EMERGENCE OF CHILD ABUSE DIAGNOSTIC EDUCATION IN EMERGENCY CARE:

A COMMON CONCERN

A Research Thesis submitted in fulfilment of the degree:

Master of Emergency Medical Care (MEMC)

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Declaration

I, Roxanne Maritz, hereby declare that the work on which this dissertation is based is my original work (except where acknowledgements indicate otherwise) and that neither the whole work nor any part of it has been, is being, or is to be submitted for another degree in this or any other university.

I empower the university to reproduce for the purpose of research either the whole or any portion of the contents in any manner whatsoever.

Signature:

Date: 6 January 2020

Dedication

This thesis is dedicated to my amazing parents, Petro and Ronnie Maritz.

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Abstract

Child abuse prevalence in South Africa is high. Despite this the pedagogy of child abuse education of emergency care practitioners is deficient. This thesis, conducted in the field of emergency medical care, intended to elucidate the emergence of child abuse diagnostic education in emergency care as a common concern. In order to achieve this, the treatment of child abuse victims needs to be understood within an out-of-hospital setting as well as from an emergency medical care student's perspective.

The research paradigm is that of critical pragmatism. A concurrent mixed-methods approach was followed. Retrospective archival data (1 323 pediatric cases) was retrieved from 12 365 pre-hospital medical records. The researcher established a pre-training workshop survey, followed by a training workshop intervention to inform participants on law and ethics as well as a screening tool for child abuse. A post-training workshop survey was conducted. The quantitative data analysis was conducted using 'R' Statistical software. The researcher used FreeMind® to synthesis and construct themes from the focus group qualitative data. The quantitative and qualitative data were contrasted and associations between child abuse knowledge (mediated by training) and self-reported diagnostic practices were identified.

The probable historical "missed" case detection for pre-hospital presentation of child abuse and neglect is an alarming 19%. The study found that all participants demonstrated knowledge of antecedent factors for child abuse such as what constitutes risk and vulnerability for abuse. However, the knowledge of conceptual definitions from the Children's Act was lacking. There was also statistical significance showing that collectively, the training workshop intervention had a positive impact on those who attended. In addition to this, the study also found that the policies and emergency care training of child abuse and neglect are deficient. This study's theoretical contribution is that it validates Archer's Morphogenesis as an analytical frame for child abuse diagnostics in emergency care. Socio-cultural actions such as clinical practice, diagnostic training, activism, learner engagement and reflective practice all have the latency for improved child abuse diagnostics, but if not sustained, prioritized and mainstreamed, 'morphostasis' rather than 'morphogenesis' is likely to prevail.

It is recommended that future research concerning the topic of child abuse diagnostics is conducted to reduce the gap in the emergency care knowledge. Higher education institutions offering emergency care qualifications are encouraged to incorporate ‘child abuse and neglect’ into their existing curricula for the ‘common good’.

Keywords: child neglect, child abuse diagnostics, Western Cape, Emergency Medical Care provider, prehospital environment, mixed-methods, morphogenesis, critical pragmatism

List of Abbreviations

AEA	Ambulance Emergency Assistant
AIDS	Acquired Immune Deficiency Syndrome
BAA	Basic Ambulance Assistant
BCS	Battered Child Syndrome
BEMC	Bachelor of Emergency Medical Care
BTECH	Bachelor of Technology
CCA	Critical Care Assistant
CDC	Centre for Disease Control
COPD	Chronic Obstructive Pulmonary Disorder
CPUT	Cape Peninsula University of Technology
DUT	Durban University of Technology
EC	Emergency Care
EMC	Emergency Medical Care
EMS	Emergency Medical Services
FGM	Female Genital Mutilation
FISDAP®	Field Internship Student Data Acquisition Project
GBV	Gender-Based Violence
HEI	Higher Education Institution
HOD	Head of Department
HPCSA	Health Professions Council of South Africa
IHD	Ischaemic Heart Disease
KZN	Kwazulu-Natal

MRC	Medical Research Council
MVA’s	Motor Vehicle Accidents
NCert	National Certificate
NDIP	National Diploma
NECET	National Emergency Care Education and Training
NGO	Non-Governmental Organization
NMU	Nelson Mandela University
NPO	Non-Profit Organization
PATCH	Prevention and treatment of child sexual abuse in the Helderberg
PBEC	Professional Board for Emergency Care
SAPS	South African Police Service
SAPSAC	South African Professional Society on the Abuse of Children
SBS	Shaken Baby Syndrome
UCT	University of Cape Town
UJ	University of Johannesburg
UN	United Nations
USA	United States of America
WC	Western Cape
WCG EMS	Western Cape Government Emergency Medical Services
WHO	World Health Organization
WMA	World Medical Association
WMACA	Woman and Men Against Child Abuse
WorldSAFE	World Studies of Abuse in the Family Environment

CHAPTER 1: Introduction

1.0. Introduction

The purpose of this study was to explore and improve the approach of the emergency care providers' preparedness and, primary response to child abuse, and reflect there-on through emergency care education and clinical practice. I assumed that emergency care providers have a professional interest in clinical practice guidelines in relation to the management of child abuse cases. It was envisaged that the findings of this study would provide more insight into the child abuse conundrum and work towards providing a community of practice for child abuse screening policies within the pre-hospital emergency care setting. It may also be of relevance to the Health Professions Council of South Africa (HPCSA) that regulates emergency care training providers and registers graduates.

As this is a mixed method study, I shall, where appropriate, refer to myself in the first person personal pronoun ("I") as it is authentic to do so and where the quantitative approach is used, I will invoke the third person personal pronoun.

1.1. Clarification of Basic Terms and Concepts

This section explains terms commonly used within the study and clarifies the meaning thereof. The fundamental terms include; child, abuse, violence, physical abuse, emotional abuse, child neglect, Emergency Medical Service and prehospital care providers.

1.1.1. Child

A child according to the Children's Act 38 of 2005, is a person under the age of 18 years (South African Government, 2010). For the study at hand, the term child will refer to all children aged 0 years (from birth) to 18 years of age. Webster (2018) defines the term child as a young person, between infancy and youth. Unborn fetuses will not be included within this definition.

1.1.2. Abuse

Abuse denotes: “ Abuse, in relation to a child, means any form of harm or ill-treatment deliberately inflicted on a child.”(South African Government, 2010, p.9).

1.1.3. Child Abuse

For the purpose of this study, child abuse implies cases of child abuse or allegation thereof. Child abuse thus implies violence and cruelty towards minors aged 0-18years of age; treating an individual in such a way as to cause harm or damage on a regular basis. The term child abuse consists of a wide spectrum (Walker and Conte, 2018). Physical visible scars and bruises are not the only forms of abuse anymore (Walker and Conte, 2018). Psychological abuse can be just as damaging even though there is no visible injury (Walker and Conte, 2018).

1.1.4. Violence

When physical force is used by an individual to damage, abuse, injure or destroy another individual (Webster, 2018).When an individual or a group intend to use their/his/her power against another group or an individual and it results in injury or death, it is classified as violence (Rutherford *et al.*, 2007). The term violence is thus differentiated from unintended injury or harm (Rutherford et al., 2007). “The intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment or deprivation.”(World Health Organization, 2002,p.4).

1.1.5. Physical Abuse

According to the World Health Organization, physical abuse is the intentional use of physical force upon a child leading to the harm of the child’s health, dignity or survival (Artz *et al.*, 2016).

1.1.6. Emotional Abuse

When an individual uses emotions as a weapon to hurt another individual (Mathews, 2016). No physical abuse is used to control another person, but instead, emotions are used in a controlling or coercive manner (Mathews, 2016). Emotional abuse can cause damage to the child's mental and physical health as well as the child's spiritual, social and moral development (Artz *et al.*, 2016).

1.1.7. Child Neglect

When the basic needs of children have not been met (Dubowitz *et al.*, 1993). Child neglect is defined as a form of child abuse. Socioeconomic status can also play a role in neglect. Furthermore, the World Health Organization defines child neglect as a failure over time for family members or parents to provide for the wellbeing of the child (Artz *et al.*, 2016).

1.1.8. Emergency Medical Services

For the purpose of this study, emergency medical services refer to the South African prehospital service providers, providing medical assistance to those in the public who have a medical emergency and require immediate intervention. Emergency medical service is an organization that is equipped to offer emergency care via an ambulance, medical rescue vehicle or a medical response vehicle (Motsoaledi, 2017).

1.1.9. Prehospital Emergency Care Providers

The term prehospital emergency care providers (ECPs refer to all those who hold qualifications within the prehospital field. This includes basic life support (BLS), intermediate life support (ILS) and advanced life support practitioners (ALS). All of the above-mentioned practitioners are registered with the Health Professions Council of South Africa (HPCSA). Their degree of training and scope of practice varies according to a period of training as well as the depth of knowledge. As per the Health Professions Act 56 of 1974, a 'health practitioner' means: "any person, including a student, registered with the council in a profession registrable in terms of this Act" (HPCSA, 2009). Emergency Care Practitioner, more specifically, is one who holds a 4-year Bachelor's degree in Emergency Care.

1.1.10. Pre-hospital/Out-of-hospital

These two terms are common within the EMS discourse. They are often interchangeably used to refer to the environment prior to or after hospital care. The intention is to place emphasis on early interventions in the community, with the hospital (or another role-player) continuing such care.

1.1.11. Missed Cases

This is defined as a person who has a communicable disease where signs and symptoms are so diminutive that medical help is not requested or the practitioner fails to recognize the disease thus makes no diagnosis. In child abuse terms, these are cases where child abuse has gone unreported. This may be due to undiagnosed cases or where cases of child abuse have been mistaken for other illnesses instead.

1.1.12. Probable Missed Cases

For the purpose of this study, the researcher defines probable missed cases as any case logged onto FISDAP® where children 0-18 years have sustained injuries due to trauma, burns, overdose, and neglect where the intent of injury was either documented as intentional or unknown.

1.1.13. Mechanism of Injury

This looks at the way a physical injury occurred (Elitsa, 2014). The mechanism of injury is generally used to estimate the forces involved to determine the severity of the injury (Farlex, 2019).

1.1.14. Trauma Incident

A trauma incident can occur due to any blunt or penetrating force which brings about an injury. Thus it is defined as a serious injury to the human body (NIH, 2019b). Within this study, trauma caused due to a motor vehicle accident or pedestrian vehicle accident will be excluded.

1.1.15. Graduate

Any person who has a degree from a college or university (Cambridge, 2019). Within this research study, a graduate will refer to a person who successfully qualifies as an Emergency Care Practitioner after a 4 year Bachelor of Emergency Medical Care Degree.

1.1.16. Intent of Injury

An injury that is either caused on purpose by another person or oneself with the aim of bringing about injury or death (CDC, 2019).

1.1.17. Burns

Identified as one of the most frequently occurring injuries amongst children in households (Khan and Solan, 2016). Affected skin cells die due to severe skin damage (Khan and Solan, 2016). Different degrees of burns exist namely first—degree burns outer layer of skin is affected), second-degree burns (outer and underlying layer of skin affected) and third-degree burns (deep layers of skin affected) (MedlinePlus, 2019). Burns can be caused by chemical, electrical or thermal sources.

1.1.18. Detection

The act of noticing something, further described as identifying something concealed (Webster, 2018b). In the case of this study, if child abuse is not detected, it cannot be treated. Detection also refers to discovering information about a certain crime in order to implicate the perpetrator (Macmillan, 2018).

1.1.19. Rural Community

A community found outside of the city. Individuals often have low income, poor housing facilities and poorer access to care.

1.1.20. Semiotic Artefacts

This term is used within social semiotics and refers to a means of making meaning (Bezemer, Yandell and Leeuwen, 2004). Semiotics refers to the philosophical theory which uses symbols and signs dealing with their functions (Webster, 2018a).

1.1.21. Readiness

This term refers to the degree of preparedness of individuals to respond to particular stimuli or occurrences (Nugent, 2013).

1.1.22. Preparedness

Being sure preventative measures are in place via an organization and involves the readiness to act towards a problem or respond to an emergency .There is an ethical and clinical purpose to preparedness in that (on the premise that preparedness improves the interaction or short-term outcomes) failed interactions or missed cases erode trust and confidence in the health system and may directly or vicariously enable continuance of the abuse and its deleterious effects, unabated (Nugent, 2013).

1.1.23. Sexual Abuse/Assault

Sexual abuse occurs when one individual forcefully has sex or exhibits sexual behavior with an unwilling individual. When this force is short of duration, infrequent or immediate, it is referred to as sexual assault. Sexual Assault: ranges from inappropriate touching, rape, life threatening attacks or any penetration of the vagina, anus or mouth (Tears, 2019). Sexual abuse can also be referred to as molestation (Tears, 2019). Sexual abuse is an act of violence

on the basis of coercive contexts, fear and disempowerment of the victim. " A person ('A') who unlawfully and intentionally sexually violates a complainant ('B'), without the consent of B, is guilty of the offence of sexual assault" (Amendment Bill, 2003,p.20). "Sexual acts are offences (crimes) if they are committed without the consent (permission) of one of the people involved in the sexual act." (Sexual Offences Amendment Act, 1972, p.3).

1.1.24. Focus Group Discussions

Focus group discussions are used for qualitative data (Derick *et al.*, 2017). This method purposely gathers data from selected groups of individuals instead of using a broader population (Derick *et al.*, 2017). Within this study, the researcher defines focus group discussions as those which occur post educative training workshop intervention.

1.2. Background

The phenomenon of 'child abuse' prevails within modern society. The potential within health care professions exists, to facilitate the development and implementation of evidence-informed child abuse prevention, detection, treatment and referral; and to promote engagement in more sustainable social customs oriented towards 'common good'[1] (Mandikonza & Lotz-Sisitka, 2016). Such social customs may build social capital. Social capital[2], and indeed health capital[3] is considered valuable organizational outcomes as they potentiate organizational capital[4] simultaneously.

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[1] Common good: This is a notion meaning " certain general conditions that are…equally to everyone's advantage" (Velasquezz *et al.*, 2014). Therefore the common good consists of having social systems, environments and institutions on which populations depend on to work in a manner that will benefit all individuals (Velasquezz *et al.*, 2014). Examples of common good include access to affordable public health care systems, safety , legal and political systems , flourishing economic system as well as peace (Velasquezz *et al.*, 2014).

[2] Social Capital: Social capital focuses on the value of social networks and relations between individuals and organizations that bring about productive individual and/or social benefits (Claridge, 2004).

[3] Health Capital: Falls under Human Capital and is essential to enable a person to realize their full potential (Parveen, 2009), particularly in relation to staying healthy or in relation to the ability to recover.

[4] Organizational Capital: This term describes the efficiency by which an organization utilizes their resources in order to implement and sustain a strategy (WG ,2018).

The South African Children's Act No. 38 of 2005 (South African Government, 2010), describes any individual under the age of 18 years as a child (Abrahams, Matthews and Viviers, 2006). Approximately 38% of South Africa's population consists of children. In 2013 the mid-year estimate was that there were 15 454 742 children under age of 14 and 5 168 797 between 15 years and 19 years of age out of the total South African population of 52.98 million (Hendricks, 2014). There were 495 540 cases of reported crime against children within 2012-2013 in SA (Hendricks, 2014). In addition to this, the July 2019 STATS SA report a population of 58,78 million and 17 million children under the age of 14 (StatsSA, 2019).

The United Nations (UN) and its signatories provided guidelines concerning the minor population, admitting this population is a vulnerable group (Hendricks, 2014). Article 19 of the UN Convention compels South Africa as a signatory state to take appropriate measures, be it socially or educationally to protect a child from all forms of abuse and violence (UN, 1989). Furthermore, Article 19(2) of the Convention states that measures used must be preventative as well as protective (Hendricks, 2014). The South African Constitution (RSA, 1996), addresses children rights and protection (Africa, God, and Sikelel, 1996). Section 28(1)(d) states that 'every child has the right to be protected from maltreatment, neglect, abuse and/or degradation' (RSA, 1996).

Section 110 of the Children's Amendment Act, 2007 (RSA government, 2008) elaborates on the right to protection in terms of section 28 of the Constitution (RSA, 1996). This section obliges all professionals to report suspected violence and neglect (Hendricks, 2014). The reporting Form 22 (HPCSA, 2005), as well as section 110 of the Children's Amendment Act, implies that reporting must occur as soon as when reasonable grounds for abuse are suspected (RSA, 2015). Professionals especially healthcare professionals may be held liable if they do not report child abuse/violence (Hendricks, 2014).

Interestingly, emergency care is not listed among those health-care professionals. Whilst the spirit of the Act implies action in relation to child abuse detection, Naidoo (2017) asserts it is hardly legally obligatory (Naidoo, 2017; HPCSA, 2005). Furthermore, Hendricks, 2014, mentions that the Health Professions Council of South Africa (HPCSA) guidelines advise reporting of illegal or unethical conduct. The Health Professions Act No.56 of 1974 states that a member's name can be removed from the register or suspension can occur if they do not

report unethical conduct against children (Hendricks, 2014). Whilst indeed possible, there is no evidence that such action has ever been taken in the emergency care profession (HPCSA, 2018). To address the emergency care obligation to report abuse and to inform one's discretion to report, Naidoo (2017) proposed the child abuse guidelines, under their mandate, to the HPCSA PBEC, who later approved the guidelines for Emergency Care (EC) curricula inclusion.

Statistics from the Centre for Disease Control and Prevention, 2010 shows 1 of 100 US children are victims of maltreatment in 2008 (Clauss, 2011). Child abuse is the main killer of children 4 years-of-age and less in the United States of America (USA). The average number of visits to the hospital before the correct diagnosis is made is two (Clauss, 2011). Previously they were misdiagnosed with vomiting and irritability. In 2009, 1 018 children were murdered in South Africa; that is, an average of three children per day (Capa, 2014). Of these murders, 45% of the children murdered was through child neglect and abuse (Capa, 2014). Physical abuse cases accounted for 28% of children suffering abuse, whereas emotional abuse cases were 42% of the abused population (Capa, 2014). In 2018, 985 children were murdered in South Africa (StatsSA, 2019).

One of the challenges facing the healthcare systems is the lack of clear policies regarding domestic violence, inclusive of child abuse (Meer & Artz, 2017). The Health Professions Council of South Africa (HPCSA), announced within their annual report for 2011-2012 (HPCSA, 2012), "…that at the start of 16 days of activism against women and children in 2011, the HPCSA board released the Domestic Violence Screening Protocol…" (Meer & Artz, 2017, p.1). In addition to this, it has been argued that the implementation of proactive screening interventions may allow escalation of violence to be prevented within the domestic context, thus decreasing the high levels of South African domestic homicides (Meer & Artz, 2017). Naidoo (2017), provides direct evidence within his 'Systematic Synthesis' publication, by stating that early recognition, as well as early intervention, is key for domestic violence prevention (Naidoo *et al.*, 2014). It is probable that this includes child abuse cases too. Educational interventions allow for health care practitioners to have a better understanding of violence and improve violence screening (Naidoo *et al.*, 2014).

1.3. Problem Statement

The problem that is to be addressed in this study is an appraisal of the implementation status of the HPCSA-approved diagnostic screening instrument in the prehospital setting and in relation to children, within a South African province so as to identify what factors promote and inhibit the implementation of this instrument. A research need exists to reconsider current approaches toward child abuse prevention, recognition and health care responses (Mandikonza & Lotz-Sisitka, 2016) within the EMS, as well as the enhancement thereof. Children, or advocates acting on their behalf, if they are to have access to criminal or social justice, must have: the opportunity to report the abuse, access to health-care and the restoration of one's dignity. Violent crimes against children are often not reported to the police (Unicef, 2012). This can be due to the fact that the child is too young to report the crime committed, older children fear speaking up as they are unsure what will happen to them if they report the crime, and frequently children do not know how and where to report the crime (Unicef, 2012). The majority of suspected child abuse cases are reported by primary care providers, however, a number of cases are still missed (Flaherty *et al.*, 2000). In South Africa, child abuses are underreported to the police (Flaherty *et al.*, 2000). Prosecution and convictions for such cases are poor. It has been reported that 12 years ago, merely 2% of cases in Durban, which went to court concerning child abuse resulted in convictions (Nxumzlo and Philander, 2017). Whilst the National Prosecuting Authority attempts to improve its own efficiencies, other societal organizations such as health institutions may have a role to play. Poor record keeping results in vital information getting lost and abuse cases being missed, meaning allocation of resources becomes a problem (Nxumzlo and Philander, 2017). There is evidence to suggest victims of abuse may disclose abuse to health workers (Leskošek *et al.*, 2017). What then might the duty of care of emergency care workers be to child abuse victims?

Violence against children can lead to economic growth obstruction due to decreased productivity and lost potential (Artz *et al.*, 2016). Long term health-related quality of life issues such as chronic obstructive pulmonary disease (COPD), liver disease and ischemic heart disease (IHD) has been related to child abuse (ChildHelp, 2018). Moreover, child abuse–as a causal link in victimology– can lead to drug addiction, alcoholism, depression, unintended pregnancies, multiple sexual partners or suicide attempts throughout the lifespan of the abused individual. The Optimus Study South Africa, first published in 2015, produced the latest national figures for child maltreatment: amongst 4 086 young people interviewed, more than

40% reported experiencing sexual abuse, emotional abuse, physical abuse or neglect (Artz *et al.*, 2016). Such an exposure rate is considered elevated, notwithstanding that maltreatment can be prevented. South Africa's children are deserving of the right to safety and freedom from neglect as these rights are universal.

The need for social change has been proposed by many social theorists, including Roy Bhaskar (1998) and Margaret Archer (1995). There remains a need to mobilize collective as well as an individual agency in ways which will produce new conditions for being (and becoming) and to bring about new social practices (Mandikonza and Lotz-Sisitka, 2016). I consider emergency care as one such social practice (albeit also a health-care modality). Naidoo (2017), proposed that emergency care workers were uniquely positioned to play a role in domestic violence prevention and intervention (Naidoo, 2017). This value proposition of EMS was later validated as domestic violence detection rates were improved nine-fold when particular attention is drawn to the risks, needs, and responses to victims of violence in routine screening of all females (14 years+) (Naidoo, 2017). This South African quasi-experimental study (Naidoo, 2017) has direct relevance for my population of interest but did not particularly focus on young children younger than 14 years and their associated vulnerability.

Through the enhancement of actions and understanding, education has the proficiency to expedite the catalytic transformation of society, that contribute to more sustainable social practices (Mandikonza & Lotz-Sisitka, 2016). The UN Decade of Education monitoring and evaluation report state that emergent social actions and understanding would be orientated to the common good (UNESCO, 2014). Master's programs too (such as the one I have been embarking upon), has the potential to critique social action (or non-action) and to derive common good, or in other words, to satisfy a public interest, albeit through scholarship. The public interest is something which affects finances, health or rights of the public at a large scale (Farlex, 2018). The management and affairs of local, provincial and national government is of common concern amongst its citizens (Farlex, 2014). Public interest is a broad term used to refer to the public weal and politic (Farlex, 2014).

1.4. Aim

The aim was to implement a diagnostic screening instrument among Emergency Care (EC) students so as to promote Emergency Care provider agency for social change in relation to child abuse cases. The study intersected the emergency medical services (as the system within which emergency care providers operate), child abuse (as an emergency care burden) and diagnostic screening (as an epidemiological imperative). The planning of the aim and how child abuse, EC students and the diagnostic screening intersect can be seen in Appendix A.

1.5. Research Question

The question in chief was: *How do we improve the EC provider preparedness, primary response to child abuse and reflection thereon through emergency care education and clinical practice?*

The thrust of Emergency Care education within the Higher Education Institution (HEI) concerned is through three modules; namely Emergency Medical Care (EMC) theory, EMC practical and EMC clinical practice. All three modules are interlinked and assess the students' competency as an emergency care provider by testing their knowledge on theory, their skills within the practical room and their performance out in the field whilst working with qualified emergency care personnel. Clinical practice shifts are assigned to individual students at over twenty locations across the province, such as level 1-3[5] hospitals, clinics and ambulance bases. The students are expected to complete a 12-hour day or night shift (depending on what was scheduled) and are then required to report on their patients which were treated for that shift onto the Field Internship Student Data Acquisition Project (FISDAP®) database.

1.6. Sub-questions:

1.6.1 How can the value proposition of EC learners in child abuse cases be promoted through operational policy and education programs?

[5] Level 1: "Level I Trauma Center is a comprehensive regional resource that is a tertiary care facility central to the trauma system. A Level I Trauma Center is capable of providing total care for every aspect of injury – from prevention through rehabilitation."(American Trauma Society, 2020, p.1).
Level 2: "A Level II Trauma Center is able to initiate definitive care for all injured patients."(American Trauma Society, 2020,p.1).
Level 3 : "A Level III Trauma Center has demonstrated an ability to provide prompt assessment, resuscitation, surgery, intensive care and stabilization of injured patients and emergency operations."(American Trauma Society, 2020,p.1)

1.6.2 How could the relevance, quality, and sustainability of the child abuse preparedness strategy be enhanced in EC?

1.7. Objectives

1.7.1 To survey the entire EC student cohort for knowledge, attitudes and beliefs of child abuse antecedent factors, interventions and consequences. Such a survey will assist in understanding both enabling and constraining factors for the implementation of the existing HPCSA-approved screening instrument among EC students.

Antecedent factors can be seen as those factors which would lead to an individual being involved in the abuse. Predominant antecedent factors in child abuse can be aggressive tendencies of the alleged perpetrator, unwanted pregnancies, alcohol and drug problems as well as poverty (Olmsted *et al.*, 2006). This was achieved via an online survey, discussed further in Chapter 3.

1.7.2 To develop and implement an educative intervention that promotes the utilization of an adaption of the HPCSA approved screening instrument among EC students.

The approved screening instrument mentioned above refers to Naidoo (2017, p.372), who developed a screening instrument for health care practitioners to recognize gender-based violence cases. It was approved by the HPCSA and enabled the emergency care providers to promote the safety of patients at risk of GBV. The screening instrument found within this study is an adaptation of that founded by Naidoo (2017). Objective two was achieved through a facilitated training workshop as an educative intervention.

1.7.3 To analyze reflective reports before and after educative intervention for self-reported narratives on child abuse screening successes or challenges.

Reflective reports refer to the self-documented reports on the online database: FISDAP®. The educative intervention was a training workshop that was presented to undergraduate Emergency Care students. Within the training workshop, the students were taught how to use the screening tool on their clinical shifts after sensitizing them to child abuse screening and identification.

1.8. Assumptions of the researcher

It is to be assumed that child abuse occurs and has lasting consequences throughout the lifespan of the individual (Feit, Joseph and Petersen, 2014a). This means that if a child has suffered abuse, they may become serial victims of such abuse and/or become serial perpetrators of abuse onto others (Feit, Joseph and Petersen, 2014a) . If abuse becomes the norm within these individual's lifestyles, it is pervasive and they may then perpetuate abuse onto their or other children. Furthermore, it is also assumed that EMS provides a 24-hour service and child abuse occurs whilst EMS availability is present. The assumption will be made that healthcare students will answer all questionnaires honestly and to the best of their abilities.

1.9. Structure of thesis

Whereas Chapter 1 expanded on the problem of child abuse diagnostics in the EC, the following Chapter provides the literature review that expands the evidence in this area. Chapter 3 provides the methodology in greater detail as well as the philosophical assumptions underpinning the study. Chapter 4 presents quantitative and qualitative findings. In Chapter 5, these findings are discussed in relation to its meaning for the study aim and objectives. Lastly Chapter 6 provides the study conclusion and recommendations for future research and development in the area of child abuse and neglect diagnostics. A reference list and a series of appendices conclude the thesis. The appendices are intended to provide transparency in the development of this thesis and adds a level of detail that is deliberately not always present in the body of the thesis.

CHAPTER 2: Literature Review

2.0. Introduction

This thesis which was conducted in the field of emergency medical care, intended to elucidate the emergence of child abuse diagnostic education in emergency care as a common concern within the Western Cape. In order to achieve this, the treatment of child abuse victims needs to be understood within an out-of-hospital setting as well as from an emergency medical care student's perspective. Understanding the current literature at present concerning the topic of child abuse and neglect is vital when considering what is known about the topic and which gap in knowledge exists. When looking for data, Archer's morphogenetic structure was followed. The search engine Google was used and key terms such as child abuse, neglect and Western Cape were included within the searches. In addition to this, studies that were conducted concerning child abuse in other countries were also searched for. A search string[6] was also run on the database PubMed of which 8 articles were generated matching the search string, and only 2 were included within the study as they were the only relevant articles when evidence informed decision making was performed. The researcher investigated what the World Health Organization has to say about child abuse as well as what laws and regulations exist within South Africa in terms of child abuse and neglect. Domestic violence was also researched as it is a broader spectrum of abuse and often includes child abuse. The literature review aims to address the following topics: Child abuse and the manifestations thereof, child abuse as a

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[6] Search String: ((("emergency treatment"[MeSH Terms] OR ("emergency"[All Fields] AND "treatment"[All Fields]) OR "emergency treatment"[All Fields] OR ("emergency"[All Fields] AND "care"[All Fields]) OR "emergency care"[All Fields] OR "emergency medical services"[MeSH Terms] OR ("emergency"[All Fields] AND "medical"[All Fields] AND "services"[All Fields]) OR "emergency medical services"[All Fields] OR ("emergency"[All Fields] AND "care"[All Fields])) AND practitioners[All Fields]) OR ("allied health personnel"[MeSH Terms] OR ("allied"[All Fields] AND "health"[All Fields] AND "personnel"[All Fields]) OR "allied health personnel"[All Fields] OR "paramedics"[All Fields]) OR ("Emerg Med Serv"[Journal] OR "EMS Mag"[Journal] OR "ems"[All Fields])) AND (("child abuse"[MeSH Terms] OR ("child"[All Fields] AND "abuse"[All Fields]) OR "child abuse"[All Fields]) OR (("pediatrics"[MeSH Terms] OR "pediatrics"[All Fields] OR "paediatric"[All Fields]) AND ("substance-related disorders"[MeSH Terms] OR ("substance-related"[All Fields] AND "disorders"[All Fields]) OR "substance-related disorders"[All Fields] OR "abuse"[All Fields])) OR (paediatrc[All Fields] AND ("violence"[MeSH Terms] OR "violence"[All Fields]))) AND ("loattrfree full text"[sb] AND "2008/04/24"[PDat] : "2018/04/21"[PDat] AND "humans"[MeSH Terms])

human rights violation, people emergent properties, structural emergent properties, cultural emergent properties, and emergency care provider agency.

Countless children in South Africa continue to be victims of abuse and neglect. Despite the multifaceted trauma caused by alleged perpetrators which have been reported within newspaper articles, books and journals, the pedagogy of child abuse education is far and few in between. Recognition, intervention and prevention remain an enigma within the social and health nuance of the child abuse burden (Berkowitz and Stewart, 2010).

2.1 Child Abuse

2.1.1. Some manifestations of child abuse and neglect

Manifestations of child abuse and neglect come in a variety of forms. It is not always the obvious physical abuse that occurs, many medical terms have been allocated to the different patterns of abuse and these terms may be unfamiliar to individuals of society as well as health practitioners. The following patterns of abuse will be discussed below: the shaken infant, the battered child, Munchausen by proxy, sexual abuse and gang violence.

Health care providers need to be aware that the abuse of children by other children can occur. When such situations are encountered or suspected, the practitioner must keep in mind that current or prior abuse of the alleged abuser can be occurring, thus the child inflicts the same treatment onto another child (WMA, 2017b). Neglect and abuse influence the child and alters elements of psychological and biological development. Thus childhood abuse has a profound effect on the child and often impacts their relational skills and puts them at risk of anti-social behaviors (Feit, Joseph and Petersen, 2014a).

The chronicity and timing of abuse have a direct effect on the outcomes as more frequent abuse leads to worsened outcomes for the child's mental and physical health. Additionally, long-term outcomes among adults who have a history of being abused and neglected could include the abuse of alcohol or alcoholism (Feit, Joseph and Petersen, 2014a). The effect of violence can lead to a vicious cycle which will likely span over generations (Jamieson, Mathews and Sambu, 2017). Violence is interlinked and cumulative in nature as children who

have been exposed to maltreatment and abuse have an increased risk of re-victimization or perpetration later on in their life (Jamieson, Mathews and Sambu, 2017).

The impact of violence often extends beyond physical injury. A negative long-lasting effect on children's' psychosocial and cognitive development will occur (Lake and Jamieson, 2017). This will also include impaired attachment, trauma, anxiety, failure to thrive, aggression, depression, self-destruction and anti-social behavior (Lake and Jamieson, 2017). It is thus imperative to intervene as soon as possible to break the intergenerational cycle of violence (Lake and Jamieson, 2017). Emergency care is well positioned in the health system to contribute to breaking these cycles of violence as it can provide disruptive intervention (Naidoo, Knight and Martin, 2013).

2.1.1.1. The shaken infant

The shaken infant or shaken baby syndrome (SBS) is an extreme form of head trauma in infants (Al-Saadoon, Elnour and Ganesh, 2011). When a parent or care taker is provoked by a crying child, they can subject to violently shaking the child in order to get them to be quiet. This can result in subdural haematomas , retinal haemorrhage, fractured ribs and cervical spine injuries (Al-Saadoon, Elnour and Ganesh, 2011). The explanation given by caretakers is usually "the baby was fine and then started having seizures" (Parrish, 2002). The degree of shaking required to cause severe intracranial injury or even death is not one that is of a non-abusive nature (Parrish, 2002).The vulnerability to the resulting injuries is due to the infants' large head and weak cervical musculature (Al-Saadoon, Elnour and Ganesh, 2011). Victims of SBS are usually under the age of 1 (Al-Saadoon, Elnour and Ganesh, 2011). Infants cannot resist the shaking action as they lack neck muscle control, whereas a toddler can to a certain extend resist this motion (Parrish, 2002). According to Bishop *et al.* (2015), broad scientific evidence exists which shows that a shaken infant provides strong evidence of abuse. Even though the shaken infant is a well-known diagnosis, courts recurrently challenge the diagnosis (Bishop *et al.*, 2015). "It is estimated that over 250 children die each year in the United States after being subjected to violent shaking" (Lopes, Einstein and Williams, 2013). The shaken baby syndrome is also a South African phenomenon (Burger and Le Roux-Kemp, 2014).

2.1.1.2 The battered child

A battered child is one which has suffered an injury due to willfulness to cause harm by the care giver, rather than accidental causes (Parrish, 2002). The battered child syndrome (BCS)

is frequently unrecognized by clinicians (Kempe *et al.*, 1985). The battered child often appears with burns, bruises at different healing stages as well as multiple fractured bones (Sims, 2019). BCS is found throughout society, however, it is more common amongst lower-income households (Sims, 2019). Care givers may suffer larger amounts of stress due to social difficulties (including vicarious traumatization, desensitization and a lack of coping skills) and this can lead to abusing children to get rid of their frustrations (Sims, 2019).

Indicators of a battered child vary. Bruises can be suggestive of accidental injury as well as non-accidental injury (NAI). Bruises are medically defined as the leakage of red blood cells due to the breakage of local capillaries when an injury occurs to soft tissues (Shiel, 2018). Children often play and fall, causing bruises on their hands, knees elbows or forehead (Pressel, 2019). However, infants cannot suffer from bruising often, because they cannot walk owing to their premature developmental ability (Pressel, 2019). The dating of bruises is guided by medical textbooks by the colour of the bruise (Pressel, 2019). Even though determining the age of the bruise via its colour is vital for medical and legal reasons within child abuse, the method is somewhat flawed. Evaluating the bruise colour does not take into consideration the patient's skin colour or whether the bruise is located over bone or soft tissue (Pressel, 2019). Bruises that are at different healing stages are strong indicators that the child is being abused continuously (Pressel, 2019). Child battering may include delayed hospital visits and far-fetched explanations of injuries (Young, 2018). Repeated visits to the emergency room for the same injuries can also be concerning and indicate abuse. Additionally, a battered child may exhibit injuries that match the shape of a belt, bite or cigarette burn (Sims, 2019; Young, 2018).

In addition to physical harm symptoms of battered children, they are also at risk of multiple behavioral problems such as difficulty at school, suicide, abuse of drugs and becoming abusive themselves (McNulty, 2018). Such children can also suffer from dissociative identity disorders, where they have multiple personalities to try to cope with the abuse that has taken place (McNulty, 2018). Young (2018), similarly states that battered child syndrome victims can develop post-traumatic stress disorder which can lead to psychological problems. Further symptoms associated with BCS include anxiety, panic attacks and irritability of the child (Young, 2018). Abused children may also cry more often than normal, or exhibit clinginess to receive attention from care givers and others (Young, 2018). Also, children may show less affect than is appropriate for their age.

2.1.1.3. Munchausen by proxy

Munchausen by proxy occurs when care givers or parents create illnesses in their children when there is, in fact, no illness, just to receive medical attention (Parrish, 2002). An illness can also be created by poisoning the child in order to seek for medical assistance (Parrish, 2002). Individuals with Munchausen by proxy do not see their behavior as harmful (Parrish, 2002). Munchausen is seen as a psychiatric disorder in adults who seek comfort and care extended to a patient at healthcare facilities (Hettler, 2007). The caretaker or parent needs the child to be sick in order for him/herself to seem nurturing (Abrahams and Kurtz, 2010). This syndrome overprovides medical treatment to their children by attending excess doctor visits when it is not required (Hettler, 2007). Munchausen may not always at first glance be defined as child neglect or abuse, however, the actions of such individuals can lead to children picking up on such behavior and at a later stage develop the syndrome themselves or become hypochondriacs (Hettler, 2007). Thus this is seen as a form of child maltreatment (Abrahams and Kurtz, 2010).

2.1.1.4. Sexual abuse

Sexual abuse can be defined as the occurrence of a sexual act when there is a large age difference between the child and adult, when the person inflicting the abuse is a person of authority or when acts are carried our against the child's will by using blackmail or acts of violence (Sexual Offences Act SA, 2013). Moreover, sexual acts between parent and offspring, sexual acts of a violent nature against children as well as between pre-pubertal children and adults are viewed as sexual abuse (Finkelhor, 1997).

Boys appear to be victimized less than girls when it comes to sexual abuse (Finkelhor, 1997). However, boys who are being sexually abused are less likely to report such an incident due to the experience of shame and associated guilt (Finkelhor, 1997). The decrease in disclosure by boys can be due to them being concerned about adults curtailing their freedom. Nondisclosure could also be due to the fact that boys fear to lose their masculine reputation and being teased about the stigma of homosexuality (Anstee and Rouger, 1988).

Intrafamilial sexual abuse is the most common form of abuse as this tends to extend over a period of time (Finkelhor, 1997). This type of abuse often occurs from fathers or father figures as well as uncles or brothers. Such abuse threatens the relationship between the child and their most important source of social support as the fathers or men in families are often the bread winners (Finkelhor, 1997). A retrospective analyzing study was conducted between 2010 and 2015 of 216 intrafamilial South African cases who were referred to the Ankara Child Advocacy Center (Kocturk and Yuksel, 2019). The victim ages varied from 3-17 years of age. The study found that 50% of intrafamilial sexual abuse is conducted by the biological father and the stepfather was the alleged perpetrator 14.4% of the time (Kocturk and Yuksel, 2019).

Sexual abuse can also be committed by youthful offenders under the age of 18 years (Finkelhor, 1997). Sexual abuse by youthful offenders can be brothers under the age of 18 years inflicting sexual abuse onto their younger siblings. The phenomenon: 'date rape' (although not specific to adolescents) occurs whereby adolescents force sexual activity onto other adolescents (Finkelhor, 1997). Victims to juvenile sex offenders are siblings or relatives to the offender in 40% of cases (Hunter, 2002).

Females are rarely sexual offenders, however, some may become offenders due to peer pressure to acquire sexual experience (Finkelhor, 1997). Other females may be forced by their boyfriends to take part in abusive activities (Finkelhor, 1997). In a 2010 Quebec population survey, it was found that only 4% of alleged sexual offenders were females (Tardif and Goulet, 2011). According to Tardif and Goulet (2011), 4% of females accounted for 208 sexual offences. A recent meta-analysis showed a ratio of male-to-female-sexual assault perpetration to be 20:1 (Tardif and Goulet, 2011). Tardif and Goulet (2011), did not include any African data in their study and thus their findings may hold true for the countries included in the study, but these conclusions cannot be directly applied to the African setting.

2.1.1.5. Gang Violence

Children playing in the street are often victims of drive-by shootings or stray bullets in parts of the Western Cape. Notwithstanding that safety and security is a global need, low economic status, absence of parents, gang-ridden communities and post-apartheid developmental challenges pose particular threats to individual and collective safety. Gang ridden communities, in particular, make for an unsafe space for children to live in and thrive.

“Gang violence is amongst the biggest contributor to child murders in the Western Cape” (Payne, 2019, p.1). A 6-year-old girl was hit by a stray bullet in Lavender Hill on, 24th August 2019, during a shooting incident (McCain, 2019). Murder statistics in the Province showed a decrease from 47 murders to 34 murders over the weekend periods[7] in August 2019, reports McCain (2019). Notwithstanding the decrease, the fact that there is still a high number of murders occurring is of concern and should not be viewed as a wholly positive observation. Of the 34 weekend murders which occurred in Western Cape, 21 of these were due to shootings, six were stabbed and seven were due to other means not described within the article (McCain, 2019). The leading cause of death to children, 10 years and older, within Western Cape is violence, especially gang violence (Jones, 2019b).

To give expression to the everyday murder of children, experiential and contextual evidence is found in newspaper articles. A 10-year-old girl from Tafelsig (Cape Town) was also shot in a cross-fire between gangsters in December 2019 and succumbed to her injuries (Nombembe, 2019). The child’s mother stated that she feared for every child’s life and safety within South Africa, as this was not the first time gangsters shoot children in their neighborhood (Nombembe, 2019). It is evident via multiple newspaper articles published, that the children in the Western Cape are not safe from gang violence and that such everyday experience of violence can prove to be fatal. In the time period between 2017-2018, Khayelitsha alone had 21 reported cases of children who were murdered (Payne, 2019). Delft police station had 18 cases of child murders, Mfuleni had 17 cases and Gugulethu had 15 cases reported to the police station (Payne, 2019). These are all districts, a few kilometers from the City of Cape Town. The same rates of murder of children are not seen in more affluent communities in Cape Town.

The Parliamentary debate about violence in the Western Cape took place in 2011, but does little to give hope. The then minister of community safety questioned what the impact of the anti-gang unit was within South Africa (RSA, 2011). The minister of community safety then continues to ask who takes responsibility for the arrest of gang members and where it lies

[7] Weekend periods: Friday, Saturday and Sunday of every weekend which took place in the month of August 2019

within the Constitution (RSA, 2011). If tension exists between provincial and national security functions, how is society meant to overcome the impact of gangsterism and its 'collateral' damage on children of the Western Cape and South Africa as a whole?

2.1.2 Child abuse as a human rights violation

The focus on child abuse reporting is about a need to ensure rights-protection and not simply about a procedural compliance monitoring tool. "The access to education is a basic human right, and education itself is seen as a common good" (Mandikonza & Lotz-Sisitka, 2016,p.3). Mandikonza and Lotz-Sistika (2016), conducted a study with in Southern Africa where they performed a case study which focuses on the Rhodes University South African Development Community Regional Environmental Education Programme (RU)/SADC REEP professional development activities (Mandikonza and Lotz-Sisitka, 2016). The study conducted by Rhodes University has reference to this study being conducted by the researcher as it gives insight into learning and common good of emergency medical care practitioners. The concept of common good proposes that all living things need a good life as they have life in common (Mandikonza & Lotz-Sisitka,2016). Emphasizing learning, education and sustainability is a humanizing concept, due to the fact that it takes into account culture, views and people's ways of being (Mandikonza & Lotz-Sisitka, 2016).

Dehumanizing, oppressive and constraining natures, in most cases, prevent people from flourishing. EMS personnel may have become 'dehumanized' to the nature of child abuse, however, it is through education that these individuals could realize that despite barriers, they may still have latent agency[8]. Furthermore, if EC providers have the potential to remove such barriers, a humanizing form of learning and pedagogy may result (Mandikonza & Lotz-Sisitka, 2016).

Children, who experience punishment in physical form, often show aggressive behavior [acting in (self-harm) or acting out (aggression to others)]. The effects of physical punishment carry on to adulthood in these individuals' lives, which is then transferred as learnt behavior to their children, albeit not consistently as there is no causal relationship but there is a strong association with generational cycles of abuse (UCT, 2018).

[8] Agency: This refers to the actions which individuals take to show their autonomy in thinking for themselves to shape their life experiences (Cole, 2019).

Presently, programs set in place for violence prevention, merely account for less than 1% of national and provincial Department of Social Development budget combined (UCT, 2018).

