2 percent said they disagreed.

The majority of the respondents agreed that the health professionals have a role to play in the prevention of child abuse, because they thought that this was a health concern. Those who agreed reasoned that it was the duty and part of the job of medical professionals to treat and heal and they were specially trained to provide such services. They also feel that health care facilities were where people turned for services and help, and the medical professionals were the first ones to come in contact with the cases, particularly physical and sexual abuse. People approached them for treatment just as with any other illnesses and

injuries. Some health professionals also said that they should treat cases even with the limited knowledge that they had, because they could help in preventing complications and possible death or deformity: they wanted to go with the adage that 'something is better than nothing'.

They also reasoned that health workers in particular were working at a grass-roots level so the community looked up to them and had trust and faith in them. Moreover, community people were in constant touch with health workers and sought advice from them for all kinds of problems. Some respondents said that prevention of child abuse was a major goal of the health system, hence they felt that this should be tackled by health workers as well. Some even offered views on when and how to go about combating child abuse in the community. They argued that a campaign should be carried out during vaccination time through the existing groups such as the Ama

Table 42: Health practitioners' role in prevention of child abuse

	Eastern region	Central region	Western region	Mid/Far Western regions
Strongly agree	20	20	32	33
92 (35.6%)	(31.7%)	(31.7%)	(47.1%)	(51.6%)
Agree	38	35	31	30
127 (49.2%)	(60.3%)	(55.6%)	(45.6%)	(46.9%)
Disagree	1	3	-	1
5 (1.9%)	(1.6%)	(4.8%)	-	(1.5%)
Strongly disagree	-	-	-	-
-	-	-	-	-
Undecided	4	5	5	-
14 (5.4%)	(6.4%)	(7.9%)	(7.3%)	-
Sub Total	63	63	68	64
Grand Total	258			

Samuha (mothers groups), Female Community Health Volunteers (FCHV) and other NGOs working in this field.

Those few who disagreed did not exactly disagree with the idea that health practitioners had a role in prevention of child abuse, but thought that the problem of child abuse was a social problem so that the medical professionals alone could not tackle the issue. They argued that it definitely needed a multi-sectoral approach.

As shown in Table 4 and Table 5 earlier, the overwhelming majority of the health practitioners have reported that they lacked knowledge and skill to treat child abuse. Nevertheless, Table 42 shows that many expressed that they can contribute to preventing child abuse. Those few who disagreed pointed out lack of specific knowledge and skills as the major factor. There were also some health workers who felt the issue of child abuse was difficult to tackle and someone more 'qualified', such as health assistants or medical doctors, should provide the services.

The health practitioners were then asked whether health practitioners should play a key role in helping the abuse victim to get justice. Forty six respondents (out of 256) did not think that health practitioners should play a role. Table 43 shows various reasons why they felt a proactive role for health practitioners was not necessary: they felt that they did not want to get involved with the legal system, that it was too time consuming, that there were more pressing matters, or that they felt powerless or at a loss. Almost 20 percent of the respondents felt that they did not have proper training.

Some also argued that helping the victim to get justice was not part of the job of the medical professionals: police and the judiciary were there to do that particular job. Some thought it was just a secondary role and their main job was to treat and write a proper report. Some felt that they just did not have the skill or knowledge needed to go about it.

Many of the health practitioners who agreed with the proposition reported that they played a key role because it was on the basis of their reports that police and court could act. Therefore, the health practitioners played a significant role, from the very initial stages of proper examination of the victim, through to proper gathering of evidence and truthful documentation. They could also play a critical role by giving evidence in the court, when and if necessary.

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Table 43: Opinions on why health practitioners should not play a role

	Eastern region	Central region	Western region	Mid/Far Western regions
Did not want to get involved	3	5	-	-
8 (17%)	(20.0%)	(22.7%)	-	-
Too time consuming	3	2	-	-
5 (10.6%)	(20.0%)	(9.1%)	-	-
Other more pressing matters	1	1	-	-
2 (4.3%)	(6.7%)	(4.6%)	-	-
Felt powerless	2	4	-	-
6 (12.8%)	(13.3%)	(18.2%)	-	-
No proper training	3	3	2	1
9 (19.2%)	(20.0%)	(13.6%)	(100.0%)	(15.3%)
Others	3	7	-	6
16 (36.2%)	(20.0%)	(31.8%)	-	(85.7%)
Sub Total	15	22	2	7
Grand Total	46			

They could advise the victims to go to the police or other authorities for justice. Some said that health workers in the community could play a key role by informing the head of the Village Development Committee or police, and by advising the victims of proper channels for legal recourse.