> "We will continue to safeguard expenditure that protects poor households. But the medium term expenditure limits are tight. Across all three spheres of government, and in state-owned companies and public entities, those responsible for deciding how money is spent have to do so with scrupulous rigour and care. It is only right that if households and firms face tough choices in balancing their income and expenses, the same disciplines must be applied in public expenditure." (Abdoll and Mayet, 2017,p.6).

The quote by Minister Pravin Gordhan in 2017 indicates that there are challenges regarding violence prevention funding within our country. The national allocated budget toward violence prevention has been constrained and is unlikely to change anytime soon (Abdoll and Mayet, 2017). At least, violence prevention funding is seen by government as protective of households, although this is by intent and (given the high mortality) not necessarily by outcome.

Among the non-fatal (and fatal) crimes against children is the crime of rape. The South African Minister of Police, Bheki Cele, revealed new statistics in 2018 showing that 40% of all rapes in South Africa are committed against children (Andersen, 2018). Out of 124, 526 total reported rape cases spanning over 3 years, 40% of victims were indeed children (Andersen, 2018). This means that 46 children are raped every day in South Africa (Andersen, 2018). Sadly, only 21% of child rape cases result in successful convictions (Andersen, 2018). It would appear that there is relative impunity associated with this crime against children, rendering it-for perpetrators-one of the 'safest' crimes to commit!

The literature above suggests child abuse is a rights violation on many levels. According to the Bill of Rights in the Constitution, section 28, every child has the right to basic health care services and social services. However, if health care services are not intervening in child abuse or treating the patient accordingly, the child's rights are again violated. Section 28 (1)(d) states that every child has the right "to be protected from maltreatment, neglect, abuse or degradation (RSA, 1996). Furthermore, section 28 (2) states " a child's best interests are of paramount importance in every matter concerning the child" (RSA, 1996). Once neglect and abuse occur, the child's best interests are being violated. The inability of the state to hold those perpetrators accountable constitutes further indignation upon victims. The above constitutional obligations also extend to health workers, other state entities and citizens to protect or to identify violations.

2.2 Social impact of child abuse and neglect

Social impact is defined as a result that takes place in society due to a deliberate set of actions that causes 'good' or 'bad' change to occur (Ross, 2017). Child abuse and neglect create a negative social impact on society, as it causes the mortality and morbidity rates of children to increase (Krug *et al.*, 2002). The extent of the problem ranges from fatal abuse, non-fatal abuse, physical abuse, sexual abuse as well as emotional and psychological abuse. Fatal abuse varies based on the income level of a country and region of the world (Krug *et al.*, 2002). Widespread misclassification occurs, however, there is a general agreement that fatalities due to child abuse are more frequent than reported (Unicef, 2003).

The most common injuries in child abuse death have been reported to be head injuries, followed by abdominal injuries (Krug *et al.*, 2002). Non-fatal abuse and neglect statistics have been drawn from official statistics, surveys and case report. However official statistics do not reveal much about the pattern of child abuse as there are no set legal or social systems in place to report and record such cases, let alone respond to them (Krug *et al.*, 2002). Physical abuse statistics from a 1995 survey conducted by WHO showed that 49 per 1000 children experienced physical abuse, this included abuse by rock throwing, hitting the child on the buttocks, kicking the child as well as threatening the child with a gun or knife (Krug *et al.*, 2002).

Krug *et al.* (2002), documents that child abuse is a globalised phenomenon. In a study in Korea, parents were questioned on how they treat their children and 45% confirmed that they kicked, beat or hit their children (Krug *et al.*, 2002). A survey in Romania found that 4.6% of children within the population suffered severe physical abuse ranging from burns, beatings, and starvation (Krug *et al.*, 2002). In Ethiopia, 64% of rural children were reported with bruises on their bodies and likewise, 21% of urban children were reported with bruises and swelling on their bodies (Krug *et al.,* 2002). These studies provide observational data indicating that child abuse is a serious problem.

The World Studies of Abuse in the Family Environment (WorldSAFE) project, which was a cross-national collaborative study administered a common core protocol to population-based samples of mothers in different countries in order to establish incident rates of child discipline

(Jeyaseelan *et al.*, 2004). The researchers measured harsh discipline to determine risk factors and to put in place protective factors. Within the WorldSAFE study, parents in India, Egypt, and the Philippines reported punishing their children by hitting them with an object on their bodies at least once during a 6-month time frame (Jeyaseelan *et al.*, 2004). Such behaviour as previously mentioned was also reported in the United States and Chile. Emotional and psychological abuse has been apportioned very little attention globally as compared to sexual and physical abuse (Jeyaseelan *et al.*, 2004). Disciplining one's child is heavily influenced by cultural practices- some of which may be interpreted by other cultural groups as psychological harm (Lansford *et al.*, 2005).

Child abuse not only creates a health burden but a financial burden too. The financial costs which are associated with long and short-term care for victims of abuse become an overall burden (Florence, Klevens and Peterson, 2018). The cost associated with medical treatment, hospital visits, doctor bills as well as other health services all relate to lost productivity, decreased quality of life, disability and premature death (Krug *et al*., 2002). Further expenditure includes a payment to prosecuting officers, the cost of social welfare organizations, foster care, education system and the cost to the employment sector due to absenteeism and low productivity (Krug *et al*., 2002).

2.2.1. People Emergent Properties in relation to state and civil society actors

As it is people that perpetrate abuse and people that are charged with the responsibility to respond to the abuse; mitigation, prevention or crisis intervention may constitute, in morphogenesis terms: people's emergent properties. To this end, the roles of state and civil society-as critical actors in the societal response to child abuse and neglect--are discussed below.

2.2.1.1. State responses to child abuse

South African murder statistics for the year 2012 were reported on by the Western Cape Government and it was found that 56 people are killed per day in the Western Cape (Western Cape Government, 2019). More closely, 46 out of 56 people killed were men, 8 were women and 2 were children (Western Cape Government, 2019). Evidently, men face the greatest mortality risk from violence (usually perpetrated by other men). However, the morbidity associated with violence against women and children is not usually presented with such mortality data.

Child abuse features as a category under the broader topic of domestic violence. The general findings of the study conducted by the Western Cape Government in 2012 concerning child abuse and domestic violence, were that there is a lack in safe houses in Khayelitsha and Wellington for victims (Western Cape Government, 2019). In addition to this, there is also a lack of trained professionals for victim friendly rooms or individuals who can run these safe houses (Western Cape Government, 2019).

The Western Cape Government reported on the Court Watching Brief Unit from April 2018 to September 2019 (Western Cape Government, 2019). Within this time frame, they found that 86 investigations of gender-based violence were incomplete. A total of 54 dockets were not at court, and 15 forensic reports were outstanding (Western Cape Government, 2019). In addition to this 2 accused of committing gender-based violence were not brought to court within 48-hours of arrest and 2 witnesses did not attend court. This amounted to a total of 159 potential failed prosecutions for gender-based violence offences. If authorities such as SAPS and social workers are failing to recognize and report such cases or not completing investigations, their actions have a domino effect on South African society and ultimately contribute to the domestic violence and child abuse conundrum. The implementation challenge demonstrated above would appear to be the blind spot of otherwise robust legislation and policy for the state response to child abuse. One therefore cannot solely rely on the criminal-justice system to address the problem.

2.2.1.2. Non-profit Organizations (NPOs)

Civil society organsations working in the GBV-space in the form of faith based organisations and non-profit community-based organisations have made and continue to make valuable contributions to social capital. In the face of inhumane acts of violence against children, they present an opportunity for hope and dignity restoration. To demonstrate the role and scope of some civil society organisations, a few cases are discussed below.

Prevention and treatment of child sexual abuse in the Helderberg (PATCH, 2000). Helderberg Child Abuse Centre supports child victims of sexual abuse within the Helderberg area of Cape Town. This non-profit organization was established in 1992 and is directed by voluntary community members which serve as a Board of Directors (PATCH, 2000). PATCH has three offices within the Helderberg basin, which forms part of the Cape Metropole, where victims of

sexual absue can be assessed. The assessment is done by qualified social workers. The local Government hospital has a 24-hour crisis centre, where children who have suffered sexual absue can be supported (PATCH, 2000). Essential awareness and prevention programmes are conducted at schools to encourage learners to report incidents of abuse and to show to them that help will be provided.

'Save the Children South Africa' is a non-profit organization that aims to ensure that no child within South Africa experiences violence. This organization promotes the use of positive discpiline and aims to uphold the ban on corporal punishment in the home (STC, 2011). Effective programmes have been set in place to prevent and resond to violent acts against children. Furthermore, the organization also provides support and mentoring in parenting skills. They are currently engaged on the nature and extent of child trafficking with the South African context (STC, 2011).

The South African Professional Society on the Abuse of Children (SAPSAC) is a multi-professional society established in March 1999 in order to provide professionals active within the field of dealing with abused children with a forum to exchange information (SAPSAC, 2019). This organization is a non-governmental, non-political organization that is registered as an NPO and it provides membership for the following: Legal Professions, Policing, Criminology, Education, Media, Psychology, Nursing and Medical Professions (SAPSAC, 2019). The aims of SAPSAC are to promote high standards to be applied within the field of child abuse handling. They also aim to promote research and comparative literature to exchange information amongst professionals inolved within the field. Moreover, they aim to promote co-ordination and co-operation between professions in persuance of a community of practice (SAPSAC, 2019).

Woman and Men Against Child Abuse (WMACA) is a non-profit child protection organisation which is committed to fighting for children rights and to end child abuse within South Africa. It was established in 1997. Alongside their service delivery, they have an advocacy role, using media to highlight the injustice towards abused children due to inadequate judicial processes (WMACA, 2019). Three clinics exist in Alexandra, Boksburg and Pretoria, these clinics provide free medical and therapeutic interventions as well as treatments to abused children (WMACA,

2019). A need for the introduction of preventative programmes to break the complex cycle of child abuse was recognized by WMACA. The cycle of child abuse has a domino-effect, affecting many people's lives by just one case of abuse (ARC, 2016). This is very costly to society and can result in a lifelong loss of potential and lead to potential physical and mental health problems (ARC, 2016).

The Teddy Bear Foundation/Clinic sitiuated in Tygerberg Hospital, aims to stop child abuse, they also provide efficient services for children who have been abused to aid with the healing process and stop any further abuse (TTBC, 2019). When a child enters into the child protection service, Teddy Bear Clinic tries to minimize any secondary harm. Abused children will be supported with medico-legal speacialists as well as forensic assessments, psychological assessments, therapeutic counseling, court preperation and support (TTBC, 2019).

The non-governemental organisations above are among many struggling civil society organisations that are commited to the upholding of child rights. Their continued existence, I would seem, bears testimony to the failure of the political society and state resources to do the same.

2.2.2. Structural Emergent Properties inherent in Global and National Policies for Child Abuse Prevention and Response

Unitary theories exist to explain the cause and effect of child abuse. Social learning suggests that child abuse is a learned behavior. Through psychoanalytic theory, it is evident that abusive behavior can be determined by conflict. The environmental sociology theory posits that poverty, violence, and unemployment can be a cause of child abuse (Eli, Imre and Price, 1981). It is important to note that not all poor families abuse their children and that having wealth is not protective of abuse.

The complexity of violence ventures a child becoming either a victim or a perpetrator, depending on their personal history, communities, close relationships and broader society (Lake and Jamieson, 2017). The Centre for Disease Control (CDC) and Prevention's social-ecological model provides a framework for the ultimate goal to stop violence before it begins (CDC, 2019b). In order to prevent violence, factors influencing violence needs to be understood.

CDC uses a four-level social-ecological model to understand violence and the effect of potential prevention strategies (CDC, 2019b). The complex interplay between individual, relationship, community, and societal factors are considered within the model. The overlapping of the model levels allows for individuals to understand how one factor can influence factors at another level of the model (CDC, 2019b). To prevent violence and sustain prevention efforts, multiple levels of the model will be required to be acted across at the same time (CDC, 2019b). The first level 'Individual' identifies the biological and personal history factors which will increase one's likelihood of becoming a perpetrator or victim (CDC, 2019b). These factors would include age, substance abuse, income or education. Specific interventions to bring about prevention would include life skill training. The second level of 'Relationship' looks at an individual's social circle-peers, family and partner whose behavior could contribute to their experience of abuse. The promotion of healthy relationships as well as mentoring and peer programs could help decrease the occurrence of abuse (CDC, 2019b). The third level 'Community', explores the setting, such as the workplace, home, schools and neighborhood. Social relationships are explored which could possibly be associated with perpetrators of violence or victimization (CDC, 2019b). Policies within workplace settings and schools can contribute to reduced violence. The final level of 'Societal' aims to explore factors which encourage violence and abuse, such as cultural and social norms accepting violence as a way to resolve conflict (CDC, 2019b). Economic, health social policies and educational factors also contribute to economic or social inequalities between societal groups.

2.2.2.1. World Health Organization (WHO)

According to the World Health Organization (2002), an estimated 57 000 children were victims of homicide in 2000. In addition to this, many child deaths are not further investigated or autopsied, thus making it difficult to know the true extent of the problem (WHO, 2002). Children aged 0-4 years old are of the highest rates of fatal child abuse (WHO, 2002).

The ill-health caused by child abuse forms a significant part of the global burden of disease (WHO, 2002). The vulnerability to child abuse ranges between different age groups. Young children are more at risk for physical abuse whereas children who have reached puberty or adolescence are at a higher risk for sexual abuse (WHO, 2002). In the majority of cases, boys are the victims of beatings and physical abuse more so than girls. Girls, on the other hand, are more prone to infanticide, prostitution, sexual abuse and neglect (WHO, 2002). Approaches to

prevent child abuse and neglect focus on providing therapy for children who are being abused or witnesses to abuse as well as treatment programs for alleged perpetrators. Furthermore, legal arrest and prosecution policies must be abided by as well as mandatory and voluntary reporting to aid in the identification of cases of abuse (WHO, 2002).

The World Health Organization has a crucial role to play within the health sector concerning child abuse. Awareness must be raised about the long-term negative health effects of child maltreatment as well as the social burden which accompanies it within the health sector (WHO, 2017). Data about prevalence must be collected and communicated as well as risk factors and health consequences of child maltreatment (WHO, 2017). Evidence-based interventions such as home visits or parenting programmes must be developed and tested. Likewise, victims of child maltreatment should be provided with services and support including psychosocial services and mental health services (WHO, 2017). Education, the criminal justice sector, as well as social welfare, should all collaborate with WHO to address child maltreatment (WHO, 2017).

Within international conventions, the United Nations (UN) acknowledge that children are vulnerable and thus provide guidelines on how their rights can be protected by signatories to the Convention on the Rights of the Child (Hendricks, 2014). Article 19 compels signatory states, of which South Africa is one, to protect a child from any form of maltreatment and abuse. Furthermore, Article 19(2) of the Convention also states that protection measures should be protective and preventative and encompass reporting procedures (Hendricks, 2014). In addition to this, Article 16 of the African Charter on the Rights and Welfare of the Child, reiterates the obligations set out within the UN Convention (Hendricks, 2014)(United Nations, 1996).

According to Pluck, Girgis and Kwang-Hyuk (2013), one of the most socioeconomically marginalized disadvantaged groups in the world consists of individuals who are homeless. The South African Constitution upholds a societal value that there must be human dignity and advancement of human rights (Yacoob, 2000). South Africa adopted The Constitution in 1997, which guarantees children's economic and social rights, this included protection against maltreatment, abuse, neglect and degradation (Abrahams, K. and Matthews, 2011).

Section 26 of the Constitution states that each individual has the right of access to adequate housing (Yacoob, 2000). Mrs. Irene Grootboom of the Grootboom case was evicted from her informal settlement and left homeless in Wallacedene (Yacoob, 2000). Half of the Wallacedene community consists of children residing in deplorable shacks (Yacoob, 2000). These living conditions provide an increased probability of child abuse and neglect. Furthermore, Section 28 of the Constitution states that "every child has the right to be protected from maltreatment, neglect and abuse. Moreover, each child has the right to basic nutrition, shelter and basic health care services" (RSA, 1996). Notwithstanding, the court's sympathy with Grootboom, she died before the provincial government could allocated a house to her and her daughter, whose interest above were so central to the legal argument. Her premature death is not a consideration for the constitutional limitation of 'progressive realization'.

The majority of homeless parents in South Africa have experienced or have been exposed to sexual and physical abuse (Hart-Shegos, 1999). Approximately one fifth of homeless pregnant females disclosed that they suffer from drug and alcohol abuse (Hart-Shegos, 1999). The substance abuse harms prenatal development and will affect the cognitive and behavioral development of children later on in their life (Hart-Shegos, 1999), child abuse is evident due to addiction. Children who are born into homelessness and have a mother who abused drugs and alcohol conventionally have a low birth weight and have higher chances of dying in the first 12 months (Hart-Shegos, 1999). Homelessness further exposes the child to factors which can endanger their health violating their right to basic nutrition and shelter as per Section 28 of the Constitution. The study "A longitudinal perspective on violence in the lives of South African children from birth to twenty plus cohort study in Johannesburg-Soweto", identified 280 data points where violence was being perpetrated. Furthermore, Richter et al. (2018), followed more than 2000 children and their families within the Gauteng Province. The cohort contained an equal amount of males and females. This study found that violence is more prevalent among disadvantaged and poorer groups of individuals within the community (Richter *et al.*, 2018). Additionally Richter et al. (2018), also report that very high levels of violence were reported in the childrens' homes, community, school, amongst peers and within intimate relationships.

Having a history of child abuse is a risk factor for physical victimization as well as a risk factor for partner violence amongst those who are part of the homeless population (Tyler and Melander, 2015). The African Charter on rights and welfare of children was endorsed in January 2000 (UNICEF, 2019). The Charter obliges all states to:

> "take specific administrative, social and educational measures to protect the child from all forms of torture, inhuman or degrading treatment and especially metal or physical injury or abuse, neglect or maltreatment including sexual abuse, while in the care of the parent, legal guardian or school authority or any other person who has care of the child" (UNICEF, 2019).

Child abuse is a multi-faceted problem, the cause of abuse which takes place cannot be linked to a single factor (UNICEF, 2019). Thus responding to child abuse requires a multi-sectorial approach as well as co-operation between government and civil society. In 1996 the need for response against child abuse was recognized (DOSD, 2019). The National Strategy on Child Abuse, Neglect and Exploitation was developed and named The National Conference on Child Abuse and Neglect (NCCAN). This draft strategy was published in 1998, and for the first time, child abuse and all its complexities were explored in one comprehensive document (DOSD, 2019). This document was developed by non-governmental as well as the government sector (DOSD, 2019). Conversely, the document was never formally adopted, however many aspects of the policy are relevant today.

Naidoo (2017), states that the South African emergency care curricula focus on teaching the clinical scope to healthcare students rather than focusing on gender-based violence which includes child abuse. The Health Professions Council of South Africa's latest clinical practice guidelines (HPCSA, 2018a) and the previous 2006 protocol (HPCSA, 2006), do not reflect any policy concerning child abuse (Naidoo, 2017). Such omissions constitute missed opportunities to provide another layer of child protective mechanisms.

2.2.2.2. State Responses to Violence in RSA

The legal and policy frameworks in South Africa are comprehensive, however, implementation is poor (Jamieson, Mathews and Sambu, 2017). South Africa is an ethically and culturally diverse society. There are different norms and values regarding childhood and discipline within the different cultural groups (Makoae, Roberts and Ward, 2012). Intra-cultural variability may

exist due to varied place of residence, parent-child interactions, children's agency as well as socio-economic status (Makoae, Roberts and Ward, 2012). Dignity, tolerance and respsect for patients who are provided with healthcare or other services are emphasized via the pricinciple of non-discrimatory social services in South Africa. Nevertheless, no evidence exists that child protection programmes and healthcare providers take into account cultural diversity to members which they are providing a service to (Makoae, Roberts and Ward, 2012). Thus this creates missed oppertunities to understand how culture is related to child maltreatment (Makoae, Roberts and Ward, 2012). Phyisical abuse is often regarded as 'justifiable' punishment under the guide of discipline, even when evidence suggests a pattern of violence (Jamieson, Mathews and Sambu, 2017). A revised version of the Draft Regulations Relating to Sexual Offences Courts, was published by the DJCD in November 2017 (Hall *et al.*, 2018). The draft policy prohibits the use of corporal punishment within the home, as part of a developmental approach to prevent child abuse (Hall *et al.*, 2018).

It has been admitted within the 'Abuse No More Protocol' *of the Western Cape Education Department* that deliberate neglect and child abuse exists and are serious problems within communities throughout South Africa (Western Cape Government, 2014). Section 110 of the Children's Act (Act 38 of 2005) states that suspected child abuse/ neglect must be reported to the Provincial Department of Social Development or Police Official (Western Cape Government, 2014). If an individual fails to report and comply with Section 110(1), then that in itself is a criminal offense (Western Cape Government, 2014). Furthermore, Section 110 of Act 38 of 2005 as amended, states that legal practitioners and medical practitioners require reasonable grounds in order to claim that a child has suffered injury, neglect or abuse (Western Cape Government, 2014).

The Centre for Justice and Crime Prevention has been established since 2005. They are a South African research NGO that works in the field of safety as well as violence prevention within South Africa, and their focus is mainly on youth and children (CJCP, 2015). University of Cape Town's 'The Children's Institute', reported child death statistics in their briefing paper on child death reviews (Rutherford, 2014). The first South African homicide study showed that children who died of homicide in 2009 were at a rate of 5.5 per 100 000 children under the age of 18 years (Rutherford, 2014). Furthermore, the study showed that 44.6% of child homicides

were due to child neglect and child abuse (Rutherford, 2014). Fatal child abuse within the 0-4year age group accounted for 74% of the deaths (Rutherford, 2014). Child homicides receive minimal attention in terms of policy and public health, in addition to this research concerning the topic is seldom researched (Martin *et al.*, 2013). The risk of being killed due to child abuse is higher in young children than adolescents, where the possible cause of death is due to interpersonal violence (Martin *et al.*, 2013). Martin *et al.* (2013) state that very little is known about child abuse and neglect leading to death (particularly in later life), however, child maltreatment is common within South Africa. Furthermore, Martin *et al.* (2013), continue to state that the need for child protection services outweighs the services already set in place to respond. Various studies have shown that even in well-resourced areas, child abuse cannot be prevented through the identification of the child at risk, nor can it be prevented by service provisions (Martin *et al.*, 2013). This is supported by the fact that the children known by child protection services continue to be killed (Martin *et al.*, 2013).

The extent of child abuse in South Africa is reported to be unknown, however, policy makers, the general public and practitioners agree that child abuse is a serious problem (DOSD, 2019). Both qualitative and quantitative research about child abuse should be initiated and pursued in research (DOSD, 2019). South Africa as a country, does not have an adequate view of the full impact and scope of child abuse, thus a gap in the knowledge exits (DOSD, 2019). It is known that child abuse is a serious concern in the Western Cape. It is also known that a diagnostic screening instrument for abuse exists and has been approved by the HPCSA; however, the gap in the knowledge reveals that it is not known how to implement training of such instruments into EMS. Thus this study aims to focus on practitioner development by improving their child abuse surveillance capabilities and thereby increasing societal beneficence.

The Minister of Social Development, the Honorable Susan Shabangu, signed a pledge at the 2018 Child Protection Week in the Free State to protect children, moving South Africa forward in its public commitment to child protection (May, 2018). Following the high number of child abuse reports and neglect for the 2017/2018 financial year, Cape Town child protection measures are to be strengthened (May, 2018). The financial year ended in March and a total of 1934 cases of sexual abuse were registered with the Department of Social Development

(DSD), furthermore, 1979 cases of neglect were reported and 876 cases of physical abuse (May, 2018). In addition to this, 356 cases of emotional abuse were reported. The DSD decide to provide R694 million into prioritizing the fight against child abuse (May, 2018).

A lack of alignment in the overall conceptual and planning frameworks for violence against women and children exists in South Africa (RSA, 2017). The relevant legislation was reviewed via a diagnostic review of the state's response to violence against women and children (VAWC) and an 'implementation gap' between the country's strong VAWC legislation and implementation thereof was found (RSA, 2017). An oversight body that can hold the government accountable for the elimination of VAWC is lacking within South African leadership (RSA, 2017). Training needs to be more nuanced in order to deal with the gaps in skill set to address the violence issue against women and children (RSA, 2017).

2.2.2.3. Children's Act 2005 (act 38 of 2005) /Child Justice Act 2008 (act 75 of 2008)

Section 110 of the Children's Amendment Act (amendment to Children's Act 38 of 2005) states every child has the rights set out in Section 28 of the Constitution (Makoae *et al.*, 2015). This section provides details and compels healthcare professionals to report any cases of neglect, maltreatment and abuse concerning children (M Hendricks, 2014). Professionals can be held accountable for not reporting such cases.

Section 111 of the Children's Act consist of Part A and Part B. Part A consists of all the reports of deliberate neglect of children as well as child abuse (Makoae, Roberts and Ward, 2012). By compiling all the reports in a register, this serves to determine patterns, trends and child abuse/neglect prevalence rates within communities (Makoae, Roberts and Ward, 2012). Part B consists of documentation of individuals who have been found unfit by child protection investigations to work with children and found to be alleged perpetrators (Makoae, Roberts and Ward, 2012). The Children's Act 38 of 2005 states that reasonable grounds must be present in order to conclude that a child has been sexually abused. The Criminal Law Sexual Offences Amendment Act 32 of 2007 aligns with the Children's Act and states that any knowledge of a sexual offence against a child must be reported (Children's Institute, 2018).

Rendering to the Health Professions Council of South Africa's (HPCSA) guidelines, healthcare providers are urged to report illegal and unethical conduct (Hendricks, 2014). Mandatory reporting intends to prevent the repetition of child maltreatment. According to the Health Professions Act No.56 of 1974, the HPCSA can suspend or issue a fine to the practitioner if they are found guilty of not reporting (HPCSA, 2009). When Healthcare Practitioners suspect abuse, but do not report it or investigate further, they are acting in favor of the alleged perpetrator and not the victim. This cannot be the intention of our thousands of practitioners but may be the effect of care omissions.

The Children's Act 8 of 2005 states that a child is protected within this act from any abuse, maltreatment or neglect from care-givers or any individual who does not have parental responsibilities (Makoae *et al.*, 2015). The White Paper on Welfare act is a guiding policy for welfare provisions and highlights the need for South Africa to provide preventative measures and allow for the well-being of children (van Niekerk, 2006). Section 7 of the Children's Amendment Act 41 of 2007, states that a child requires protection if the child is exposed to circumstances that may cause physical, emotional or social harm to that child. Furthermore, the child will require protection if he or she is exposed to neglect, being maltreated, abused or degraded by a care-giver, parent or any individual under whose care the child is (South African Government, 2010). As per Section 15/110 of the Child Care Amendment Act, any person with the responsibility to care for the child, be it a teacher, social worker, paramedic or doctor, suspecting child abuse, must report it to the provincial Department of Social Development (South African Government, 2010). Moreover, according to The Prevention of Family Violence Act 133 of 1993 (Section 4), suspected child abuse should be reported to child welfare, a police officer or a social worker (South African Government, 2010).

Legislation to protect children is prudent because, notwithstanding that children enjoy human rights, they do not enjoy the same autonomy as adults. This creates a dependence that can render them safe (in the care of law-abiding adults) or vulnerable. For some, children are perceived as possessions whereby adults can exert their authority and power over. Thus, children are not seen as distinct social entities or as human beings. This makes them powerless and voiceless and dependent on adults to provide for their basic needs (DOSD, 2019). In addition, within the South African context, there are linkages between poverty and

child neglect (DOSD, 2019). Poverty does not directly cause child abuse/neglect, but it does increase the risk of abuse from occurring and is a social determinant of health (Solar and Irwin, 2010). Conditions that are usually associated with poverty such as inadequate living arrangements and decreased levels of privacy, make children vulnerable to abusive behavior from adults and other children (DOSD, 2019).

2.2.2.4. Domestic Violence Act 116

This act focuses on removing perpetrators instead of victims (DOSD, 2019). The Domestic Violence Act 116 of 1998 regulates domestic violence in South Africa (RSA, 2014). This Act includes protection against physical abuse, sexual abuse as well as economic and psychological abuse (OSSAFRICA, 2014). The Domestic Violence Act makes it a legal duty of South African Police Services to help all victims suffering from violence be it with seeking medical help or finding suitable accommodation for the victim (OSSAFRICA, 2014). The Act also makes provision for an officer to arrest any alleged perpetrator who may have committed the domestic violence, and to seize any weapons on the premises (OSSAFRICA, 2014).

Children below the age of 18 can apply for a protection order of domestic violence (Fredericks and Sanger, 2014). Protection orders can be applied for at the nearest magistrate's court. At the magistrate's court, the domestic violence clerk will then attend to the victim and help process the protection order. An application for a protection order may be brought on behalf of the complainant via another person, this includes health care service providers, SAPS, counsellor or any individual whom has an interest in the wellbeing of the complainant (Jurisdiction, 2008). The application must be brought in with the written consent of the complainant, except that this is not valid if the complainant is a minor, mentally retarded, unconscious or a person who is unable to provide the required consent (Jurisdiction, 2008). Notwithstanding, any minor or an individual on behalf of the minor, may apply for a protection order without the assistance of a guardian or parent (Jurisdiction, 2008).

The Women's Legal Center (WLC) was established by women lawyers and aims to address violence against women (Women's Legal Centre, 2018). This center advances women's rights, equality and aims to protect marginalized and vulnerable women (Women's Legal Centre, 2018). Furthermore, the WLC creates awareness of women and hold the state accountable for

the implementation of policies and laws pertaining to women and their protection against abuse (Women's Legal Centre, 2018).

2.2.3. Cultural Emergent Properties

Cultural realizations are taken into account when a child is abused or harmed and may be accepted that this is in fact not abuse but a cultural practice(World Medical Association, 2019). Notwithstanding cultural differences, it is vital for healthcare providers to still be aware of the UN Convention concerning the rights of children and abusive behaviour (World Medical Association, 2019). South African legislation may well serve to criminalise certain cultural practices in the interest of child protection. Healthcare providers, social workers, and SAPS need to be culturally sensitive and aware of the different belief systems and practices that exist amongst the diverse culture of the South African society (Killion, 2017). Certain healing practices among different cultural groups may appear as child abuse (Killion, 2017).

The following cultural health practices may be seen as counter-current to western medicine and identified as harmful and potential abuse: coining, spooning, cupping, moxibustion and *caida de mollera* (fallen fontanel) (Killion, 2017). Coining is a dermabrasion therapy whereby the skin is rubbed intensely with the addition of herbal oils, this ancient practice is used by the Vietnamese (Killion, 2017). When coining is performed on a child's skin, it leaves an erythematous (red) patch on the skin. Furthermore, minor burns can result from the heated oil catching fire on the skin and could lead to the medical requirement of skin grafts (Killion, 2017). Similarly spooning, a cultural practice in China, results in ecchymosis on the skin when a spoon is used to rub wet skin (Killion, 2017). Moxibustion involves burning pieces of moxa herb in a cigar form. The lesion from this Asian practice appears the same as a circular burn from cigarettes (Killion, 2017). *Caida de mollera* is when an infant has fallen (sunken) fontanels; the cultural belief is to shake the infant in order to correct this. The shaking is said to be non–violent, however it can be confused with the shaken baby syndrome and may even result in the negative effects of the shaken baby syndrome if performed incorrectly (Killion, 2017). The physical manifestation of these cultural practices presents similar to those of child abuse and confusion is inevitable if the practitioners are not familiar with the different practices (Killion, 2017). It is prudent to understand who uses these cultural practices and recognize when such practices can place the child's health at risk (Killion, 2017).

Child sexual abuse is a challenge in all cultures (Shafe and Hutchinson, 2014). Some cultures believe that the way in which girls dress causes abuse (Shafe and Hutchinson, 2014). In certain cultures children are viewed as their parent's properties (termed 'ethic of Xiao'), meaning they must obey their parents (Shafe and Hutchinson, 2014). Sangomas' encourage men who are looking for wealth to sleep with virgin girls (Shafe and Hutchinson, 2014). The same practice of sleeping with virgin girls is used to "cure" Acquired Immune Deficiency Syndrome (AIDS) (Shafe and Hutchinson, 2014). Shafe and Hutchinson (2014), also report that the cultural belief of curing AIDS by sleeping with a virgin girl has caused 60 children per day to be raped within South Africa alone.

Female genital mutilation (FGM) may be seen as cultural and religious practices. FGM consists of all procedures which involve the partial or total removal of a female's external genitalia (WHO, 2018). It is often used to safeguard the girl's virginity or to cure some ailments as well as to attenuate sexual desires (Shafe and Hutchinson, 2014). The traditional circumcisers carry out such practices, however medical professionals often also perform the procedure of FGM as they believe that the procedure is safer when performed by a medical professional (WHO, 2018). The World Health Organisation urges professional medical care providers not to perform such procedures (WHO, 2018). Internationally, FGM is considered a violation of human rights and it is also seen as an extreme form of abuse against women and girls (WHO, 2018). Moreover, it is usually performed on minors and this is a violation of children's rights (WHO, 2018). Similarly, FGM is a violation of a person's rights to health. More than 200 million females have undergone FGM spread across 30 countries in Africa, Asia and the Middle East (WHO, 2018).

Ritual abuse is another form of child abuse in a ceremonial way (Shafe and Hutchinson, 2014). The phenomenon of ritual abuse involves children playing sexual games, ingesting laxatives and drugs as well as having child-child and child-adult sexual relations (Cozolino, 1989). Rituals are performed by cults and often children are forced into silence. In an extreme case, an adult survivor reported on her experience of a particular cult when she was a child. The ritual included her being raped by multiple males and an infant was killed, cooked, and

thereafter the cult members ate the infant (Cozolino, 1989). Members of the cult may see nothing wrong with this behaviour but it is also, in fact, a violation of children's rights.

There is ever changing demographics amongst individuals living in South Africa and health care practitioners assisting and treating the patient/victim may have been raised differently than the upbringing of the child/victim of child abuse (McIntyre and Silva, 1992). Practitioners should have a cultural knowledge base and have an open mind regarding the discipline of children as well as abuse and child rearing practices (McIntyre and Silva, 1992). Being culturally sensitive and still acting professionally will allow practitioners to distinguish between cultural practices that are acceptable and those which are in direct violation of child rights.

2.2.3.1. Child Abuse Stigma and Myths

Various myths[9] concerning child abuse and maltreatment exists, such as alcohol and drugs cause child abuse (Widom and Sturmhofel, 2017). Although a strong link has been found between alcohol use and child abuse (World Health Organization, 2006), it cannot be said that abuse will only occur when an individual has consumed alcohol. Likewise, it cannot be assumed that individuals who do consume alcohol abuse their children, as alcohol is a risk factor (albeit a strong one) towards child abuse.

Another myth exists that 'it's only abuse if it's violent'. Physical abuse is one form of abuse. Emotional, sexual abuse and neglect can cause the same severity of damage to the child as physical abuse (Smith, Robinson and Segal, 2019). It is a disservice to children and adults to assume that the 'only' form of child abuse is that in a physical form. 'Only bad people abuse their children' is a common myth. Not all abusive parents intentionally harm their children, there may be an underlying mental issue or they simply do not know any other way of treating their children as they themselves have been victim to abuse (Smith, Robinson and Segal, 2019). Most abusers tend to be someone the child knows, whilst abuse by strangers does often happen.

[9] Myth: a popular belief or traditional story of historical events which serves to unfold the world view of belief, people, practice or natural phenomenon (Merriam, 2019). It is often a false notion.

Most child sexual abuse is perpetrated by individuals that are known. Sexual violence by strangers is considered rare (Matters, 2019). The statement that 'children are usually sexually abused by strangers' is not true as 85% of sexual abuse is conducted by someone known to the victim (Matters, 2019). It is also said that 'most children who are abused did something to cause the abuse', however children are never to blame for the abuse. This represents a denial of responsibility. Certain children will be at more risk of abuse due to special needs, or chronic illnesses, thus exposing them to greater harm (Matters, 2019). Amongst all the myths which exist around child abuse, 'neglect is not as bad as the other types of abuse' also features. Not only does neglect contribute to child abuse, but it can also play a role in other causes of death such as fatal accidents and suicide. Indeed, 40% of all child deaths are due to neglect (Matters, 2019).

2.3. Emergency Care Provider Agency

2.3.1. The Health Care response to Child Abuse

Nationally, 561 174 young people have experienced physical abuse within their household, as per the Optimus Study conducted in South Africa (Artz *et al.*, 2016). "The Optimus Study provides the first ever representative data in South Africa on child maltreatment and exposure to other forms of violence" (Burton *et al.*, 2016,p.2). The study is one of an international comparative series of studies, with previous studies conducted in Switzerland and China (Burton *et al.*, 2016). Within this study, physical abuse, emotional abuse, child neglect and several forms of sexual abuse were explored (Burton *et al.*, 2016). The study consisted of a population survey of 15-17 year-olds in schools (4 086 participants) and households (5 631 participants) as well as focus group discussions and in-depth interviews with agency directors servicing the communities and their frontline staff (Artz *et al.*, 2016). The study found that a total of 784 967 cases of sexual abuse has occurred amongst young people in South Africa with victimization by the age of 17 years (Artz *et al.*, 2016).

A study conducted by Boyes *et al.*, (2017), namely "Disclosure of physical, emotional and sexual abuse, help-seeking and access to abuse response services in two South African Provinces", cites that 85.6% (n= 3515) of abuse victims did not receive help due to inactivity of services or non-disclosure. In a study conducted by Wright *et al.* (2018), when health care providers were asked whether they knew how to identify physical child maltreatment, only

38.8% (n= 3515) could identify the abuse. Of the 49 providers (doctors) interviewed from Mavalance General Hospital in Maputo, Mozambique, 51.1% strongly disagreed that they feel comfortable and confident treating child abuse cases (Wright *et al.*, 2018). Child abuse and maltreatment have been identified as a leading public health problem internationally (Wright *et al.*, 2018). Yet, health care providers are expected to play a vital role in the management and prevention of such cases. Health care providers are often reluctant to screen for violence due to the absence of distinctive guidelines (Meer & Artz, 2017). Moreover, practitioners feel that it is not their responsibility to intervene. The legal process linked to domestic violence causes reluctance and ambivalence[10] among practitioners (Meer & Artz, 2017).

Moreover, the economic burden of violence against children in South Africa is substantial (Fang *et al.*, 2017). The exact extent of child abuse in South Africa is unknown as definitions of severity differ (Jamieson, Mathews and Sambu, 2017). A national prevalence study published in 2016 approximates that one in three children are victims of sexual and physical abuse before the age of 18 years (Jamieson, Mathews and Sambu, 2017). As mentioned by Naidoo, 2017, Gender-based violence (GBV) persists as a substantial burden for health institutions worldwide, this includes violence against children. Similarly, Naidoo (2017) mentions that there have been limited prehospital studies, in relation to GBV. Limited studies have been conducted regarding child abuse education and the prehospital environment. In order to enable EC providers to effectively deal with child abuse cases, additional comprehensive training is required (Dessena, 2015).

The absenteeism of response protocol to GBV in a Health Profession Council of South Africa (HPCSA) delimited profession, suggests practitioner discretion will be relied on (Naidoo, 2017), analogously with child abuse. The use of guidelines is seen as practice interventions (Lillian, Talia and Gray, 2017). It is recommended by Meer and Artz (2017) that guidelines for working with victims of domestic violence be used to identify appropriate management and to properly refer the individuals by all health care practitioners within the South African context. Currently, there is no existing legislation that requires health care practitioners to screen for

[10] Ambivalence: Healthcare Practitioners have simultaneous and contradictory attitudes towards child abuse (Webster, 2018a). There is uncertainty as to which approach to follow- do they report child abuse or do they stay out of what is considered to be ‘private’ matters?

domestic violence and child abuse, for adequate care as well as preventative care, such screening should be a routine part of the workforce (Lillian, Talia and Gray, 2017).

Germany, Serbia, Spain, Finland, Vietnam, and the United States have all established guidelines, laws and policies enforcing health care providers to screen for domestic violence and intervene when required, hence South Africa needs to implement similar practices (Meer & Artz, 2017). If child abuse is suspected by the health care provider, such suspicions must be reported to a designated authority (Meer & Artz, 2017). By composing EC providers as agents of change through education as a cultural mediator, child abuse detection rates could improve.

Dessena (2015), found in her Master's study that EMS personnel and emergency care registrars of South Africa, all believe that they are inadequately trained to deal with child abuse cases. These practitioners remain capable of treating physical injuries, however, they feel helpless and inadequate when confronted with incidents of child abuse (Dessena, 2015). Comprehensive training is required in order for EMS personnel to confidently handle child abuse incidents (Dessena, 2015). In addition to this, Gihwala (2016), states that EMS personnel have done training to treat medical emergencies as well as trauma cases, but have no training on how to treat rape victims. The health care system lacks education and awareness regarding these victims (Gihwala, 2016).

2.3.2. Healthcare Providers' Obligations and Education

The World Medical Association (WMA) (2017), states that if child abuse is suspected, a comprehensive assessment must be conducted by practitioners with expertise on the topic or specialized training in child abuse (WMA, 2017a). However when one looks at the *Diagnostic and Statistical Manual of Mental Disorders – DSM5* (American Pscyhiatric Association, 2013), a diagnostic handbook for psychologists, it is evident that child abuse appears rather shallowly.

In addition to this, the textbook *Critical Care Nursing 3rd Edition* contains a chapter on pediatric considerations in critical care, conversely, within this chapter, there is no mention of child abuse (Aitken, Marshall and Chaboyer, 2015). Furthermore, the textbook *Emergency Nursing Core Curriculum* by Saunders (2007), contains a chapter called Abuse and Neglect/Sexual abuse. Even though this chapter is included in this textbook for nursing students, the topic

child maltreatment only features within 2 pages of the chapter (Saunders, 2007). The *AFEM Handbook of Acute and Emergency Care* (Wallis and Reynolds, 2013), states on their cover page "The only handbook for emergency care in sub-Saharan Africa". This 1000 page handbook deals with varieties of emergencies and medical conditions, yet no reference or mentioning of child abuse is made. Thus these textbooks for healthcare providers are insufficient with information regarding child abuse and maltreatment. As previously stated, the World Medical Association claims that specialized training is required to deal with child abuse, however within all the above mentioned training handbooks/textbooks for various healthcare professionals minimal information concerning child abuse is present.

Given that child safety is constitutional protection (RSA, 1996), surveillance of child abuse is a function of the state and that of institutions (Human Rights Commission, 2015). Emergency Medical Services, as an organ of state, has the potential to document child abuse cases in the emergency care environment, especially those cases who do not go to the hospital or the cases where abused children die en-route to the hospital on the ambulance. The quality and purpose of practitioners cannot be incoherent in relation to cases of child abuse as seeing and dealing with child abuse cases erodes self-esteem and results in vicarious traumatization.

Despite international conventions and progressive children's rights legislation, crimes against children remain alarmingly high (Hendricks, 2014). Healthcare practitioners have the legal duty to report child abuse, however, a barrier exists in that practitioners misunderstand child abuse reporting legislation. Existing mandatory reporting practices within South Africa should be enhanced to ensure the safety of children (Hendricks, 2014). Hendricks (2014) suggests that all individuals who work with children, be it healthcare professionals or educators, should be trained on how to identify abused children and those at risk.

The Department of Health in South Africa published the National Emergency Care Education and Training Policy (NECET) in April 2017 (Sobuwa and Christopher, 2019). Section 16 of the Health Professions Act 56 of 1974 makes provision for the regulation of emergency care education. The objective of the NECET policy is to create and NQF-aligned framework within the emergency medical care training (NECET, 2017). Furthermore, the NECET policy aims to produce emergency care workers which can render efficient and effective services to society

(NECET, 2017). Many emergency care personnel lack the understanding of how to go about reporting and identifying abuse (King, Baker and Ludwig, 1993). Moreover, they are uncertain as to what their role is concerning child abuse. King, Baker and Ludwig (1933), suggest from their study that the subject of child abuse requires further study. They also mention that child abuse information should be reinforced and strengthened throughout emergency medical care education (King, Baker and Ludwig, 1993). In the South African setting, this was re-enforced by Naidoo (2017).

A study conducted in Australia used the following method: Following a systematic search of MEDLINE and CINAHL Plus databases, the university library collection, Google and the websites of Australian ambulance services, Paramedics Australasia (PA) and the Council of Ambulance Authorities (CAA), 31 reports, 12 journal articles, and three texts are included in this review (Johnson *et al.*, 2018). It was found that pre-hospital personnel who have received training on how to identify and report child abuse were more likely to correctly identify the abuse, and more likely to have followed the reporting procedure (Johnson *et al.*, 2018). It was also found that a continuous education program on identification and reporting of neglect and abuse showed improved knowledge amongst emergency care providers (Johnson *et al.*, 2018).

2.3.3. Child Abuse cases giving expression to the public interest principle

The public interest principle is defined as the inclusivity of all society and the protection as well as enhancement of their general welfare and rights (IFAC, 2012). It suggests what is in the best interest of the public. Despite the presence or absence of any public outcry, it refers to the interests of society. The many victims of abuse give identity and face to the problem. Such cases include the ones discussed below:

Hamzah Khan a 4-year-old boy from the United Kingdom was starved to death by his mother in 2009. The mummified body was then only found by authorities in his mother's home in 2011. Bradford social services admit that they had missed signs that could have led them to take action against the abuse of Hamzah Khan (Pidd, 2013a). Neither Hamzah nor any of his siblings were 'at risk' on social service registers (Pidd, 2013a). Poppie Van der Merwe, a 3-year-old from Pretoria, was continuously abused by her step father and mother. She was thrown against solid walls and kicked in the stomach on numerous occasions (Kormorant,

2017). Unfortunately, Poppie succumbed to her injuries. Similar to Poppie and Hamzah, many children are abused and authorities are not noticing the warning signs, thus leaving the children vulnerable and at risk of further abuse and even death.

In March 2015, two Cape Town teenagers- Sinoxolo Mafevuka, who was strangled to death in Khayelitsha and Franziska BlÖchliger, who was attacked in Tokai forest were both raped and murdered (Lake and Jamieson, 2017). Ashwin Jones (12) from Uitsig, was killed in a hail of bullets outside a mosque whilst guarding cars (Petersen, 2019). The stories are brutal and flabbergasting; however, they are not isolated events. Violence in South Africa, especially against women and children, is pervasive (Lake and Jamieson, 2017). According to the Children's Institute, 500 children die annually due to neglect or abuse (Petersen, 2019). Petersen (2019), states that most of these murders occur within the Western Cape. Jones (2019), states that a total of 279 children were killed in 2017 and 2018. "This is the highest number of child murders reported in a South African province for the 2017 and 2018 reporting period" (Jones, 2019a,p.1). Mortuary data for 2014- 2016 (a total sample of 1593 deaths), showed that the death of children 1 year of age was mainly perpetrated by the mother (Jones, 2019a).

2.3.4. Theoretical posturing

To observe change and expansion of child abuse reporting, Archer's (1995) concept of morphogenesis must be scrutinized. Basic realist ontology assumes that the possibility exists to separate being (ontology) from knowledge (epistemology) (Mandikonza and Lotz-Sisitka, 2016). Thus allowing the independent study of knowledge and being using analytical dualism, whilst still recognizing their interrelatedness.

Critical realist and social theory and the principle of emergence (Archer, 1995), suggest that what is observed in society, are developing powers and properties from the collaboration of generative mechanisms (Mandikonza & Lotz-Sisitka, 2016). The realist social theory is a form of critical realism, which looks at the three orders which exist namely natural, practical and social to explain the stratification of social reality (Mandikonza & Lotz-Sisitka, 2016). The natural order looks at self and physical being. Practical order views people, whereas the social order views interaction. The social process further aims to observe structure, culture, and

people. In addition to this, observation of people involves agency which gives rise to power and properties (Mandikonza & Lotz-Sisitka, 2016).

Critical realism defines an objective reality as existing independently from individual perception (Taylor, 2018); however it does recognize the role that individual interpretation may play within defining the reality (Taylor, 2018). Social constructivism is the theory that looks at the development of knowledge via interactions that occur between individuals (Taylor, 2018). Thus the social constructivism theory looks at the specific learning an individual will gain via the interaction process.

2.4. Summary

This literature review aimed to view the role of Emergency Care providers' agency for social change in relation to child abuse cases. The review also aimed to intersect the emergency medical services (as the system within which emergency care providers operate), and child abuse (as an emergency care burden). The phenomenon of child abuse remains a wicked problem within society. It is complex and relies on many different aspects and multidisciplinary approaches to improve detection rates. Systems of intervention are required to allow for the society as a whole to abide by laws and professional practices of South Africa. Moreover, educational interventions could be improved upon.

A gap in knowledge has been detected amongst emergency health care providers to be on child abuse dynamics and symptomology (Wright *et al.*, 2018). Research concerning child abuse and neglect entails challenges. The widespread problem occurs in a wide range of domains, such as public health, child development, medicine and child welfare (Feit, Joseph and Petersen, 2014a). Moreover, what is required is research on augmentation and implementation of laws or policies regarding child abuse and neglect, rather than research on the policy or law itself (Feit, Joseph and Petersen, 2014a). In this respect, the emergency care implementation gap for child abuse diagnostics is the lacuna in the knowledge that this study aims to address.

CHAPTER 3: Methodology

3.0. Introduction

This chapter discusses the research methodology of the study. A summary of the research design is also included. The study followed a concurrent mixed methods approach consisting of a review of archival data, a pre- and post-educative intervention online survey as well as a training workshop (as an educative intervention). Prior to the online surveys being sent to respondents, a pilot study was conducted. The research study included all students registered on the BEMC program at CPUT (training workshop and online-survey). The archival data included two different graduate year groups and their complete 4 years of studying (a 5-year time span in total). The following chapter aims to address the research design and methodology that was followed, the significance of the research, ethical considerations as well as the dissemination strategy.

The researcher sent an email to the HOD of the EMS Department at CPUT, requesting for permission to use the students within her study. The letter for request as well as the approval letter can be obtained in Appendix B.

3.1. Paradigm: Critical Pragmatism

The research paradigm is that of critical pragmatism. Critical pragmatism focuses on analyzing a particular practice (Forester, 1993a). Furthermore critical pragmatism views individuals' lived experiences in an ever changing world (Kadlec, 2007), whereas pragmatism deals with problems in a practical way and does not use abstract principles in dealing with problems (Collins, 2019).

"Presently, critical pragmatism is neither a developed planning approach nor an analytic approach" (Forester, 1993, p.95). However critical pragmatism allows us to analyze practice and learn from it (Forester, 1993b). Planning is important for the distribution of resources and thus it is concerned with value judgment (Forester, 1993b). Value judgments are influenced by individual's roles in planning, their values and their intentions and these three themes provide the themes for the notion of critical pragmatism (Forester, 1993b).

Two strands of critical pragmatism exists (Ulrich, 2012). The first strand is that of cultural and educational theory development (Ulrich, 2012). Critical pragmatism emphasizes that a need exists to use liberal and progressive values in order to apply knowledge to everyday problems which exist (Ulrich, 2012). Thus an everyday problem in our society is that child abuse and knowledge regarding this problem (treatment, recognition and intervention), need to be explored further to bring about improved values and solutions for the problem. The second strand which exists is one of ethics and philosophy (Ulrich, 2012). The researcher mainly uses the first strand of critical pragmatism based on cultural and educational theory development.

3.2. Research Design and Methodology

A concurrent mixed-methods approach to data collection had with an equal emphasis on quantitative (QUANT) and qualitative data (QUAL). The researcher chose to use concurrent mixed methods due to the nature of the study requiring both quantitative and qualitative data. The data was concurrent as both qualitative and quantitative data were analyzed at the same time. Mixed-methods allowed the researcher to capture the voice of the participants and ensure that the quantitative data findings were located in the participants' experiences (Wisdom and Creswell, 2013). Thus this study is reflective of the participants' point of views in the textual analysis. In addition to this the mixed-methods approach allows the researcher to have methodological flexibility (Wisdom and Creswell, 2013). This approach allows more information to be elucidated than which could be obtained in only quantitative or only qualitative research (Wisdom and Creswell, 2013). The integration of concurrent mixed-methods allows for the potential to enrich the data findings and analysis (Wisdom and Creswell, 2013).

Concurrent mixed-methods is an emergent methodology gradually being used by researchers within the health sector (Tariq & Woodman, 2013). Tariq and Woodman (2013), continue to voice that the integration of qualitative and quantitative data can produce acuities[11] into the research question. The mixed method approach was used within this study, allowing the research question to be addressed more comprehensively than with the use of 'monochromatic' research. An explanatory, concurrent descriptive design was followed. Qualitative and quantitative data were collected and analyzed concurrently.

[11] Acuities: This refers to the keenness or acuteness of perception or thought (Farlex, 2018a).

The quantitative and qualitative data was used in isolation and in combination to answer the intended objectives. The quantitative and qualitative data were contrasted and associations between knowledge and self-reported practices were searched for. The use of mixed methods provided an in-depth understanding of the research question. The mixed-methods approach included: a pre-survey online questionnaire, an educative workshop intervention, a focus group discussion within the workshop and a post-workshop online survey.

3.2.1. Data Collection

3.2.1.1. FISDAP® Archival Data

Phase I: Quantitative data from the FISDAP® database:

BEMC Students are required to log all patient interactions (including prehospital cases of child abuse) onto an electronic data capturing system named Field Internship Student Data Acquisition Project (FISDAP®). FISDAP® is a database where Emergency Care Students enter information about their clinical experience within the field during their allocated shifts. It is an online subscribed database to help students log their required skills[12] to meet the Health Professions Councils of South Africa (HPCSA) minimum standards (FISDAP, 2019). All records are stored on this database and are available at any time to individuals who have access to it. FISDAP® skills tracker documents the students' learning process. Reports show achievements as well as growth (FISDAP, 2019). After a student has worked their scheduled shift for the day, they document their experience on FISDAP®, class simulations can also be recorded (FISDAP, 2019). Lecturers who have access to the database can track the students' progress. Comprehensive reports can be pulled from FISDAP® in order to provide proof of skills performed. Furthermore, the students can write narratives on their reports, explaining their thought process. All students' accountability is increased due to Skills Tracker which is integrated with FISDAP® which can detect an assigned shift automatically appearing on the students' account (FISDAP, 2019).

[12] The HPCSA requires evidence of scope and skill completion and CPUT enables this through FISDAP compliance.

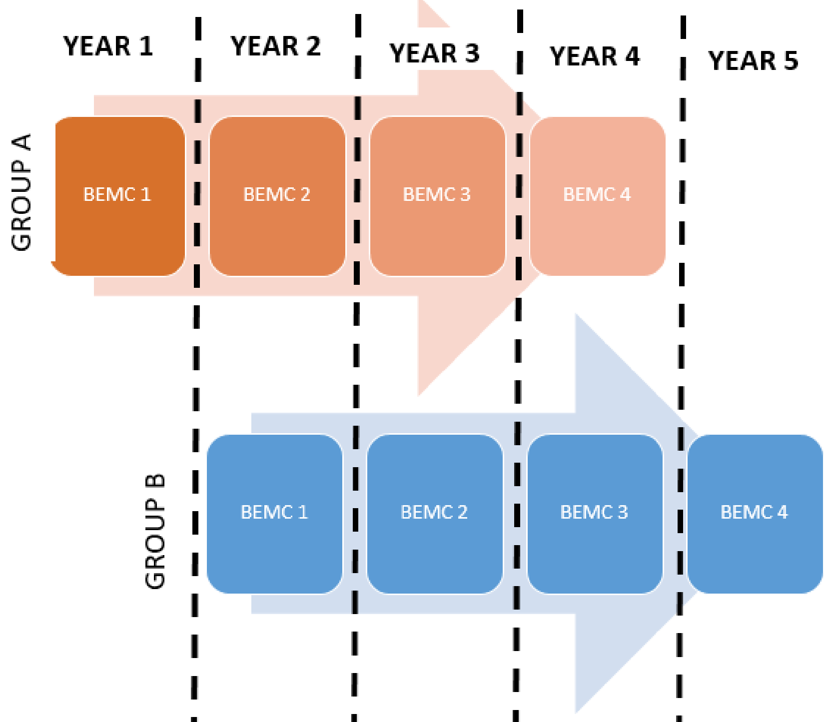

Figure 1: Visual indication of a 4 year degree (BEMC 1-BEMC 4) archival data on FISDAP®,

The FISDAP® database collects student patient contact data. On the assumption that FISDAP® has legitimacy for the understanding of current and past student patient interactions during clinical practice, the researcher under took to analyse the historical clinical practice records for EMC student graduates over five years looking at two different year groups (Group A and Group B). This serves to bench-mark any improvement, stasis or risk associated with the CA screening interventions implemented in this study. In keeping with the concurrent mixed method design, this historical data constituted the quantitative phase of the design. When viewing archival data on FISDAP®, only exit level graduates' (BEMC 4) data was looked at across their entire 4-years of study. Group A and Group B completed their BEMC degree by the end of the 5-year period reviewed. This is illustrated in Figure 1 above.

The aim of the archival data was to view how the students reported cases and to pick up on any probable "missed" cases. As mentioned in Chapter 1, for the purpose of this study, the researcher defines probable missed cases as any case logged onto FISDAP® where children

0-18 years have sustained injuries due to trauma, burns or overdose where the intent of injury was either documented as intentional, non-accidental or unknown.

3.2.1.1.1. Instrumentation for FISDAP archival data

Both the pre- and post- workshop survey was not intended to document the evaluation of the screening tools in total. The evaluation of the tool in enabling a screening culture for child abuse was likely to be reflected in the FISDAP data where real world applications were documented with a self-reflection thereon. The post training workshop survey explanation can be found in Appendix K. Students and practitioners may currently screen for child abuse because it is within their scope of practice, albeit not consistently. The study's purpose was to advance consistency in screening. In addition to this, the online FISDAP® instrument used for archival data as well as post training workshop data collection is an approved tool that originated at the first annual NAEMSE[13] Symposium in 1996 (FISDAP, 2018). The instrument is used to represent different EMS institutions and it is also used for research purposes. The usability of this instrument again relies on Wi-Fi accessibility and speed. Furthermore, training is required in order to extensively collect data on this platform. The researcher compiled a step by step diagram for the two research assistants to use. This step by step diagram can be found in Appendix O.

The findings from the process outlined in Appendix O then served as a historical, proxy measure of child abuse detection and reporting thereof by emergency care students. Graduates from two sequential academic year groups were used (over a 5-year period) and named Group A and Group B out of concern for group harm. Two undergraduate students were appointed as research assistants to help with the data capturing and were trained in the required work process by the researcher. Factors of analysis included all detected cases and all probable "missed"[14] cases.

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[13] NAEMSE symposium: The National Association of Emergency Medical Services Educators symposium started in 1996, where they built a database named FISDAP® (Rosen, 2014). This database which was created provided great relevance for emergency medical service programs. These programs could now track specific skills and log patient encounters throughout the student internship period (Rosen, 2014).

[14] "Missed" cases: the researcher defines missed cases as any case where children 0-18 years have sustained injuries due to trauma, burns or overdose where the intent of injury was either documented as intentional or unknown. The limitation is that psychological harm from emotional abuse is not always apparent.

3.2.1.2. Pre- and post- child abuse responsivity questionnaire/survey

Phase 1: Quantitative Questionnaire:

The questionnaire implementation occurred over a period of 2-4 weeks to account for any participants who were not in class due to illness or competing study interests.

Pilot study: A pilot study was conducted of the online questionnaire. The survey was piloted amongst graduates (staff members) who have experience in education and research. It was sent to 6 individuals and 4 responded. The constructive critique was accommodated in the redesign of the questionnaire. The questionnaire[15] took 30-40 minutes and the online version of the questionnaire was meant to improve the accessibility of the questionnaire as Wi-Fi is provided on the campus and there is internet connectivity in the computer laboratory. Internal validity was confirmed by performing a pilot study as mentioned above using staff members in the Department of Emergency Medical Care at CPUT.

3.2.1.2.1. Instrumentation for the Child Abuse Responsivity Questionnaire

The questionnaire used in the study was copy-written by Roxanne Maritz [see Appendix J]. The tool was an adaptation from the work of Naidoo (2017) where similar questions on gender based violence and domestic violence were validated. Naidoo, developed the original tool, which screens for GBV, with input from the Medical Research Council (MRC) and UCT's Forensic Medicine Department. Naidoo granted permission for the researcher to use and adapt the questionnaire, the permission letter can be found in Appendix I. The head of the Gender Health and Justice Unit at UCT had also endorsed the original tool as relevant to understanding practitioner perspectives on domestic violence. The tool deliberately had a victim age bias in the questionnaire for 14 years of age and older. The gap in the knowledge related to children younger than 14, the researcher had adjusted the tool, with permission from the originator, to include a victim age of 0-18 years to be aligned with the Children's Act.

The study showed observable relationships between child abuse beliefs as well as myths associated with child abuse and demographic factors. The authenticity and rigor of the training workshop data were achieved by allowing participants freedom of expression. The sampling

[15] Questionnaire online link: https://docs.google.com/forms/d/1FRRmc44g7PrjoBCUHW2_a5DiRb96kqTeU72UNTuz4S8/edit?usp=drive_web.

was purposeful and data was participant-driven. The participants' perceptions were accurately represented via transcription by the researcher, followed by an analysis of the content, and the role of the researcher was diminished. Credibility was achieved by portraying true insider perspectives from the training workshop data.

Additional proof of the original tool validity is the peer reviewed publication of its findings in the MRC African Safety Promotion Journal. The amendment has been guided by the existing literature for child abuse in South Africa, relevant legislation, HPCSA policy, and guidelines and is intended to be sensitive for the emergency care community as the focus is on prehospital screening, early detection, confounding preconceptions, ideological bias (Naidoo, 2017) and fallacious reasoning. Open ended questions in the questionnaire were deliberate so as to allow a deeper analysis of the participant perspectives and to allow participants the opportunity to explain their quantitative choices. This mode of inquiry aligns well with the philosophical assumptions and axiology of Critical Sociology.

The pre-questionnaire appeared long in the format presented, but in reality was not. The previously tested questionnaires took 30-45 minutes to complete. The researcher then created an online questionnaire to render its completion and analysis more efficient. The questionnaire was implemented prior to training intervention to document knowledge attitudes and beliefs prior to the educative intervention. The post-intervention survey was used to determine training efficacy and knowledge retention on information disseminated. This survey was done online. The survey post- intervention was intended to gauge new learning during the training workshop (educative intervention) and readiness to implement the child abuse screening protocol. This is an ethical obligation to prepare practitioners and students for the real world.

3.2.1.3. Educative Training Workshop Intervention and Focus Group Discussion

A. Phase 2: Qualitative data:

Qualitative data was collected through an educative intervention in the form of a facilitated training workshop followed by a focus group discussion. The training workshop lesson plan stated the purpose of the training workshop: To give expression to the HPCSA act in relation to child abuse as well as the general objective: to develop and implement an educative intervention that promotes the utilization of the approved screening instrument among EC students. The training intervention (over 4 weeks), the training workshop lesson plan, training workshop information booklet, cases, and PowerPoint can be found in Appendix K, L, M and O respectively. The focus group discussion involved discussing the cases presented in the workshop. The participants were first split into their groups where they discussed the structured questions surrounding each case. Thereafter all groups came together for a general focus group discussion on all cases. The researcher transcribed all the material by writing on paper and later retyped all the data onto her laptop for analysis. Once the general focus group discussion was complete, the students' were shown video footage regarding each case to create awareness of the severity and reality of child abuse.

3.2.1.3.1. Instrumentation for case study development

The use of case studies within the classroom (and in educational research) is a useful technique (Dunne and Brooks, 2004). Students/participants can be either deductive or inductive learners. The majority of students/participants are inductive learners, thus they grasp concepts better when provided with examples (Dunne and Brooks, 2004). Case studies help the student/participant to apply the knowledge and skill set learnt to real world scenarios (Dunne and Brooks, 2004). These cases can be done individually or in teams to share the workload and to allow students/participants to learn from one another (Dunne and Brooks, 2004).

An advantage of using case studies as a teaching method allows students to problem solve, make decisions in complex situations and teaches them to cope with ambiguities (Dunne and Brooks, 2004). When planning a case study, the context/situation should be decided first and foremost. Thereafter as much information regarding the topic must be gathered in order to analyze the different elements affecting and influencing the situation (Bates, 2012). By gathering all the information the situation/ problem can be adequately described within the

case allowing the reader to grasp the situation and have an overall understanding of what is happening, thus allowing them to seek a solution (Bates, 2012). Constructing cases that are about individuals that the reader can relate to will make it easier for them to envision the situation and answer questions to follow (Patel, 2015). Providing a background is important within a case study to allow for the reader to view facts and figures from authoritative sources such as articles and journals (Bates, 2012). Adding real statistics to case studies acts as proof that the problem does exist and it will also indicate the seriousness thereof (Patel, 2015). The background servers to give the reader enough information to allow them to draw their own conclusions (Bates, 2012).

Case studies should aid in guiding the reader through the thought process instead of telling the reader what to think (Bates, 2012). Case studies should also be constructed in a way which is easy to read and understand, the format of a case study is vital (Patel, 2015). Appealing to different types of learners should also be remembered when creating a case study, as learners have different methods of absorbing information (Patel, 2015).

In terms of preparation, the researcher considered the above evidence and planned the content to be discussed. The training workshop content consisted of all relevant laws pertaining to children and their abuse and was in the form of a PowerPoint presentation, short videos of DV cases, focus group discussions on the DV cases and a plenary for group feedback and consensus finding among participants. The researcher planned to draw on her own knowledge regarding the subject as well as on the experience and knowledge of the participants. In this way, the co-creation of knowledge is facilitated (Bagayogo *et al.*, 2014). The pace of the training workshop was aimed to be fast as the researcher had a high ability participant group. The teaching method used was informal-democratic in order to ensure instructional stimulus variation. Class participation was also vital to relieve emotion and tension. In order to communicate with the students, the researcher spoke in English, she also used voice confidence and direct eye contact due to the serious nature of the topic. To ensure class participation, she used questioning techniques that promote engagement throughout the training workshop.

Assessment of the students' participation took place by assessing cognitive outcomes via the online survey. Their perception of child abuse and affect were evaluated during the training workshop and their psychomotor development as a skill was assessed in the management of cases. Teaching aids that were used were cost-efficient, functional and selected based on the fact that the lesson could be repeated by any individual who would want to replicate the training workshop. Thus real-life cases were used together with (publically available) video footage and the adapted HPCSA-approved screening tool.

The researcher then created lesson notes which were handed out to the class with references for extra reading and in the interest of reciprocity. These notes also contained important numbers to call for support and referral when suspecting child abuse. The cases which were presented in the training workshop were real-life cases as mentioned previously. The cases were located in the public domain and the assessment that they are 'typical' or 'atypical' was a matter for the discussion. The cases consisted of Hamzah Khan from England (Pidd, 2013b) to show that child abuse is a global issue, Poppie van der Merwe (van der Merwe, 2017), Franziska Blöchliger (Etheridge, 2017), Tebetso Phale (Venter, 2017a) and Baby J (Venter, 2017b). Each case was presented to the students in the narrative (text) format, supported by open-source video material. Thereafter, within their groups consisting of 3-4 students per group, they answered 4 questions which were created by the researcher. The 4 questions were as follows:

1. What could be red flags/warning signs in this situation?

2. Who would you suspect as the perpetrator of this scene? Why?

3. What is the nature of the abuse?

4. What subjective and objective information would you gather from this case?

Following the discussions within the individual groups, a focus group discussion occurred where each group had the opportunity to present their answers to the questions and engage with one-another discussing their opinions. Video footage reporting on the Hamzah Khan (BBC News, 2013), Poppie van der Merwe (eNCA, 2018) and Franziska Blöchliger (news24, 2016) cases were downloaded from the internet to display to the students, once focus group discussions were finished. This was to conclude each case and to sensitize the students to

the harsh reality of child abuse. Baby J and Tabetso Phahle's video footage was not available to protect the identity of the victim, thus it was not included. Thereafter the students were taught how to use the screening tool. Once the training workshop concluded, each participant was sent the link to the post-training workshop survey for completion.

3.2.1.3.2. Instrumentation for the lesson plan for the educative intervention

A summary of the lesson plan can be found below. This provided the structure to manage time and to achieve objectives.

Objective/Purpose	Implementation	Time	Quality Criterion
• All Emergency Care Providers have an ethical and legal duty to protect children • All Emergency Care Practitioners are accountable for non-reporting of cases against child abuse	Power Point	20minutes	• Stick to time • Must have relevance to EC providers • Consensus must be reached
• The identification of the EC needs of a child in a child abuse situation; • The evaluation of the EC needs of a child in a child abuse situation with due regard to his or her safety and the implementation of precautions to ensure his or her safety;	4 Cases, Questions for discussion and videos	20minutes per case – 10minute focus group discussion answering questions, followed by 10minute class discussion	• Strict on time • Consensus must be reached
• The evaluation of the EC needs of a child in a child abuse situation with due regard to his or her safety and the implementation of precautions to ensure his or her safety; • The rescue of a child from a child abuse situation or from a potential child abuse situation; • The provision of EC to a child in a child abuse situation; and • The prevention of further injury to, and the combating of possible complications of an	Screening Tool	30 minutes	• Time constraint • Content fits Context

illness or injury, to a child in a child abuse situation.			
• To see whether the training workshop has made a difference and proven to be helpful towards child abuse recognition	Post training workshop Questions – Online Survey	30 minutes	• Organize computer lab • Send out the link at end of the training workshop

3.2.1.3.3. Summary of the data collection pathway

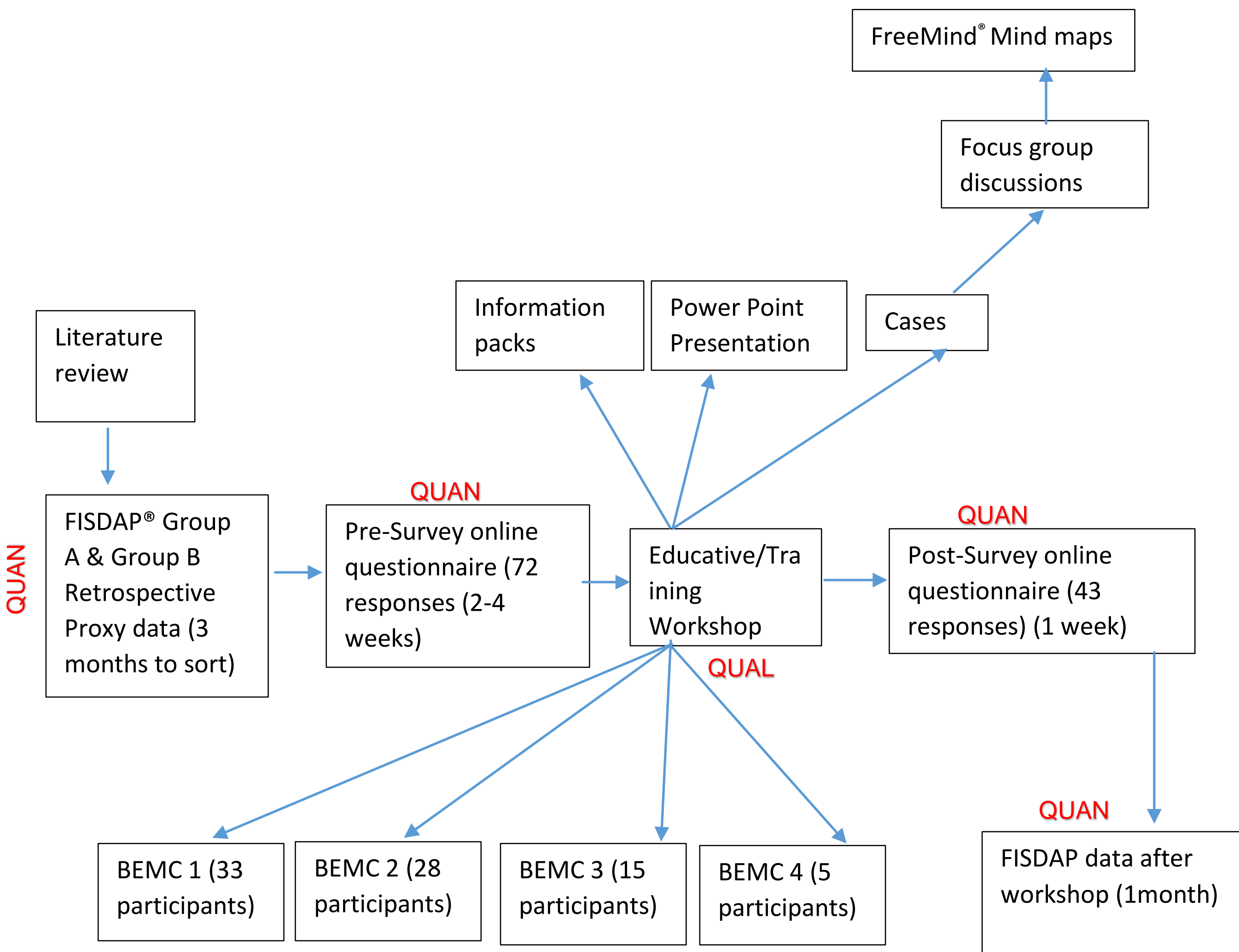


Figure 2: Summary of data collection pathway

In Figure 2 above, the summary of the methodological pathway which was followed is illustrated. The researcher first did a literature review about the problem at hand. A concurrent mixed method approach was followed. Both quantitative and qualitative data are capitalized as both data sets are of equal importance within this study.

When viewing archival data on FISDAP®, only exit level graduates (BEMC4) data was considered across their entire 4 years of study for a cross-sectional analysis. The aim of the archival data was to view how the students reported cases and to pick up on any probable "missed" cases. The probable "missed" cases consisted of any trauma which was reported and the intent of injury was either unknown or intentional. Furthermore, burns and overdose/poisoning and neglect were also added to "missed" cases where the intent of injury was also unknown or intentional. Only cases for children aged 0-18 years were retrieved and analysed.

Whilst the archival data was captured from FISDAP®, the pre-training workshop survey questionnaire link was emailed to all students willing to part take in the study to complete. Once the pre-survey was completed, the survey was locked and a training workshop then followed to give the students more information about child protection policy and legislation, reporting procedures and to introduce the screening tool. Four training workshops were held, one for each year group. The students were handed information packs in the training workshop for further reading in their own time and to the depth of their own interest. They were also presented with real-life cases, followed by focus group discussions based on the cases.

The participants were trained on how to use the child abuse screening tool in the training workshop and could utilize the screening tool within the field. Thereafter they were expected to report their findings following encounters with children in the field onto their FISDAP®. Only one participant reported using the screening tool. The under reporting of the screening tool on FISDAP® is attributed to competing academic interests and a low frequency probability of child cases due to a rostering bias.

3.2.2. Sampling Strategy

The researcher used various sampling strategies for the different data collection platforms. The use of various sampling strategies is due to the fact that her methodology followed a concurrent mixed-method design. The researcher used a mixed purposeful sampling scheme as she compared quantitative and qualitative data results which emerged (Onwuegbuzie and Collins, 2007).

The FISDAP® archival data sampled was over a 5 year period. Nonprobability-purposive sampling was used. Nonprobability sampling does not allow for mathematical random selection to occur (Wurtz, 2016). The researcher chose this method as it allowed her to select the graduate year group from which she wanted to retrieve the archival FISDAP® data. Purposive sampling is acceptable in the context that specific cases are selected with a purpose in mind (Wurtz, 2016). The researcher specifically selected to look at Group A and Group B's FISDAP® archival data, as these two year groups utilized the tool to its full potential and logged detailed patient narratives. While the sampling of the archival data would allow for generalization to a population, the overall focus of this study was to mix findings from quantitative and qualitative data and to generalize towards an existing theory (Onwuegbuzie and Collins, 2007). All paediatric cases of the medical records located on FISDAP® for the sample size of two specific graduate groups was chosen due to the nature of the data being quantitative. The sample size allowed for exploratory research to take place.

The choice of frequency and size of the focus groups were guided by Onwuegbuzie and Collins (2007). The minimum recommended focus group discussion participant size is 6 and the maximum is 9. The sample size of the focus groups within this thesis consisted of 6-8 individuals per focus group. In addition the focus groups totalled 13. In terms of focus group size and focus group frequency this study met and exceeded that of the minimum recommendations by Onwuegbuzie and Collins (2007).

The pre- and post-survey used a simple sample approach. The simple sampling strategy is suitable for quantitative research, and includes all the members of a population (Surbhi, 2017). All individuals within the simple sampling scheme have an independent and equal chance of being chosen for the study (Onwuegbuzie and Collins, 2007). The pre-survey was emailed to 137 BEMC students (the desired BEMC population), therefore the researcher aimed to enumerate each student registered on the BEMC programme. The post-survey was only emailed to those who attended the workshop (n= 81), however this still followed a simple approach as the entire population attending each workshop received the post-survey link.

3.2.2.1. FISDAP® Archival Data

Regarding the historical records in the FISDAP® database, the inclusion criterion was two graduate groups of BEMC students (N=30), within a 4-year BEMC program that participated in clinical practice. The total amount of cases reported on FISDAP by the two groups were N= 12 365. Furthermore, archival data only included cases where the intent of injury was unknown or intentional in the form of trauma, overdose and burns. For exclusion Criteria: all non-BEMC students at CPUT within Western Cape were excluded from the study. Graduates which were not part of the two groups (A or B: year not stated to prevent group harm and to provide anonymity), were excluded. Child abuse follow-ups (if any) were excluded. The researcher did not include motor vehicle accidents as an inclusion criterion for probable "missed" cases (discussed further under limitations).

An appraisal of the status quo with regards to the implementation of the approved screening instrument among EC scholars served as the first objective. Participants to be involved were EC scholars as mentioned above, BEMC1-BEMC4. This was a total of 137 students. The appraisal of the *status quo* was obtained by using FISDAP® data. This was done to appraise the existing implementation/uptake of the child abuse screening instruments by the population of interest. The time period for this data collection was 1 month.

The FISDAP® archival data sampled was over a 5 year period. Nonprobability-purposive sampling was used. Nonprobability sampling does not allow for mathematical random selection to occur (Wurtz, 2016). The researcher chose this method as it allowed her to select the graduate year group from which she wanted to retrieve the archival FISDAP® data. Purposive sampling is acceptable in the context that specific cases are selected with a purpose in mind (Wurtz, 2016). The researcher specifically selected to look at Group A (N=18) and Group B's (N=12), FISDAP® archival data, as these two year groups utilized the tool to its full potential and logged detailed patient narratives. All paediatric cases of the medical records located on FISDAP® for the sample size of two specific graduate groups was chosen due to the nature of the data being quantitative. The sample size allowed for exploratory research to take place.

3.2.2.2. Responsivity questionnaire (pre- and post-workshop) and educative training intervention

The pre- and post-survey used a simple sample approach. The simple sampling strategy is suitable for quantitative research, and includes all the members of a population (Surbhi, 2017). All individuals within the simple sampling scheme have an independent and equal chance of being chosen for the study (Onwuegbuzie and Collins, 2007). The pre-survey was emailed to 137 BEMC students (the desired BEMC population), therefore the researcher aimed to enumerate each student registered on the BEMC programme. The post-survey was only emailed to those who attended the workshop, however this still followed a simple approach as the entire population attending each workshop received the post-survey link.

The size of the sample included the Bachelor of Emergency Medical Care (BEMC) students at the Cape Peninsula University of Technology (CPUT) within the Western Cape. This was a group sample out of a bigger population between the 4 Universities that offer the BEMC degree (University of Johannesburg [UJ] 112 students, Nelson Mandela University [NMU] 90 students and Durban University of Technology [DUT] 100 students). The three institutions namely UJ, NMU, and DUT were excluded from this study due to the narrow scope and logistical constraints of this study. The researcher also had direct access to the CPUT curriculum and sample to enable efficient data collection. Furthermore, inherent heterogeneity was associated with different institutions. CPUT has a bilateral agreement with the Western Cape Government Emergency Medical Services (WCG EMS), and findings of this study would be of mutual interest. The population of the study, as mentioned above, consisted of BEMC students. The sample size with a confidence level of 95%, and a population proposition of 50% was 101; this is illustrated by Figure 3, representing a screenshot of the calculator used online (Survey System, 1982). However, due to the historically reported low detection rates of child abuse cases (DGMT, 2015), the researcher used all 137 participants.

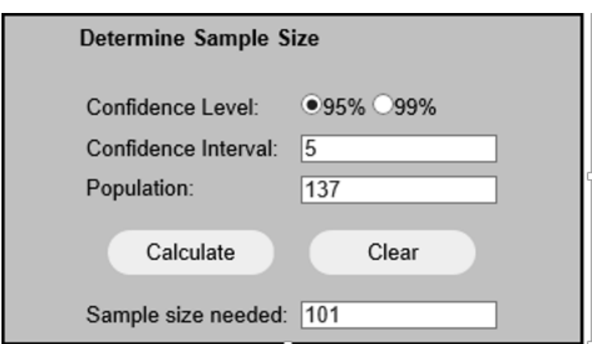


Figure 3: Sample size calculator (Survey System, 1982).

The second objective (1.7.2) to document and understand enabling and constraining factors for the implementation of the approved screening instrument among EC scholars involved BEMC1-BEMC4 (137 students). A self-administered online questionnaire with closed and open-ended questions was given to the participants which took 40 minutes of their time. This phase took 4 weeks to allow for individuals who missed class due to illness or other reasons, the opportunity to participate as well. Objective 1.7.2 could only be enquired into once objective 1.7.1 was completed.

The final objective (1.7.3) was to develop and implement educative interventions that promote the utilization of the approved screening instrument among EC scholars. As previously stated, BEMC1-BEMC4 students were the participants (137 students in total). This objective was achieved by formally embedding the screening instruments into the curriculum, considering consolidation or fragmentation of implementation and assessment criteria. The screening tool to be taught to participants was Screening Protocol for Abuse (Naidoo, 2017) [Appendix E]. The screening instrument was adjusted from a heavy focus on gender-based violence to be more enquiring about child abuse. This was then followed by an appraisal of the FISDAP® data 1 month after the training/sensitization intervention to detect any change in reporting frequency when compared to preceding years (5-year time span) and to the period prior to the intervention. This analysis observed patterns. Where reports post-intervention was made, those cases were appraised for completeness and screening utility. The implementation of objective three aimed to promote agency, patient safety, and regulatory compliance. Once objective 2 had been completed, objective 3 was set into motion and the duration was 4 weeks. An outline of the above-mentioned objectives can be seen in Table 1 below.

Workshops create rigorous education in a short time frame (Kansas University, 2019). Considering the time available to run the workshop is vital. A workshop can range from being an hour in duration to days or weeks depending on the objective (Kansas University, 2019). Short workshops are usually 45-90 minutes in duration whereas medium workshops can range from 90 minutes to 3 hours (Kansas University, 2019). Long workshops are classified as being over 3 hours in duration (Kansas University, 2019). The pedagogical model assumes that adults have a readiness to learn when they are assisted by a facilitator to identify the gap in their knowledge (Machera, 2017). All questions asked by students during a workshop environment provides an opportunity for growth and learning (Machera, 2017). Adult learners come with their own experience and the facilitator should not reject these experiences (Machera, 2017). The previous experience provides a foundation for subsequent learning and both parties, the learner and facilitator can learn from one another (Machera, 2017). Adults tend to be more problem-centered, thus they are eager to find solutions to these problems (Fry, Ketteridge and Marshall, 2015).

Table 1: Summary of objectives 1-3, including a timeline, who is involved, how objectives will be achieved and why/when.

Objectives (What)	**Who**	**How**	**Why?**	**When**
1. An appraisal of the status quo with regards to the implementation of the approved screening instrument among EC scholars	EC scholars: BEMC students – Group A and Group B over 5 year time span	FISDAP® archival data	To appraise existing implementation/ uptake of the child abuse screening instruments.	5 years (historical)
2. To document and understand enabling and constraining factors for the implementation of the approved screening instrument among EC scholars	BEMC 1-4 137 students	Self-administered Questionnaire with Closed and open-ended questions	To deduce and induce the risks, needs, and opportunities to respond to child abuse cases. To explain current uptake, enablers, and barriers to uptake and to	After objective 1 2-4 weeks

			infer what is possible.	
3. To develop and implement educative interventions that promote the utilization of the approved screening instrument among EC scholars	BEMC 1-4 137 students	Determine the probable missed case detection in the historical records. Use this finding to motivate participants to change practice. Develop critical case studies from contextual evidence that will serve to draw on participants lived experiences and affect. Focus group discussions on presented cases were facilitated with a view to consensus finding. This was followed by an appraisal of the FISDAP® data 1 month after the training/ sensitization intervention to detect any change in reporting frequency when compared to the same period in preceding years and to the period prior to the intervention. This analysis observed patterns. Where reports post intervention was made, these cases were appraised for completeness and screening utility.	Promote agency, patient safety, regulatory/ Protocol compliance.	After objective 2 2-4weeks

Within *Table 2: Questions for screening implementation (Joubert et al., 2010)* below, questions were asked to ensure that the screening tool which will be implemented is suitable and will prove to be valid.

Table 2: Questions for screening implementation (Joubert et al., 2010)

Questions	**Responses**
Is this an important public health problem?	Yes, mortality and morbidity studies confirm this
Do we know the natural history of the disease, with and without treatment?	Yes. Child Abuse is can cause children to become adults who abuse their children and so the vicious cycle continues. No treatment results in the poor quality of life, stress and premature death (Naidoo, 2017).
Is there an effective treatment?	Yes. Child helpline and child care centres are established to help the abused, as well as social workers.
Is the screening test valid and reliable?	The screening tool has been approved by the HPCSA
Is there a capacity to confirm and treat everyone diagnosed?	The Emergency Care student will be trained to screen for child abuse, as well as how to respond once abuse has been detected. Reporting detected cases will come from the students' in good faith; however, some cases may be missed.
Is there good evidence that such screening programmes have been effective?	Yes. The findings from Naidoo N, Artz L, Martin LJ, Zalgaonker M. (2014). 'A stitch in time…may save nine': A systematic synthesis of the evidence for domestic violence management and prevention in Emergency Care. African Safety Promotion Journal: A Journal of Injury and Violence Prevention (ASP).12(2),30-48
Will the programme be effective and cost-effective compared to other priorities?	Yes. Training expenses will be the only cost of pre-hospital services.

3.2.2.3. Workshop and focus group discussions

The workshop and the focus group discussions used simple purposive sampling. The researcher chose the purposive sampling strategy, because this strategy allowed her to select specific case scenarios which were relevant to the EC field and child abuse/neglect. The focus group discussions were transcribed by the researcher.

3.2.3. Analytical Frame: Archer's Morphogenetic cycle

Archer's Morphogenetic cycle as depicted in Figure 4, was used to analyse data. The morphogenetic cycle is used as a retrospective tool which explains social action (Mandikonza

and Lotz-Sisitka, 2016). T_1 indicates a point in time where social conditioning may begin. Within social conditioning, “agency is influenced by preexisting structural and cultural conditions” (Mandikonza and Lotz-Sisitka, 2016, p.6). Social conditioning criteria focused on structure and how constraint and enabling factors of change could be brought about. T_2-T_3 is a period in time which indicates social elaboration which includes the use of tools to bring about cultural mediation (Mandikonza and Lotz-Sisitka, 2016). Social elaboration criteria documents what needs to be done to bring about social change. T_4 indicates a point in time where structural elaboration takes place, whereby a particular structure is reproduced (Mandikonza and Lotz-Sisitka, 2016). Additionally, structural elaboration criteria within this thesis, determines whether a change to EMS education and social structure has occurred after the study has been completed (morphogenesis). In this case, EC training in the form of a training workshop was used to mediate cultural and social change through the three emergent properties for social conditioning namely; cultural emergent properties, people emergent properties and structural emergent properties.

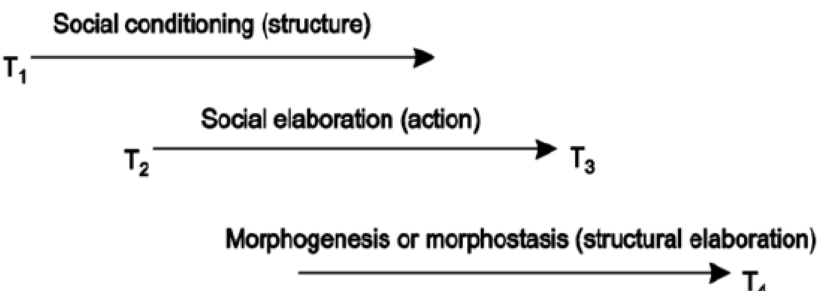


Figure 4: The morphogenetic cycle (Archer, 1995, p.157; Mandikonza & Lotz-Sisitka, 2016).

The study analyzed structural emergent properties (SEPs), cultural emergent properties (CEPs), as well as people’s emergent properties (PEPs) (Mandikonza and Lotz-Sisitka, 2016). SEPs assessed human and non-human resources such as rules, guidelines, and regulations. Accordingly standard of practice, laws pertaining to violence and diagnostic screening

instrument was appraised. CEPs evaluated[16] the relationship between people, and within this study CEPs focused on the relationship between EC providers and victim of child abuse. Where no prior child abuse experience was had, the child abuse cases presented would suffice. Hence CEPs involved child abuse diagnostic intervention training workshops. Lastly, PEPs focused on the nature of personal interactions and relations. PEPs recognize that a person exists in a society with other people (Mandikonza & Lotz-Sisitka, 2016), therefore whatever decision is made by an individual will influence that individual's interaction with other persons. On the assumption that EC providers have the latent capacity to influence the reporting of child abuse cases learning (in EC) was mediated by the use of physical and semiotic artifacts (Mandikonza & Lotz-Sisitka, 2016). Semiotic artefacts is used within social semiotics and refers to a means of making meaning (Bezemer, Yandell and Leeuwen, 2004). Semiotics refers to the philosophical theory which uses symbols and signs dealing with their functions (Webster, 2018a).