When asked about where cases of child abuse were referred to, the majority of the respondents reported the cases were generally referred to a better health facility (75 per cent). This was followed by cases being referred to the local police. Table 44 shows that the percentage of cases referred to police is much higher in the Mid/Far Western regions than in the other three regions. Many of the officer level health practitioners responded that the health system, police or NGOs should manage child abuse cases.

Table 44: Referrals of child abuse cases

	Eastern region	Central region	Western region	Mid/Far Western regions
Better facility	14	17	40	9
80 (74.8%)	(63.6%)	(85.0%)	(87.0%)	(47.4%)
Police	6	2	5	9
22 (20.6%)	(27.3%)	(10.0%)	(10.9%)	(47.4%)
NGOs	2	-	-	1
3 (2.8%)	(9.1%)	-	-	(5.2%)
Local authorities	-	-	-	-
-	-	-	-	-
Others	-	1	1	-
2 (1.9%)	-	(5.0%)	(2.1%)	-
Sub Total	22	20	46	19
Grand Total	107			

6.4 Responses to Corporal Punishment

Table 45 reveals that the majority of the health practitioners either strongly disagreed or disagreed with the idea

that it is justifiable to inflict corporal punishment on children. The majority of the respondents replied that they disagreed with corporal punishment even by parents and teachers. Many reasoned that corporal punishment was harmful, but not only physically but also mentally. They said children suffering corporal punishment went through a lot of mental tension and stress that might result in mental disturbance, disobedience, dropping out of school and so on. It was also reported that corporal punishment had a negative, rather than positive, impact on the child.

Table 45: Opinions on whether corporal punishment on children is justifiable

	Eastern region	Central region	Western region	Mid/Far Western regions
Strongly agree	2	-	-	2
4 (1.6%)	(3.2%)	-	-	(3.2%)
Agree	8	8	7	7
30 (11.9%)	(12.9%)	(12.7%)	(10.6%)	(11.3%)
Disagree	34	36	40	30
140 (55.3%)	(54.9%)	(57.1%)	(60.6%)	(48.4%)
Strongly disagree	18	19	19	23
79 (31.2%)	(29.0%)	(30.2%)	(28.8%)	(37.1%)
Sub Total	62	63	66	62
Grand Total	253			

Table 45 shows that about 13 percent of the respondents agreed that corporal punishment was justifiable. The reasons for supporting corporal punishment were that it was traditionally and culturally accepted in Nepal and had been tested over time. The other reason was that parents had rights to their children and could do whatever they liked to their own children. Many also reasoned that corporal punishment was necessary for discipline to create good habits and that it was for the betterment of children anyway. Others reasoned that if children were not punished, they would have no way of knowing right from wrong.

Practice of Health Practitioners regarding Child Abuse

This chapter presents the study's findings on the types of child abuse cases that the medical facilities come in contact with. Another intention was to find out if the medical facilities, as structured in the present day, are capable of coping with cases of child abuse. In the process of gathering the data, it became apparent that the present day medical institutions are not able to cope with the cases of child abuse in their existing structure. Many of the medical professionals responding from the sub health posts and VDC level – that is, the community level – did not take part in answering the questionnaire because they did not have personal experience of child abuse cases in their day-to-day work and felt they did not have enough exposure, experience and education regarding this issue.

7.1 Extent of Child Abuse Cases Reported

The study explored the extent of reporting of child abuse at the health care service facilities. Of the 88 respondents

who responded to this query, the majority (82 percent) reported dealing with only a few child abuse cases a year, while about 13 percent reported dealing with a few cases a month (Table 46). Three medical doctors from the district and zonal hospitals were in the latter category; they were from Rupandehi, Palpa and Sunsari districts. Two of these doctors were obstetric/gynecologist specialists, so they were called upon to examine cases of sexual abuse.