The methods included theory, protocol, and practice and the investigation of how the EMS curriculum gave expression to the needs that emerge from practitioners/BEMC students' lived experiences. Figure 5 below shows the (linear) relationship between the three components. The Red Cross indicates where this study was located. The researcher investigated how EMS curriculum/protocol/policy gives expression to lived experiences in clinical practice, thereafter; Archer's morphogenetic cycle theory was used as an analytical tool to provide an explanation of the data to make meaning of findings, within the context of the socio-cultural theory.

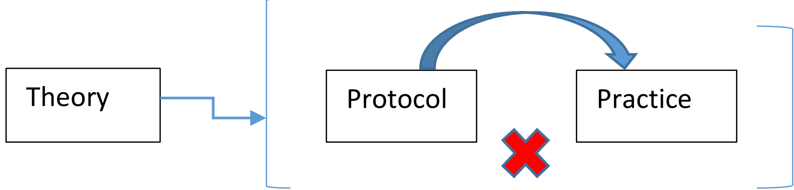


Figure 5: Illustration of the relationship between theory, protocol, and practice

[16] Note that any reference to evaluation is in the context of the critical sociology paradigm; and not in the positivist paradigm. It is the subjective nature of practitioner experiences that I seek to document and not necessarily an objective quantification of success or failure of policy implementation.

3.2.4. Data Analysis and Interpretation

The theoretical lens used to frame this study topic and underpin its analysis was Critical Sociology, with the analytical frame being that of Archer's morphogenetic cycle. Critical sociology critiques cultures and society through the knowledge of humanities and social sciences (Oer, 2018). The theoretical lens of Critical Sociology coheres well with the paradigm of critical pragmatism as it considers cultural development (Ulrich, 2012). Hence, there is coherence between critical sociology and the paradigm of critical pragmatism.

3.2.4.1. FISDAP® Archival data

The retrospective archival data was retrieved from FISDAP® by the researcher's two research assistants (Mr C Chippe and Mr T Naidoo). The researcher compiled a document with step by step illustrations on how to retrieve the data from FISDAP®, which was provided to the research assistants (Appendix O). The archival data was entered into Excel and a statistician analysed the FISDAP® data using 'R' statistical software® and DescTools® for implementing the Cochran-Armitage Trend Test. Fischer's Exact test was also used as well as a regression model.

Fisher's Exact Test, tests for any association between the before and after frequencies vs. the null hypothesis of independence (Team, 2019). Cochran-Armitage Trend Test tests for a directional association between the before and after frequencies, and is thus only relevant for ordered factors (i.e. where the categories can be ranked in some logical increasing order) (Al, 2019). A 5% significance level is used, so relationships are deemed statistically significant only when p-values are < 0.05.

The regression analysis was used as a method in order to identify which variables have an impact on the child abuse topic (Foley, 2018). A regression model allows one to determine which factors can be ignored, which factors are important and how both these factors influence one another (Foley, 2018). The dependant variable used was probable "missed" child abuse cases and the independent variables were age, gender and injury. These three variables were selected as the researcher wanted to see which age group between 0-18 years of age has the highest probable "missed" child abuse cases. Furthermore, by knowing the age, it can be linked to the type of injury sustained by the child. The researcher chose to include gender to

eliminate the stereotype that girls are abused more than boys. In addition to the abovementioned, expert consensus agreed that these three variables would provide robust data.

3.2.4.2. The responsivity questionnaire and educative training workshop intervention

All quantitative data was auto-translated from Google forms to Excel. This was cleaned and statistical analysis was conducted by a statistician. In order to interpret the qualitative information, the open-access computer program Freemind® was used to synthesize the data toward an analysis. This provided for a transparent data handling and analysis process. All open-ended questions were logged onto Freemind® followed by manual coding. Pre- and post-survey questions were analyzed using 'R' statistical software® and DescTools for implementing the Cochran-Armitage Trend Test.

Freemind® is an open source mind-mapping software program which is written in Java (Kumar, 2008). This tool is used by placing a topic in the middle of the mind-map and branching out with related ideas (Kumar, 2008). This form of mind-mapping software can be used to conceptualize ideas with a simple and intuitive interface (Kumar, 2008).

3.2.5. Limitations and de-limitations of the study:

The traits of participants were not consistent. EC providers did not all have the same demographics, there were mixed ages, genders, and race. The number of participants dropping out of the study could not be controlled as it was voluntary and at any time if participants felt uncomfortable or wanted to remove themselves from the study they could do so. Only one individual completed the screening tool, this was due to shift placement not involving a higher frequency probability of child-related emergencies, time constraints and the competing academic interests of the participants. When viewing the retrospective 'proxy' data, the researcher did not include motor vehicle accidents as an inclusion criterion for probable "missed" cases. The nuance was that the researcher could not tell which parents acted negligently and did not buckle up their children. On the basis that many children do suffer injuries with or without restraints in car accidents, injury is likely to occur. These MVA figures are probably conservative. Thus conservative figures are de facto neglectful and would skew the data from other forms of neglect and abuse. On this basis, the researcher excluded it. If

the researcher was able to discriminate MVA injury judiciously, cases of neglect would increase considerably. Furthermore, the researcher did not have control over which cases were duplicated between shift partners. This was not a problem as the researcher did not focus on the exact amount of cases per say but rather on the probable “missed” cases.

Anonymity was thought necessary in this research in the interest of group harm reduction or medico-legal implication. FISDAP® data was anonymous as the database accessed lacked identifiers. This database provided a great deal of rigor and accountability. Self-administered questionnaires were anonymous. The online survey did not have any names linked to participants, blinding the researcher to the identity of the author.

Training used the blended learning[17] approach. The value of this was multiple modes of teaching and learning. This addressed any pedagogic biases which the researcher may have as a teacher. The training used a team approach with co-facilitators to hold the researcher to account and avoid overexposure. The researcher was not the examiner of the students for an exam, thus no risk of cohesion was present. The researcher had a bias towards human rights promotion and the protection of children from child abuse. The participants, as registered EC students with the HPCSA, had the same ethical obligations.

Inconsistency from the research assistants/participants and the risk of them being affected by engaging with child abuse material would have been counter-productive to the study. Counseling was made available to students as well as research assistants if they experienced any negative effects from the study and felt they needed to speak to someone [see Appendix G and H]. The reporting procedure was in line with the general learner guide to allow the department every opportunity to resolve complaints or adverse events. The researcher took full responsibility to refer the participants to student counseling, however, participants had the responsibility of self-reporting to researcher or student counseling in the interest of autonomy. Refer to Figure 6 below for the reporting procedure pathway. The green block is the ideal

[17] Blended learning refers to the teaching practice of using both face-to-face and online learning experiences (Reform, 2013). Thus for this study the blended learning approach involves the diagnostic screening instrument training aspect (face-to-face) and the online data capturing tool FISDAP®. This may also be referred to as hybrid learning or mixed-mode learning (Reform, 2013).

primary pathway for reporting, whereas the purple block is the secondary pathway for reporting and should only be followed if the primary pathway did not work. The blue solid arrows indicate the pathway of reporting, the participant could report directly to student counseling, researcher or their class representative and then follow the chain of hierarchy namely year coordinator, HOD and Dean. The orange stippled arrow is direct reporting to the researcher from the hierarchy members.

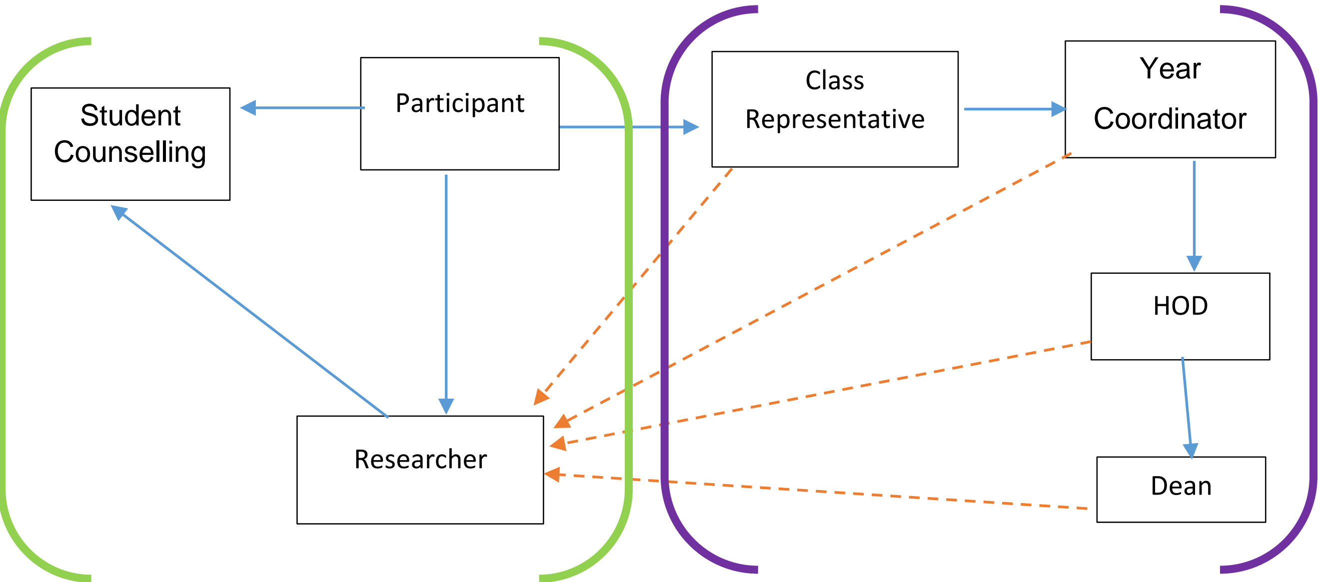


Figure 6: Reporting procedure

As a researcher of child abuse, the researcher herself may be at risk of vicarious traumatization. As a master's student, she was also entitled to the same counselling benefit. The limitation, however, was that in both cases it must be self-reported. In the interest of her own wellbeing, she undertook to voluntarily seek counselling at an appropriate time or after data collection. She would advise participants to do the same.

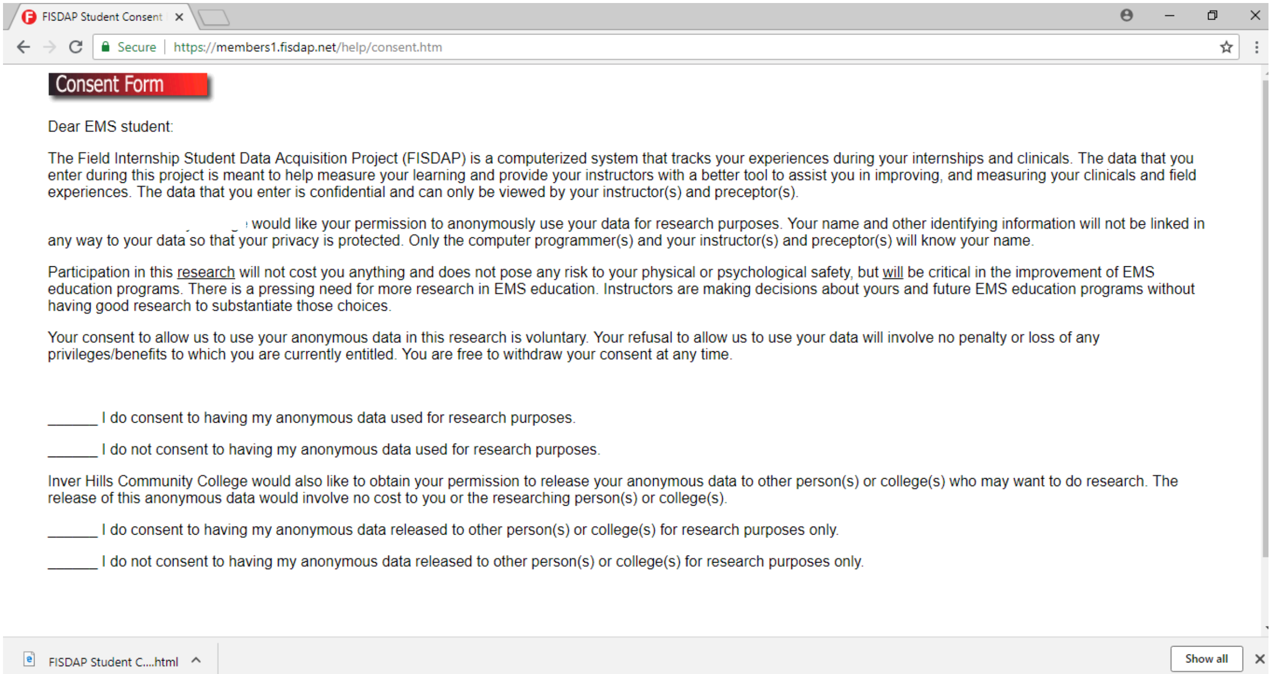
The risk of group harm may be present in that should the study find participants are deficient in screening for child abuse that this deficiency may accrue to the group i.e. the paramedic fraternity. This risk, however, is greater in the graduate population where the expectation for child abuse screening competence is higher. The student population presents a reduced risk of group harm in that student practitioners are professionals in the development and are

expected to have areas of growth for professional practice

3.3. Ethical Considerations

In relation to clinical care, ethical decision making provides limited options within the prehospital field (Kenneth, 2007). The biggest problem which occurs is that EC providers do not realize the ethical realism but rather view the medical realism (Kenneth, 2007). In addition to this, there is a misperception of ethics as to what worldly or religious laws command (Kenneth, 2007). Technical decisions and interventions are scientifically validated and protocol is driven (HPCSA, 2004). On the other hand, ethical decisions involve thought processes and judicious deliberation (HPCSA, 2004). Ethical decision-making relies on a practical structured approach within the EC environment (HPCSA, 2004), this applies to all treatment of patients, namely trauma or medical. Informed consent involves disclosing adequate information to a competent individual allowing the individual to make their own decision as to accept or refuse what is being proposed to them (De Bord, 2014). This is complex when the caregiver is the custodian and the abuser.

In relation to health research, all participants must be informed about the research they will be participating in (De Bord, 2014). The participants must also be informed about the limits of confidentiality, such as sharing of information, archiving or data coding (De Bord, 2014). Participants must also be allocated a contact number that they have access to in case any questions may arise concerning the research which they are partaking in (De Bord, 2014). All participants received a letter/consent form acquiring their consent to part take in the study, undergo training and thus the use of their FISDAP® data as well as undertake a self-administered online survey/questionnaire before and after the training [see Appendix C &D]. Page 1 of the user agreement on FISDAP® states the terms and conditions, the students agree for data to be used for research purposes by default when signing up for FISDAP®. Notwithstanding, informed consent was attained from all participants. The consent form for FISDAP® is shown in Figure 7 below.



FISDAP Student Consent

Secure | https://members1.fisdap.net/help/consent.htm

Consent Form

Dear EMS student:

The Field Internship Student Data Acquisition Project (FISDAP) is a computerized system that tracks your experiences during your internships and clinicals. The data that you enter during this project is meant to help measure your learning and provide your instructors with a better tool to assist you in improving, and measuring your clinicals and field experiences. The data that you enter is confidential and can only be viewed by your instructor(s) and preceptor(s).

would like your permission to anonymously use your data for research purposes. Your name and other identifying information will not be linked in any way to your data so that your privacy is protected. Only the computer programmer(s) and your instructor(s) and preceptor(s) will know your name.

Participation in this research will not cost you anything and does not pose any risk to your physical or psychological safety, but will be critical in the improvement of EMS education programs. There is a pressing need for more research in EMS education. Instructors are making decisions about yours and future EMS education programs without having good research to substantiate those choices.

Your consent to allow us to use your anonymous data in this research is voluntary. Your refusal to allow us to use your data will involve no penalty or loss of any privileges/benefits to which you are currently entitled. You are free to withdraw your consent at any time.

______ I do consent to having my anonymous data used for research purposes.

______ I do not consent to having my anonymous data used for research purposes.

Inver Hills Community College would also like to obtain your permission to release your anonymous data to other person(s) or college(s) who may want to do research. The release of this anonymous data would involve no cost to you or the researching person(s) or college(s).

______ I do consent to having my anonymous data released to other person(s) or college(s) for research purposes only.

______ I do not consent to having my anonymous data released to other person(s) or college(s) for research purposes only.

FISDAP Student C....html

Show all

Figure 7: Screenshot from FISDAP® website showing the user agreement for students

FISDAP® data was completely anonymous as stated previously. This is necessary to avoid risk of any medico-legal implication and group harm. The data capturers retrieved reports and whilst doing so, selected the “Anonymize data” block to ensure complete anonymity. Figure 8 below illustrates a screenshot of the page; the red arrow indicates the block which must be selected by the researcher or data capturers.

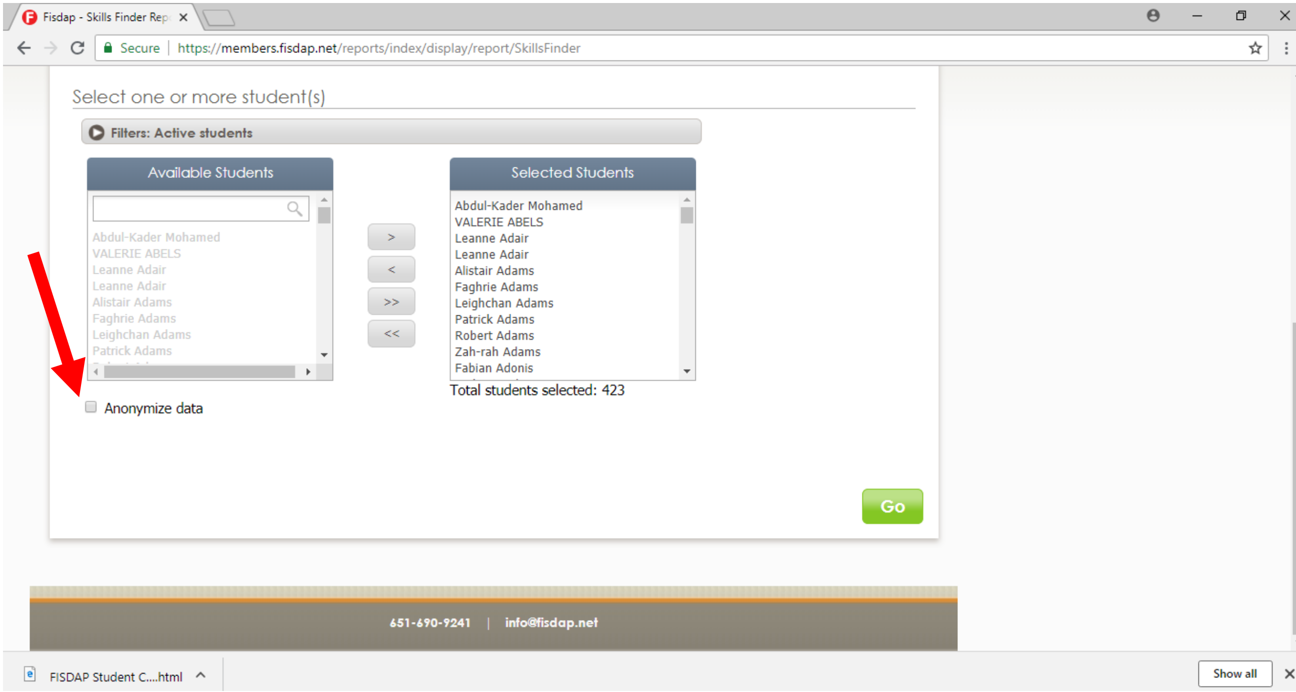


Figure 8: Screenshot of FISDAP® Report Evaluation and anonymity

3.3.1. Institutional Approval

Approval for the research study was obtained from the Ethics Committee of the Faculty of Health Sciences of the university (CPUT/HW-REC 2018/H29). There were no adverse events or complaints during the duration of the study. Risk of vicarious traumatisation and any realisation of prior victimisation were ethical risks addressed under limitations above. Apart from enduring ethics approval, the researcher is a registered emergency care practitioner at the HPCSA. She is professionally obliged to conduct herself ethically at all times. Participants will be aware of this obligation and their right to report any adverse event or ethical misconduct. The researcher's supervisors are experts in EMS and education and she undertook to raise any ethical dilemmas with them for guidance.

3.3.2. Informed Consent

Informed consent was attained from all participants, and online surveys were anonymous. Participants were provided with an information sheet providing a brief overview of what the study entails and what their role would be (refer to Appendix C and D).

The researcher ensured that each data collection platform had informed consent from the students. When students register on FISDAP®, a user agreement is provided for consent. Nevertheless, the researcher gave students the option to withdraw their archival data (no withdrawals occurred). Informed consent documents were handed out to each student for the pre- and post-workshop survey, as well as the focus group discussion. All of the consent forms were kept safely in a locked safe to which only the researcher and her supervisors had access to.

3.3.3. Right to Privacy and Confidentiality

In order to ensure confidentiality and anonymity, the online survey was anonymous and no names were recorded. The data which was sent for statistical analysis did not contain any personal information such as names or personal identifiers. All documents were kept confidential and only the researcher and supervisors had access to the information. All collected data from the focus group discussions were stored on an external hard drive which was locked in the safe and in transit was then locked in a bag with a padlock.

Recruitment did not involve any unfair inclusion/exclusion in that a simple approach was used. Students who wished not to participate exercised their right not to, without reprisals. As the training workshop content presented curricular objectives, participants could choose to attend only the training workshop and still deny permission for any of their data to be used. The researcher facilitated such respect for autonomy. During the training workshop, due to the communal nature of the workshop, a commitment to confidentiality within the group, in the form of a non-disclosure agreement was set in place. Complete anonymity, however, became improbable in a training workshop setting.

3.4. Dissemination Strategy

This research study should be accessible to all which will benefit from the research at hand. Furthermore, the content of this study should also be disseminated to educational institutions offering similar BEMC programs. All students enrolled within the Emergency Medical Care field should be allowed access to this study. The HPCSA as a policy maker should receive a copy so that they can be informed about the pros and cons of health care practitioners and child abuse. By disseminating this research study to the HPCSA, they can be granted the

opportunity to inform new policies and promote new actions. In addition publications and conference proceedings will be targeted as dissemination opportunities.

3.5. Summary:

The paradigmatic lens was that of critical pragmatism. The researcher chose to follow a concurrent mixed-methods approach as she required both quantitative and qualitative data to hear the 'voice' of the students and to be able to interpret their lived experiences which have been documented. By conducting the mixed-methods approach, the researcher was able to make connections between quantitative and qualitative data. The quantitative methods obtained from archival FISDAP® data generated findings through nonprobability-purposive sampling. A simple sampling strategy was followed for the pre- and post-survey. Additionally, a purposive sampling strategy was used for the workshop and focus group discussions.

Four main instruments were adapted in this study. Firstly the Child Abuse Responsivity Questionnaire was adapted for child abuse specificity, with permission from the author who developed the domestic violence responsivity survey. The survey of this thesis was piloted and enabled statistically significant findings that are documented in Chapter 4. The FISDAP® archival data were based on medico-legal records of each patient encountered by the students. The gender based violence screening intervention (which is approved and validated by the HPCSA), was adapted for child abuse and neglect screening. The case scenarios were constructed by the researcher using real life scenarios to show relevance and severity of child abuse/neglect. The researcher did not receive any reports of ethical breach for the duration of the study. In addition the lesson plan for the workshop also constitutes an instrument [see Appendix F, J, K and N].

Chapter 4 which follows, presents the quantitative and qualitative results which emerged from various data collection techniques. The results are then discussed comprehensively within Chapter 5.

CHAPTER 4: Qualitative and Quantitative Data

4.0 Introduction

In this chapter, the results of each method employed in the pursuance of the study objectives, are presented. This is intended to give transparency and show the nuance of the methods concerned. The methods are Archival Research (QUAN), Focus Group Discussions (QUAL), pre- and post-intervention surveys (QUAN). The relationship of the methods to the objectives is displayed in Table 3. Regarding the analytical frame, the gaze of Archer's morphogenetic cycle is used to make meaning of these results, the explications of which are to be found in Chapter 5 (Discussion).

Table 3: Coherence between objectives and methods

OBJECTIVE	METHOD
1.7.1 To survey the EC student cohort for knowledge, attitudes, and beliefs of child abuse antecedent factors, interventions and consequences.	Pre-workshop Survey , and Post-workshop Survey (QUAN)
1.7.2 To develop and implement an educative intervention that promotes the utilization of the approved screening instrument among EC scholars.	Training workshop with Focus Group Discussions (QUAL)
1.7.3 To analyze reflective FISDAP® reports before and after educative intervention for self-reported narratives on child abuse screening successes or challenges.	Archival research (Group A and Group B graduates) (QUAN)

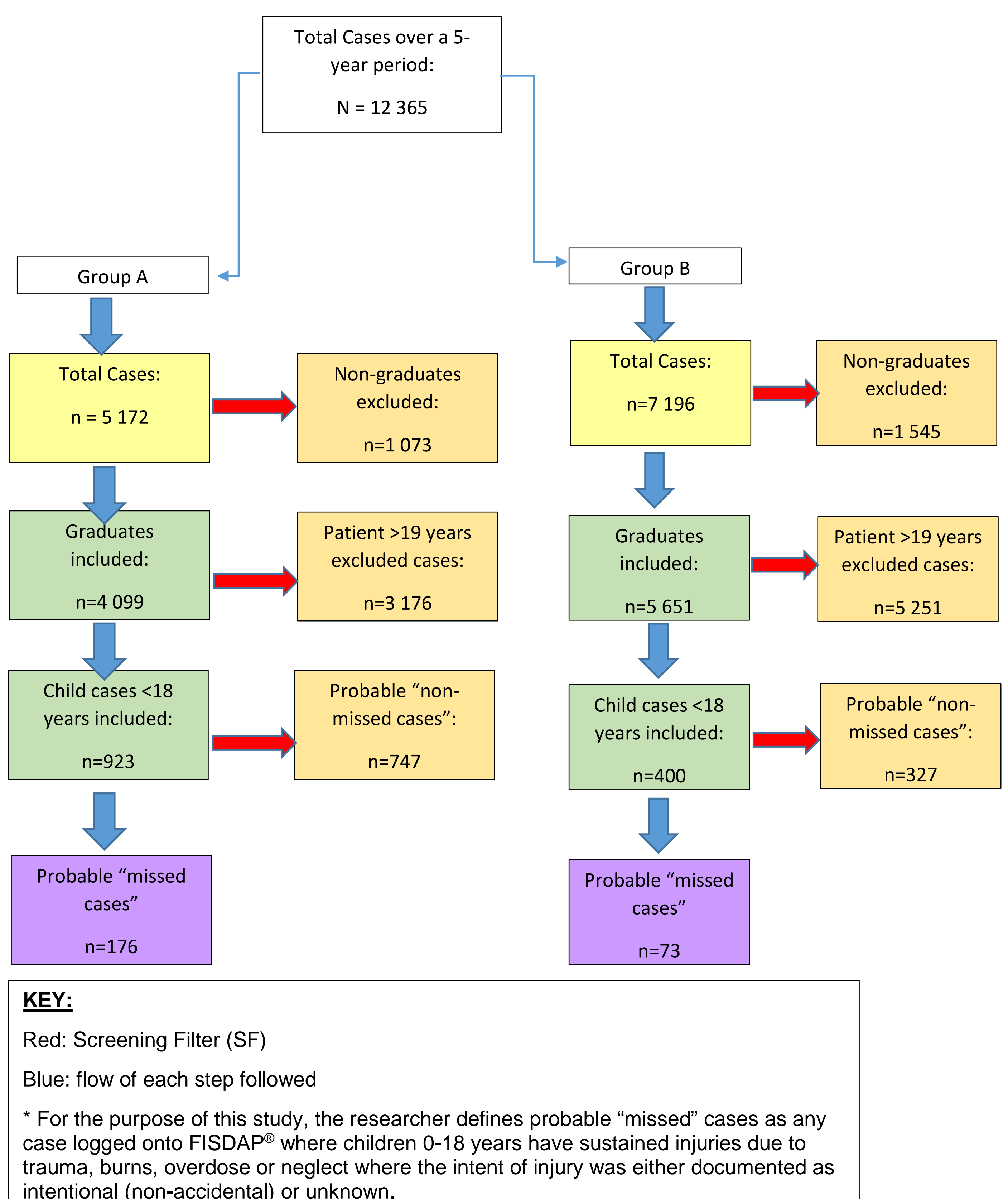
4.1 Group A and Group B Archival FISDAP® Data

Group A had a total of 27 participants registered on the course (with a combined exposure of 5172 patient cases) however only 23 participants graduated (with a combined exposure of 4099 patient cases). The remaining 4 participants (with a combined exposure of 1073 patient cases) were excluded for further review. After applying the selection criteria (screening filter),

only 923 child cases were identified. These cases were then further filtered using the researcher's definition of "missed" cases. By doing this, 176 cases were identified as probable "missed" cases of non-accidental injury, abuse or neglect over the four years of study. Thus Group A had a total of 19% probable "missed" cases throughout their 4-year undergraduate study.

Group B had a total of 28 registered participants. Of these 28 participants (with a combined exposure of 7196 patient cases), only 23 were graduates (with a combined exposure of 5651 patient cases). The 5 participants who were unsuccessful at graduating (with a combined exposure of 1545 cases) were excluded from further review. Screening filter for child cases aged 0-18 years of age occurred and only 400 cases were identified. The second round of screening filter occurred to screen for probable "missed" cases as per the criteria and 73 probable missed patient cases were identified over four years. Thus Group B had a total of 18% probable "missed" cases.

Their historical records for the previous 4-years prior to graduation were included in the study. The following description considers the clinical interactions with actual cases in the field and sought to filter the exposure to child cases in the field as well as in hospitals where clinical practice exposure occurred. This sample excluded reports of simulated cases in the class room. The researcher noted that duplicated cases could be reported as shift partners could both have reported on the same patient; however, this is not a limitation as the factor under analysis is participant exposure to at-risk patients and not the frequency of at-risk patients. It is entirely possible for the same patient to present serially or repeatedly, given the serial and protracted nature of abuse and neglect (Middleton, Sachs and Dorahy, 2017). The only criterion required was that the participants had to be registered on the academic program. In Figure 9 below, the process of archival data collection is depicted.



KEY:

Red: Screening Filter (SF)

Blue: flow of each step followed

* For the purpose of this study, the researcher defines probable “missed” cases as any case logged onto FISDAP® where children 0-18 years have sustained injuries due to trauma, burns, overdose or neglect where the intent of injury was either documented as intentional (non-accidental) or unknown.

Figure 9: Flow diagram indicating the process of archival data collection for Group A and Group B

The nature and types of cases had a wide variation from poisoning to drowning. The most frequent type of medical condition was a respiratory complaint (235 in Group A and 105 in Group B). The least common patient presentation was bites and stings (4 in Group A and 1 in Group B) as well as drowning (1 in Group A and 0 in Group B). Group A reported 18 cardiac cases, whereas Group B reported 11. When looking at obstetrics and gynaecology, Group A had 46 cases and Group B had 14. The number of cardiac cases in group A was 18 and Group B was 11. Sepsis and infection resulted in 37 cases for group A and 16 cases for Group B. Table 4 below illustrates the different types of incidents that were encountered by participants on their shifts and logged onto the FISDAP® platform.

Table 4: Types of Incidents Encountered

The categorisation of child-patient presentations	Group A n=923 cases included	Group B n=400 cases included	TOTAL (N=1323)
Medical			
Overdose / Poison	13	6	19
Other Medical	144	40	184
Behavioural / Psychiatric	4	3	7
Obvious Death (Medical)	12	1	13
Abdominal Pains	45	12	57
Allergic Reactions	10	9	19
Cardiac	18	11	29
Hypovolemic Shock	12	6	18
Neurological	89	48	137
Obstetrics and Gynaecology	46	14	60
Respiratory	235	105	340
Sepsis and Infection	37	16	53
Bites and Stings	3	1	4
Not-Described	38	10	48
Healthy Screening	26	0	26
Trauma			
Extremities	55	30	85
Multi-systems	17	18	35
Head	52	39	91
Chest	16	8	24
Abdomen	3	2	5
Back and Neck	11	8	19
Burns	36	13	49
Drowning	1	0	1

When looking at the frequencies of probable “missed” cases, Group A had a total n = 176 and Group B had a total probable “missed” cases n = 73. The frequency of non-missed cases for Group A was n = 746 and for Group B, n = 326. The data is depicted in Figure 10: Suspected Missed Child Abuse Cases, Group A vs. Group B below.

Analysis of Filtered FISDAP Case Data, Group A and Group B

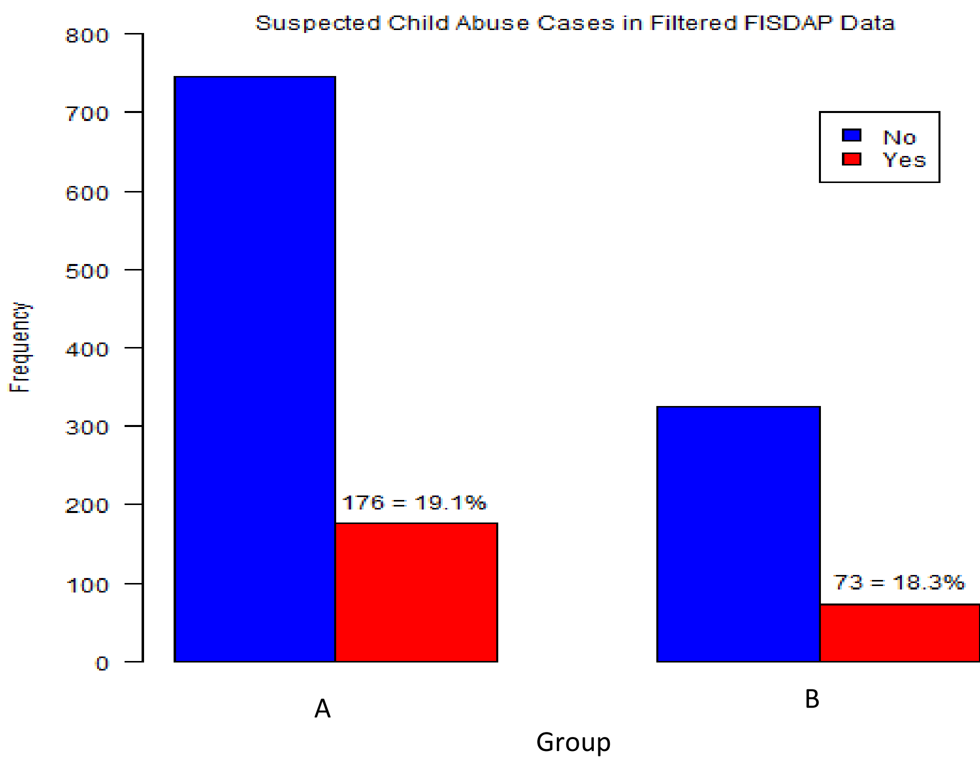


Figure 10: Suspected Probable “Missed” Child Abuse Cases, Group A vs. Group B

To determine the association of probable “missed” case or not WITH age, gender, and injury type of children, a logistic regression model was used shown in Table 5: Output for Logistic Regression on Probable “missed” Cases

Table 5: Output for Logistic Regression on Probable “Missed” Cases

Variable	Coefficient Estimate	Standard Error	*z* Statistic	Significance *p*-value
Intercept	-3.20388	0.25192	-12.718	$< 2 \times 10^{-16}$
Male	0.12016	0.21700	0.554	0.580
Age Years	0.08969	0.01606	5.586	2.32×10^{-8}
Trauma	3.24261	0.22066	14.695	$< 2 \times 10^{-16}$
Year2018	-0.81932	0.22206	-3.690	2.25×10^{-4}

The response variable in the logistic regression was ‘Child Abuse Suspected’ (Yes vs. No). Gender was *not* a statistically significant predictor of missed child abuse cases. However, age, case type (trauma vs. medical), and year (2018 vs. 2017) were all statistically significant predictors at a 5% significance level. The coefficient estimates can be interpreted as odds ratios as below. Odds refer to the ratio of the probability that an event happens to the probability that an event does not happen. In our case, the event of interest is that a case attended by the student is a missed child abuse case. Thus:

$$Odds(\text{case is a missed child abuse case}) = \frac{\Pr(\text{case is a missed child abuse case})}{\Pr(\text{case is not a missed child abuse case})}$$

With respect to age, A: $e^{0.08969} = 1.0938$. Thus, for every one-year increase in the child’s age, the expected odds of a case being a missed child abuse case increase by 9.38%. **Thus, in general, the older the child, the higher the risk of a missed child abuse case.**

With respect to Trauma: $e^{3.24261} = 25.6005$. Thus, the expected odds of a case being a missed child abuse case are 25.6005 times as much if the case is classified as ‘trauma’ compared to if the case is classified as ‘medical’. Thus, in general, the risk of a probable “missed” child abuse case is far greater with trauma cases than with medical cases.

With respect to Year effect: $e^{-0.81932} = 0.4407$ or $e^{0.81932} = 2.2690$. Thus, the expected odds of a case being a probable missed child abuse case in Group B was 0.4407 times as much as the expected odds of a case being a probable “missed” child abuse case in Group A. Put differently, the expected odds of a case being a probable missed child abuse case in Group A was 2.2690 times as much as the expected odds of a case being a probable missed child abuse case in Group B. Thus, the risk of a probable “missed” child abuse case is lower in Group B compared to Group A.

The Year effect appears to be very slight in the bar graph in Figure 10 since the percentage of probable “missed” child abuse cases in Group A and Group B are nearly the same. However,

one reason why the percentage was almost as high in Group B was that the rate of trauma cases was much higher in Group B (see below). Once this is taken into account (as the logistic regression model does), the risk of a probable “missed” child abuse case is seen to have been considerably higher in Group A than Group B.

Prehospital presentations of paediatric cases presented as a burden of ‘trauma’ or ‘medical’ cases as broad generalisations or as EMS dogma. The medical burden appears disproportionate. This may be a function of the sampling bias inherent in the participant exposures in the different years. In Group B, participants mostly undertook clinical practice on weekends whereas, in the preceding year, they experienced clinical rosters over several weeks at a time. The frequency probability of medical and trauma emergency cases (whilst erratic) are likely to be affected by day and time of the week (and related risk factors), among other determinants of medical and trauma cases.

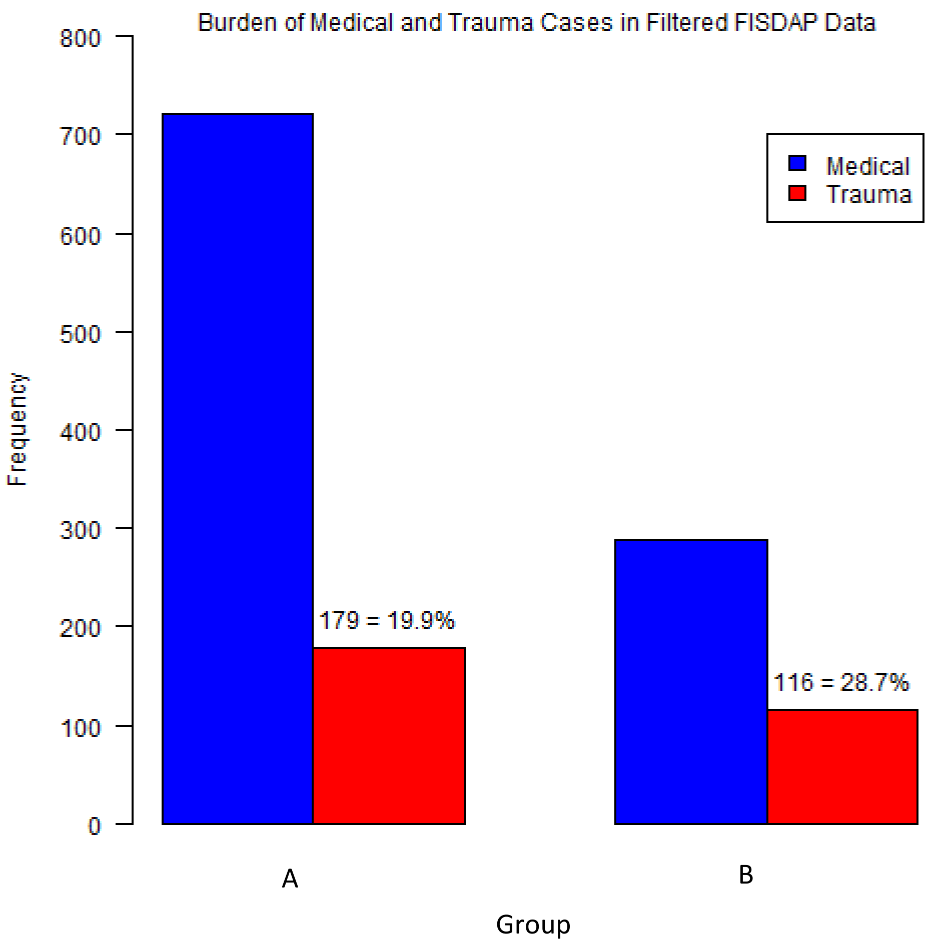


Figure 11: Burden of Medical and Trauma Cases, Group A vs. Group B

Trauma that is intentional or unintentional is another worthy factor of analysis. Group A's intent of injury was n = 50 intentional, n = 21 unintentional and n = 105 unknown. Group B's intent of injury was n = 29 intentional, n = 43 unintentional and n = 15 unknown. It is of concern that the intent behind injury carries a large proportion of unknown cases as depicted by Figure 12: Trauma Cases by Intent of Injury, Group A vs. Group B

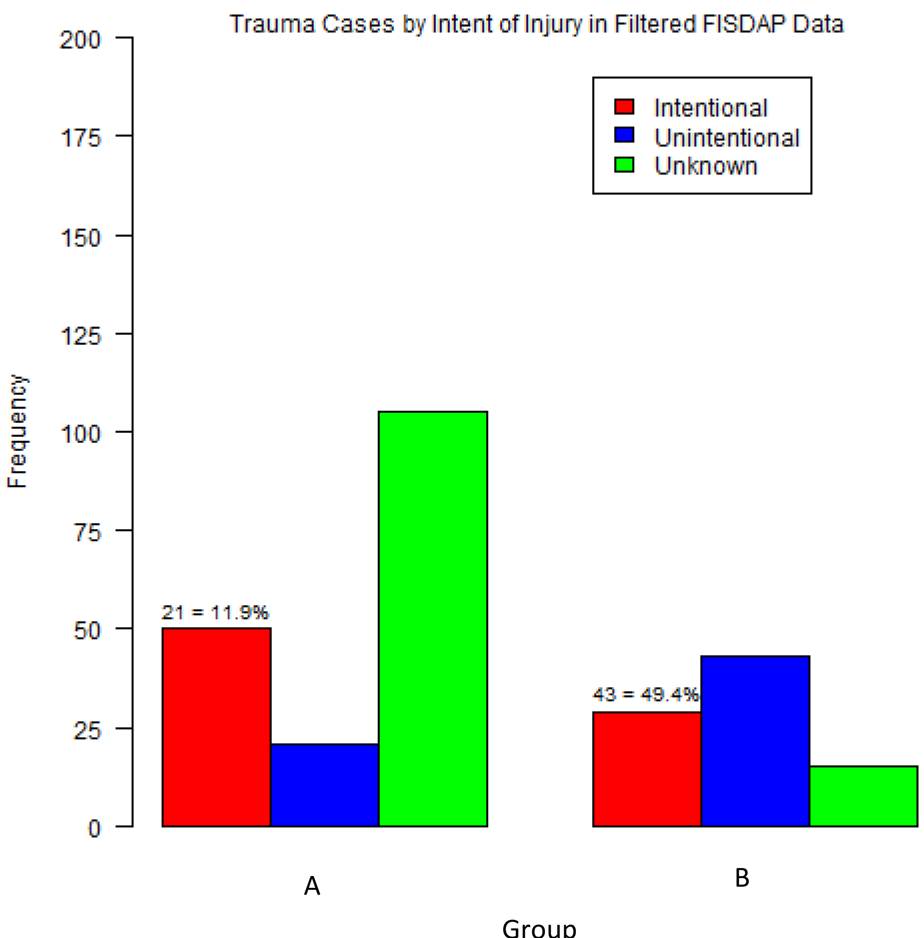


Figure 12: Trauma Cases by Intent of Injury, Group A vs. Group B

A summary of the archival data findings and the correlating objective as well as the method used is illustrated below in *Table 6: Summary of Archival data in relation to objective and method used.*

Table 6: Summary of Archival data in relation to objective and method used

OBJECTIVE	METHOD	FINDING
To analyze reflective reports before and after educative intervention for self-reported narratives on child abuse screening successes or challenges.	Archival data (Group A and Group B graduates) QUAN	Group A: 19% "missed" cases Group B 18% "missed" cases

The above documents an alarming probable missed case detection of almost 1 probable case of abuse or neglect of every 5 cases of children presenting to EMS cadres.

4.2 Focus Group Discussion Findings

The training workshop aimed to educate and create awareness so that participants can comprehend that child abuse happens to all individuals, not only to certain cultural or ethnic groups. The training workshop also provided information to participants so as to increase the level of CA detection amongst emergency care cadres and thereby decrease child abuse missed cases. Finally, the training workshops intended to equip participants with knowledge in order to use a child abuse screening tool. CA Cases 3 and 4 are excluded from the findings presented here as insufficient data resulted from these two cases. This may have been due to the nature of the cases being difficult to answer and too little detail was found and presented on each case during case construction.

For the focus group discussion training workshop intervention was conducted so as to encourage individual participation and inclusivity. It became a safe space for sharing of direct or indirect experiences and vulnerabilities. Working in groups promoted participation and offered protection against any vulnerability. The layout of the FG training workshop followed Bloom's Taxonomy. Objectives were stated to establish a pedagogical interchange between researcher and participants alike, ensuring that the purpose of the training workshop was understood (Vanderbilt, 2017). By implementing objectives, the researcher could plan and deliver appropriate instructions to the participants attending the FG training workshop as well as ensure that instructions and post FG training workshop surveys are aligned with the objectives (Vanderbilt, 2017). Data captured (transcribed by the researcher) during focus group discussions can be found in Appendix N.

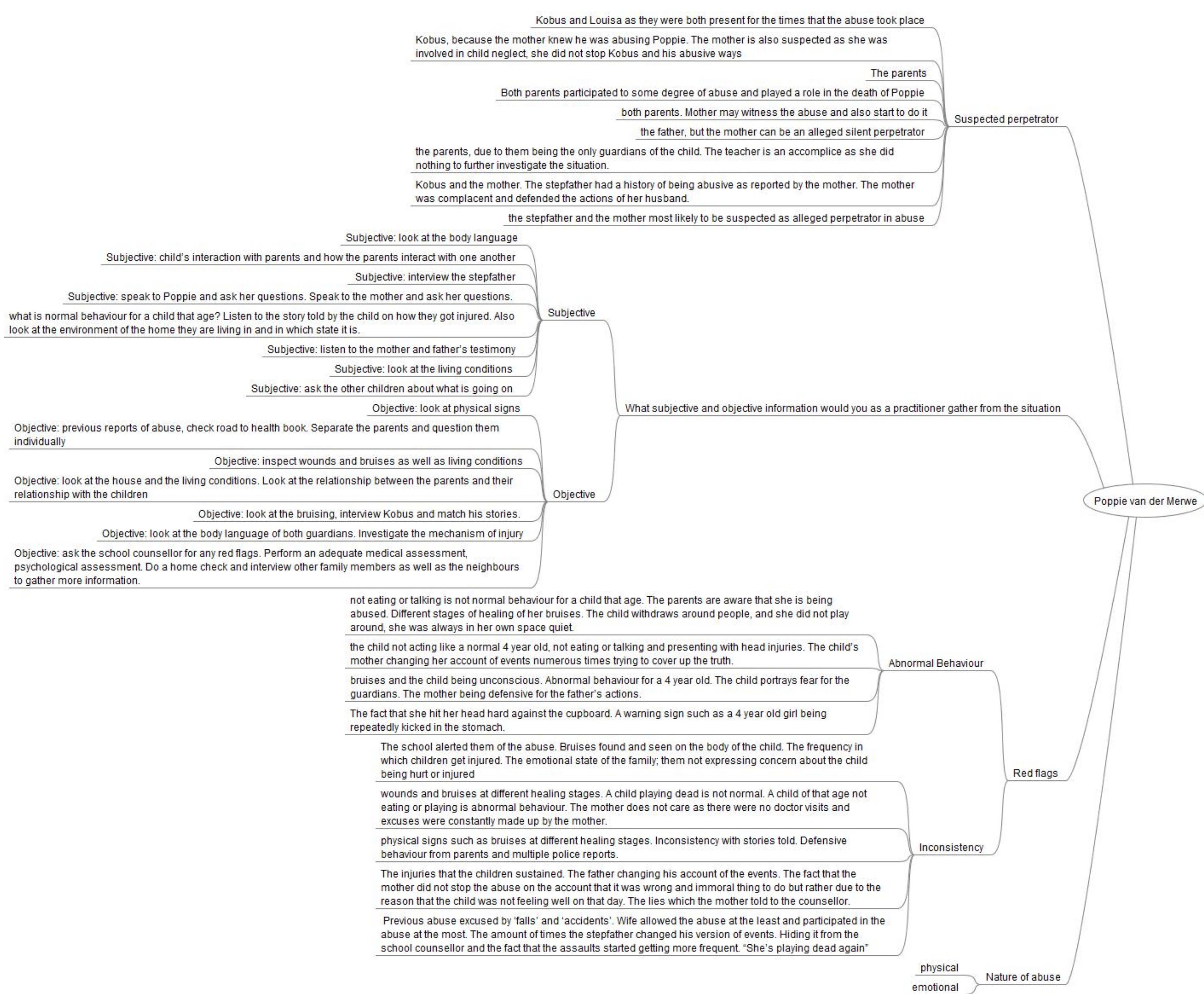


Figure 13: Poppie van der Merwe focus group discussion result

Hamzah Khan

Suspected perpetrator?

- The mother as she was the only one whom lived in the house with her children. There could also be a long term abuse within the family.
- The mother, because it is her house, and she is the primary guardian.
- The mother, because she neglected the child
- The mother would be the most probable, but other options such as family members can also be explored
- The parent or guardian of the child
- The mother
- The mother, the child's older brother specifically mentioned the mother abusing them. The police as accomplices as they had knowledge of what was happening but did not do anything about it
- The mother, it is a parents' responsibility to care for their child to the best of their ability, this includes medical care and feeding their child.
- the mother, because she did not report any abuse to her child.

What subjective and objective information would you as a practitioner gather from the situation?

Red Flags?

nature of abuse?

- physical
- emotional

Figure 14 a: Hamzah Khan focus group discussion results

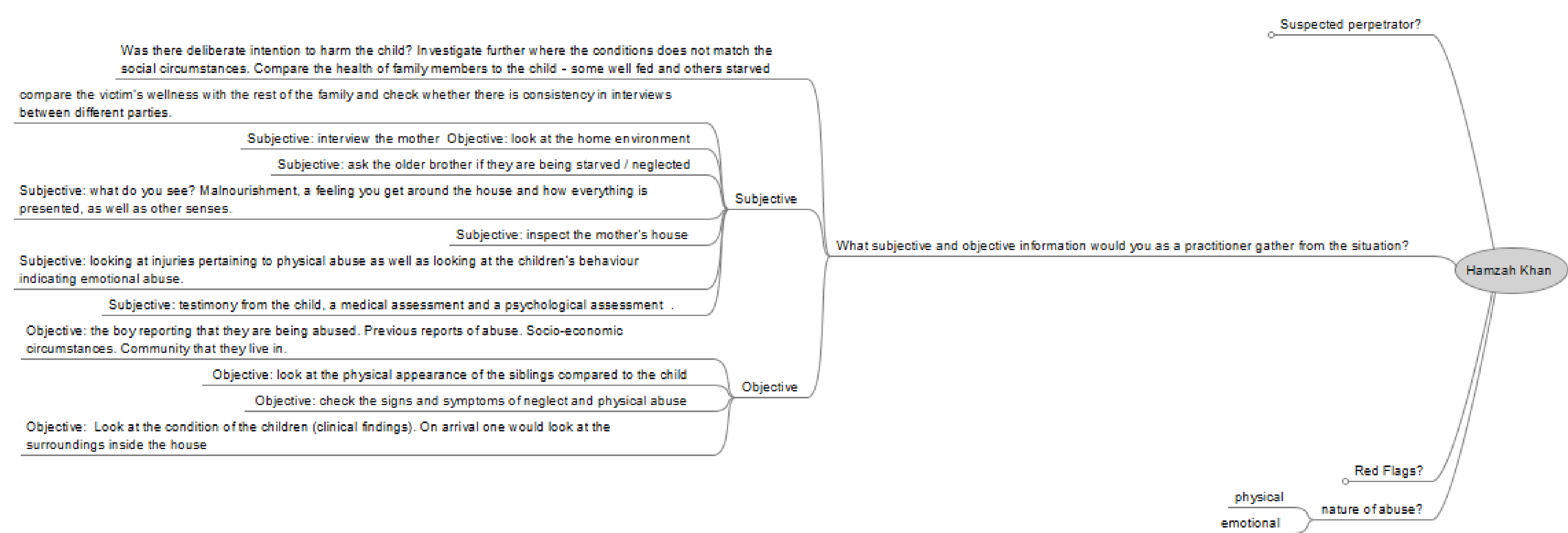


Figure 14 b: Hamzah Khan focus group discussion results

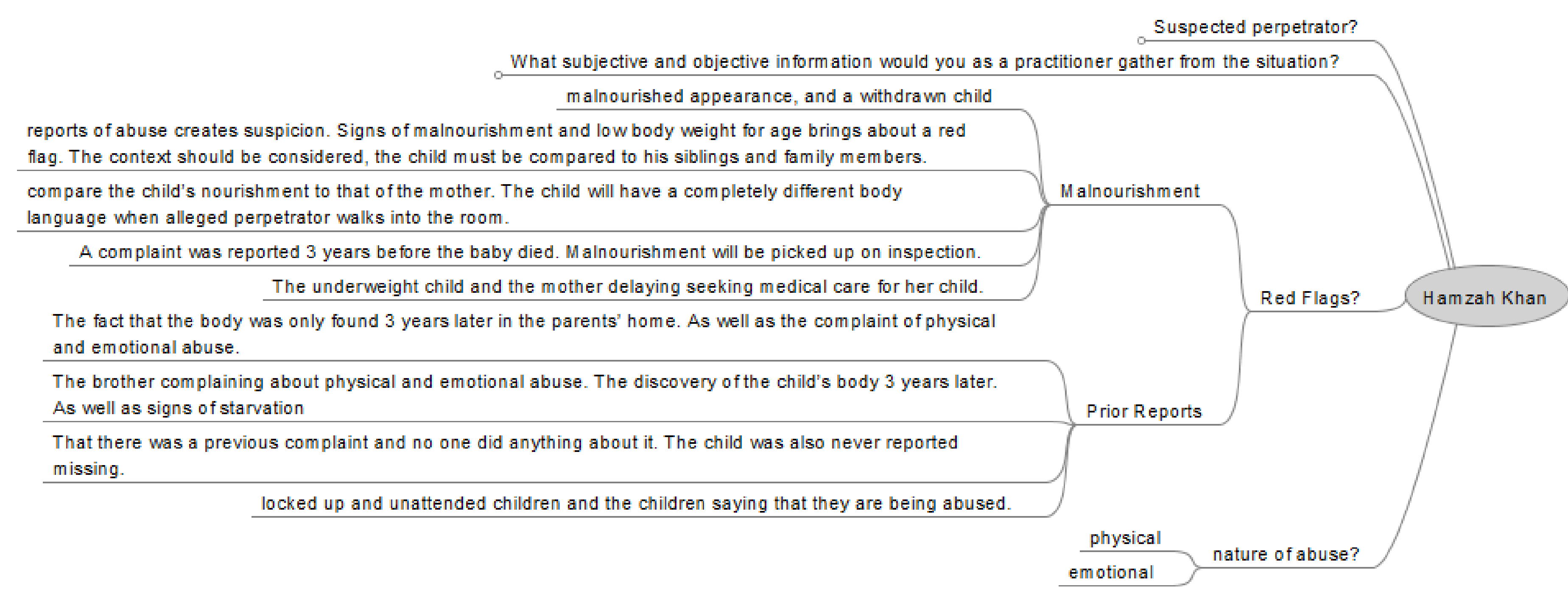


Figure 14 c: Hamzah Khan focus group discussion results

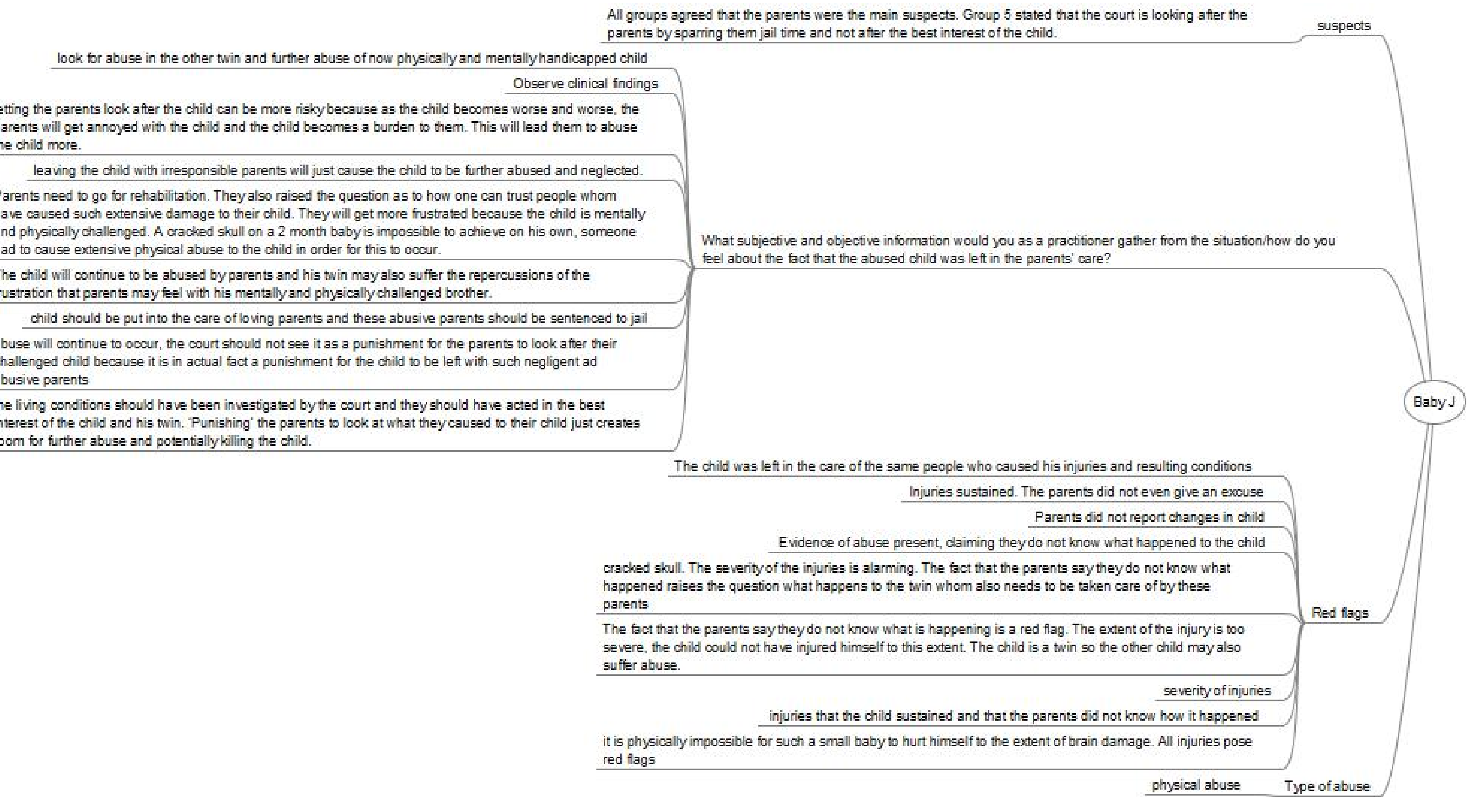


Figure 15: Baby J focus group discussion results

4.2.1. Finding 1: Convergence between answers provided by different year groups

All year group answers converged. The level of participation, depth, and alignment of the answers provided were not associated with an academic year of study. It is interesting to note because one would have expected senior participants to be more informed/ experienced in this research area to the extent that the depth of study is neutral to the experience and knowledge and interpretation of child abuse cases is of interest. Examples of the convergence between answers is presented below.

Who would be suspected as the alleged perpetrator on the scene in the Hamzah Khan case?

> Group 1: ..:“The mother as she was the only one who lived in the house with her children. There could also be a long term abuse within the family…”
>
> Group 2: …“The mother, because it is her house, and she is the primary guardian...”
>
> Group 4: …“The mother would be the most probable, but other options such as family members can also be explored…”

What are red flags and warning signs in Poppie’s case?

> Group 1: …“The fact that she hit her head hard against the cupboard. A warning sign such as a 4-year old girl being repeatedly kicked in the stomach...”
>
> Group 2: “…The injuries that the children sustained. The father changing his account of the events. The fact that the mother did not stop the abuse on the account that it was the wrong and immoral thing to do but rather due to the reason that the child was not feeling well on that day. The lies which the mother told to the counsellor...”
>
> Group 4: …“Previous abuse excused by ‘falls’ and ‘accidents’. The wife allowed the abuse at the least and participated in the abuse at the most. The number of times the stepfather changed his version of events. Hiding it from the school counsellor and the fact that the assaults started getting more frequent. ‘She’s playing dead again…’”

4.2.2. Finding 2: Identification of red flags

The participants were able to identify red flags and warning signs within all three cases and admitted that they would previously not have been aware of this when entering a patient's home.

> Group 1: … "The brother complaining about physical and emotional abuse. The discovery of the child's body 3 years later. As well as signs of starvation…"
>
> Group 8: … "Reports of abuse creates suspicion. Signs of malnourishment and low body weight for age brings about a red flag. The context should be considered, the child must be compared to his siblings and family members…"
>
> Group 6: … "not eating or talking is not normal behaviour for a child that age. The parents are aware that she is being abused. Different stages of healing of her bruises. The child withdraws around people, and she did not play around, she was always in her own space quiet…"

Their vigilance has shown progress since the training workshop captures their responses. The participants have also become more critical about the information that was given by patients and they now question signs and symptoms upon inspection. By going through the cases, participants immediately compared what normal behaviour is for a child as opposed to abnormal behaviour.

4.2.3. Finding 3: Subjective and objective information gathering

The participants learnt how to differentiate between gathering subjective and objective information when treating a patient within the field as per their feedback on the cases. They struggled to comprehend some cases as a deeper understanding of the context was required. Non-fatal strangulation would not show marks on the throat, thus participants would not have considered this a sign as they lack knowledge in this area, showing that inductive leaps of logic are present.

4.2.4. Finding 4: Identification of people emergent properties in a child abuse context

In terms of context, many of the participants were able to agree that the health system, as well as police and social workers, are also to 'blame' for the abuse happening as they are aware of the situation but do not respond or address the problem. Thus the general consensus was that all members of society have a role in protecting children.

Group 7: … "The parents, due to them being the only guardians of the child. The teacher is an accomplice as she did nothing to further investigate the situation…"

Group 5: … "The court is looking after the parents by sparring them jail time and not after the best interest of the child…"

4.2.5. Finding 5: Participants are alarmed at the reality of child abuse

Participants were in complete shock when they found out that Hamzah Khan's body was only discovered 3 years after he had died.

Anonymous 1: …"A complaint was reported 3 years before the baby died and no one did anything…"

Anonymous 2: … "That there was a previous complaint and no one did anything about it…"

Anonymous 3: …"The discovery of the child's body 3 years later is shocking…"

It was observed by the participants facial expressions that they were 'shocked' at the fact that the child's body was only found 3-years later, however, the response was muted when hearing the child died of neglect and abuse.

Anonymous 4: …"Wow, 3 years!!! That is a long time…"

Anonymous 5: …"Geez like, did it not stink..."

4.2.6. Finding 6: Even detection rates between academic year 1 and year 4

There was an even distribution of participants between year 1 and year 4. Across all year groups, equal deficiency was noted regarding detection rates of child abuse.

4.2.7. Finding 7: Behavioural response of BEMC participants

The BEMC participants' behavioural response is insufficient and not aligned to the patient's need and child abuse pathology. Their knowledge of how to treat child abuse cases was insufficient and they were unaware that a GBV screening tool already existed.

A summary of the focus group discussion findings can be found in *Table 7: Summary of focus group findings as well as the correlating method and objective used* below.

Table 7: Summary of small group findings as well as the correlating method and objective used

OBJECTIVE	METHOD	RESULT
To develop and implement an educative intervention that promotes the utilization of the approved screening instrument among EC scholars.	Training Workshop-Focus group discussion (QUAL)	1. All year group answers converged.
		2. The participants were able to identify red flags and warning signs within all three cases
		3. The participants learnt how to differentiate between gathering subjective and objective information when treating a patient within the field
		4. In terms of context, many of the participants were able to agree that the health system, as well as police and social workers, are also to blame for the abuse happening as they are aware of the situation but not attending to the problem
		5. Participants were in complete disbelief when they found out that Hamzah Khan's body was only discovered 3 years after he had died
		6. There was an even distribution between year 1 and year 4, this finding may suggest that everyone is equally deficient
		7. The BEMC participants' behavioural response is insufficient and not aligned to the patient need and child abuse pathology

4.3 Online Survey findings

The respondents were sent a quantitative questionnaire (pre training workshop survey), which was adapted from Naidoo (2019, p. 352-362). This survey was made available to participants over a period of 2-4 weeks to ensure that any participants who were not in class due to illness or

competing study interests would have an opportunity to respond. The questionnaire[18] took between 30-40 minutes to complete. The online version of the questionnaire was meant to improve the accessibility of the questionnaire as Wi-Fi is provided on the CPUT campus in the computer laboratory as mentioned in Chapter 3. Once the training workshop concluded, the participants were emailed a post training workshop survey for completion. The intention of the post training workshop survey was to evaluate the extent to which the training workshop improved child abuse recognition.

4.3.0. Sampling Bias, representivity and statistical significance

The realised sample size in the pre-questionnaire was 71. The number of attendees at the training workshop was 81 and the realised sample size in the post-questionnaire was 43, both from a population of 137. There is always the risk that patterns of non-response could lead to a biased sample, i.e. one that is unrepresentative of the target population. One way of checking this, in the present case, is to test for demographic differences between the population represented by the pre-questionnaire sample and the population represented by the post-questionnaire sample. If no statistically significant demographic differences are identified, we can reasonably conclude that both samples are representative of the same population, and therefore that non-response bias is not responsible for differences between pre- and post-questionnaire responses. Statistically significant patterns and trends from pre- to post-questionnaire responses may thus be reasonably attributed to the effects of the training workshop and rather than to sampling bias.

To this end, Fisher's Exact Test was implemented to check for a statistically significant difference in the distribution of gender, race, and age group, respectively. The p-values for these tests were 0.47 (gender), 0.86 (race), and 0.97 (age group). As all of these are well above our significance level of 0.05, we conclude that there is no evidence of demographic differences between the populations represented by the pre-questionnaire data and post-questionnaire data. Thus, despite the lower sample size achieved in the post-questionnaire, it appears that both data sets are representative of the same population. The number of respondents for the pre and post training workshop survey is indicated by Figure 16 below (a complete diagram can be found in Chapter 3).

[18] Questionnaire online link: https://docs.google.com/forms/d/1FRRmc44g7PrjoBCUHW2_a5DiRb96kqTeU72UNTuz4S8/edit?usp=drive_web.

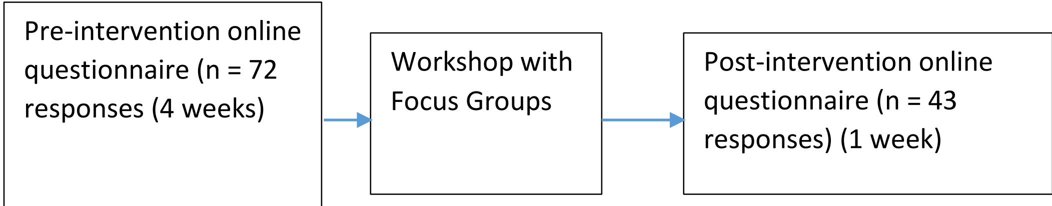


Figure 16: Representation of pre and post intervention responses

4.3.1. In your experience, perpetrators of child abuse are mostly…

P-values: Fisher's Exact Test: 0.0052

As seen in Figure 17 below, pre intervention, participants answered that perpetrators of child abuse are 63.6% men, 30.3% women and 6.0% children. Within the post-survey, participants answered that perpetrators of child abuse are 90.4% men, 7.1% women and 2.3% children. Thus respondents in the post intervention are more likely to answer 'Men' and less likely to answer 'Women' than respondents in the pre intervention survey.

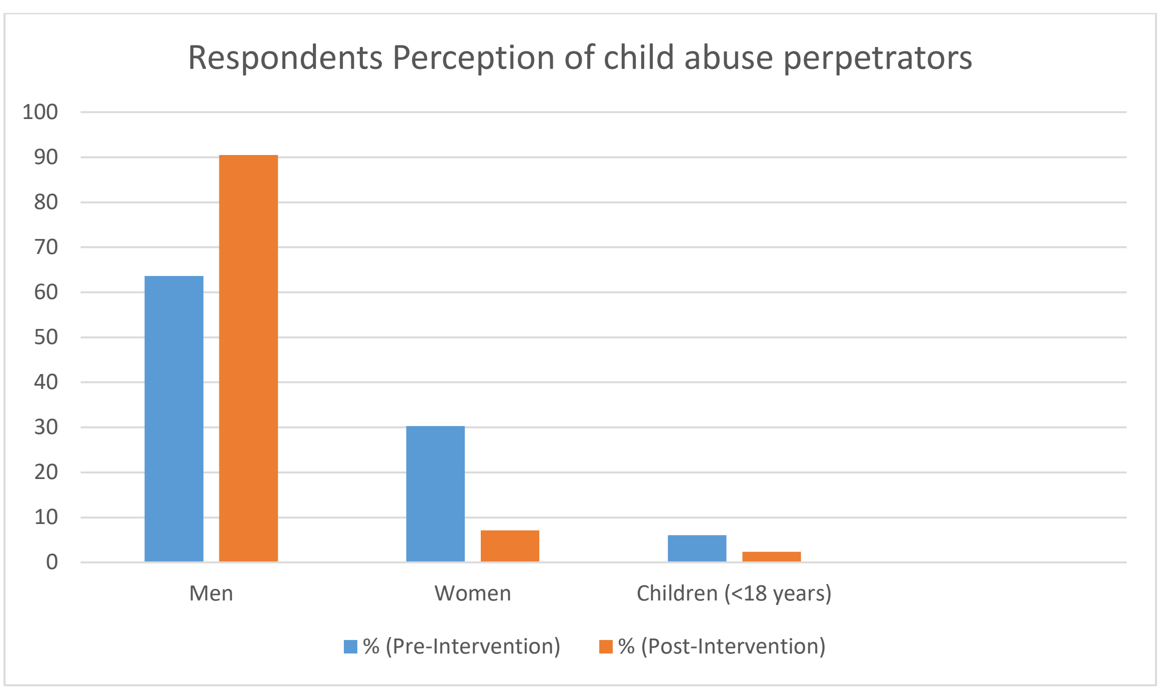


Figure 17: Respondents perceived perception of perpetrators of child abuse pre and post-intervention

4.3.2. Do alcohol and drugs cause child abuse?

P-values: Fisher's Exact Test: 0.034

In response to the question that alcohol and drugs cause child abuse, pre-intervention, 28.6% of respondents answered Yes, and 62.9% answered Sometimes and 8.6% answered No. Post-survey: 11.6% answered Yes, 67.4% answered Sometimes and 20.9% answered No. Thus the respondents in the post-intervention are more likely to answer 'No' and less likely to answer 'Yes' than respondents in the pre survey. The respondents' perception of alcohol and drugs related to child abuse pre and post survey can be seen in Table 8 below.

Table 8: Respondents perception of alcohol and drugs related to child abuse pre and post survey

Cochran-Armitage Trend Test: 0.010

Respondents perception of alcohol and drugs related to child abuse pre and post-intervention		
	% (Pre-Intervention)	% (Post-Intervention)
Yes	28.57143	11.62791
Sometimes	62.85714	67.44186
No	8.571429	20.93023

4.3.3. Abused children can leave an abusive home whenever they want to

P-values: Fisher's Exact Test: 1.8×10^{-11}

Cochran-Armitage Trend Test: 5.9×10^{-11}

Regarding the statement: "Abused children can leave the abusive home whenever they want to"…, pre-intervention the respondents answered 10% Yes, 32.9% Sometimes and 57.1% No. Whereas post-survey they answered 2.3% Yes, 55.8% Sometimes and 41.9% No. Respondents in the post-intervention are more likely to answer 'Sometimes' and less likely to answer 'Yes' or 'No' than respondents in the pre survey. Respondents' responses to whether abused children can leave the abusive home whenever they want to can be seen in Figure 18 below.

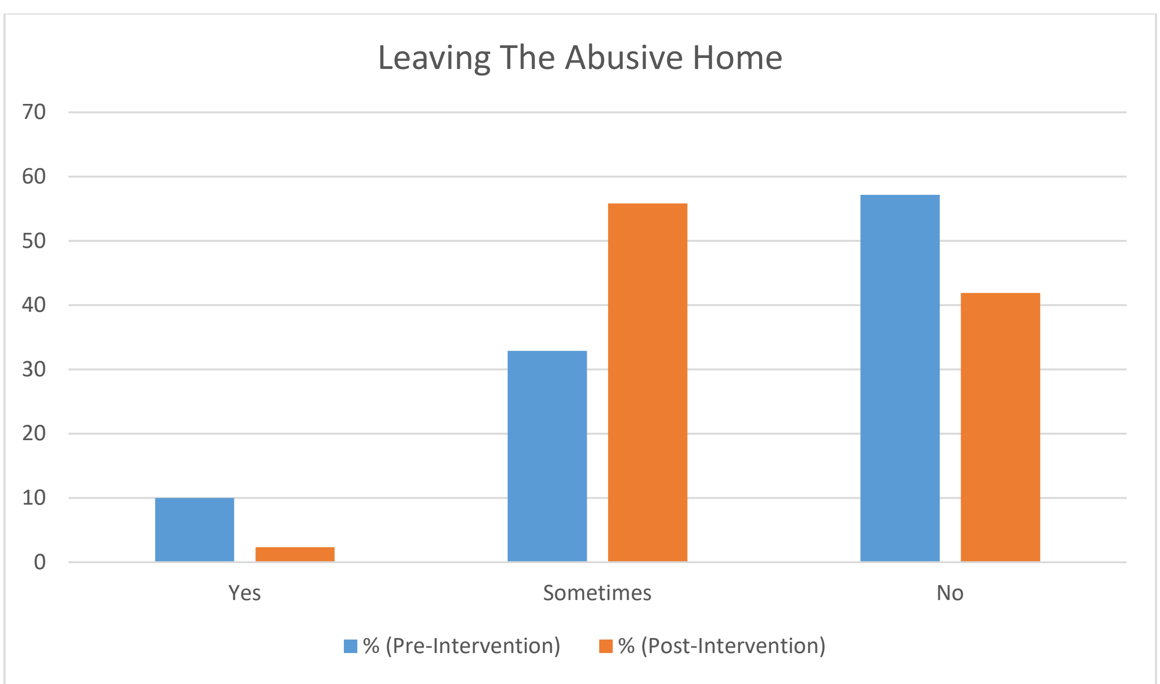


Figure 18: Respondents perception of victims leaving the abusive home

4.3.4. Is routine child abuse identification important for emergency care providers?

P-values: Fisher's Exact Test: 0.085 (**not statistically significant**)

Cochran-Armitage Trend Test: 0.025 (one-sided alternative; statistically significant)

Pre-intervention results show that the respondents answered 77.1% Yes, 17.1% Uncertain and 5.7% No to the question "Is routine child abuse identification important for emergency care providers?" Post-intervention the results were 93.0% Yes, 4.7% Uncertain and 2.3% No. The respondents in the post-intervention are more likely to answer 'Yes' than respondents in the pre survey. Respondent's perception of the importance of routine child abuse screening in EMS can be seen in Figure 19.

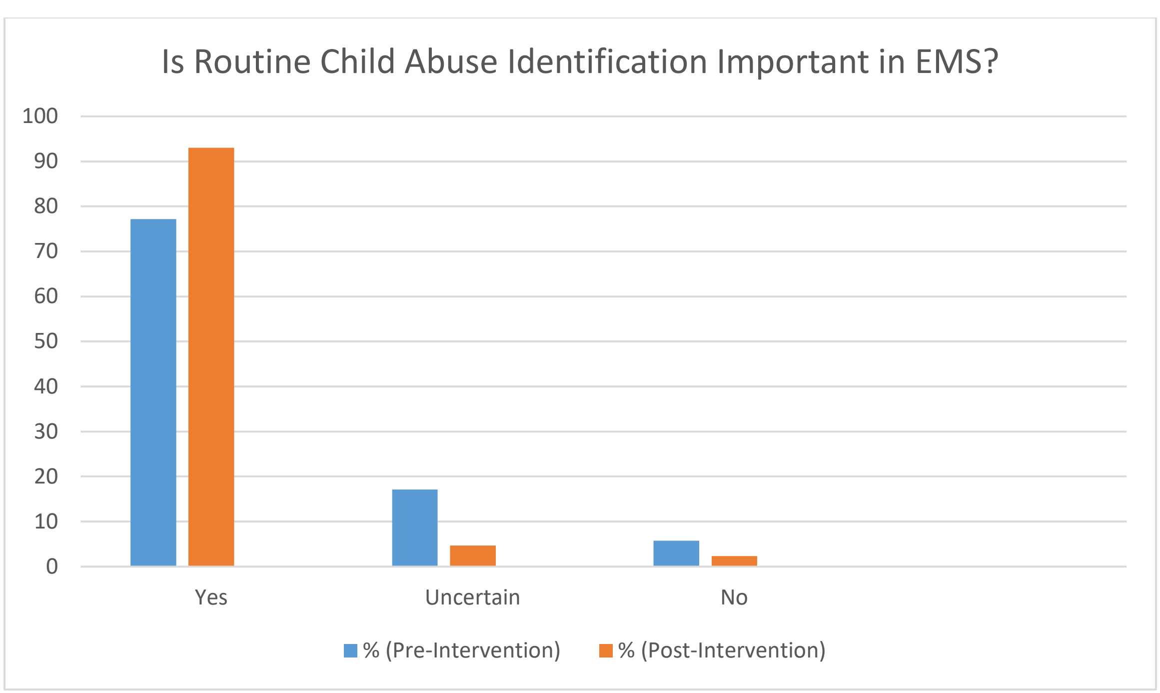


Figure 19: Respondents perception about the importance of routine child abuse screening in EMS

4.3.5. To whom would you refer child abuse victims?

P-values: Fisher's Exact Test: 0.0029

Pre-intervention 26.5% of respondents would refer child abuse victims to a clinic or hospital, 18.4% would refer the victims to police, 0% would refer to religious organizations, 12.2% would refer the victims to a crisis centre and 42.9% were uncertain of the referral. Whereas post-intervention, 60.7% would refer to a clinic or hospital, 21.4% would refer to the police, 3.6% would refer to religious organizations, 3.6% said they would refer to a crisis centre and 10.7% still said that they were uncertain of the referral. Respondents in the post-intervention are less likely to answer 'Uncertain of referral' and more likely to answer any of the other options—especially Clinic or Hospital—than respondents in the pre survey. The respondents' referral of child abuse victims can be seen in Table 9 below.

Table 9: Respondents referral of child abuse victims

Respondents referral of child abuse		
	%(Pre-Intervention)	%(Post-Intervention)
Clinic or hospital	26.53061	60.71429
Police	18.36735	21.42857
religious organization	0	3.571429
Crisis centre/non-governmental	12.2449	3.571429
Uncertain of referral	42.85714	10.71429

4.3.6. Are you aware of any service provider that deals with child abuse?

P-values: Fisher's Exact Test: 5.9×10^{-7}

Cochran-Armitage Trend Test: 3.2×10^{-6} (one-sided alternative)

Pre-intervention 21.4% of respondents' were aware of service providers that deal with child abuse, 40% were uncertain and 38.6% were not aware of service providers dealing with child abuse. Post-survey 72.1% were aware of service providers, 11.6% were still uncertain and 16.3% were still not aware of service providers dealing with child abuse. The respondents in the post-intervention are more likely to answer 'Yes' and less likely to answer 'Uncertain' or 'No' than respondents in the pre survey. Respondents' awareness of service providers dealing with child abuse is shown in Figure 20 below.

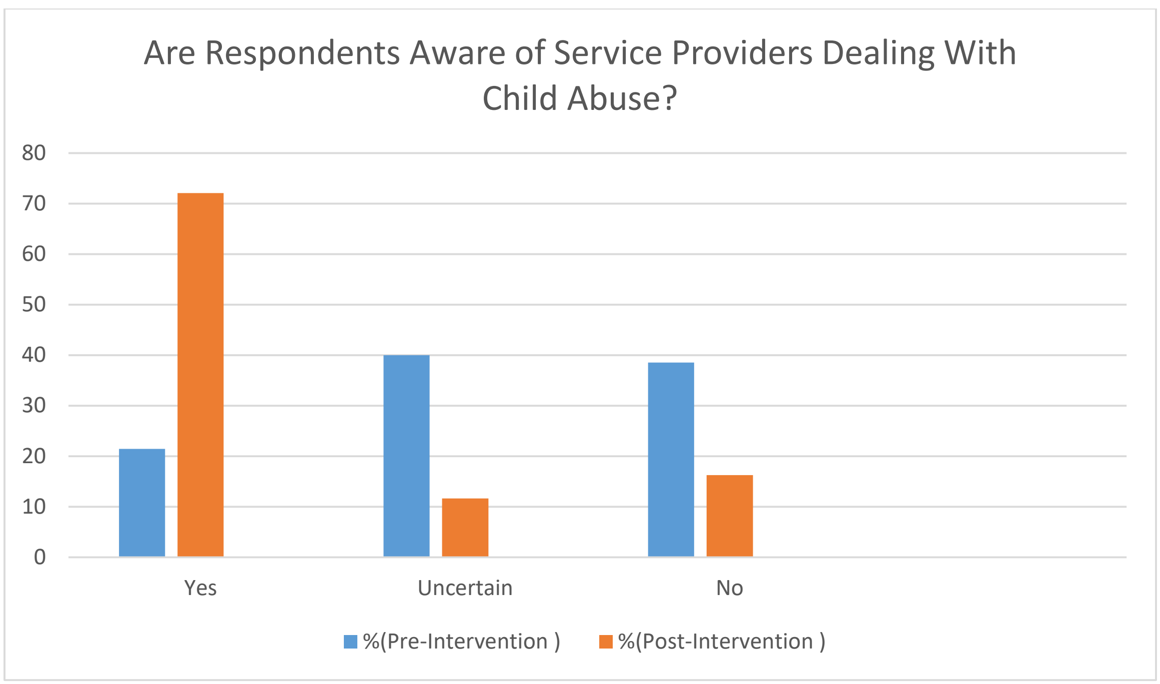


Figure 20: Respondents awareness of service providers dealing with child abuse

4.3.7. Do you have a referral resource book/ centre to consult?

P-values: Fisher's Exact Test: 1.9×10^{-8}

Cochran-Armitage Trend Test: 6.5×10^{-9} (one-sided alternative)

Pre-intervention results show that 11.6% of the respondents said that they have a referral resource book and 88.4% answered that they do not have a referral resource book. Post-survey, 62.8% of respondents answered Yes to having a referral resource book and 37.2% answered No. Respondents in the post-intervention are more likely to answer 'Yes' and less likely to answer 'No' than respondents in the pre survey. Respondents' awareness of referral book/consultation centres is shown in Figure 21 below.

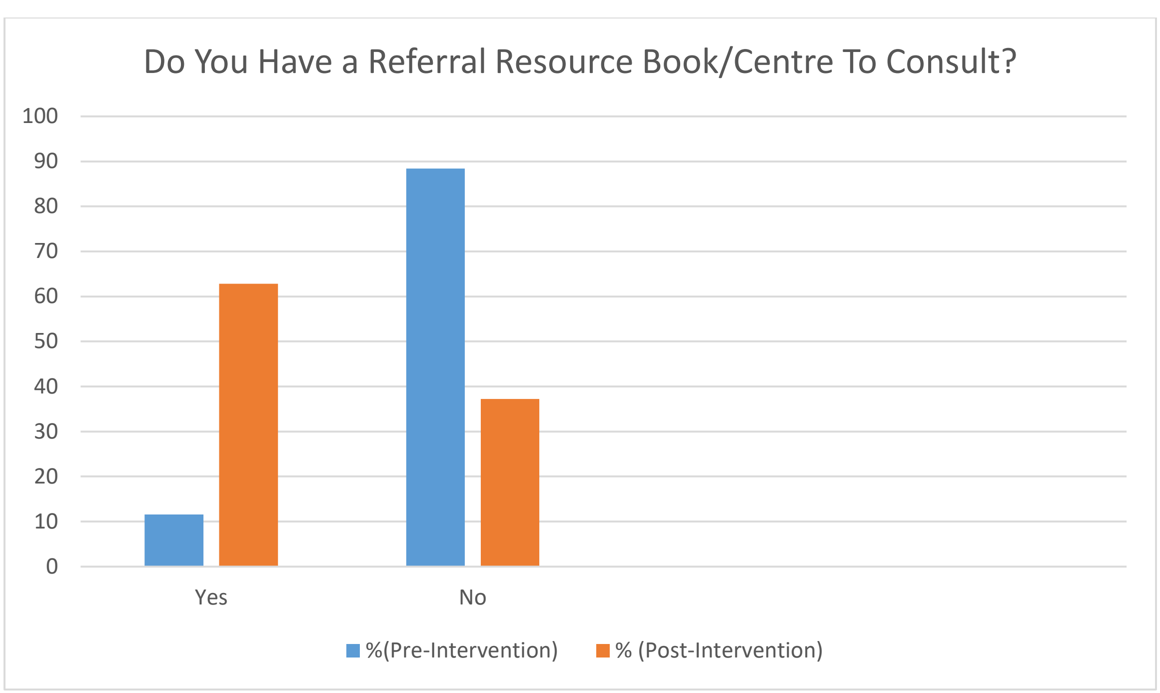


Figure 21: Respondents awareness of referral book/consultation centres

4.3.8. I feel confident I have an understanding of the emotional needs of survivors of child abuse

P-value: Fisher's Exact Test: 4.6×10^{-4}

Cochran-Armitage Trend Test: 9.5×10^{-6} (one-sided alternative)

In the pre-intervention, the respondent results of the question "I feel confident I have an understanding of the emotional needs of survivors of child abuse" were as follows; 7.1% strongly agreed, 22.9% agreed, 30% were undecided, 32.9% disagreed and 7.1% strongly disagreed. Post-survey results showed the following; 20.9% strongly agreed, 44.1% agreed, 27, 9% undecided, 7% disagreed and 0% strongly disagreed. The respondents in the post-intervention are more likely to Strongly Agree or Agree and less likely to Disagree or Strongly Disagree than respondents in the pre-intervention. Respondents' confidence in having an understanding of the emotional needs of survivors of child abuse is shown in Table 10 below.

Table 10: Understanding the emotional needs of survivors of child abuse

Respondents confidence in having an understanding of the emotional needs of survivors of child abuse		
	%(Pre-Intervention)	%(Post-Intervention)
Strongly Agree	7.142857	20.93023
Agree	22.85714	44.18605
Undecided	30	27.90698
Disagree	32.85714	6.976744
Strongly Disagree	7.142857	0

4.3.9. I know the minimum services that should be available for survivors of child abuse

P-values: Fisher's Exact Test: 5.2×10^{-7}

Cochran-Armitage Trend Test: 3.7×10^{-7} (one-sided alternative)

"I know the minimum services that should be available for survivors of child abuse", pre-intervention 5% of the respondents strongly agreed to the statement, 40% agreed, 37.5% were undecided, 17.5% disagreed. Whereas post-survey 41% of the respondents strongly agreed that they knew the minimum services that should be available for survivors of child abuse, 53.8% agreed, 5.1% were undecided and 0% disagreed as well as strongly disagreed. The respondents in the post-intervention are more likely to Strongly Agree or Agree and less likely to Disagree or be Undecided than respondents in the pre survey. Respondents' knowledge about minimum services available for child abuse survivors is shown in Figure 22 below.