Table 46: Number of child abuse cases dealt with by the health practitioners

	Eastern region	Central region	Western region	Mid/Far Western regions
One case a day	-	-	-	3
3 (3.4%)	-	-	-	(12.5%)
One case a week	1	-	-	1
2 (2.3%)	(4.5%)	-	-	(4.1%)
A few cases a month	3	-	4	4
11 (12.5%)	(13.7%)	-	(21.1%)	(16.7%)
A few cases a year	18	23	15	16
72 (81.8%)	(81.8%)	(100.0%)	(78.9%)	(66.7%)
Sub Total	22	23	19	24
Grand Total	88			

Availability of Special Forms to Record Child Abuse

The health practitioners were asked whether any special forms for recording child abuse were available: the data reveals that about 83 percent of the respondents said there were no such forms (Table 47). Many who replied that special forms for child abuse did exist were medical doctors who worked with police. The medical doctors or officer level respondents who replied in the negative also said that the report forms were provided by the police, not by the Ministry of Health. One obstetric/gynecologist specialist from a district hospital, who had previously worked in the Maternity Hospital in Kathmandu, said the hospital had developed a form for recording and writing reports for sexually abused cases. Only those staff with knowledge of the special forms had actually filled them in.

Table 47: Availability of special reporting forms

	Eastern region	Central region	Western region	Mid/Far Western regions
Yes	10	10	16	10
46 (17.4%)	(15.6%)	(15.9%)	(22.2%)	(15.4%)
No	54	53	56	55
218 (82.6%)	(84.4%)	(84.1%)	(77.8%)	(84.6%)
Sub Total	64	63	72	65
Grand Total	264			

The respondents explained that the main reason for not filling out the reporting forms was that the victim wanted to keep the abuse hidden and secret. People do fear social stigma associated with abuse and the medical personnel often do not want to create a burden on the victim, especially when he/she is living in a very closely knit society, such as the villages or towns of Nepal. Customs and culture are difficult to bypass, and with stringent laws it may

sometimes be difficult for the medical personnel to report cases. As shown in Table 43 above, many health professionals responded that it was not part of their job to report abuse cases, and that their duty was only to provide treatment. Others replied that making an official report was too tedious and time consuming. This is one of the stumbling blocks for reporting, because a legal process can begin only after a case is reported. And the legal process may, and often does, take a long time, which means that if a health practitioner did report a case, he/she would have to be involved with it for a long period of time. This discourages health practitioners from reporting. The health workers also said they did not want to get involved with the police.

Provision of Facilities for Photographic Recording and Forensic Investigation

The provision of facilities for both photographic recording and forensic investigation is important for enabling health practitioners to determine and establish abuse cases. This further enhances the evidence required to prosecute the abuser. However, Table 48 and 49 reveal such facilities are lacking. This view was expressed unanimously by the respondents.

Table 48: Availability of photographic recording

	Eastern region	Central region	Western region	Mid/Far Western regions
No	64	63	72	65
264 (100%)	(100%)	(100%)	(100%)	(100%)
Yes	-	-	-	-
-	-	-	-	-
Sub Total	64	63	72	65
Grand Total	264			

Table 49 shows that more than 94 percent of practitioners do not have facilities for sending evidentiary materials for forensic investigation. Many of those who replied that they had facilities for forensic investigation were officers who worked in the Zonal or District hospitals. The health practitioners from the Central region who replied in the affirmative had access to the hospitals in Kathmandu, while the practitioners from the Eastern and Western regions who replied in the affirmative had access to private medical colleges.

Table 49: Availability of facilities for forensic investigation

	Eastern region	Central region	Western region	Mid/Far Western regions
Yes	4	6	6	-
16 (6.1%)	(6.2%)	(9.5%)	(8.3%)	(0.0%)
No	60	57	66	65
248 (93.9%)	(93.8%)	(90.5%)	(91.7%)	(100%)
Sub Total	64	63	72	65
Grand Total	264			

Availability of the 'Rape Kit'

A 'rape kit' consists of instructions and a check-off sheet, history and physical documentation forms, patient discharge information form, and materials necessary for gathering samples such as blood, semen, hair, saliva etc. This 'rape kit' is used by medical professionals for gathering evidence in sexual abuse cases and should be handy in all institutions where such cases are reported in order to identify the abuser and legally prosecute the abuser in a court of law. However, access to the 'rape kit' is almost negligible. Table 50 reveals that over 99 percent of the respondents stated that they did not have access to the

'rape kit'. During the interviews it became clear that the majority of health practitioners in fact had no knowledge of what a rape kit is and the study team had to explain the concept and provide information during the interview. Two medical officers who replied that there was the 'rape kit' in Dhanusa district (Central region) replied that it had been donated some time ago, and that they had used it in a few rape cases. They were gynecologist/obstetricians by profession.