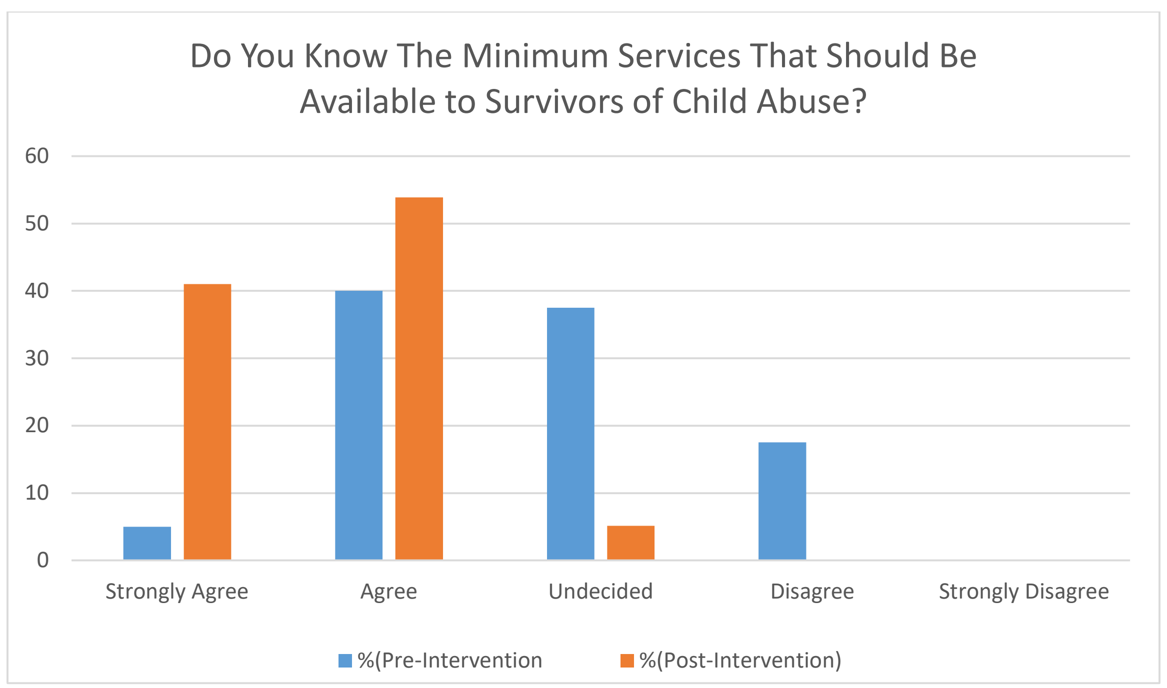


Figure 22: Respondents' knowledge about minimum services available for child abuse survivors

4.3.10. I feel confident that I know how to refer a survivor to the appropriate services.

P-values: Fisher's Exact Test: 5.6×10^{-14}

Cochran-Armitage Trend Test: 5.6×10^{-13} (one-sided alternative)

In the pre-intervention 1.4% of respondents strongly agreed that they felt confident in knowing how to refer a survivor to an appropriate service, 17.1% agreed, 24.3% were undecided, 38.6% disagreed and 18.6% strongly disagreed. On the other hand within the post-survey, 34.9% strongly agreed in feeling confident, 55.8% agreed, 2.3% were undecided, 7% disagreed and 0% strongly disagreed. The respondents in the post-intervention are more likely to Strongly Agree or Agree and less likely to Strongly Disagree, Disagree or be Undecided than respondents in the pre survey. Respondents' confidence in referring a survivor to appropriate services is shown in Figure 23 below.

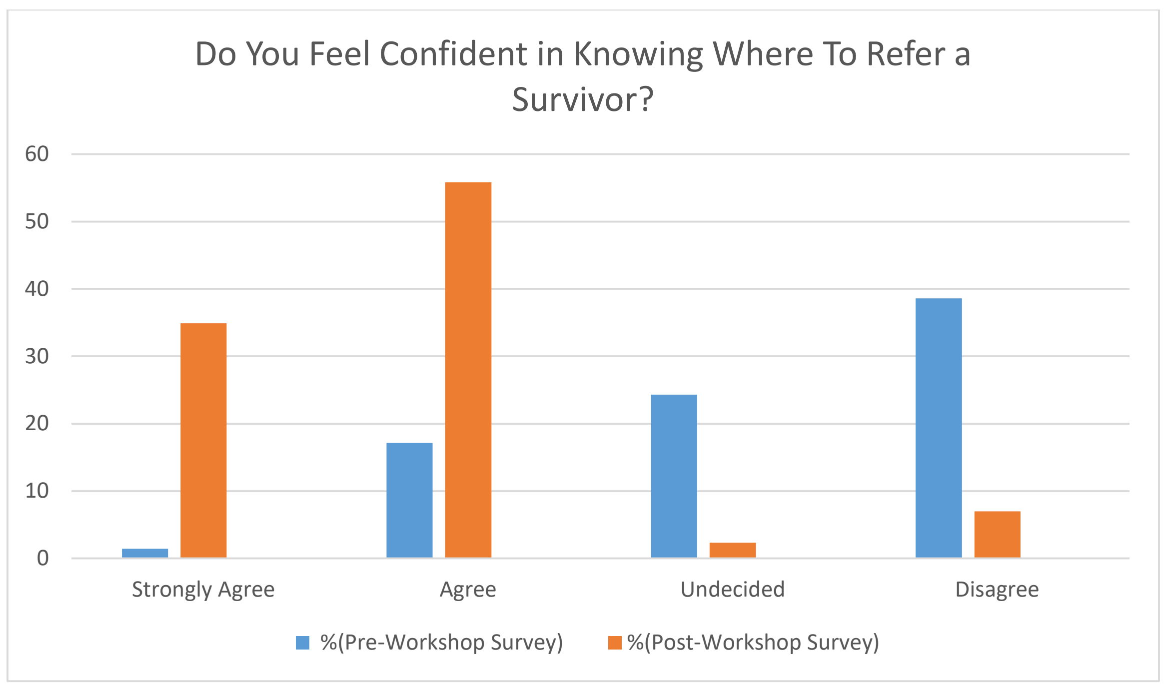


Figure 23: Respondents' confidence in referring a survivor to appropriate services

4.3.11. I feel confident that I know at least two self-care techniques to help prevent or address stress I may experience because of my work with child abuse survivors.

P-values: Fisher's Exact Test: 4.5×10^{-4}

Cochran-Armitage Trend Test: 3.9×10^{-5} (one-sided alternative)

In the pre-intervention 1.4% of respondents strongly agreed that they felt confident in knowing how to refer a survivor to an appropriate service, 17.1% agreed, 24.3% were undecided, 38.6% disagreed and 18.6% strongly disagreed. On the other hand within the post-survey, 34.9% strongly agreed in feeling confident, 55.8% agreed, 2.3% were undecided, 7% disagreed and 0% strongly disagreed. The respondents in the post-intervention are more likely to Strongly Agree or Agree and less likely to Strongly Disagree, Disagree or be Undecided than respondents in the pre survey. Respondents' knowledge of self-care techniques to address/prevent stress due to working with child abuse survivors is shown in Table 11 below.

Table 11: Respondents' knowledge of self-care techniques to address/prevent stress due to working with child abuse survivors

Respondents knowledge on self-care techniques to address/prevent stress due to working with child abuse survivors		
	%(Pre-Intervention)	%(Post-Intervention)
Strongly Agree	15.71429	34.88372
Agree	38.57143	53.48837
Undecided	14.28571	9.302326
Disagree	21.42857	0
Strongly Disagree	10	2.325581

4.4 Summary

The above data shows through statistically significant findings that collectively, there is strong evidence that the training workshop had a positive impact on those who attended. The participants demonstrated knowledge of antecedent factors for child abuse such as what constitutes risk and vulnerability for abuse. They also showed knowledge of child neglect. The participants, however, did not know conceptual definitions from the Children's Act. Similarly, they were unsure of factors

that affect vulnerability such as rights and obligations of care givers. Following an epidemiological model of primary prevention, secondary early detection and tertiary care, participants were able to demonstrate knowledge of what prevention opportunities are probable and desirable in the emergency care milieu. Such opportunities include situational awareness, training, risk factor identification, appraisal of the living environment, diagnostic probity and referral pathways. Moreover the participants showed a lack of knowledge concerning the consequence management for child abuse. The findings which transpired will be dealt with in Chapter 5 (Discussion).

Chapter 5 – Discussion

5.0. Introduction

In this chapter, morphogenesis and the three pillars will be discussed as well as morphostasis. The three pillars of emergent properties of Archer's morphogenesis are structural emergent properties (SEPs), cultural emergent properties (CEPs) and people emergent properties (PEPs). SEPs will assess human and non-human resources such as rules, guidelines, and regulations. Accordingly standard of practice, laws pertaining to violence and diagnostic screening instrument will be appraised. CEPs will evaluate[19] the relationship between people, within this discussion; CEPs will focus on the relationship between EC providers and victim of child abuse. Hence CEPs will involve the findings from the child abuse educative intervention that took place. Lastly, PEPs will focus on the nature of personal interactions and relations. PEPs recognize that a person exists in a society with other people (Mandikonza & Lotz-Sisitka, 2016), therefore whatever decision is made by an individual will influence that individual's interaction with other persons. We were on the assumption that EC providers have the latent capacity to influence the reporting of child abuse cases. In contrast, morphostasis describes a state in a society that remains static due to a lack of personal and social change (Esmond and Wood, 2017).

Table 12 below acts as summary, to illustrate how the findings from both the quantitative and the qualitative research links to the three emergent properties of social elaboration within Archer's morphogenetic cycle which will be discussed within this chapter.

[19] Kindly note that any reference to evaluation in the proposal is in the context of the critical sociology lens and not necessarily in the positivist paradigm. It is the subjective nature of practitioner experiences that I seek to document and not necessarily an objective quantification of success or failure of policy implementation.

Table 12: Quantitative and Qualitative findings according to the three emergent properties of social elaboration within Archer's morphogenetic cycle

Quantitative And Qualitative Findings According To The Three Emergent Properties of Social Elaboration within Archer's Morphogenetic Cycle			
Finding	*QUAN	*QUAL	Emergent Properties: **PEPs, **CEPs, or **SEPs
Group A and Group B archival FISDAP® data			
Documented cardiac cases	QUAN		PEPs
Obstetrics and gynaecology cases	QUAN		PEPs
Sepsis and infection	QUAN		PEPs
Trauma to extremities	QUAN		PEPs
Trauma to head	QUAN		PEPs
Trauma from burn injuries	QUAN		PEPs
Drowning as trauma	QUAN		PEPs
Bites and stings	QUAN		PEPs
Healthy screening	QUAN		PEPs
Gender and vulnerability	QUAN		PEPs
Age and vulnerability	QUAN		PEPs
Focus group discussion findings			
Convergence between answers between year groups		QUAL	CEPs
Identification of red flags		QUAL	CEPs
Subjective and Objective information gathering		QUAL	CEPs
Identification of people emergent properties in a child abuse context		QUAL	PEPs
Participants alarmed at the reality of child abuse		QUAL	CEPs
Even detection rates		QUAL	PEPs
Behavioural response		QUAL	CEPs
Online survey findings			
Child abuse perpetrators	QUAN		PEPs
Alcohol and drugs	QUAN		CEPs
Abused children can leave an abusive home	QUAN		PEPs
Routine child abuse identification	QUAN		SEPs
Referral of child abuse victims			PEPs
Awareness of service providers	QUAN		PEPs
Referral resource books	QUAN		PEPs
Confidence of understanding emotional needs of survivors	QUAN		PEPs
Minimum services that should be available	QUAN		PEPs
Confidence in referral	QUAN		PEPs
Self-care techniques	QUAN		PEPs

Key: *Quantitative and Qualitative are both capitalized as they have equal importance

** CEPs: Cultural Emergent Properties; SEPs: Structural Emergent Properties; PEPs: People Emergent Properties

5.1. Cultural Emergent Properties (CEPs) of Structural Elaboration

The analytical frame for this discussion is guided by morphogenesis. Morphogenesis can be split into two parts; 'morpho' which acknowledges that a preferred state in society exists and 'genetic' recognises that unintended and intended activities influence the state of society (Little, 2012). Thus morphogenesis is the change to social structures such as relationships due to the ever changing actions of society which can have a positive or negative impact (Little, 2012).

5.1.1. Convergence between answers provided by different year groups within the educative intervention

The neutrality of responses in the results may suggest that a 4th year student in EMS undergrad is no-more the wiser or experienced than a 1st year learner with respect to child abuse diagnostics. The NQF-aligned nature of a four-year degree is such that there must be a scholarly progression in the form of constructive alignment toward goal attainment and an increase in depth and level of complexity as the course progresses (Biggs, 2003). This can be seen within the South African higher education framework (HET, 2010) On the premise that CHE approved programmes satisfy the HEQSF requirements for appropriate level description from level 5-8, this finding may constitute an 'indictment' on the programme. This is likely to be an unintended blind spot or structural deficiency as the programme has particular reference to the emergency medical care of women and children within emergency medical care theory, emergency medical care practical and emergency medical care clinical. This begs the question: if it is intended that students who participated in this study are progressively developed in the area of child abuse education, then why does structural deficiency happen?

As per the constructive alignment of the BEMC course, the curriculum is set out with clear outcomes which state the level of understanding required by the participants for each subject (Döbler and Döbler, 2019). Child abuse does not feature as a main topic within the curriculum and participants are assessed on the treatment of children, but not abuse per say, thus the structural emergent properties (SEPs) in relation to assessing the standard of practice for child abuse diagnostics are insufficient to promote morphogenesis.

5.1.2. Subjective and objective information gathering and Identification of red flags

Human beings are born with instinctive tendencies (Dewey, 1957). When humans learn habits as expressions of growth, such as being more vigilant and investigating signs and symptoms for abuse, the habit is a form of executive skills. The habit only becomes efficient the more it is carried out and when it becomes relatively passive. Education expresses an essential growth phase

(Dewey, 1957). The ‘cultural emergent properties’ (CEPs) is useful to describe the relationship between the emergency care provider participants and prospective child abuse victims. By observing the data obtained from the small group discussions in the training workshop, it is evident that the participants have shown progress in their nature whereby they would treat victims of abuse. Even though emergency care workers are among the first on scene majority of the time and have access to the home environment of the injured child, their potential contribution toward child protection may be underestimated (Johnson *et al.*, 2018). It is assumed that the training which emergency care students receive is sufficient for them to differentiate between accidental and intentional injury (Johnson *et al.*, 2018). This assumption is based on the BEMC curriculum which is approved by the HPCSA board. Nonetheless, it is still noted that the EC students/ participants struggle to differentiate between accidental and intentional injury. This was evident within the educative intervention as well as in the archival data with high percentages (Group A n=19% and Group B n = 18%) of probable “missed” child abuse cases. Therefore an insufficiency in knowledge and training exists amongst the EC students.

Johnson *et al.* (2018), suggest including changes in the curriculum of existing programs to create a life-saving level of care for society. Lamkin and Saleh (2010), in the Encyclopaedia of Curriculum Studies, hold that for critical pragmatists, the curriculum is the vehicle to bring about the desired social changes for the advancement of society. Curriculum change must include improved diagnostic capability through subjective and objective information gathering (Lamkin and Saleh, 2010). It includes inductive and deductive logic with the assumption that children presenting to an EMS may already constitute an at-risk population as abuse or neglect commonly manifests as health care needs. Naidoo (2017) quantified the extent of the emergency care practice gap, with an alarming missed case detection of 42.8 per 1000 patients (females, 14 years plus). There remains a need to understand the diagnostic nuance associated with children younger than 14 years.

Child abuse is an arduous area for investigation due to the hidden nature thereof. It also involves complex sociology which is associated with the setting in which the abuse occurs (Johnson *et al.*, 2018). If one understands the complex sociology of abuse, the behavioural pathology associated with victims and perpetrators and the environmental factors that enable serial and often escalating abuse, then one is better equipped for early identification or crisis intervention that is possible in the prehospital field. In this way, hidden, concealed abuse (by victims and perpetrators) can be seen as a latent diagnostic opportunity for discovery.

5.1.3. Behavioural response of BEMC participants

An analogous behavioural response can be seen in Naidoo (2017), work whereby a similar context with graduates and operational EC providers in the field was observed. Within the operational practice, there are certain things preventing awareness of child abuse such as practitioners' being oblivious to the fact that abuse exists or just not knowing how to screen for abuse. A core risk factor in emergency medical services is the fast pace of the work (Substance Abuse and Mental Health Services Administration, 2018). The level of criticality and focus of a practitioner and student should also be taken into consideration when it comes to reporting of child abuse, as working a 12-hour shift takes its toll on a person and attending to a call at 4 am in the morning could lead to missed abuse cases. The long duration of shifts and fast tempo thereof can lead to practitioners' inability to integrate their work experience and knowledge (Substance Abuse and Mental Health Services Administration, 2018). In addition to this, another factor that can contribute to insufficient behavioural response is education. Naidoo (2017), states that there is the admission that educators are not knowledgeable about DV cases (including child abuse) and thus do not teach it. Furthermore, prescribed textbooks do not adequately deal with and explain cases of DV (as mentioned in Chapter 2) (Naidoo, 2017). The HPCSA (2006) practice protocol document, guided the clinical scope for practitioners for over 10-years and did not exhibit any child abuse or GBV related protocol (Naidoo, 2017). Sadly, the most recent clinical practice guidelines (CPG's) also do not include child abuse detection (HPCSA, 2018a)

5.1.4. Alarming reality of child abuse

The participants in the focus group discussions, failed to acknowledge that the time period in which the body was found proves inconsequential when compared to the harsh reality that a helpless child was abused and suffered the worst outcome thereof. The fact that they were shocked at the time period and not at the actual abuse occurring, shows how 'normal' the act of child abuse and neglect has become to society- to the extent that it does not even shock individuals anymore. Still, the delayed detection was found to be unacceptable.

5.1.5. Alcohol and drugs

Majority of respondents answered that alcohol and drugs 'sometimes' cause child abuse. Being under the influence of alcohol does not cause one to abuse a child. Poverty and life struggles can lead individuals to consume and abuse alcohol, but the argument cannot hold that alcohol abuse is causative of child abuse. It may be a strong associated factor, but the evidence is also that abusers are also sober. We do not then say that sobriety causes child abuse. The use of

alcohol and drugs sometimes provides a conditional requirement or suggests an ambivalence. This view may be led by ones experience.

5.2. Structural Emergent Properties (SEPs) of Structural Elaboration

5.2.1. Importance of routine child abuse identification for emergency care providers

Section 110 (1) of the Children's Amendment Act states that any suspected child abuse has to be reported to police, social development or protection organizations (ChildLine South Africa, 2017). Reporting of suspected child neglect or abuse must be done as soon as the abuse is suspected based on reasonable grounds[20] (Hendricks, 2014). The "good faith"[21] principle is linked to reporting of child abuse cases. All Health Care Practitioners in South Africa can be held accountable if they do not report suspected abuse. According to the Health Professions Act No.56 of 1974 (Sabinet, 1974), a fine can be issued to the practitioner or the practitioner can be suspended from their work for a period of time if they are found guilty of non-reporting (Hendricks, 2014). In addition to this, a member's name can also be removed from the register depending on the court ruling (Hendricks, 2014). Failure of Health Care Practitioners in SA to report sexual abuse of children as well as the exploitation of mentally handicapped children can lead to a 5-year imprisonment sentence for the practitioner as per Section 54 (b) of the Sexual Offences and Related Matters Act (Sabinet, 1974).

The research interventions in this study showed that it is possible to alter the SEP's even with brief disruptions to the status quo. Within the post-intervention survey, 93% of the respondents agreed that routine child abuse identification is important for emergency care providers; however, this routine identification is not done in ambulances. Before the workshop, 43% of respondents were uncertain of the referral of a suspected abuse victim. Post workshop, only 10% were still uncertain and 61% stated that they would refer abuse victims to a clinic or hospital. When asked if they had a referral resource book, only 12% said yes pre-workshop, however after the workshop, 63% said that they do have a referral resource book for important numbers[22] to contact if they

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[20] Reasonable Grounds: Facts must be obtained objectively by looking at a set of evidence such as signs and symptoms or using one's senses to explore the living environment of the patient (Hendricks, 2014). A third party will be given the same facts and if they come to the same conclusion as the person whom reported suspected abuse, reasonable grounds will be deemed (Hendricks, 2014).

[21] Good Faith: This is the duty of an individual to act honestly and with no malicious intent, reporting must be done if person truly suspects abuse (Hendricks, 2014).

[22] Important numbers: Childline South Africa (24-hour toll-free helpline 0800 055 555); Childline Wynberg (021 762 8198); Childline Tygerberg (021 930 0859); SAPS (10111 or the crime stop number 08600 1011)

come across a child abuse victim. Still, minor alterations in the structure are likely to provide large effects in EMS systems. In a quasi-experimental cohort design, Naidoo (2017) showed that voluntary screening improved domestic violence detection three-fold. However, deeper statistical analysis revealed that had the screening been obligatory, then the DV detection rate would improve nine-fold. Structural changes in professions, it seems, can promote opposing environmental responses to those that rectify and perpetuate the silence and shame associated with child abuse.

5.3. People Emergent Properties of Structural Elaboration

People Emergent Properties (PEPs), focuses on the nature of personal interactions and relations in a society. By forming a consensus that all individuals of society are responsible to protect abuse victims, participants denote that society, as well as its emergency care providers, have the latent capacity (and a higher duty) to influence reporting of abuse cases. The cases below looks at people that emerge as 'presenting cases' and what transformative 'yield' they might have.

5.3.1. Documented Cardiac Cases as possible missed cases of neglect

As healthcare practitioners, one would not expect the number of cardiac cases in children to be high, as they do not suffer from atherosclerosis (build-up of plaque causing arteries to narrow (NIH, 2019a)). However a joint total of 29 cases were reported on FISDAP® by Group A and Group B. Sudden cardiac arrest in children can occur if the child has been born with a congenital heart defect (CHP, 2018). A congenital heart defect occurs when the heart has a structural abnormality compared to that of a normal heart (CHP, 2018). Risk factors for sudden cardiac arrest can be due to exposure to medications and drugs (CHP, 2018). If children are exposed to medications and drugs due to the negligence of parents to store it in a safe space out of reach of young children and teenagers, this can prove to be harmful.

The cardiac cases reported on FISDAP® do not indicate the cause. These cardiac cases could have been due to nature (the child was born with a congenital heart defect) or it could have been due to negligence (drugs, medications or even infectious agents left in close proximity for children to reach). If the latter occurred, then cardiac arrest would have resulted from poisoning or overdose. Based on the assumption that overdose may have occurred due to infectious agents, drugs or medication ingested by children, probable "missed" cases can then be seen if they were reported as cardiac cases and not overdose or child abuse cases. This implies a detailed history

of preceding events and that an uncommon incidence means that the complaint should not happen commonly.

5.3.2. Obstetrics and Gynaecology Cases

When looking at Chapter 4 (Results), it is noted that a joint total of 60 obstetrics and gynaecology cases were reported on FISDAP®. It is not the norm to associate obstetrics and gynaecology to children being the bearers of another child. This raises concern as 60 cases is a substantial amount being reported within this category. Thus the question arises, how many of these cases were pregnancies due to sexual abuse? The cases logged onto FISDAP® were captured as 'obstetrics and gynaecology', but nowhere is it indicated why the child called an ambulance for such a case.

Women can become pregnant as soon as they start ovulating (Live Science Staff, 2011). A woman as young as 11-years of age can become pregnant provided that she has reached puberty (Live Science Staff, 2011). The early onset of menstruation can also occur within some women and this is referred to as 'precocious puberty' (Live Science Staff, 2011). The youngest confirmed mother in medical history is a 5-year-old-girl (Lina Medina) who was raped and then gave birth when she was almost 6-years old (Live Science Staff, 2011). A child who is pregnant due to sexual abuse may have hatred towards the unborn child as they see the unborn child as a constant reminder of the atrocious act that was perpetrated onto them. This hatred can lead to the mother (a child herself) to enact violence onto her unwanted child and so the vicious cycle of abuse continues.

Notwithstanding that some of the gynaecology and obstetrics cases could have been teenagers who were sexually active at a young age and experimenting. Due to the ambiguity of the nature of the call reported, it is vital for practitioners to conduct an accurate history taking and to investigate whether the under age child is suffering obstetrics and gynaecology emergencies due to abuse. The high number of obstetrics and gynaecology cases reported on FISDAP® indicate that probable "missed" child abuse cases are present among this grouping of patient encounters. This is supported by the evidence that sexual activity may have been preceded by grooming, manipulation and other forms of abuse (Pollack and MacIver, 2015). The Child law Practice Journal article concludes: "With each victim who is groomed and sexually abused, we question how it could have happened, how signs leading up the abuse were missed. Knowledge, training, and awareness are our best weapons, and our best chance to prevent abuse before it occurs" (Pollack and MacIver, 2015).

It is interesting to note that within the HPCSA 2018 Clinical Practice Guidelines, the guidelines provide accurate step by step information concerning obstetrics and gynaecology (HPCSA, 2018a). These guidelines include how to handle a woman in labour, how to treat abnormal deliveries, what drugs to administer when and how to initiate appropriate new-born care to name a few (HPCSA, 2018a). However not once do the guidelines mention what to do when treating a pregnant child who was sexually abused. The HPCSA 2018 Clinical Practice Guidelines are the standard of professional practice for emergency medical practitioners, yet this most important document which guides the entire pre-hospital profession lacks vital information concerning pregnancies due to child sexual abuse. This suggests a leadership crisis in emergency care with regard to child abuse intervention and rights protection.

5.3.3. Sepsis and infection

Due to the inclusion and exclusion criteria of the study, the researcher did not include sepsis and infection (due to its generality) as child abuse, however, it is important to note that sepsis and infection can occur due to neglect. Sepsis is very dangerous in infants and children alike. If left untreated, sepsis can lead to tissue damage, organ failure, and death (Owusu-Ansah, 2017). Within the United States, 75 000 children develop sepsis each year and almost 7000 of them die (Owusu-Ansah, 2017). A retrospective chart review study conducted at Khayelitsha District Hospital (KDH), Western Cape, looked at patients' 12-years and younger who were treated in the resuscitation room of KDH during a six-month period. The study ran from 1 November 2014 until 30 April 2015. A total of 317 patients were enrolled in the study and it was found that neonatal sepsis was one of the top 5 diagnoses which lead to death (Richards *et al.*, 2018). In such settings, patient safety and infection control measures must be enquired into as they render the health system complicit.

Sepsis occurs due to an untreated infection. To the extent that the infection was left untreated because of the caregivers' delayed health seeking behaviour, may technically constitute neglect. This is difficult to prove in a low middle income country (LMIC) setting where barriers to accessing care abound and where there are many culturally alternate health-seeking practices, however, denying access to health care does constitute a violation of health rights.

5.3.4. Trauma Cases among the population of interest

5.3.4.1. Trauma to Extremities

Groups A and B reported a joint number of 60 cases of trauma to extremities. A retrospective case series study conducted in a Children's Hospital in Columbus, looked at children 18 months and younger with lower extremity injuries (Coffey *et al.*, 2005). The retrospective study viewed cases from 1998-2002 (n = 5 497). Coffey *et al.*, (2005), found that lower extremity trauma due to abuse in children above the age of 18-months was uncommon. On the contrary, children under 18 months who were abused, commonly suffered from lower extremity injuries, particularly fractures (Coffey *et al.*, 2005). Accordingly, it is vital that practitioners do a thorough assessment of children within this age group (<18 months) presenting with lower extremity injuries as it could likely be due to child abuse. When logging the cases onto FISDAP®, it is recorded as trauma and not child abuse, once again suggesting that probable "missed" cases of child abuse could be present within this category.

5.3.4.2. Trauma to the Head

Collectively, 91 Head trauma cases were reported on FISDAP® by Groups A and B. As mentioned in Chapter 2 (Literature Review), head trauma due to child abuse is often termed Shaken Baby Syndrome. The injuries sustained from shaking can cause permanent brain damage in an infant (Deutsch, 2019). Abusive head trauma occurs in babies and toddlers 2 years and younger (Deutsch, 2019).

Healthcare practitioners should know how to differentiate head trauma from a child who has fallen from shaken baby syndrome head trauma. It is difficult to diagnose shaken baby syndrome without doing the necessary computerized axial tomography scan (CT Scan) and X-rays to detect brain swelling or bleeding (Deutsch, 2019). However, detailing any history of the baby having been shaken, is a precursor to ordering the above medical imaging. Shaken baby Syndrome is not the only form of head trauma due to child abuse. Children aged 2 and older can also suffer from head trauma due to various abuse. A child can be kicked in the head and suffer trauma. Children rarely sustain serious accidental injuries within the home environment which can lead to serious brain damage (Fairbairn, 1926).

A study conducted at Red Cross Hospital in Western Cape, reviewed medical records of patients (children who sustained fractures) admitted from January 1991 to October 2005 (van As *et al.*,

2007). The study found that 1 per 100 patient attendances to Red Cross Children's Hospital Trauma Unit, suffered non-accidental injuries such as fractures. This is indicative of potential child abuse. "Of the 149 fractures, 57 were of the skull (the most common fracture site)." (van As *et al.*, 2007, p.1) . That 57 out of 149 fractures were skull fractures indicates that abuse is likely present. Children are unlikely to inflict skull fractured onto themselves by accidental trauma. The force that needs to be applied to the skull must be of a great velocity and impact to cause such damage and trauma.

5.3.4.3. Trauma from Burn Injuries

Trauma caused by burns resulted in a joint total of 49 reports on FISDAP® for Group A and Group B. These cases were logged as burns and treated as burns; however, the obscurity behind the intent of injury raises the suspicion of alleged child abuse or neglect. Child victims of burns are mostly under the age of 10 (Peltier, Purdue and Shepherd, 2001). "Burn injuries make up about 10 percent of all child abuse cases" (Peltier, Purdue and Shepherd, 2001, p.1). The percentage of burn injuries (10 percent), is a problem because burns have a very high mortality rate. The mortality rate due to burns is 2.1% per 100,000 person years in developed countries (Jiburum and Olaitan, 2006).

In addition, burns are also extremely painful. Many sequelae are linked to burns. They pose a risk of sepsis due to burnt skin being exposed to the environment and bacteria. Burns can also be disfiguring when hands, face, fingers, and perineum are burnt. Perineum burns raise a great deal of concern as the acute burnt area will be exposed to faecal flora, thus increasing the risk of infection and sepsis (Boxma and Centre, 1995). Similarly, facial burns are dangerous as they can cause respiratory compromise, resulting in inhalation and exhalation difficulty (Zatriqi *et al.*, 2013).

Children are burnt for different reasons. If children are found playing near pots and stoves, the care givers may want to 'teach' them a lesson by putting their hands into boiling water to show them that they can get hurt. This acts as a scarring tactic (Peltier, Purdue and Shepherd, 2001). Inflicted burns leave patterns that can be easily recognized by healthcare practitioners, such as contact burns (cigarette burns, lighter burns or curling iron) (Peltier, Purdue and Shepherd, 2001). Contact burns usually leave a mark representing the object which was used to inflict the burn (Peltier, Purdue and Shepherd, 2001).

5.3.4.4. Drowning as Trauma

It is difficult to distinguish accidental drowning from drowning due to child abuse (Griest and Zumwalt, 1989). The difficulty arises when the circumstances of the immersion are concealed (Griest and Zumwalt, 1989). In rural communities, bath tubs and buckets remain a major site for childhood drowning – be it accidental or intentional (Griest and Zumwalt, 1989). Drowning in the bathtub can be accidental; however, if the care taker was not providing adequate supervision and thus the child drowned, this can be seen as neglect. "With 70.0% of drowning in children aged 0 - 4 years occurring in or around the home in buckets, bathtubs and swimming pools"(Saunders, Sewduth and Naidoo, 2018, p.3).

Group A reported one case of drowning, whereas Group B recorded 0. These low figures are alarming because a systematic review of drowning incidence in South Africa by Saunders, Sewduth and Naidoo (2018, p. 6), states that "drowning mortality rates are high [43.2%] in children aged <15 years, particularly in those aged <5". The World Health organisation Statistics from 2007 and 2009, illustrate that the drowning mortality rate is 2.5 per 100 000 individuals (Saunders, Sewduth and Naidoo, 2018). The under-reporting of drowning on FISDAP® could be due to several aspects. The low drowning count is likely due to the provision of other services not included in the study or fatalities at the drowning site (Saunders, Sewduth and Naidoo, 2018).

5.3.5. Medical

Collectively, the 48 medical cases logged onto FISDAP® by Group A and Group B were not described. This data proves insufficient and could not be added to the probable "missed" cases as no information was given to aid the researcher in including this data. Other categorisations are described below in relation to missed case detection risk.

5.3.5.1. Bites and stings

A total of 4 bites and stings were reported by Group A and Group B, however, it is not indicated whether the bites were from animals or humans. Bites and stings were not included in the researcher's definition of probable "missed" cases. However, it should be noted that human bites can be an abusive nature. It is not a normal human action to bite another human.

5.3.5.2. Healthy Screening

The participants logged 26 patients as healthy. This too provides insufficient data for the researcher to conclude whether or not there was a probable "missed" case of child abuse. Even though a child appears healthy, they could still be emotionally abused. Bruises heal and a child may appear healthy, until the next time they are abused and appear battered. Probable "missed" cases of child abuse could be present due to the vagueness of the term "healthy screening".

5.3.6. Gender and vulnerability to abuse

Within this study, gender was not a statistically significant predictor of probable "missed" child abuse cases. In spite of this finding, a study that analysed data collected from a demographic sample of the United States child abuse reports (n = 1249 case files) found that boys with disabilities were physically and sexually abused more than boys and girls with no disabilities. A total of 65% of abused children within the study were boys with disabilities (Sobsey, Randall and Parrila, 1997). Moreover, the study found that healthy boys were physically abused, whereas girls were more likely to be sexually abused (Sobsey, Randall and Parrila, 1997). Conversely to Sobsey, Randal and Parrila (1997), Farber *et al.*, (2009) state that there are surprisingly few differences between girl and boy victims of sexual abuse. Within their study, 81 girls, as well as 81 boys, were sexually abused during their 3-year period of conducting the study (Farber *et al.*, 2009).

In some studies, girls are abused more frequently than boys. One in 3 girls are sexually abused, whereas 1 in 5 boys are sexually abused (Lauren, 2019). It is also reported that 30% of sexual abuse cases are never reported (Lauren, 2019). Out of the 30% of sexual abuse cases not reported, a significant percentage of boys could be present. Under reporting of boys being sexually abused could be due to them feeling embarrassed about what has happened to them. They could feel that their masculinity has been taken away from them or they could be ashamed and scared of the stigma that comes with homosexuality (if they were sexually abused by a male). Similarly Finkelhor (1997), states that boys appear to be victimized less than girls when it comes to sexual abuse (Finkelhor, 1997). However, boys who are being sexually abused are less likely to report such an incident due to the experience of shame and associated guilt (Finkelhor, 1997). The decrease in disclosure by boys can be due to them being concerned about adults curtailing their freedom (as mentioned in Chapter 2). Child abuse occurs across every socioeconomic level, be it gender, ethnicity or religion (Lauren, 2019).

5.3.7. Age and vulnerability to abuse

It has also been found within this study that in general, the older the child, the higher the risk of a missed child abuse case. It is not necessarily only young children that cannot report abuse. Just because an older child can speak for him/herself and report abuse that is occurring to them, does not mean that they will do so (Seibel and Scott, 2008). They could be living in fear of the perpetrator and what could happen to them if they do tell someone (Dessena and Mullan, 2018). Additionally, the perpetrator could be the bread winner and the child could be scared that there would be no provider for their family if they report the abuse. In many cultures, the families live together and a child may be afraid of the judgement from the family members if he/she were to speak up about the abuse that is taking place, or they may feel that no-one would believe them (Dessena, 2015).

5.3.8. Identification of people emergent properties in the child abuse context

When looking at the case studies provided in the training workshop, participants stated that health systems, police and social workers are to blame for abuse happening. These individuals act to serve the community, however they failed each child that was abused as they were aware of the situation but did nothing to help. Members of society each have the role of protecting children from abuse and they have the autonomy to speak up for those who cannot.

Children are in need of being protected against child abuse and neglect, however, globally it has been recognized that they do not receive sufficient services from professionals and this leads to poor outcomes (Smook *et al.*, 2017). The Signs of Safety®[23] model for child protection which was developed by Turnell and Edwards (1997), is currently implemented over 12 countries which include Australia, United States of America and the United Kingdom (Smook *et al.*, 2017). Conversely, South Africa has a gap in providing professionals with such a model for child protection and interventions with child abuse and neglect (Smook *et al.*, 2017). The qualitative study conducted by Smook *et al.*, (2017), aimed to develop a model to aid with interventions for safety placement of children as well as the removal from a dangerous environment (Smook *et al.*, 2017). The study was conducted within the Cape Peninsula in the Western Cape Province. Data collection and analysis involved semi-structured interviews with social workers (Smook *et al.*,

[23] Signs of Safety® Model: This is an integrated framework for professionals dealing with child abuse and neglect (Sepers, de Roos and van Arum, 2012). The model provides a range of tools for assessing, engaging, planning and making decisions regarding children who have been abused or neglected and their families (Sepers, de Roos and van Arum, 2012). In addition to this, the model returns child intervention as the catalyst which initiates behavioural changes within families (Sepers, de Roos and van Arum, 2012).

2017). Within the study conducted by Smook *et al.*, (2017), it was noted that the Children's act is not being used to its full potential. In addition to this, a lack in training results in professionals relying on instinct and cultural views when in practice (Smook *et al.*, 2017).

5.3.9. Child abuse perpetrators

The respondents post intervention were more likely to answer 'Men' and less likely to answer 'Women' than the respondents pre intervention. A study was conducted within South Africa, whereby 3 515 children aged between 10-17 years were interviewed through randomly selected census enumeration areas (Boyes *et al.*, 2016). Boyes *et al.*, (2016), conducted "the first study which assessed self-reported child abuse through a large, community-based sample in South Africa" (Boyes *et al.*, 2016, p.1). Furthermore, Boyes *et al.*, (2016), found that the main perpetrators of abuse were primary caregivers and relatives for physical abuse and emotional abuse and girlfriend/boyfriends for sexual abuse.

5.3.10. Even detection rates

There was an even distribution of participants between year 1 and year 4 of study on the BEMC, yet there did not appear to be any distinction of the knowledge of CA. This finding may suggest that everyone is equally deficient. So if the EC cohort is detecting such low levels of child abuse, it is disproportionate to child abuse incidence. Missed child abuse cases result in low reporting numbers. This finding links to finding 1 (convergence between answers provided by all year groups- Chapter 4) around the neutrality concept. It would appear that scaffolding and increase in knowledge are extensive regarding the treatment and recognition of other emergency care topics such as myocardial infarction or rapid sequence intubation. This is an anomaly that it isn't so with abuse of a vulnerable group.

5.3.11. Abused children can leave the abusive home whenever they want to

Respondents in the post-intervention were more likely to answer 'Sometimes' and less likely to answer 'Yes' or 'No'. 'Sometimes' (as the dominant answer to the statement above), is a reflective of an ambivalence that suggests respondents do not fully understand that the extent of the controlling nature of abuse includes control over ones freedom of movement. The effect of this notion that victims can sometimes leave is that it creates the fallacious argument that victims can sometimes leave at will and if they don't, it is because of a choice to stay. The abusive context is a coercive context and victims in coercive context cannot exercise the freedom of choice. That they are minors, nuances their reliance on the adult perpetrator. If the alleged perpetrator is the

breadwinner of the family, this can cause the child to not report the abuse as he/she may be worried about income to the family if the breadwinner is sent to jail. There is evidence to suggest that many homeless children may in fact be escaping abusive homes (Penney, 2015).

5.3.12. Referral of child abuse victims, referral resources and awareness of minimum services available for referral

The respondents strongly agreed that they knew the referral of child abuse victims. They also responded that they do have referral resources and are aware of services which deal with child abuse. Majority of the respondents are claiming that they have referral resources such as books and are confident in referring a child abuse/ neglect victim, yet probable 'missed' cases can be identified. Thus this indicates that even though they have confidence in referring a victim, they still lack the necessary education and knowledge to efficiently do so. Having referral resources and knowledge about where to refer the child is invaluable if the practitioner does not know how to adequately identify that the child is being abused/neglected.

5.3.13. Confidence in understanding emotional needs of survivors of child abuse

Respondents strongly agree that they have confidence in understanding the emotional needs of survivors of child abuse. Due to the sensitive nature of child abuse/neglect, it is important for practitioners to know how to deal with children experiencing the abuse and neglect and to understand that these individuals are fragile. This is not a skill which just comes naturally, professionals must be taught how to handle survivors and how to keep the child's trust. The trust for any human being is already broken due to the alleged perpetrator inflicting pain onto the child and causing traumatization.

5.3.14. Self-care techniques

Respondents indicated that they know self-care techniques to prevent self-harm from occurring when dealing with victims of child abuse/neglect. Self-care techniques are of importance as continuous exposure to child abuse can lead to long term post-traumatic stress disorders. Practitioners in the field of medicine are continuously exposed to traumatic injuries caused to innocent children due to abuse, which could leave them feeling helpless. By implementing self-care techniques the practitioner is protecting themselves from vicarious traumatization.

5.4. Morphostasis

The study was designed to use Archer's morphogenetic cycle and shows how morphogenesis or morphostasis relates to child abuse diagnostics in emergency care. The risk of a probable "missed' child abuse cases is far greater with trauma than with medical cases. This could be because of the large array of trauma that can be due to abuse or accidental injury and present with the same signs and symptoms. Many conditions exist which can mimic non-accidental injury, by producing lesions that resemble bruising or burns (Wheeler and Hobbs, 1973). An example of such conditions includes Mongolian spots which appear on the back and buttocks of children and have a blue-grey colour, often mistaken for bruises due to abusing the child by spanking (Nazer and Smyth, 2017). Many other conditions exist and thus diagnosing a child is a complex procedure and involves the need for the practitioner to have knowledge of abuse injuries as well as cutaneous conditions that mimic child abuse (Nazer and Smyth, 2017).

Child abuse and neglect cases can be missed by the participants as they focus more on signs and symptoms of a particular illness or injury instead of linking all of the signs and symptoms together and formulating a bigger picture to question whether abuse has in fact taken place. Missed cases could also be attributed to limited exposure to children aged 0-18 years on road and clinical shifts. Thus the students are not familiar with treating a child and how to adequately inspect their injuries. Within the BEMC program, the students are taught how to treat burn cases and trauma injuries. This leads to students 'boxing'[24] cases and treating injuries according to protocol. They do not investigate why the child was burnt, could it have been due to neglect from the parents' side? In addition to this, trauma injuries are just viewed as penetrating stab wounds or blunt trauma. The students do not interpret a 16-year old stabbing another 16-year old as a case of child abuse. There seems to be a lack in relating age, signs and symptoms, mechanism of injury and intent of injury with one another.

The risk of a probable "missed" child abuse case is lower in Group B compared to Group A. This finding could be attributed to the fact that Group B had minimal access to different bases and hospitals as they were off limits for this particular year group, whereas Group A had access to their locations in previous years. Thus Group B had limited exposure to different cases and this

[24] Boxing: This is a metaphorical word used to describe the action of seeing something (an injury) and figuratively placing it inside a box and treating it as such (Chen, 2011). One does not take into account anything else outside of the figurative box that could influence such an injury. It is a case of "what you see is what you get". There is no thinking beyond what is in front of you or what may have led to the situation.

could be the reason that the probable "missed" cases were lower than that of Group A. Another explanation could be that Group B was taught more efficiently with regards to child cases and abuse and there this group did not have as many probable "missed" cases. A probable "missed" case detection of one probable case of abuse or neglect of every five cases of children presenting to EMS cadres is alarming. As trained professionals, there should be an ideal of zero missed cases. This statistic indicates that there is a flaw in the system and a lack of either education or knowledge on how to recognize child abuse cases.

The screening tool which was taught in the workshop was assumed to help the participants improve their child abuse detection rates and decrease the probable "missed" cases of child abuse reported on FISDAP®, conversely, the participants (save for one) did not implement the screening tool. The lack of participants using the screening tool could have been attributed to the fact that they had other responsibilities or tasks which required their attention. Only one participant implemented the screening tool, therefore future recommendations regarding the screening tool and its implementation need to be made.

5.5. Quality Appraisal of the Qualitative Component

Arguably, the above discussion would be incomplete if the qualitative nature and methods of research are not criticized against principles of quality. In this regard Northcote (2012) is particularly helpful in the selection of criteria to evaluate the qualitative research. Using her guiding principles and criteria for evaluating quality, I will respond to the guiding questions posited by Northcote (2012, p6.).

In relation to the question: "Have the findings of the study contributed to our knowledge and understanding of educational beliefs of university teachers and students?" This study has generated original knowledge around the emergent properties for structural elaboration in society. This was in relation to the emergency care role in child abuse diagnostics. Academics and students now have evidence of the construct validity of Archer's morphogenetic cycle in EC. This benefits both critical sociology and EC care disciplines.

"Are the methods used rigorous, systematic and transparent?" In this regard, the gathering of data is made explicit in Chapter 3. There is evidence of within method and between method

triangulation and convergence of data. The interpretation and analysing of data follows a guided theoretical analysis through the work of Archer. There is theoretical coherence between the paradigm of critical pragmatism, the axiology of critical sociology and the analytical dualism of the Morphogenetic cycle. The sampling strategy is specific to the method used and insures no unfair exclusion or selection bias. The reporting of findings in Chapter 4 is comprehensive and are supported by the many appendices in the interest of full disclosure. Care has been taken not to promote any publication bias. In this way, the claim for rigorous conduct can be made.

"Is the research design defensible and trustworthy and linked to the research questions?" This study is defensible in design as the research strategy addresses the questions posed. The caveat however is that the narrow data collection window for the post facto medical records resulted in data not being available at the time of publication. This does not however imply a malaligned methodology. On the whole my sense is that the findings are credible and supported by evidence derived from this study.

This study included member checking and consensus findings in the workshops, participant confirmability and a constant search for meaningful coherence enabled by the use of mind mapping software. There is evidence of theoretical descriptive and interpretive validity and no doubt the relevance of the topic methods and findings speak to an enhancement of diagnostic probity in prehospital child abuse responses. Lastly the study has been affective in nature for both the researcher and the participants who found the cases of child abuse to be appalling. The qualitative data collection noted the sincerity and moral effort of researcher and participants.

Chapter 6- Conclusion and Recommendations

6.0. Conclusion

Due to the overlapping nature of data obtained, some of the results served dual categories within this thesis. This deliberate duality of data provides within-method and between-method triangulation evidence for the objectives. The quantitative data within this study has trustworthiness, as the data were analysed by a statistician. Data was captured on verified statistical databases. In addition to this, the qualitative data had credibility as participants were truthful and participated on grounds of good faith (Statistic Solutions, 2019). Furthermore, the qualitative findings are authentic because participants described their real life experiences. By applying their real life experiences to cases, transferability took place as the findings are applicable to other similar child abuse contexts. The researcher did not skew the participants' responses to fit a certain narrative, accordingly, the findings of the study have confirmability as there was no bias present from the researcher (Statistic Solutions, 2019).

The aim of the study was to implement a diagnostic screening instrument among Emergency Care (EC) students so as to promote Emergency Care provider agency for social change in relation to child abuse cases. The study intersected the emergency medical services (as the system within which emergency care providers operate), child abuse (as an emergency care burden) and diagnostic screening (as an epidemiological imperative). The aim was achieved by implementing the diagnostic screening instrument amongst the EC students. Even though only one student actually implemented the screening instrument, all other participants of the educative intervention gained knowledge on the screening instrument and thus allowing them the opportunity to have the agency for social change in relation to child abuse in the future. The strengths of the study were the pre- and post-survey, as this was well planned and very easy to distribute to respondents. A pilot study was conducted. This allowed the researcher to make changes and provide a sound survey. A weakness of the study was definitely the educative intervention's (workshop) time allocations, as many of the students were busy and could not attend, despite 4 weeks being allocated. If this study were to be repeated, multiple workshop dates should be available for each year group.

The paradigm, critical pragmatism, proved to be advantageous in implementing multiple methods and documenting the three pillars of emergent properties (CEPs, PEPs, and SEPs) of Archer's Morphogenetic cycle. The methodology, concurrent mixed-methods, provided invaluable answers

in the form of quantitative and qualitative data which verified sufficient evidence in relation to the EC student cohort knowledge, beliefs, and attitudes regarding child abuse.

The educative intervention proved to be successful, however, the EC student cohort in general still has a misperception of child abuse antecedent factors, interventions and consequences. Therefore objective 1.7.1[25]. (Mentioned in Chapter 1), was not completely met. The knowledge of child abuse is there but it is fragmented. Thus the EC student cohort still struggles to form a cohesive relationship between child abuse risk, manifestations and interventions. The analysis of reflective reports after the educative intervention proved to be unsuccessful as participants had other competing commitments to attend to or they simply did not have enough exposure to child abuse cases during the reporting period. Objective 1.7.2[26] was met in the fact that the screening instrument was developed (adjusted from GBV screening instrument) and implemented via the educative intervention, but utilization by students was lacking. Exposure frequency is dependent on rostering in clinical practice/ Child abuse, however, is constantly occurring within our country and in the rest of the world. Objective 1.7.3[27] was met by analysing archival reflective reports on FISDAP® before the educative intervention, yet only one reflective report was obtained after the educative intervention. Taking into consideration all three objectives, additional information was obtained via the archival data providing insight into probable "missed" child abuse cases, providing enriched data for future similar studies.

The value proposition of EC learners in child abuse cases can be promoted through education programs by implementing educative interventions such as workshops and reflective practice to enforce the child abuse screening tool and its potential benefits. Furthermore, curriculum reform

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[25] Objective 1.7.1: To survey the EC student cohort for knowledge, attitudes and beliefs of child abuse antecedent factors, interventions and consequences. Such a survey will assist in understanding both enabling and constraining factors for the implementation of the HPCSA approved screening instrument among EC students.

[26] Objective 1.7.2: To develop and implement an educative intervention that promotes the utilization of the HPCSA approved screening instrument among EC students.

[27] Objective 1.7.3: To analyze reflective reports before and after educative intervention for self-reported narratives on child abuse screening successes or challenges.

should be considered and all educational staff should receive training on the screening tool and the child abuse burden.

Child abuse occurs every day throughout the world, and no country is immune to such a scourge. The relevance and sustainability of child abuse preparedness interventions can be enhanced throughout emergency care by incorporating the screening tool into continuous professional development (CPD) training programmes for all healthcare practitioners with some adaptation. In addition to this, preventative measures should be in place to protect practitioners from possible vicarious traumatisation that can result from the sensitive and traumatic nature of child abuse cases.

The advised handbooks (discussed in Chapter 2), for EMS providers/ students as well as for nurses and nursing students similarly lack information on how to recognize and treat child abuse. If practitioners who are first responders on a scene (emergency medical practitioners) or practitioners that provide continuous care (nurses) have minimal academic texts to refer to and learn from, people emergent properties will deteriorate. If professionals do not know how to interact and intervene within child abuse cases, it also suggests that structural emergent properties in South African health and social care are weak. Policies and guidelines exist (GBV screening tool), yet the majority of the practitioners and EC students do not know that they are available and should be implemented. With both people emergent properties and structural emergent properties being deficient, cultural emergent properties will also take its toll destructively. How must healthcare providers improve a child abuse burdened society and bring about a sustainable service when society provides minimal educative interventions to create knowledgeable practitioners? It is a social cycle that needs to be broken at best or interrupted at the very least.

6.1. Recommendation

Child abuse is a multi-faceted burden of society and thus it is imperative that EC providers have the necessary knowledge regarding this topic. The researcher, therefore, advocates the following recommendations for future researchers and Higher Education Institutions:

6.1.1. Future Research

Further research is required in the field of child abuse screening, recognition, intervention, and treatment within the emergency medical service context. Child abuse screening has been under-studied within the EC profession and should be explored further to document its full potential.

As mentioned in Chapter 5, older children are often afraid to report that they are being abused due to the stigma associated with homosexuality in cases of sexual abuse, or simply because they feel they will not be believed. Even though they have autonomy and freedom of speech, they may feel that they cannot voice what is happening to them and thus it is recommended that studies be conducted on the teenage cohort and cases of abuse.

Within the findings of this study, the risk of missed child abuse cases was lower in Group B, than Group A, therefore it is proposed that a similar study be conducted looking at a larger group of graduates (from all higher education institutes offering the BEMC program) over a longer time period.

Children aged 0-4 years old are of the highest rates of fatal child abuse (WHO, 2002). A research study should be conducted to discover which injuries are more prominent in causing the high fatality rates amongst this age group and what primary and secondary interventions are possible to circumvent premature death from protracted abuse.

6.1.2. Higher Education Institutional Responses

A primary health care or community service learning project (community engagement) can be implemented into the BEMC curriculum of all Universities which offer this program whereby students target schools of their communities rural and urban to create awareness of child abuse and neglect. The community service projects can incorporate teaching the school learners about the different types of abuse, what laws pertaining to child abuse exists as well as how to report if you are being abused. Additionally, basic first aid can be offered to school learners where they are taught how to treat burns which can result from abuse, or how to treat common trauma injuries resulting from abuse.

Universities offering health science programmes should adjust their curricula to incorporate the greater substance of child abuse in each subject throughout the 4-year Bachelor of Emergency Medical Care degree, this should hold true for the nursing curricula as well. When dealing with burns as a topic in the first year within the BEMC curricula, burns due to child abuse should be included and the screening instrument should be taught in the first year subject emergency

medical care theory. If the screening instrument is taught from year one, the students will be exposed to it through all four years of study and eventually, the screening instrument will become easier to implement and screening for child abuse will become second nature to students, which will continue when they become qualified practitioners. Within the second year, child abuse and neglect can be dealt with in primary health care, as well as the subject emergency medical care theory. Similarly, the third year subject emergency medical care theory can also integrate child abuse and link it to drowning. Moreover, the fourth year BEMC students deal extensively with paediatrics and paediatric emergencies. Child abuse and neglect can be incorporated into this as many of these emergencies result due to neglect and abuse.

Child abuse clinical case scenarios should be incorporated into all higher education institutions' skills laboratories, to ensure that EC students gain confidence in dealing with sensitive topics as such. In the interest of mainstreaming interest, these cases should be taught from year one all the way to year four, increasing in difficulty as skill sets and scope increase per year. Practical cases can also be implemented into the nursing curriculum as well as radiography.

6.1.3. Building a Community of Practice

For social change to occur within a society, structural and people emergent properties need to improve. Policies and guidelines concerning child abuse (such as the child abuse screening instrument), should be made explicit and taught to practitioners from different healthcare settings and disciplines in order to create and sustain a community of practice. Social services, SAPS and the judiciary should also be made aware of the screening instrument as they deal with children on a daily basis and the instrument will aid in helping recognize that abuse is present. It should be considered to conduct a study comparing the BEMC curriculum to that of other health professions curricula in South Africa regarding child abuse.

The HPCSA should include a comprehensive section on child abuse within their CPG's, and incorporate this into continuous professional development (CPD) training. To incorporate child abuse into CPD's, the HPCSA should consult and collaborate with the National Department of Health (NDOH). By consulting with one another and creating a collaboration, international standards and best practice can be adopted. Training on child abuse treatment by HPCSA should consist of qualification-neutral approaches to widen and standardise the practice of early detection Child abuse recognition and the implementation of the screening instrument should be taught to all qualifications regardless of their scope. Furthermore, the HPCSA can use their website to

educate and promote awareness of child abuse and neglect and in this way, show leadership in child abuse responses.

6.2. The significance of this study

The value of this study was to warrant that emergency care practitioners be endowed with sufficient knowledge to permit them to handle child abuse cases with self-assurance and agency. The proposed study may have had a modest contribution to the recognition, intervention, and prevention of child abuse within the prehospital setting. Furthermore, the study may likely have facilitated the catalytic transformation of the emergency care community through the empowerment of knowledge regarding child abuse within South Africa. The theoretical contribution was to appraise the contextual relevance and implications of Archer's morphogenetic cycle on emergency care responses to child abuse.

The expected outcomes were to conduct a critical analysis of the current educational status of prehospital child abuse recognition amongst emergency care practitioners, with the intention to facilitate training on the usage of a diagnostic screening instrument to help recognize and intervene if probable abuse was suspected. In this regard, several pedagogic and research instruments were developed. Whilst structural elaboration is time-mediated, this study served to critique social structure through its emergent properties and to implement social action in the form of child abuse detection and diagnostics.

Child abuse and neglect has been an ongoing burden throughout the world and will not be solved overnight. Nevertheless, if society works together to implement change for the good, social agency will likely improve and the burden will be subsided for future generations. Speaking about universal access and social determinants of health, Pitt (2018) proclaims:

> "Let us be the ones who say we do not accept that a child dies every three seconds simply because he does not have the drugs [or freedom from abuse] you and I have. Let us be the ones to say we are not satisfied that your place of birth [and exposure to conscience-free abusers] determines your right for life. Let us be outraged, let us be loud, let us be bold." (Pitt, 2018, p.1)

Similarly, the words from my own childhood resonate: "Unless someone like you cares a whole awful lot, nothing is going to get better. It's not." (The Lorax, 2012). Who would have thought that Dr Seuss may have been referring to resolving the tension between morphogenesis and morphostasis in championing issues in society that are of… *common good*?

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Appendix A: Planning of topic

Child abuse (1)

- Global policies
- Lifespan
- Mortality
- Morbidity

EMS (2)

- Response : support of right protection , NGO, schools , parents , children, social welfare , education
- National policy
- Child act
- DV act
- Risk ; death , morbidity , fear , poor education
- Needs : rights

Screening instrument (3)

- Emergency care diagnostics
- Detection
- Validity

Appendix B: Letter to Cape Peninsula University of Technology to request for permission to implement the proposed study

Dear Mr. de Waal

RE: REQUEST FOR AUTHORIZATION TO CONDUCT RESEARCH AT YOUR INSTITUTION

In partial fulfillment of a master's degree in emergency medical care, I am conducting research titled: *Emergence of Child Abuse Diagnostic Education in Emergency Care: A Common Concern*. I kindly request authorization to conduct the above-mentioned research amongst EMS students in your department. A questionnaire will be used as well as a screening instrument. Furthermore, students will also be undergoing training. Furthermore, I would like to request direct permission for authorization of access to the FISDAP® database.

Violence is customary within the Western Cape and as EMS are often first responders on the scene, it is fundamental to provide adequate care to the victims. Child abuse, in particular, is often undervalued and thus this study aims to understand the current methods/ practices set in place to treat such individuals. Furthermore, this study asks for responses regarding your personnel's experiences. Counseling interventions are set in place should any participant experience discomfort. The data which will be collected is confidential and anonymous. Participation is voluntary and consent informed. Data obtained within this study may be used in other future studies.

Data that will be acquired (questionnaires), will be collected during work hours when selected participants are in class. Service delivery will not be compromised or interfered with, as students will be taught a new set of skills aiming at empowering their agency of change.

For any further questions or more details, please feel free to contact me. Should there be any ethical concerns, the Research Ethics Committee can also be contacted.

A summarized version of the proposed study at hand can be found in the attachment. Thank you for considering this request.

Kind Regards

………………………………………………………………..

Miss Roxanne Maritz (BEMC, BSc Human Life Sciences)

MEMC: Emergency Medical Care master student (CPUT) [Student Number: 214028089]

Emergency Care Practitioner (HPCSA: ECP 0006 289)

Laboratory Technician: Emergency Medical Sciences, Cape Peninsula University of Technology

Contact Details:

Miss Roxanne Maritz, CPUT: EMS, Room E0.24, Education Building, Private Bag X24, Bellville, 7535, Telephone: 021 959 6534/073 7322461

E-mail: maritzr@cput.ac.za / roximaritz@gmail.com

Supervisor: Dr. Navindhra Naidoo

Office: 021 9538408

Email: naidoon@cput.ac.za

Co-Supervisor: Mr. Lloyd Christopher

Office: 021 9538409

Email: lloydc@cput.ac.za

FACULTY: HEALTH & WELLNESS SCIENCES

Department: Emergency Medical Sciences

Contact: Ms N Deliwe (DeliweN@cput.ac.za)
Telephone: 021 953 8408 Fax: 021 959

Ref: 184/EMC/18

Date: 01 October 2018

Student Number:	214028089
Student Name:	Ms Roxanne Tamlyn Maritz
	413 Tyger Ridge, Tyger Falls, Bridal Close, Bellville, 7530

Dear Ms Maritz

Re: Proposed MEMC study at CPUT, EMS

Your application to this department to pursue a Master: EMC study and to use the Department of Emergency Medical Sciences as a study site has reference.

Your study titled: "*Emergence of child abuse diagnostic education in emergency care: a common concern"* is of great relevance to the profession and to the department. Your application has been studied and Departmental permission is hereby granted to collect data from the Department's student population on the following conditions:

1. Participation is voluntary and informed consent [for FGD] will be attained.
2. There will be no unauthorized disruption of the learning programme.
3. You attain Faculty Research and Ethics Committee approval

We wish you well on your post-graduate endeavour.

Kind regards

Mr. Benjamin de Waal

Acting Head of Department: Emergency Medical
Sciences Faculty of Health and Wellness Sciences
Cape Peninsula University of Technology

Appendix C: Letter to participants

Dear Bachelor of Emergency Medical Care Student,

Study Title: *Emergence of Child Abuse Diagnostic Education in Emergency Care: A Common Concern*

I, Miss Roxanne Maritz, am doing research on the *Emergence of Child Abuse Diagnostic Education in Emergency Care: A Common Concern.* I would like to acquire knowledge of current emergency care recognition, prevention, and intervention regarding the topic of child abuse. This study is being conducted in hopes of improving current practices in place. This research is also part of a Master's study in Emergency Medical Care from the Cape Peninsula University of Technology.

Due to the fact that you are a soon to be emergency care practitioner, you are invited to participate in this research study. You will be required to attend a training workshop and to complete a simple questionnaire by answering questions that relate to the recognition, prevention, and intervention of child abuse within the prehospital environment. The questionnaire should take about 40minutes of your time. All responses will be anonymous and information will be confidential to the best of my ability. All cases which you log onto FISDAP® concerning the topic child abuse will be used for data collection.

Participation is completely voluntary and at any time if you feel uncomfortable or wish to not partake within the study, you can withdraw without fear. I would appreciate it if you do inform me of such decisions. Participants are also expected to sign an agreement of non-disclosure. Counseling will be available for participants who feel that they require extra support due to the nature of the study. Your HOD has been made aware of the study and consent was applied for data collection during work hours.

There is no remuneration or direct benefits for participation, however, it is hoped that emergency care service can be improved with the findings of this study.

Kind Regards

…………………………………………………………………..

Miss Roxanne Maritz (BEMC, BSc Human Life Sciences)

Master of Emergency Medical Care student (CPUT) [Student Number: 214028089]

Emergency Care Practitioner (HPCSA: ECP 0006 289)

Contact Details:

Miss Roxanne Maritz, CPUT: EMS, Room E0.24, Education Building, Private Bag X24, Bellville, 7535, Telephone: 021 959 6534/073 7322461

E-mail: maritzr@cput.ac.za / roximaritz@gmail.com

Supervisor: Dr. Navindhra Naidoo

Office: 021 9538408

Email: naidoon@cput.ac.za

Co-Supervisor: Mr. Lloyd Christopher

Office: 021 9538409

Email: lloydc@cput.ac.za

Appendix D: Letter to obtain informed consent from participants

Informed Consent and Non-Disclosure Agreement Form

This Informed Consent Form is directed to Emergency Care students studying at CPUT, Bellville who are invited to participate in a research study, titled "Emergence of Child Abuse Diagnostic Education in Emergency Care: A Common Concern".

Name of Researcher:	**Miss. Roxanne Tamlyn Maritz**
Name of Supervisors:	**Dr. N Naidoo and Mr. L Christopher**
Name of Institution:	**CPUT**
Name of Project:	**Emergence of Child Abuse Diagnostic Education in Emergency Care: A Common Concern**

This Informed Consent Form has two parts:

- **Part I: Information Sheet (to share information about the study with you)**
- **Part II: Certificate of Consent (for signatures if you choose to participate)**

You will be given a copy of the full Informed Consent Form

Part I: Information Sheet

Introduction

I am currently enrolled in a Master's Degree in Emergency Medical Care at CPUT. In order to achieve this qualification, I am required to conduct a research project titled the emergence of child abuse diagnostic education in emergency care: a common concern. You are invited to participate in this research. You will also be informed about the results once the research has been conducted.

Purpose of the research

I, Miss Roxanne Maritz, am doing research on the Emergence of Child Abuse Diagnostic Education in Emergency Care: A Common Concern. I would like to acquire knowledge of current emergency care recognition, prevention, and intervention regarding the topic of child abuse. This study is being conducted in hopes of improving current educational practices in place. This research is also part of a Master's study in Emergency Medical Care from the Cape Peninsula University of Technology

Due to the fact that you are a soon to be emergency care practitioner, you are invited to participate in this research study. You will be required to attend a training workshop and to complete a simple questionnaire by answering questions that relate to the recognition, prevention, and intervention of child abuse within the prehospital environment.

Type of Research Activity

This research will involve your participation in training, questionnaires and FISDAP recording of data.

Participant Selection

You are invited to be part of this research study, as you may come in contact with children who have suffered abuse or violence as patients when you work on the road for clinical practice or one day when you are a qualified ECP.

- Participants will have to be registered as students in the Bachelor of Emergency Medical Care program at CPUT.
- They will also need to be registered with the HPCSA as a Paramedic or ECP student.

Voluntary Participation

Your participation in this research is entirely voluntary. It is your choice whether to participate or not. Your participation is completely anonymous and you may withdraw from the study at any given time if you feel uncomfortable. Withdrawal from the study will not impact your academic record in any way.

Procedures

If you accept, you will be asked to participate in a questionnaire. FISDAP data will need to be recorded if you come across a victim of child abuse during your clinical practice shifts. Questionnaires will be anonymous and will be locked up in a safe to which only I have access to. In transit, they will be locked inside a bag with a padlock.

Duration

The questionnaire will take 40 minutes. Training will be done over a time period of 2-4weeks.

FISDAP data will be recorded for a time period of 1 month.

Risks

Due to the sensitive nature of the topic, participants may experience post-traumatic stress symptoms. If this does occur, counseling will be made available to these participants. Dealing with abused children may constitute a critical incident that may result in critical incident stress. Re-traumatization may occur when revisiting previously traumatic experiences. Practitioners are not protected from this risk as there are no controls for preventing exposure to an abuse victim. Practitioners then have to manage this risk or the consequences thereof. Should students self-report signs of anxiety or stress during or after the participation in the study, I will facilitate a referral to University student counseling services to which students are entitled at no additional cost. Should participants evoke memories of personal traumas, I will immediately stop their participation and provide a safe space for disclosure or referral. Peer support will then be provided.

Benefits

There may be a benefit to both you and the child abuse victims you encounter on the road if your participation is educative. The study may equip you on how to adequately screen for child abuse within the pre-hospital setting. The knowledge that you gain is intended to be directly applicable to your clinical practice.

Knowledge and screening have benefits for subjects such as Primary Healthcare, Emergency Medical Care, Foundations of Professional Practice, Educational Techniques and Diagnostics. Such knowledge is empowering and positions the practitioner as part of the solution and not part of the problem. It has the potential to build agency and negate learned helplessness.

Reimbursements

No financial incentive will be provided for part taking within this research.

Confidentiality

The information which will be collected from the research will remain confidential. All information will receive a number. Your name will not be mentioned anywhere within the write up of the research. All information is confidential and only the researcher and supervisors will have access to it. Furthermore, all questionnaires will be locked in a safe to which only the researcher has the key to.

Sharing the Results

Results may be published, however, no attribution to participants will be made by name. Students will also receive feedback on the results obtained.

Right to Refuse or Withdraw

Participation is completely voluntary and at any time if you feel uncomfortable or wish to not partake within the study, you can withdraw without fear. I would appreciate it if you do inform me of such decisions. Participants are also expected to sign an agreement of non-disclosure. Counseling will be available for participants who feel that they require extra support due to the nature of the study. Your employer has been made aware of the study and consent was applied for data collection during work hours.

Who to Contact

- If you would like to gather more information on this study feel free to contact me (Roxanne Maritz; researcher) or any of my supervisors
- Miss. Roxanne Maritz
  - Cell: 072 732 2461
  - Office: 021 9538408
  - Email: roximaritz@gmail.com
- Dr. Navindhra Naidoo
  - Office: 021 9538408
  - Email: naidoon@cput.ac.za
- Mr. Lloyd Christopher
  - Office: 021 9538409
  - Email: lloydc@cput.ac.za

This proposal has been reviewed and approved by the CPUT Health and Wellness Sciences Research Ethics Committee. The committee aims to make sure that research participants are protected from any harm. If you want to find out further information about your rights feel free to contact Miss. Seth at 021 9596917(or at sethn@cput.ac.za)

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Ethics Clearance Number: CPUT/HW-REC 2018/H31

Part II: Certificate of Consent and Non-disclosure Agreement

I have been invited to participate in research concerning child abuse screening. My participation in this study involves answering a questionnaire, recording FISDAP data and being part of the training. I am aware that I can withdraw from the study at any point in time without any repercussions.

> **I have read the information sheet for the study *Emergence of Child Abuse Diagnostic Education in Emergency Care: A Common Concern.* I understand what my involvement in the study means and I voluntarily agree to participate and not disclose any information regarding the study.**

Print Name of Participant__________________

Signature of Participant __________________

Date ___________________________

Day/month/year

Appendix E: Analytical tool to judge the information collected by ems

Child Abuse Routine Screening Implementation in EMS

A. Demographic information: Tick all the categories that apply to the 3 groups below

1. Practitioner

Age (years)	20-29	30-39	40-49	50-59	60+
	1	2	3	4	5

Race	Black African	Indian	Coloured	White
	1	2	3	4

Gender	Male	Female
	1	2

Tick all your qualifications	
ECP	1
ECT	2
NDip EMC	3
CCA	4
AEA	5
BAA	6
Specify Other	

EMS experience in years	
1-5	1
6-10	2
11-15	3
16-20	4
21-25	5
26-30	6
31-35	7

2. Patient

Age (years)	0-3	4-6	7-9	10-12	13-15	16-18
	1	2	3	4	5	6

Race	Black African	Indian	Coloured	White
	1	2	3	4

Gender	Male	Female
	1	2

Chief complaint (presenting)			
MVA	1	Other trauma	7
Assault	2	Gynaecology	8
Burns	3	Asthma	9
Shooting	4	Cardiac	10
Rape	5	Overdose	11
12 Domestic Accidents	6	Infectious Disease	12
Specify Other			

Frequency of EMS use (in general/ for any complaint)	
daily	
At least once a week	2
At least once a month	3
Every 2-3 months	4
2-3 times a year	5
Once a year	6
First time	7

3. Alleged Perpetrator

Age (years)	12-19	20-29	30-39	40-49	50-59	60+
	1	2	3	4	5	6

Race	Black African	Indian	Coloured	White
	1	2	3	4

Gender	Male	Female
	1	2

Type of abuse (can tick more than 1)	
Physical	1
Sexual	2
Emotional	3
Psychological (Including: Intimidation, harassment or stalking)	4
Verbal	5
Economic	6
Specify 7 Other	

Frequency of Abuse (if applicable)	
Almost daily	1
At least once a week	2
At least once a month	3
Every 2-3 months	4
2-3 times a year	5
Once a year	6
First time	7

(Adapted from: Naidoo, 2017)

Child Abuse Routine Screening Implementation in EMS

EMS location		Patient History (Can tick more than 1)							
Urban (City)	1	Previous domestic violence 1 injury needing health care						Has a chronic medical condition (e.g. asthma)	4
Peri-urban (Stellenbosch/Paarl/Atlantis)	2	Previous domestic violence 2 injury not reported to EMS						Believes EMS should screen for DV	5
Rural (Winelands)	3	Previous domestic violence 3 Protection Order obtained						Would like telephonic advice on rights and services	6
Specify if inter-facility transfer		Period/length of abuse in years						Specify Other (e.g. Pregnancy)	
4		<2	2-5	5-10	10-15	>15		12	
		7	8	9	10	11			

B. Child Abuse (CA) Screening: Choose 1, 2 or 3 and tick all the categories that are applicable

Direct questioning 1			Indirect questioning 2		
1. CA DETECTED		**2. UNCERTAIN**		**3. CA NOT DETECTED**	
Patient discloses abuse		Patient does not disclose abuse but you suspect the presence/history of abuse		The patient does not disclose abuse and you have no suspicion of abuse	
New admission of abuse to health care	1				
Provided information	2	Provided information	1	Provide information	1
Supported patient	3	Discharged on scene	2	Discharged on scene	2
Documented observations and took a history	4	Treated presenting pathology	3	Treated presenting pathology	3
Informed patient of rights in relation to the DV Act	5	Referred to hospital with a handover of uncertainty	4	Referred to hospital having excluded DV presence	4
Protected chain of evidence	6	Specify 5 other:		Specify 5 other:	

C. Conduct a Safety assessment: If Child Abuse is detected (1 above) or if you are uncertain (2 above), tick YES, NO or UNCERTAIN for each of the 6 questions below.

SAFETY ASSESSMENT	YES	NO	Uncertain
1. Has the violence increased?	1	2	3
2. Does the perpetrator use alcohol and drugs?	1	2	3
3. Has the perpetrator threatened to kill her/ him?	1	2	3
4. Does the perpetrator have access to weapons?	1	2	3
5. Is the patient afraid to go home?	1	2	3
6. Has the patient/perpetrator thought about killing herself/ himself?	1	2	3

Explain____

D. Where did you refer the patient? : Tick all the categories that are applicable.

Police	Hospital ED	Clinic	Non-governmental Organisation	Faith based organisation	Not referred, discharged on scene	Other
1	2	3	4	5	6	7

Explain (say to whom you handed over)

____

E. To what extent did the training prepare you for screening of this case? Tick

Not at all	Not sure	Somewhat	Mostly	Extremely well
1	2	3	4	5

Explain____

F. What aspect of the screening was challenging for you?
Tick all the categories that you found challenging during screening.

Asking directly	Asking indirectly	Documenting the case	Supporting victims	Conducting a Safety assessment	Victim Referral
1	2	3	4	5	6

Explain____

G. Please make any other relevant comment?

____

End. Thank you for completing the screening Instrument.

Appendix F: Questionnaire: Child abuse responsivity by emergency care providers

Adapted from Naidoo, 2017

This was developed in Microsoft Word and will be printed in A4 format.

QUESTIONNAIRE:

CHILD ABUSE RESPONSIVITY BY

EMERGENCY CARE PROVIDERS

MEMC Candidate: Roxanne Maritz

Supervisor: Dr. Navindhra Naidoo (CPUT) and Mr. Lloyd Christopher

Cape Peninsula University of Technology

Department of Emergency Medical Sciences

Faculty of Health and Wellness Sciences Private

Bag X24, Bellville, 7535,

Cape Town

E-mail: roximaritz@gmail.com/ maritzr@cput.ac.za

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Dear Participant,

Consent to Participate in Research on Child Abuse Responsivity by Emergency Care Providers Questionnaire

Study Title: ***Emergence of Child Abuse Diagnostic Education in Emergency Care: A Common Concern***

Thank you for your willingness to participate as a volunteer in the research study conducted by Miss Roxanne Maritz. Miss Maritz may be contacted at 072 7322461 at any time if there are questions concerning the research.

The participation is completely voluntary, and at any given time if you feel the need to withdraw, you may do so. No penalties or loss of benefit will occur. Your lecturer in charge has been informed about the research study to be conducted.

Please note that counseling is available should you require such services within your period of part-taking in the study.

Before commencing please sign below for consent. All questions must be marked clearly with an (X) where needed and explanations provided where a request arises.

Multiple answers/selections are acceptable for this questionnaire. Please answer earnestly. Your identity will remain anonymous.

Acknowledgement/ Informed Consent

I have read the information sheet for the study: Prehospital *child abuse recognition among emergency care providers.*

I understand what my engagement in the study means and I hereby agree to voluntarily participate.

……………………………………. ………………………………..

Signature of Participant Date

Date: ___________________2018 Study Site/Employer: __________________________

1. Indicate your gender.

Male	Female
1	2

2. Indicate your age group.

<25	25-29	30-34	35-39	40-44	>/=45
1	2	3	4	5	6

3. Indicate your qualifications.

BAA	AEA	CCA	NDIP	NCert	BTECH EMC	Other
1	2	3	4	5	6	7

Explain other qualifications: ____

4. Where your work is mostly positioned.

Urban	Rural	Communication	Operations	Education	Management
1	2	3	4	5	6

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5. Where will/ did you complete your medical qualification?

KZN	WC COEC	DUT EMC&R	CPUT EMS	UJ EMC	UCT	Other
1	2	3	4	5	6	7

6. How many years have you been working in the medical field?

0-1	2-5	6-10	11-15	16-20	>20
1	2	3	4	5	6

7. Indicate your race:____

PART II: EXPERIENCE AND KNOWLEDGE OF CHILD ABUSE

Adapted from Naidoo, 2017

8. How many emergency calls, on average, were you dispatched to in the last month?

0-25	25-50	51-75	76-100	101-125	126-150
1	2	3	4	5	6

9. In your estimation, what was the percentage of these responses (above) in which you identified the presence of child abuse?

0-10%	10-20%	20-30%	30-40%	40-50%	50-60%	60-70%	70-80%
1	2	3	4	5	6	7	8

10. Within the last year, how many child abuse cases did you diagnose as child abuse related calls?

0-10%	10-20%	20-30%	30-40%	40-50%	50-60%	60-70%	70-80%
1	2	3	4	5	6	7	8

11. In your experience, perpetrators of child abuse are mostly…

Men	Women	Children
1	2	3

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12. Do you agree with the following statements?

STATEMENT	YES	NO	SOMETIMES
Alcohol and drugs are the main causes of child abuse.	1	2	3
Abused children can leave home whenever they want to.	1	2	3
Men who beat their children are mentally ill and cannot control their violence.	1	2	3
Child abuse is a private matter.	1	2	3
A child who nags is asking to be abused.	1	2	3
Physical abuse is worse than emotional abuse.	1	2	3
Children who do not listen to their parents deserve to be abused.	1	2	3
Only poor, uneducated and mostly black/colored children are abused.	1	2	3
Violence includes any controlling, abusive or fear-inducing act that	1	2	3

threatens to harm the health, well-being or safety of a person.			
Violence and love cannot exist together in one home.	1	2	3
Children who are abused enjoy it or are mentally ill.	1	2	3

(Adapted from Naidoo, 2017)

13. Do you think that there is an underreporting of child abuse violence incidents to the EMS sector

Yes	No	Uncertain
1	2	3

14. What are the reasons for the under-reporting of child abuse to the Emergency Medical Service?

No telephonic access	Reporting is not seen as a priority by the victim	The communication center does not prioritize child abuse	There is poor handling of child abuse calls by EMS	The victim is ashamed to call for help	The victim is afraid to call for help
1	2	3	4	5	6

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Other reasons for under reporting to the EMS are:

15. Is there any special handling of child abuse calls in terms of education, call taking, dispatch and response in EMS?

Yes	No	Uncertain
1	2	3

If yes, explain:

16. Are there any laws that empower emergency care personnel to support victims of domestic violence?

Yes	No	Uncertain
1	2	3

If yes, list them:

17. Is routine child abuse identification important for emergency care providers?

Yes	No	Uncertain
1	2	3

Why?

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18. As an emergency care practitioner, when or where would you detect child abuse?

____

____

____

19. Do you experience difficulty in diagnosing the history or presence of child abuse in routine calls?

Yes	No	Never diagnosed
1	2	3

If yes, do you encounter difficulty because…

It is difficult to safeguard	You are uncomfortable to ask routinely	Victims of abuse are ashamed or afraid to admit	There is no point, as there is nothing you can do about it	You do not want to get involved in a private matter
1	2	3	4	5

Other reasons are…

____

____

20. Have you referred victims of child abuse in the last year?

Always	Sometimes	Not at all
1	2	3

21. To whom would you refer child abuse victims?

Clinic or hospital	Police	Crisis Centre/Non-governmental	Social worker/Psychologist	Religious organization	Uncertain of referral
1	2	3	4	5	6

Other referral choices: ____

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22. Are you aware of any service provider that deals with child abuse in your area of work?

Yes	No	Uncertain
1	2	3

23. If yes, what is the domestic service provider name, telephone number and address?

    Name:____________Tel:_______________Address:______________________

    ____

24. Do you have a referral resource book/center to consult?

Yes	No
1	2

25. Did your EMS education prepare you for responding and dealing with child abuse?

Not at all	Inadequate	Adequate preparation	Well prepared
1	2	3	4

26. Specify what particular child abuse/domestic violence training you have had and by whom.

    ____

    ____

    ____

27. What, in your opinion, is the cause/s of child abuse?

    ____

    ____

    ____

    ____

    ____

    ____

    ____

    ____

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28. What is your current treatment of child abuse cases?

29. What is needed and possible in the treatment of child abuse victims in EMS?

Current Practice with respect to	**What is needed and possible in the EMS**

30. Should EMS personnel detect and report child abuse in their daily practice? Why?

31. How can EMS be more responsive to child abuse victims and survivors?

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32. Define the term “child abuse”

33. Name the physical and/or psychological effects of child abuse on the survivor.

34. How can you as a health care provider, support survivors of child abuse and provide safety in your current role in EMS?

PART III: SELF-PERCEPTION OF LEARNING AND EXPERIENCE

Adapted from Naidoo, 2017

Please indicate with a cross (X) how strongly you agree/disagree with the following statements.

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35. I feel confident I have an understanding of the emotional needs of survivors of child abuse

Strongly Agree	Agree	Undecided	Disagree	Strongly Disagree
5	4	3	2	1

36. I feel confident I have the communication skills needed to work with children who have been victims of violence.

Strongly Agree	Agree	Undecided	Disagree	Strongly Disagree
5	4	3	2	1

37. I know the minimum services that should be available for survivors of child abuse

Strongly Agree	Agree	Undecided	Disagree	Strongly Disagree
5	4	3	2	1

38. I feel confident that I know how to refer a survivor to the appropriate services.

Strongly Agree	Agree	Undecided	Disagree	Strongly Disagree
5	4	3	2	1

39. I feel confident that I know at least two self-care techniques to help prevent or address stress I may experience because of my work with child abuse survivors.

Strongly Agree	Agree	Undecided	Disagree	Strongly Disagree
5	4	3	2	1

PART IV: YOUR VIEW ON EMERGENCY CARE PROVIDERS

Adapted from Naidoo, 2017

In your experience, perception or reports from clients…

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40. Emergency Care Providers feel confident and have the skills needed to create a safe environment for patients of child abuse.

Strongly Agree	Agree	Undecided	Disagree	Strongly Disagree
5	4	3	2	1

41. Emergency Care Providers feel confident and have basic knowledge of how to medically examine a child abuse patient.

Strongly Agree	Agree	Undecided	Disagree	Strongly Disagree
5	4	3	2	1

42. Emergency care Providers feel confident that they have basic knowledge of how to document their findings and be objective when dealing with a child abuse patient.

Strongly Agree	Agree	Undecided	Disagree	Strongly Disagree
5	4	3	2	1

43. Conclusions should be made by medical staff and staff should act responsibly on their findings of child abuse.

Strongly Agree	Agree	Undecided	Disagree	Strongly Disagree
5	4	3	2	1

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Appendix G: Letter to service counselling requesting their services if students require the need to seek professional help

Dear Sir/Madam

RE: REQUEST FOR AVAILABILITY OF YOUR SERVICES IF STUDENTS REQUIRE COUNSELLING

In partial fulfillment of a master's degree in emergency medical care, I am conducting research titled *Emergence of Child Abuse Diagnostic Education in Emergency Care: A Common Concern.* I kindly request authorization to have access to your services if students, facilitators or data capturers undergo a trauma or require counseling due to the sensitive nature of the research at hand.

Violence is customary within the Western Cape and as EMS are often first responders on the scene, it is fundamental to provide adequate care to the victims. Child abuse, in particular, is often undervalued and thus this study aims to understand the current methods/ practices set in place to treat such individuals.

For any further questions or more details, please feel free to contact me. Should there be any ethical concerns, the Research Ethics Committee can also be contacted.

A summarized version of the proposed study at hand can be found in the attachment. Thank you for considering this request.

Kind Regards

……………………………………………………………..

Miss Roxanne Maritz (BEMC, BSc Human Life Sciences)

MEMC: Emergency Medical Care master student (CPUT) [Student Number: 214028089]

Emergency Care Practitioner (HPCSA: ECP 0006 289)

Laboratory Technician: Emergency Medical Sciences, Cape Peninsula University of Technology

Contact Details:

Miss Roxanne Maritz, CPUT: EMS, Room E0.24, Education Building, Private Bag X24, Bellville, 7535, Telephone: 021 959 6534/073 7322461

E-mail: maritzr@cput.ac.za / roximaritz@gmail.com

Supervisor: Dr. Navindhra Naidoo

Office: 021 9538408

Email: naidoon@cput.ac.za

Co-Supervisor: Mr. Lloyd Christopher

Office: 021 9538409

Email: lloydc@cput.ac.za

Appendix H: Letter to counselling – email

From: Roxanne Maritz

To: Naythan Kayser

Subject: Re: request for counseling for participants in masters study

Date: 04 October 2018 12:25:23

Dear Mr. Kayser,

Thank you for the help, will contact Miss Smith. Kind Regards

Roxanne Maritz

From: Naythan Kayser <kaysern@cput.ac.za> **Sent:** Thursday, October 4, 2018, 10:13 AM **To** Roxanne Maritz

Cc: Navindhra Naidoo; Elisabet Smit

Subject: RE: request for counseling for participants in masters study Dear Roxanne

Thank you for your email, the contents are noted. I've been on leave hence only being able to reply to you now.

I can be one of the teams of counselors you use for your study but cannot be the only one doing it. I suggest you reach out the Head of The Student Counselling Unit Ms. Eisabeth Smith, to request the assistance of her psychologist and counselors at the various campuses her email is : SmitE@cput.ac.za (tell: 021 460 3399).

Alternatively, I suggest you reach out to a trauma center as they are also available to do containment counseling when and where needs are. You can find their details on google.

Wishing you all the best with your data collection process.

Regards,

Naythan Kayser

From: Roxanne Maritz

Sent: 02 October 2018 01:09 PM

To: Naythan Kayser

Cc: Navindhra Naidoo

Subject: request for counseling for participants in master's study

Dear Mr. Kayser,

I hope this mail finds you well.

In partial fulfilment of a master's degree in emergency medical care, I am conducting research titled: *Emergence of Child Abuse Diagnostic Education in Emergency Care: A*

Common Concern. I kindly request that counseling be available for students partaking in this study if they shall require it due to the sensitive nature of the topic.

Violence is customary within the Western Cape and as EMS are often first responders on the scene, it is fundamental to provide adequate care to the victims. Child abuse, in particular, is often undervalued and thus this study aims to understand the current methods/ practices set in place to treat such individuals. These individuals will be exposed to sensitive questions and thus may require debriefing or counselling.

Counseling will need to be available for 1st, 2nd, 3rd and 4th years on the BEMC program. Thus the total amount of students will be 250. I assume that not all students will require counseling but as precaution access to such services will greatly help those who are affected by the content.

For any further questions or more details, please feel free to contact me. Should there be any ethical concerns, the Research Ethics Committee can also be contacted.

Your consideration is greatly appreciated. Kind
Regards

Kind Regards

Roxanne Maritz **(BSc Human Life Sciences, BEMC) Laboratory Technician**

Department of Emergency Medical Sciences Faculty of Health and Wellness Sciences

Cape Peninsula University of Technology | #WeAreCPUT

t: +27 (0) 21 953 8408 | e: maritzr@cput.ac.za| w: www.cput.ac.za/DEMS |

New Health and Wellness Sciences Building, 1st Floor Room, E1.25, Bellville Campus | PO Box 1906 Bellville 7535 | Symphony Way, Bellville, Cape Town, South Africa

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Reply Reply All Forward

Tue 09/10/2018 12:08

Elisabet Smit

Re: request for counselling

To Roxanne Maritz

You replied to this message on 09/10/2018 12:45.

Dear Roxanne,

Any registered CPUT student can request counseling / therapy from a student counselor (registered psychologist) at Student Counselling. This service is free of charge.

The student in need of counseling / therapy can just approach our offices on the Bellville, District Six, Mowbray or Wellington campuses.

I assume that it will EMS students, so they can get assistance from Student Counselling Bellville, Ground Floor, New Extension to the Library Building, Our offices are open week days from 08h00 - 16h00.

Kind regards.

Appendix I: Letter of consent from Dr. Naidoo to use and adapt his questionnaire

From: Roxanne Maritz
Sent: 17 October 2018 04:00 PM
To: Navindhra Naidoo
Subject: permission request

Dear Dr. Naidoo

I hereby write this email to request permission to use and adapt the questionnaire used within your masters and thesis document as part of my masters research concerning child abuse.

Kind Regards
Roxanne Maritz

Wed 17/10/2018 16:06
Navindhra Naidoo
RE: Permission request to use/adapt research instrument
To Roxanne Maritz

Hello Ms Maritz
Thank you for your request.

I have no objection for you to use or adapt the Domestic Violence Responsivity Questionnaire to be more descriptive/sensitive to cases/knowledge of child abuse.

Very best wishes.