Table 50: Availability of 'rape kit'

	Eastern region	Central region	Western region	Mid/Far Western regions
Yes	-	2	-	-
2 (0.8%)	(0.0%)	(1.6%)	(0.0%)	(0.0%)
No	64	62	72	64
262 (99.2%)	(100.0%)	(98.4%)	(100%)	(100%)
Sub Total	64	64	72	64
Grand Total	264			

7.2 Actions Taken by Health Practitioners when Child Abuse is Reported

Health practitioners were asked about the actions they took when dealing with child abuse cases. Only 82 health practitioners responded to this question. The extent of services provided to the victims varied, as can be seen from Table 51. Out of the 82 health practitioners who responded, 17.1 percent of them had done just their basic duty of treating the physical injuries; 45.1 percent also provided guidance and counseling; 24.4 percent went a little further and informed the authorities of the abuse cases, and 13.4 percent also went to court to give evidence in the abuse cases that they examined and treated. This

also shows that something is being done by the medical professionals, because the professionals from the Eastern, Central and Western regions have gone to the court to give evidence or verify their medical reports.

Table 51: Services provided to abused victims

	Eastern region	Central region	Western region	Mid/Far Western regions
Treated the injuries and discharged	2	3	6	3
14 (17.1%)	(11.8%)	(13.7%)	(31.6%)	(12.5%)
Treated the injuries, gave advice and Counseling	6	7	7	17
37 (45.1%)	(35.3%)	(31.8%)	(36.8%)	(70.8%)
Treated the injuries, gave advice, counseling and informed the authorities	5	7	4	4
20 (24.4%)	(29.4%)	(31.8%)	(21.1%)	(16.7%)
Treated the injuries, gave advice, counseling, informed the authorities and gave evidence in court	4	5	2	-
11 (13.4%)	(23.5%)	(22.7%)	(10.5%)	-
Sub Total	17	22	19	24
Grand Total	82			

Places where Treatment is Given

Health practitioners were asked about where they treated cases of child abuse. Table 52 reveals that the majority (75.5 percent) of the respondents provided treatment to the abused child in a health post or hospital. Focus group discussions revealed that the majority of the cases treated were physical abuse cases, followed by sexual abuse cases

and psychological abuse cases. Most sexual abuse cases were apparently brought by the police to the hospital, where the obstetric/gynecologist doctor checked the victim. Physical abuse was tackled mostly by an emergency doctor, or by a specialist where necessary.

Table 52: Places where the abused child is examined

	Eastern region	Central region	Western region	Mid/Far Western regions
At the patient's home	1	4	1	8
14 (13.7%)	(5.0%)	(13.8%)	(5.3%)	(23.5%)
In the private clinic	1	4	-	2
7 (6.9%)	(5.0%)	(13.8%)	-	(5.9%)
Health post/hospital	18	21	18	20
77 (75.5%)	(90.0%)	(72.4%)	(94.7%)	(58.9%)
School	-	-	-	-
-	-	-	-	-
Others	-	-	-	4
4 (3.9%)	-	-	-	(11.7%)
Sub Total	20	29	19	34
Grand Total	102			

Referral System

As discussed earlier, one facility or even one sector alone cannot provide comprehensive support to victims of abuse; hence, referrals are very important. However, Table 53 reveals that more than half (58.7 percent) of the respondents reported that they did not have a referral system for child abuse cases. Most of the junior level medical practitioners, including doctors, replied that they did not have such a system. This indicates that the existing system does not give the attention required for child abuse cases. It was only in the Western region that the majority (69.4 percent) of the health practitioners reported a referral system.

Further analysis of the data by professional categories and levels shows that medical doctors seem to be more aware of referrals. For instance, all but one medical doctor from Sankhuwasabha district replied in positive. There appears to be a system of referrals in the district and zonal hospitals for child abuse cases, but this may not be true at the health posts and sub health posts and services at community level. Although a referral system is designed for referrals from the lower-level facility to a higher one, this does not seem to have come into practice yet in many communities.

Respondents stated that child abuse was reported to a better facility, police and support service providers such as NGOs. There were also complaints about the actual feasibility of referrals in certain places and under certain conditions: in some areas, there were no facilities available to report to, or the patient/victim often could not afford the cost involved or wanted to keep the case a secret, so no referral was possible. Other respondents said they had no idea where to report or refer the case to.

Table 53: Existence of referral system for child abuse

	Eastern region	Central region	Western region	Mid/Far Western regions
Yes	17	20	50	22
109 (41.3%)	(26.6%)	(31.7%)	(69.4%)	(33.8%)
No	47	43	22	43
155 (58.7%)	(73.4%)	(68.3%)	(30.6%)	(66.2%)
Sub Total	64	63	72	65
Grand Total	264			

Counseling and Interviewing

Table 54 shows that 73.9 percent of the respondents had done some counseling work. It is important to note that the nature or scope of 'counseling' was not defined in the question. Thus, whether it was of a clinical nature or just advice to the victims, all respondents referred to it as 'counseling'.

Table 54: Provision of counseling to child abuse victims

	Eastern region	Central region	Western region	Mid/Far Western regions
Yes	15	59	18	25
117 (73.9%)	(88.2%)	(84.3%)	(42.9%)	(96.2%)
No	2	11	24	1
38 (26.1%)	(11.8%)	(15.7%)	(57.1%)	(3.8%)
Sub Total	17	70	42	26
Grand Total	155			

It was observed during the FGDs that most of the health workers were unaware of the different aspects of counseling. The respondents seem to have given advice on various subjects such as physical abuse, sexual abuse, gender discrimination and so on. Except for the Western region, the majority of health practitioners appeared to have provided counseling (although, as mentioned, its nature and scope is unclear). It is also interesting to note that it was in the Western region that the majority of respondents reported the existence of a system for referring victims to better facilities and services.

Table 55 further shows that counseling provided by the health practitioners was not limited to abuse victims only. In fact, 42.6 percent of the respondents reported that they counseled victims' families, followed by 31.9 percent who

reported they counseled the victims themselves. Some (7.4 percent) also addressed counseling to the abusers as well, yet it is apparent that the most overlooked parties involved in or affected by the abuse are the abusers. It is important to bring in the abuser also into the net of counseling as far as possible.

Table 55: Health practitioners reporting on who received counseling

	Eastern region	Central region	Western region	Mid/Far Western regions
The victim	6	9	6	18
39 (31.9%)	(28.6%)	(20.0%)	(27.3%)	(52.9%)
Victim's family	9	25	8	10
52 (42.6%)	(42.8%)	(55.6%)	(36.3%)	(29.4%)
Abuser	-	5	2	2
9 (7.4%)	(0.0%)	(11.1%)	(9.1%)	(5.9%)
All of the above	6	6	6	4
22 (18.1%)	(28.6%)	(13.3%)	(27.3%)	(11.8%)
Sub Total	21	45	22	34
Grand Total	122			

The respondents also reported that the existing health facilities were not adequate for counseling work. Only about 14 percent of the respondents replied that the existing facilities were sufficient for counseling work (Table 56).

Table 56: Existence of adequate facility for counseling

	Eastern region	Central region	Western region	Mid/Far Western regions
Yes	7	13	9	9
38 (14.3%)	(12.3%)	(20.6%)	(12.5%)	(13.8%)
No	57	50	63	56
226 (85.7%)	(87.7%)	(79.4%)	(87.5%)	(86.2%)
Sub Total	64	63	72	65
Grand Total	264			

Regarding interviewing victims, there were diverse responses. There were respondents who felt that interviews with the victim children should be conducted separately, as the children were often afraid of their parents, or shy or reluctant to talk about what had happened in front of them. Some respondents also said they could get the 'genuine' facts and more information from the victim if interviews were conducted with the child alone. More importantly, as some pointed out, we should not forget that the abuser maybe the parents themselves.

On the other hand, respondents who said that victim children should be interviewed together with their parents said it was easier and less time consuming. Others said that the children felt more confident with their parents present and that a responsible person should be present during the interview, as it was easier to control the children. Others felt that the parents knew more and could speak out and that the parents would tell the truth. Some, however, said that the decision depended on the age of the child, and children of different ages needed different settings.

Testifying

As discussed earlier, documenting evidences and testifying by medical experts is a critical part of criminal prosecution of child abuse cases. Table 57 reveals that only 19 (7.2 percent) of health practitioners out of 264 had ever been called by the authorities to testify on the child abuse report they had filed. This suggests that even when cases of child abuse are identified, only a very limited number of cases are addressed by the judiciary.

Table 57: Reporting on whether the authorities ever called the health practitioners to testify

	Eastern region	Central region	Western region	Mid/Far Western regions
Yes	2	7	1	9
19 (7.2%)	(3.1%)	(11.1%)	(1.4%)	(13.8%)
No	62	56	71	56
245 (92.8%)	(96.9%)	(88.9%)	(98.6%)	(86.2%)
Sub Total	64	63	72	65
Grand Total	264			

Table 58 shows that over 50 percent of the respondents identified the victims' families as the people who brought cases of child abuse to the health practitioners. This was followed by police: 26.4 percent of the respondents reported that local police brought cases to them. Social workers (community development workers) seem to be quite active in the Mid/Far Western regions. Only one respondent, working in Western region, reported that cases were brought in by NGOs.

Table 58: Identification on who brought in child abuse cases to the health facilities

	Eastern region	Central region	Western region	Mid/Far Western regions
Family	11	17	25	16
69 (53.5%)	(50.0%)	(54.8%)	(59.5%)	(47.1%)
Local authorities	-	2	2	1
5 (3.9%)	-	(6.5%)	(4.8%)	(2.9%)
NGOs	-	-	1	-
1 (0.8%)	-	-	(2.4%)	-
Social worker	4	1	6	9
20 (15.5%)	(18.2%)	(3.2%)	(14.3%)	(26.5%)
Police	7	11	8	8
34 (26.4%)	(31.8%)	(35.5%)	(19.0%)	(23.5%)
Sub Total	22	31	42	34
Grand Total	129			

Prevention of Child Abuse

As discussed earlier, many health practitioners said they believed that they could play a significant role in addressing child abuse, including taking preventive measures. Nevertheless, in reality, only about 23 percent of the health practitioners surveyed had ever been involved in any preventive interventions (Table 59).

Table 59: Responses on whether the health practitioners could play a significant role in prevention of child abuse

	Eastern region	Central region	Western region	Mid/Far Western regions
Yes	11	20	2	27
60 (22.7%)	(17.2%)	(31.7%)	(2.8%)	(41.5%)
No	53	43	70	38
204 (77.3%)	(82.8%)	(68.3%)	(97.2%)	(58.5%)
Sub Total	64	63	72	65
Grand Total	264			

The respondents who were involved in the preventive aspects of the child abuse issue said it was part of their job to give health education and that they touched on the issue of child abuse as well. Some answered that they talked on the issue of child rights and even made adults aware of child abuse. Some said they disseminated messages about health issues during village meetings/gatherings and in schools, and talked about the issue of child abuse as well. Others reported that they spoke with both the victim and the abuser when cases came to them. Some of the respondents from the Mid/Far Western region incorporated the issue of child abuse into the school health program.

7.3 Suggestions for Coordinating Reporting and Response

Most of the respondents suggested that training for all the parties concerned was of utmost importance. Besides such training, there should be regular seminars and meetings between the parties concerned. The respondents also said that the trained human resources should be properly utilized. All the parties concerned should take an active role in addressing child abuse and keeping the issue at the top of the agenda. Others suggested that various curriculums should be developed and implemented in medical colleges, schools, and the legal and justice systems. Guidelines should be developed for all the parties concerned, and the responsibility of each organization involved should be clearly identified. There should be

more stringent laws concerning child abuse, and these should be implemented and practiced. There should be a large-scale awareness program for all – from policy makers to grass-roots communities. A good relationship should be developed between the parties concerned, and to achieve this there should be networking, regular exchange of ideas and transparency in reporting and activities. Some also suggested that a pilot program should be developed and implemented in the most affected districts. Existing 'good practice', such as a medical reporting format for sexual abuse cases at the Maternity Hospital, should be replicated in other medical institutions as well. Lastly, they also responded that there should be lab equipment and other facilities at all levels of the health system.

Recommendations

This assessment clearly suggests that health practitioners at all levels can play a significant role in addressing more effectively the issue of child abuse in Nepal. The recommendations that evolve from this assessment are as follows:

8.1 Recommendations related to the Ministry of Health and Health Practitioners

Immediate actions

- Drafting 'medical record forms' for cases of child abuse
- Identifying a pool of counselor(s) in each region to whom child abuse cases may be referred
- Developing a 'standard operating procedure' (SOP) for cases of child abuse, according to the level of health facilities
- Conducting short-term training on child abuse for health workers and partners involved in this field
- Identifying different organizations working to address child abuse at regional level, and developing better regional networks
- Identifying laboratories to which forensic materials can be sent in each region, and identifying one central lab
- Providing 'rape kits' to zonal hospitals at all times

Long term actions

- Including the subject of child abuse in courses for health workers at all levels
- Including the subject of child abuse in the school health program
- Continuing training programs and refresher courses for health practitioners
- Identifying the specific tasks carried out by health workers, police and legal authorities in handling child abuse cases and developing a protocol to bring awareness among them on how to better handle cases of child abuse
- Bringing about awareness in the public by using the different media available

8.2 Mass Awareness Program

Though a high proportion of child abuse is perpetrated by people who are known to their victims, mostly at home, school and community, the community at large does not realize that these incidents are in fact child abuse cases and that they need to be addressed. A massive awareness program, addressing child abuse, its consequences and what action is required, needs to be launched at the community level.

8.3 Interventions to Address All Types of Child Abuse

Child abuse prevention programs conducted by various governmental organizations and NGOs are usually limited to drug abuse, child trafficking and child labor. The other types of child abuse have not been adequately addressed. There is clearly a need for these organizations to address other types of child abuses. Also, when designing programs, gender or age-specific interventions should be considered. Certain types of abuse may place girls or boys of certain age groups at higher risk.

8.4 Mandatory Reporting System to Appropriate Authorities

Apart from the people in whom the victim has confided, medical practitioners are usually the first ones who can detect abuse cases that require medical attention. Since health practitioners do not have any guidelines or protocols regarding further investigation or reporting procedures, these cases are usually treated clinically, as if they were any other health problem. A mandatory reporting system requiring reports to appropriate authorities may be considered for suspected abuse cases in all hospitals, health posts, sub health posts and private clinics. However, the subject of

mandatory reporting requires further investigation and research. The existing studies also show that in some cases, unless there is a proper support system in place for victims, mandatory reporting can cause more damage and harm to the child and may not be in best interests of the child.

8.5 Strong Coordination and Effective Teamwork between Medical Practitioners and Law Enforcement Personnel

Strong coordination and effective teamwork between medical practitioners and law enforcement personnel is necessary, as they are key players who can be instrumental in identifying and treating child abuse victims, taking legal actions against abusers, and preventing future abuses. In this regard, it is important that police personnel be trained to provide basic first aid treatment and care, as basic treatment in the initial stages can be crucial in saving the lives of the victims. They also need to be aware of the importance of safeguarding forensic evidence and able to preserve these materials as evidence. Medical practitioners too should be trained and sensitized with regard to the legal aspects of such cases and the type of investigation that needs to be done immediately for collection and preservation of forensic evidence.

Annex 1

Names of the personnel interviewed

1. Dr. B. Chataut
Director, Health Service Division, Ministry of Health
2. Mandira Shahi
Lecturer, Medical Education Department, Tribhuvan University Teaching Hospital
3. Sagar Mani Lamsal
Curriculum Officer, Council for Technical Education and Vocational Training
4. Rebeca Sinha
Campus Chief, Lalitpur Nursing Campus
5. Shashi Kant Mainali
Secretary, Ministry of Women, Children and Social Welfare (MoWCSW)
6. Sudha Neupane
Officer, Child Division, MoWCSW
7. Baburam Regmi
Joint Secretary, Ministry of Law, Justice and Parliamentary Affairs
8. Farindra Raj Kafle
Lecturer (Sociologist), Nepal Medical College
9. Dhruv Bahadur Basnyat
Chief Administrator, Nepal Medical College
10. Dr. Muniraj Pandey
General Physician, Nepal Medical College
11. Dr. Kishore Raj Pandey
Pediatrician, Nepal Medical College
12. Kamala Manandhar
Coordinator, Gunaraj Pathak Memorial Nursing Campus
13. Shashi Shah
Coordinator, Binayak College of Health Science
14. Subala Subba
Program Officer, CWIN
15. Ranju Sigdel
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