Kind Regards

Dr Navindhra Naidoo **(BTech EMC, HDE, MPH, PhD)**
Acting Head of Department: Emergency Medical Sciences
Emergency Care Practitioner (HPCSA)
Department of Emergency Medical Sciences
Faculty of Health and Wellness Sciences
Cape Peninsula University of Technology | #WeAreCPUT

t: +27 (0) 21 953 8408 | e: naidoon@cput.ac.za | w: www.cput.ac.za/DEMS |
New Health and Wellness Sciences Building, 1st Floor Room, E1.25, Bellville Campus |
PO Box 1906 Bellville 7535 | Symphony Way, Bellville, Cape Town, South Africa

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Appendix J: Post training workshop survey

The post-survey will address the following knowledge areas using an online survey system that facilitates the answering of multiple choice questions in an efficient manner. The value of this is that initial analysis can help identify knowledge gaps and provide an immediate opportunity for remediation. In this way, the ethical requirement for preparedness prior to screening is met. The post workshop survey can be found via the following link: https://docs.google.com/forms/d/1T0rWSO_xIBJLO681Y-mrUUzMOTvKSmvIntUQkTEcCjU/edit?usp=drive_web

The caveat is that the following assessment is not necessarily an evaluation of the screening tools but rather an evaluation of knowledge gained through the workshop held.

The knowledge areas include;

1. Antecedent factors for child abuse
   Participants should demonstrate knowledge of antecedent factors for child abuse such as what constitutes risk and vulnerability for abuse. This includes knowledge of child neglect, conceptual definitions from the children's act and factors that affect vulnerability such as rights and obligations of care givers.
2. Prevention opportunities for child abuse
   Following an epidemiological model of primary prevention, secondary early detection and tertiary care, participants will demonstrate knowledge of what prevention opportunities are probable and desirable in the emergency care milieu. Such opportunities include situational awareness, training, risk factor identification, appraisal of the living environment, diagnostic probity and referral pathways.
3. Consequence management for child abuse.
   Once screened and identified cases of child abuse must follow a particular medical legal pathway. This includes immediate emergency medical care, post exposure prophylaxis, and engagement of child protection unit of SAPS and forensic emergency care. The role of Thuthuzela centers should be known.

Appendix K: Lesson plan for the training workshop

Presented by: Miss RT Maritz

On 6 June 2019 at 09h00

Duration: 3 hours

SUBJECT : Child Abuse Intervention & EMS Screening Implementation

PURPOSE :

- All Emergency Care Providers have an ethical and legal duty to protect children
- All Emergency Care Practitioners are accountable for non-reporting of cases against child abuse
- To give expression to the HPCSA act in relation to child abuse
    - Child Abuse protocol/guideline development will help to personalise the responsibility of EC providers. Regulation 2 of the Scope Regulations of The Health Professions Act (Health

  Professions Act, Act 56 of 1974) deems acts that pertain especially to the profession of EC as:
        - The identification of the EC needs of a child in a child abuse situation;
        - The evaluation of the EC needs of a child in a child abuse situation with due regard to his or her safety and the implementation of precautions to ensure his or her safety;
        - The rescue of a child from a child abuse situation or from a potential child abuse situation;
        - The provision of EC to a child in a child abuse situation; and
        - The prevention of further injury to, and the combating of possible complications of an illness or injury, to a child in a child abuse situation.

OBJECTIVES:

General Objective:

To develop and implement an educative intervention that promotes the utilization of the approved screening instrument among EC scholars.

The approved screening instrument mentioned above refers to Naidoo (2017), a screening instrument that was designed for health care practitioners to recognize gender based violence cases, and was approved by the HPCSA, provided the emergency care providers promote the safety of patients. The screening instrument found within this study is an adaptation of that found in Naidoo (2017), dissertation

1. PREPARATION

In terms of :

- Content
- Lesson notes
- Planning
- Viewing videos of abused children
- Training on Screening Tool
- Case presentations
- Focus discussions

Objective/Purpose	Implementation	Time	Quality Criterion
• All Emergency Care Providers have an ethical and legal duty to protect children • All Emergency Care Practitioners are accountable for non-reporting of cases against child abuse	Power Point	20minutes	• Stick to time • Must have relevance to EC providers • Consensus must be reached
• The identification of the EC needs of a child in a child abuse situation; • The evaluation of the EC needs of a child in a child abuse situation with due regard to his or her safety and the implementation of	4 Cases, Questions for discussion and videos	20minutes per case – 10minute focus group discussion answering questions, followed by	• Strict on time • Consensus must be reached

precautions to ensure his or her safety;		10minute class discussion	
• The evaluation of the EC needs of a child in a child abuse situation with due regard to his or her safety and the implementation of precautions to ensure his or her safety; • The rescue of a child from a child abuse situation or from a potential child abuse situation; • The provision of EC to a child in a child abuse situation; and • The prevention of further injury to, and the combating of possible complications of an illness or injury, to a child in a child abuse situation.	Screening Tool	30 minutes	• Time constraint • Content fits Context
• To see whether the workshop has made a difference and proven to be helpful towards child abuse recognition	Post Workshop Questions – Online Survey	30 minutes	• Organize computer lab • Send out the link at end of the workshop

In terms of the Audience/group :

- High ability group i.e. Bachelor of Emergency Medical Care students 1st – 4th year

- Size: small group i.e. Focus group
- Language: English
- Gender : Male & Female
- Cultural background: Varied

In terms of Venue :

- Medium sized room
- Consider seating arrangement
- Consider audibility and visibility
- Consider environmental conditions i.e., ambient noise, temperature etc.

PRESENTATION

CONTENT:

- **Quantity & Timing:** The content shall consist of all laws associated with child abuse. They should follow each other after the Introduction. This should take no longer than 20minutes and be in the form of a PowerPoint presentation.
- **Knowledge Subject:** I shall lean on my own knowledge but also draw on the experience and knowledge of the audience.
- **Structure:** See Workshop Notes
- **Pace:** Should be fast because of high ability audience but as a guide use less than 1 min/law.
- **Teaching Methods:** Informal democratic
  - a) Ensure instructional stimulus variation, activity change or sensory channel shift.
  - b) Use auxiliary reinforcement ie.illustrations, analogy, anecdotes, and examples.
  - c) The class must participate, relieve emotion, tension and concentration with humour and limiting lecture to 20 minutes.
- **Structure :**
  1. Secure attention – greeting, orientation
  2. Interest Arousal – topic contextualisation – seek a definition of child abuse
  3. Statement of Linkage – a recent enquiry into EMRS child abuse cases
  4. State Objectives / general / specific
  5. State duration (15min) / procedure : interactive / active
  6. Evaluation – group presentations on cases, followed by a 30min online survey
- **Communication :**
  - The language used will be English
  - NB. Remember to use my voice confidence, as well as eye contact and mobility
  - Delivery style

    * democratic

    * accessible

    * serious (because of nature of topic)
  - Use praise and positive re-enforcement
- **Rapport / Class Participation :**
  - Hold class attention

- Use spontaneous involvement
- Use questioning techniques

- **Class Management**
  - Be fair but firm and relaxed
  - Ensure good organization
  - Maintain class control/discipline

- **Evaluation / Assessment of Students**
  - To assess cognitive outcomes
    * use questions/ online survey
    * evaluate perceptions of definitions of child abuse
  - To assess psychomotor development (skill) :
    * discuss management of cases and implementation of the screening tool

CONCLUSION

- Recapitulation – restate main points
- Summary application

TEACHING AIDS

SELECTION BASED ON:

- Cost efficiency
- Functional
- Historical success
- Visual/auditory stimulation
- Suitability for group size
- Can the lesson be repeated
- Movement/Mobility
- Learning space available
- Resources available
- Ability to fit in with a strategy

Therefore use:

- Oxford Medical Dictionary
- Thesaurus
- Real Life Cases
- Pictures/ Videos
- HPCSA Paramedic Handbook
- HPCSA Approved Screening Tool

Appendix L: Training workshop information booklet

ROXANNE MARITZ

Supervisor: Dr. Navindhra Naidoo

Office: 021 9538408

Email: naidoon@cput.ac.za

Co-Supervisor: Mr. Lloyd Christopher

Office: 021 9538409

Email: lloydc@cput.ac.za

Presented by: Miss RT Maritz

On 6 June 2019 at 09h00

Duration: 3 hours

SUBJECT : Child Abuse Intervention & EMS Screening Implementation

CHILD ABUSE WORKSHOP:

Purpose of the workshop?

1. All Emergency Care Providers have an ethical and legal duty to protect children

2. All Emergency Care Practitioners are accountable for non-reporting of cases against child abuse

3. To give expression to the HPCSA act in relation to child abuse

DV protocol/guideline development will help to personalise the responsibility of EC Providers. Regulation 2 of the Scope Regulations of the Health Professions Act (Health Professions Act, Act 56 of 1974) deems acts that pertain especially to the profession of EC as:

a) The identification of the EC needs of a child in a child abuse situation;

b) The evaluation of the EC needs of a child in a child abuse situation with due regard to his or her safety and the implementation of precautions to ensure his or her safety;

c) The rescue of a child from a child abuse situation or from a potential child abuse situation;

d) The provision of EC to a child in a child abuse situation; and

e) The prevention of further injury to, and the combating of possible complications of an illness or injury, to a child in a child abuse situation.

The Health Professions Council of South Africa (HPCSA) Professional Board for Emergency Care (PBEC) Draft Practice Guideline: Emergency Care provider's obligation to report abuse against children, found at the end of this document, indicates how Emergency Care Providers need to handle child abuse cases in their practice, the following workshop will show how we will implement the teaching in order to ultimately achieve such practice.

1) Course Outcomes

Training level descriptions must be adjusted for each professional category, but at the end of an academic programme, the pre-hospital EC provider student should have the following general pedagogic outcomes.

1.1. The core curriculum

This should include key concept, guiding principles, screening guidelines and a key concept in clinical management:

- Understand key concepts in child abuse and the role of EC
  - What defines child abuse? What is the global and site specific burden of child abuse?
- Understand guiding principles for helping victims of child abuse and the protection of human rights
  - What is the role of EC as an entry point and sometimes only point of contact
  - What is the role of EC in public health, violence prevention, and as community health resources?
  - What is the EC role in preventing the recurrence of violence?
  - Understand the inter-disciplinary and integrated approach to child abuse and the role of EC.
- Understand how child abuse may present in the pre-hospital setting
- Be able to implement a child abuse screening tool on a routine and universal basis. Advanced practitioners must implement clinical case finding.
- Be able to manage all pre-hospital relevant aspects of child abuse patient care, including physical injury, psychosocial concerns, emotional abuse and sexual abuse
- Be able to refer and connect victims of child abuse to local resources to help and sheer their future safety and empowerment

1.2 Specific Objectives will include:

To develop and implement an educative intervention that promotes the utilization of the approved screening instrument among EC scholars. The approved screening instrument mentioned above refers to Naidoo (2017), a screening instrument that was designed for health care practitioners to recognize gender based violence cases, and was approved by the HPCSA, provided the emergency care providers promote the safety of patients. The screening instrument found within this study is an adaptation of that found in Naidoo (2017), dissertation

1.3 Guiding Curriculum Principles should include:

- **The survivors'/victims' rights and needs are first and foremost**
  - Right to privacy
  - Right to confidentiality
  - Right to choose/autonomy
  - Equity and non-discrimination
  - Right to dignity
  - Ensure accessibility
  - Assess and manage safety
  - Do no harm
  - Promote effectiveness
- **Human rights protection and promotion**
  - Global (universal)
  - Local enactment (Constitutional/provincial / regulatory)
- **Quality of care: What is the duty of EC Providers?**

The knowledge areas include;

4. Antecedent factors for child abuse
   Participants should demonstrate knowledge of antecedent factors for child abuse such as what constitutes risk and vulnerability for abuse. This includes knowledge of child neglect, conceptual definitions from the children's act and factors that affect vulnerability such as rights and obligations of care givers.
5. Prevention opportunities for child abuse
   Following an epidemiological model of primary prevention, secondary early detection and tertiary care, participants will demonstrate knowledge of what prevention opportunities are probable and desirable in the emergency care milieu. Such opportunities include situational awareness, training, risk factor identification, appraisal of the living environment, diagnostic probity and referral pathways.
6. Consequence management for child abuse.
   Once screened and identified cases of child abuse must follow a particular medical legal pathway. This includes immediate emergency medical care, post exposure prophylaxis, and engagement of the child protection unit of SAPS and forensic emergency care. The role of Thuthuzela centers should be known.
7. Reporting post facto (create a reflective tool) (1. Own educational growth, 2. how does this prepare you for reporting in the real world when you are a graduate)

2) Key Concepts in Child Abuse

2.1. What is a Child?

For the study at hand, the term child will refer to all children aged 0 years- 18 years of age. Webster (2018) defines the term child as a young person, between infancy and youth.

2.2. What is Abuse?

Abuse denotes to treat with violence or cruelty on a regular basis (Oxford, 2018a). Furthermore, the Oxford dictionary defines abuse as treating someone in such a way to cause harm or damage. Physical maltreatment is associated with the term abuse (Webster, 2018).

2.3. What is Child Abuse?

For the purpose of this study, child abuse implies overt cases of child abuse or allegation thereof. As mentioned above, abuse denotes to treat with violence or cruelty on a regular basis (Oxford, 2018a). Child abuse thus implies violence and cruelty on a regular basis for minors aged 0-18years of age. Treating an individual in such a way as to cause harm or damage on a regular basis (Oxford, 2018a).

2.4. Violence

When physical force is used by an individual to damage, abuse, injure or destroy another individual (Webster, 2018).

2.5. Physical Abuse

According to the World Health Organization, physical abuse is the intentional use of physical force upon a child leading to the harm of the child's health, dignity or survival (Artz *et al.*, 2016).

2.6. Emotional Abuse

Emotional abuse can cause damage to the child's mental and physical health as well as the child's spiritual, social and moral development (Artz *et al.*, 2016)

2.7. Child Neglect

When the basic needs of children have not been met (Dubowitz *et al.*, 1993). Child neglect is defined as a form of child abuse. The Oxford dictionary refers to the term neglect as an act of not taking care of someone (Oxford, 2018b). Socioeconomic status can also play a role in

neglect. Furthermore, the World Health Organization defines child neglect as a failure over time for family members or parents to provide for the wellbeing of the child (Artz *et al.*, 2016).

2.8. Detection

The act of noticing something, further described as identifying something concealed (Webster, 2018b). In the case of this study, if child abuse is not detected, it cannot be treated. Detection also refers to discovering information about a certain crime in order to catch the perpetrator (Macmillan, 2018).

2.9. Missed Cases

Cases where child abuse has gone unreported or have been mistaken for other illnesses instead.

3) Screening :

Table 1: Questions for screening implementation (Joubert *et al*, 2010)

Questions	**Responses**
Is this an important public health problem?	Yes, mortality and morbidity studies confirm this
Do we know the natural history of the disease, with and without treatment?	Yes. Child Abuse is can cause children to become adults who abuse their children and so the vicious cycle continues. No treatment results in the poor quality of life, stress and premature death (Naidoo, 2017).
Is there an effective treatment?	Yes. Child helpline and child care centres are established to help the abused, as well as social workers.
Is the screening test valid and reliable?	The screening tool has been approved by the HPCSA
Is there a capacity to confirm and treat everyone diagnosed?	The Emergency Care student will be trained to screen for child abuse, as well as how to respond once abuse has been detected. Reporting detected cases will come from the student's good faith, however, some cases may be missed.
Is there good evidence that such screening programmes have been effective?	Yes. The findings from Naidoo N, Artz L, Martin LJ, Zalgaonker M. (2014). 'A stitch in time…may save nine': A systematic synthesis of the evidence for domestic violence management and prevention in Emergency Care. African Safety Promotion Journal: A journal of Injury and violence Prevention (ASP).12(2),30-48
Will the programme be effective and cost-effective compared to other priorities?	Yes. Training expenses will be the only cost of pre-hospital services.

SCREENING TOOL:

Adapted from Naidoo, 2017

Child Abuse Routine Screening Implementation in EMS

A. Demographic information: Tick all the categories that apply to the 3 groups below

1. Practitioner

Age				years
20-29	30-39	40-49	50-59	60+
1	2	3	4	5

Race			
Black African	Indian	Coloured	White
1	2	3	4

Gender	
Male	Female
1	2

Tick all your qualifications	
ECP	1
ECT	2
NDip EMC	3
CCA	4
AEA	5
BAA	6
Specify Other	

EMS experience in years	
1-5	1
6-10	2
11-15	3
16-20	4
21-25	5
26-30	6
31-35	7

2. Patient

Age		years			
0-3	4-6	7-9	10-12	13-15	16-18
1	2	3	4	5	6

Race			
Black African	Indian	Coloured	White
1	2	3	4

Gender	
Male	Female
1	2

Chief complaint (presenting)			
MVA	1	Other trauma	7
Assault	2	Gynae-cology	8
Burns	3	Asthma	9
Shooting	4	Cardiac	10
Rape	5	Over-dose	11
12 Domestic Accidents	6	Infectious Disease	12
Specify Other			

Frequency of EMS use (in general/ for any complaint)	
daily	
At least once a week	2
At least once a month	3
Every 2-3 months	4
2-3 times a year	5
Once a year	6
First time	7

3. Alleged Perpetrator

Age					years
12-19	20-29	30-39	40-49	50-59	60 +
1	2	3	4	5	6

Race			
Black African	Indian	Coloured	White
1	2	3	4

Gender	
Male	Female
1	2

Type of abuse (can tick more than 1)	
Physical	1
Sexual	2
Emotional	3
Psychological (Including: Intimidation, harassment or stalking)	4
Verbal	5
Economic	6
Specify 7 Other	

Frequency of Abuse (if applicable)	
Almost daily	1
At least once a week	2
At least once a month	3
Every 2-3 months	4
2-3 times a year	5
Once a year	6
First time	7

Child Abuse Routine Screening Implementation in EMS

EMS location		Patient History (Can tick more than 1)						
Urban (City)	1	Previous domestic violence 1 injury needing health care					Has a chronic medical condition (e.g. asthma)	4
Peri-urban (Stellenbosch/Paarl/Atlantis)	2	Previous domestic violence 2 injury not reported to EMS					Believes EMS should screen for DV	5
Rural (Winelands)	3	Previous domestic violence 3 Protection Order obtained					Would like telephonic advice on rights and services	6
Specify if inter-facility transfer		Period/length of abuse in years					Specify Other (e.g. Pregnancy)	
4		<2	2-5	5-10	10-15	>15	12	
		7	8	9	10	11		

B. Child Abuse (CA) Screening: Choose 1, 2 or 3 and tick all the categories that are applicable

Direct questioning 1			Indirect questioning 2		
1. CA DETECTED		**2. UNCERTAIN**		**3. CA NOT DETECTED**	
Patient discloses abuse		Patient does not disclose abuse but you suspect the presence/history of abuse		The patient does not disclose abuse and you have no suspicion of abuse	
New admission of abuse to health care	1				
Provided information	2	Provided information	1	Provide information	1
Supported patient	3	Discharged on scene	2	Discharged on scene	2
Documented observations and took a history	4	Treated presenting pathology	3	Treated presenting pathology	3
Informed patient of rights in relation to the DV Act	5	Referred to hospital with a handover of uncertainty	4	Referred to hospital having excluded DV presence	4
Protected chain of evidence	6	Specify 5 other:		Specify 5 other:	

C. Conduct a Safety assessment: If Child Abuse is detected (1 above) or if you are uncertain (2 above), tick YES, NO or UNCERTAIN for each of the 6 questions below.

SAFETY ASSESSMENT	YES	NO	Uncertain
1. Has the violence increased?	1	2	3
2. Does the perpetrator use alcohol and drugs?	1	2	3
3. Has the perpetrator threatened to kill her/ him?	1	2	3
4. Does the perpetrator have access to weapons?	1	2	3
5. Is the patient afraid to go home?	1	2	3
6. Has the patient/perpetrator thought about killing herself/ himself?	1	2	3

Explain____

D. Where did you refer the patient? : Tick all the categories that are applicable.

Police	Hospital ED	Clinic	Non-governmental Organisation	Faith based organisation	Not referred, discharged on scene	Other
1	2	3	4	5	6	7

Explain (say to whom you handed over)

E. To what extent did the training prepare you for screening of this case? Tick

Not at all	Not sure	Somewhat	Mostly	Extremely well
1	2	3	4	5

Explain____

F. What aspect of the screening was challenging for you?
Tick all the categories that you found challenging during screening.

Asking directly	Asking indirectly	Documenting the case	Supporting victims	Conducting a Safety assessment	Victim Referral
1	2	3	4	5	6

Explain____

G. Please make any other relevant comment?

End. Thank you for completing the screening Instrument.

Health Professions Council of South Africa (HPCSA)
Professional Board for Emergency Care (PBEC)
Draft Practice Guideline: Emergency Care provider's obligation to report abuse against children (Naidoo, 2017)**.**
Note: To be read in conjunction with other relevant HPCSA PBEC policy, specifically: The PBEC Position Statement on the Social Determinants of Health and the PBEC Domestic Violence Screening Protocol.

Red flags (increased suspicion with injuries) include:

- the explanation doesn't fit the injury as to pattern, timing, or the developmental ability of the child
- explanation keeps changing
- the child is consistently blamed as a cause of repeated injuries
- significant injuries attributed to a young sibling
- delay in seeking medical care
- history of multiple ED visits
- frequent change of primary care provider

Fractures are the second most common injury caused by child physical abuse whereas bruises are the most common injury.
Failure to identify an injury caused by child abuse and to intervene appropriately may place a child at risk for further abuse, with potentially permanent consequences for the child (Dessena, 2015).

A fracture should be suspicious for child abuse in the following circumstances:
There is no history of injury or the history described is not consistent with the injury sustained (Dessena, 2015).
The caregiver provides inconsistent or changing histories.
The fracture is in a non-ambulatory child.

> "*Approximately 80% of all fractures caused by child abuse occur in Children younger than 18 months*"

The fracture has a high specificity for child abuse; in infants and toddlers, these

include classic metaphyseal lesions of long bones and rib, scapular, sternal, and spinous process fractures (Dessena, 2014).

> *"Rib fractures are highly suggestive of child abuse. Most abusive rib fractures result from anterior-posterior compression of the chest. For this reason, rib fractures are frequently found in infants who are held around the chest, squeezed, and shaken. Rib fractures have a high probability of being caused by abuse."*

- There are multiple fractures or fractures of different ages.
- The child has other suspicious injuries.
- The caregiver delayed seeking medical treatment.

Recommended Readings:

1)Hendricks, ML. 2014. Mandatory reporting of child abuse in South Africa: Legislation explored. *S Afr Med J*; 104(8):550-552. DOI:10.7196/SAMJ.8110

2)Naidoo, N. 2017. Gender-based Violence: Strengthening the role and scope of Prehospital Emergency Care by promoting theory, policy and clinical praxis. Ph.D. Forensic Medicine Thesis: UCT, Cape Town

Extra Readings:

1) Emalee G. Flaherty, Jeannette M. Perez-Rossello, Michael A. Levine, William L Hennrikus, et al. Evaluating Children With Fractures for Child Physical Abuse. PEDIATRICS Volume 133, Number 2, February 2014

2) Loder RT, Feinberg JR. Orthopaedic injuries in children with nonaccidental trauma: demographics and incidence from the 2000 kids' inpatient database [published correction appears in J Pediatr Orthop. 2008;28(6):699]. J Pediatr Orthop. 2007;27(4):421–426

3) Jenny C, Hymel KP, Ritzen A, Reinert SE, Hay TC. Analysis of missed cases of abusive head trauma [see comment; published correction appears in JAMA. 1999; 282(1):29]. JAMA. 1999;281(7):621–626

4) Ravichandiran N, Schuh S, Bejuk M, et al. Delayed identification of pediatric abuse related fractures. Pediatrics. 2010;125(1): 60–66

5) Skellern C, Donald T. Suspicious childhood injury: formulation of forensic opinion. JPaediatr Child Health. 2011;47(11):771–775

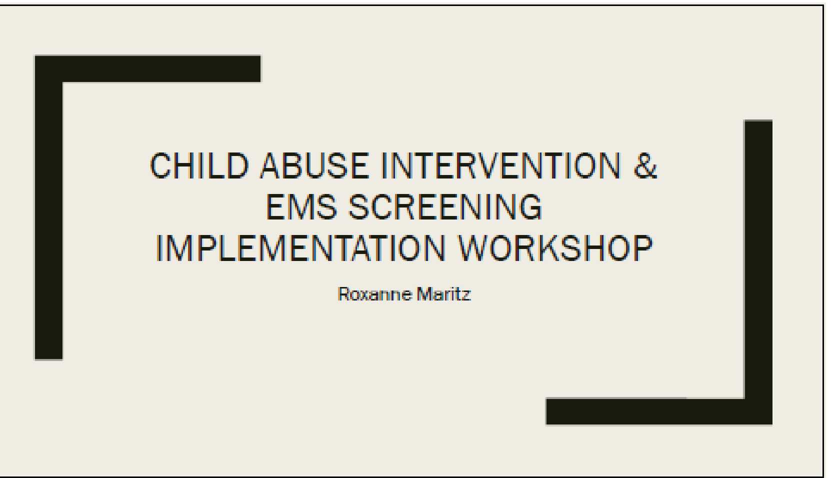
6) Mokhantšo Makoae, Hazel Roberts and Catherine L. Ward. Child Maltreatment Prevention Readiness Assessment: South Africa. Report submitted to the World Health Organisation Department of Violence and Injury Prevention and Disability, Geneva

IMPORTANT NUMBERS

- **Childline South Africa – 24 hour free helpline 08000 55555,**
- **Tygerbear Foundation Cape Town – 021 931 6702**
- **Childline Wynberg – 021 762 8198**
- **Childline Mitchells Plain- 021 376 000**
- **Childline Tygerberg – 021 930 0859**
- **SAPS – 10111 (Mowbray)**
- **Or the crime stop number 08600 10111.**
- **Red Cross Children's Hospital – 021 658 5111**

Appendix M: Training workshop PowerPoint

Information contained within the slides were adapted from Dessena (2014) and Hendricks (2014). It is important to note that this slide show was not disseminated to the students attending the workshop.



Objective

- To develop and implement an educative intervention that promotes the utilization of the approved screening instrument among EC scholars.
- The approved screening instrument mentioned above refers to Naidoo (2017), screening instrument which was designed for health care practitioners to recognize gender based violence cases, and was approved by the HPCSA, provided the emergency care providers promote safety of patients.
- The screening instrument found within this study is an adaptation of that found in Naidoo (2017),

What defines child abuse?
What is the global and site specific burden of child abuse?

Nationally 561 174 young people have experienced physical abuse within their household as per the Optimus study conducted in South Africa (Artz *et al.*, 2016)

It is said that children who experience punishment in physical form, often show aggressive behavior. The effects of physical punishment carry on to adulthood in these individuals lives, which is then carried over to their children (UCT, 2018).

Legislative Framework

- Convention on the Rights of the Child commits the UN and it's signatories to the vulnerability of children and opportunities for prevention.
- Article 19 of the Convention compels signatory states, of which SA is one, to 'take all appropriate social and educational measures to protect the child from all forms of physical or mental violence, injury, neglect or negligent treatment, maltreatment or exploitation including sexual abuse'.
- Article 19(2) of the Convention makes it clear that measures used to protect children need to be protective and preventive and should encompass the identification, reporting, referral, investigation and treatment of child abuse.
- Article 16 of the African Charter on the Rights and Welfare of the Child echoes the obligations set out in the UN Convention. The Charter obligates the African Union (AU) and its signatories to establish special monitoring units and to provide the necessary support for the abused child and his/her caretakers.
- The South African Constitution explicitly addresses the rights of children and affords them specific protection. Section 28(1) (d) holds that 'every child has the right to be protected from maltreatment, neglect, abuse and/or degradation'. The Children's Act
- No. 35 of 2005 and its amendment 41 of 2007 (promulgated in 2010) addresses children's rights in its entirety. Section 110 specifically deals with the protection of children and resonates with the UN Convention and the AU Charter on the protection of children's rights.

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Attending to the problem

- Often victims are scared to lay a charge against the alleged perpetrator
- Breadwinner – dependant on him/her – thus will not lay a charge
- Feeling too weak or afraid to take the matter further
- Refusing to believe your family member could do such a thing
- Culture – where families live together and if a charge is laid then how do you face the rest of the family

Attending to the problem

- When someone confides in you, it is not an easy thing for them to do
  - *They feel ashamed , guilty and that no one will believe them*
- It has probably left them with many sleepless nights
- Always make eye contact
- Give your full attention to them
- Do not ask too many questions making them feel like you are interrogating them
- Don't react in horror, disgust or anger
- Be patient, do not interrupt them
- Don't promise something you cannot carry out
- Make it clear you believe them
- Remind them they can always talk to you
- Remember confidentiality

Mandatory Reporting of Abuse

- Section 110 of the Children's Amendment Act provides details of the right to protection that children are afforded in terms of section 28 of the Constitution.
- This section compels certain professional sectors to report any child abuse, neglect or maltreatment that is suspected on reasonable grounds to a designated child protection organisation, the provincial department of social development or a police official.
- If the reporting is done in good faith and substantiated to the relevant authorities, the professionals responsible will not be held liable to civil claims as a result of their reporting.
- The Act further stipulates that the Department of Social Development must assess and further manage the situation in the best interests of the child.
- In addition, section 54 of the Sexual Offences and Related Matters Act compels '[a] person' who knows or who has a 'reasonable belief or suspicion' of any form of sexual abuse against a child or mentally challenged individual to report it to a police official.
- If such reporting is done in good faith, in terms of section 54(2) (c), the person reporting cannot be held liable in criminal or civil proceedings.
- Section 110 of the Children's Amendment Act does not specifically identify emergency care workers to identify abuse, but the spirit of the Act requires that where a child has been abused 'in a manner causing physical injury, sexually abused or deliberately neglected'.
  - *Ordinary citizens are given the discretion to report abuse but are not compelled to do so in terms of section 110.*
- The Sexual Offences Act, however, compels all citizens (i.e. all persons living in SA who are entitled to the rights promised by the Constitution in terms of section 3) who are aware of the sexual exploitation of children to report the offence to the police.

Who to Report to?

- Section 110(1) of the Children's Amendment Act stipulates that suspected child abuse must be reported to child protection organisations, the provincial department of social development or the police.

When must reporting be done?

- Section 110 of the Children's Amendment Act implies that reporting of the suspicion of abuse must be done as soon as the suspicion is formed on reasonable grounds. The purpose of reporting is ultimately to ensure the safety and protection of the child in question. The reporting of a sexual offence must be done 'immediately' according to section 54(1) (a) of the Sexual Offences Act. 'Immediately' can be interpreted as on becoming aware of the sexual abuse or when there is a reasonable suspicion of abuse of a sexual nature.

The 'good faith' principle

- Both acts state that the reporting has to be done in 'goodfaith'.
- The 'good faith' principle is an internationally recognised common-law duty to act honestly, openly and with conscientious impartiality.
- In the context of mandatory reporting legislation, the person reporting must report his/her belief of wrong doing without any malicious/spiteful intent.
- The primary objective is the safety and protection of the child involved.
- The 'good faith' standard is measured objectively against standards of decency and fairness set by the community (in this instance represented by professionals and professional organisations) and not against the individual's subjective beliefs of impartiality.

- 'Grounds' must be based on the facts obtained from objectively exploring (with one's five senses) a particular situation or set of evidence.
- After considering or evaluating the facts from different objective points of view, a conclusion is drawn.
- If the conclusion remains the same, even when the facts are viewed from different perspectives, one is said to have grounds that a particular set of facts has merit.
- The courts, however, apply a measure of objectivity – that of the reasonable person – to ascertain whether the grounds for believing a set of facts are reasonable. The reasonable person refers to a fictional person who is deemed similarly situated to the one reporting, i.e., the reasonable emergency care provider. 'Reasonable grounds' are said to exist if this reasonable person would come to the same conclusion under these similar circumstances.
- In terms of the Sexual Offences Act, reporting can also based on the 'disclosure' of the victim. The English courts have ruled that evidence obtained from a secondary source (eye witness) likewise gives rise to the legal obligation to report to the relevant authorities.

Accountability

- Emergency care professionals can be held accountable for not reporting abuse of children under the conditions described above.
- HPCSA guidelines urge members to report any unethical or illegal conduct.
- According to the Health Professions Act No. 56 of 1974, the HPCSA can order a fine or a suspension for a period of time, or remove a member's name from the register, or impose a lesser penalty in the case of a guilty finding.
- Furthermore, in terms of section 54(b) of the Sexual Offences and Related Matters Act, failure to report sexual abuse or exploitation of children and mentally handicapped persons is deemed an offence and is punishable with a fine or imprisonment of up to 5 years, or both, if the person is found guilty.

Help lines

- Childline South Africa – 24 hour free helpline 08000 55555 ,
- Tygerbear Foundation Cape Town – 021 931 6702
- Childline Wynberg – 021 762 8198
- Childline Mitchells Plain- 021 376 000
- Childline Tygerberg – 021 930 0859
- SAPS – 10111 (Mowbray)
- or the crime stop number 08600 10111.
- Red Cross Childrens Hospital – 021 658 5111

CASES-
15min each

Appendix N: Cases for training workshop/data collected

WORKSHOP CASES:

Case 1: Hamzah Khan

A 4 year old boy Hamzah Khan was starved to death and died in 2009. Authorities only found his body in his mother's home in 2011. An older brother of an "invisible" boy starved to death by their mother in Bradford complained to police and social services about physical and emotional abuse in the family home three years before the little boy died.

1. What could be red flags/warning signs in this situation?
2. Who would you suspect as the perpetrator on the scene? Why?
3. Nature of abuse?
4. What subjective and objective information would you gather?

Case 2: Poppie van der Merwe

On the day of her death, Poppie van der Merwe did not want to eat or talk.

The evening before, her stepfather Kobus Koekemoer allegedly hit her head hard against a closet.

Little Poppie (3) lay on the mat in front of the television on the morning of 25 October 2016, on the farm near Mamogaleskraal outside of Brits.

She was "half-awake, half-asleep", her mother Louisa testified on Wednesday in the Pretoria High Court.

"Kobus had come home from town and kicked Poppie in the stomach as she lay on the mat. I told him in advance that she was tired.

"He often kicked her in the stomach," said Louisa, who is also being charged with her daughter's murder.

Louisa testified that Kobus told her she should go take groceries he had bought from the bakkie.

"I cannot remember if she cried or not when he kicked her. I told him he could not kick her because she did not feel well, she just needed to rest a little but he didn’t listen to me. . . "

Louisa claims that Poppie wasn’t lying on the carpet anymore when she entered the house, after getting the groceries.

She claims Kobus told her "Poppie is playing dead again".

Louisa testified that when she found her child in the bathroom, she was already blue around her mouth.

She tried to resuscitate Poppie by giving her mouth-to-mouth, but it didn’t work. Her blonde-haired, blue-eyed daughter was already dead.

The court heard earlier that Poppie was declared dead at the Brits hospital upon arrival.

The doctor on duty called the police after he became suspicious of the injuries on Poppie’s body.

Kobus (44) has already changed his version of events many times. He was arrested at the hospital, while Louisa was arrested a month later after further investigation.

As part of her testimony on Wednesday, Louisa denied that she had ever assaulted her child.

The times she was present when the children were "injured", she claimed they had fallen or accidentally bumped their heads.

”Most cases” when they had blue patches or injuries, "was after Kobus assaulted them," she claimed.

She argued that she hadn’t asked for help because Kobus threatened to kill her family.

She admitted she also hid it for Heidi Smit, the counsellor at Poppie's school.

"Kobus said I should not tell them what was going on, otherwise they will take the children away."

She claimed the assaults started getting worse and more frequent when they moved to Brits.

1. What could be red flags/warning signs in this situation?
2. Who would you suspect as the perpetrator on the scene? Why?
3. Nature of abuse?
4. What subjective and objective information would you gather?

Case 3: Franziska Blochliger

Oliver, from Westlake, made his admission in the Cape Town High Court yesterday, where he is on trial for rape, robbery, and murder.

In an affidavit handed to the court, he explained how he grabbed the 16-year-old jogger from behind and dragged her into fynbos at Tokai Forest.

"I dragged her body deep enough so that no one could see us. I went through the process of removing the cellphone, earphones, and ring from her. I saw a watch on her when I grabbed her but when I looked for it I could not find it," said his affidavit.

He admitted to using shoe laces to tie her hands and gag her. He then pushed her face down into the ground, removed her clothing and raped her.

"Before leaving her I discovered that she was not breathing. My legal representative informed me that the post-mortem noted the cause of death as suffocation by pressing the face against the ground and manual throttling."

1. What could be red flags/warning signs in this situation?
2. Who would you suspect as the perpetrator on the scene? Why?
3. Nature of abuse?
4. What subjective and objective information would you gather?

Case 4: Tebetso Phahle

In another case involving a 3-year-old, Judge Neil Tuchten sentenced a man from Mamelodi to an effective 10 years in jail for beating the child to death for soiling himself.

The judge remarked on the anguish the child must have felt while being beaten by William Tjane, 35, saying he found it hard to put the horror of it behind him.

Tebetso Phahle apparently cried out “mamma” before his mother found him on a bed in a house she shared with Tjane.

She rushed him to hospital in a taxi, but by that time he was dead.

Tjane claimed the boy fell out of the tub when he tried to clean him up after he had soiled himself.

1. What could be red flags/warning signs in this situation?
2. Who would you suspect as the perpetrator on the scene? Why?
3. Nature of abuse?
4. What subjective and objective information would you gather?

Case 5: Baby J

The parents of a 2-month-old baby boy - one of a twin - have been spared jail, but their punishment is to look at their child and deal with the damage they had caused.

The child, only identified as Baby J, was left with extreme brain damage, is spastic and cannot walk, eat by himself or talk, five years after he was severely beaten.

He suffered a cracked skull and bleeding on the brain. His parents, in whose care he was, simply said they had no idea what had happened.

1. What could be red flags/warning signs in this situation?
2. Who would you suspect as the perpetrator on the scene? Why?
3. Nature of abuse?
4. What subjective and objective information would you gather?

The Screening workshop aimed to bring about comprehensibility so that students can comprehend that child abuse happens to all individuals, not only to certain cultural or ethnic groups. The motivation behind the workshop aims to decrease child abuse and increase child abuse detection. Furthermore, the manageability on how to achieve this is equipping students who partake within the workshop with the required skills in order to use the child abuse screening tool. Case 3 and 4 are excluded as insufficient data resulted from these two cases.

Case 1: Hamzah Khan

A) When the students were asked what the red flags or warning signs were to Hamzah Khan's situation, the following responses were noted:

Group 1: The brother complaining about physical and emotional abuse. The discovery of the child's body 3 years later. As well as signs of starvation.

Group 2: The fact that the body was only found 3 years later in the parents' home. As well as the complaint of physical and emotional abuse.

Group 3: The underweight child and the mother delaying seeking medical care for her child.

Group 4: That there was a previous complaint and no one did anything about it. The child was also never reported missing.

Group 5: locked up and unattended children and the children saying that they are being abused.

Group 6: A complaint was reported 3 years before the baby died. Malnourishment will be picked up on inspection.

Group 7: malnourished appearance, and a withdrawn child

Group 8: reports of abuse creates suspicion. Signs of malnourishment and low body weight for age brings about a red flag. The context should be considered, the child must be compared to his siblings and family members.

Group 9: compare the child's nourishment to that of the mother. The child will have a completely different body language when the alleged perpetrator walks into the room.

B) Who would be the suspected perpetrator on the scene and why?

Group 1: The mother as she was the only one who lived in the house with her children. There could also be a long term abuse within the family.

Group 2: The mother, because it is her house, and she is the primary guardian.

Group 3: The mother, because she neglected the child

Group 4: The mother would be the most probable, but other options such as family members can also be explored

Group 5: The parent or guardian of the child

Group 6: The mother

Group 7: The mother, the child's older brother specifically mentioned the mother abusing them. The police as accomplices as they had knowledge of what was happening but did not do anything about it

Group 8: The mother, it is a parents' responsibility to care for their child to the best of their ability, this includes medical care and feeding their child.

Group 9: the mother, because she did not report any abuse to her child.

C) Nature of abuse?

All groups agreed that the nature of the abuse was emotional and physical

D) What subjective and objective information would you as a practitioner gather to form the situation

Group 1: Subjective: testimony from the child, a medical assessment and a psychological assessment

Objective: scope out the home environment, ask neighbours and family members about the current family situation.

Group 2: Subjective: looking at injuries pertaining to physical abuse as well as looking at the children's behaviour indicating emotional abuse.

Objective: Look at the condition of the children (clinical findings). On arrival, one would look at the surroundings inside the house

Group 3: no answer

Group 4: Subjective: inspect the mother's house

Objective: check the signs and symptoms of neglect and physical abuse

Group 5: Was there a deliberate intention to harm the child? Investigate further where the conditions do not match the social circumstances. Compare the health of family members to the child – some well fed and others starved

Group 6: Subjective: ask the older brother if they are being starved/neglected

Objective: look at the physical appearance of the siblings compared to the child

Group 7: Subjective: interview the mother

Objective: look at the home environment

Group 8: Subjective: what do you see? Malnourishment, a feeling you get around the house and how everything is presented, as well as other senses.

Objective: the boy reporting that they are being abused. Previous reports of abuse. Socio-economic circumstances. The community that they live in.

Group 9: compare the victim's wellness with the rest of the family and check whether there is consistency in interviews between different parties.

Case 2: Poppie van der Merwe

A) Red flags and warning signs

Group 1: The fact that she hit her head hard against the cupboard. A warning sign such as a 4 year old girl being repeatedly kicked in the stomach.

Group 2: The injuries that the children sustained. The father changing his account of the events. The fact that the mother did not stop the abuse on the account that it was the wrong and immoral thing to do but rather due to the reason that the child was not feeling well on that day. The lies which the mother told the counsellor.

Group3: the child not acting like a normal 4 year old, not eating or talking and presenting with head injuries. The child's mother changing her account of events numerous times trying to cover up the truth.

Group 4: Previous abuse excused by 'falls' and 'accidents'. The wife allowed the abuse at the least and participated in the abuse at the most. The amount of times the stepfather changed his version of events. Hiding it from the school counsellor and the fact that the assaults started getting more frequent. "She's playing dead again"

Group5: The school alerted them of the abuse. Bruises found and seen on the body of the child. The frequency in which children get injured. The emotional state of the family; them not expressing concern about the child being hurt or injured

Group 6: not eating or talking is not normal behaviour for a child that age. The parents are aware that she is being abused. Different stages of healing of her bruises. The child withdraws around people, and she did not play around, she was always in her own space quiet.

Group 7: wounds and bruises at different healing stages. A child playing dead is not normal. A child of that age not eating or playing is abnormal behaviour. The mother does not care as there were no doctor visits and excuses were constantly made up by the mother.

Group 8: bruises and the child being unconscious. Abnormal behaviour for a 4 year old. The child portrays fear for the guardians. The mother being defensive for the father's actions.

Group 9: physical signs such as bruises at different healing stages. Inconsistency with stories told. Defensive behaviour from parents and multiple police reports.

B) Who would you suspect as the perpetrator on scene and why?

Group1: Kobus and Louisa as they were both present for the times that the abuse took place

Group 2: Kobus, because the mother knew he was abusing Poppie. The mother is also suspected as she was involved in child neglect, she did not stop Kobus and his abusive ways

Group 3: The parents

Group 4: Both parents participated to some degree of abuse and played a role in the death of Poppie

Group 5: both parents. Mother may witness the abuse and also start to do it

Group 6: the father, but the mother can be an alleged silent perpetrator

Group 7: the parents, due to them being the only guardians of the child. The teacher is an accomplice as she did nothing to further investigate the situation.

Group 8: Kobus and the mother. The stepfather had a history of being abusive as reported by the mother. The mother was complacent and defended the actions of her husband.

Group 9: the stepfather and the mother most likely to be suspected as alleged perpetrator in abuse

C) Nature of abuse?

All groups agreed that the nature of the abuse was both physical and emotional

D) What subjective and objective information would you as a practitioner gather from the situation

Group 1: Subjective: ask the other children about what is going on

Objective: ask the school counsellor for any red flags. Perform an adequate medical assessment, psychological assessment. Do a home check and interview other family members as well as the neighbours to gather more information.

Group2: Subjective: look at the living conditions

Objective: look at the body language of both guardians. Investigate the mechanism of injury

Group3: no answer

Group4: Subjective: listen to the mother and father's testimony

Objective: look at the bruising, interview Kobus and match his stories.

Group 5: what is normal behaviour for a child that age? Listen to the story told by the child on how they got injured. Also look at the environment of the home they are living in and in which state it is.

Group 6: Subjective: speak to Poppie and ask her questions. Speak to the mother and ask her questions.

Objective: look at the house and the living conditions. Look at the relationship between the parents and their relationship with the children

Group 7: Objective: inspect wounds and bruises as well as living conditions

Subjective: interview the stepfather

Group 8: Subjective: child's interaction with parents and how the parents interact with one another

Objective: previous reports of abuse, check road to health book. Separate the parents and question them individually.

Group 9: Subjective: look at the body language

Objective: look at physical signs

Case 5: Baby J

A) Red flags and warning signs

Group 1: The child was left in the care of the same people who caused his injuries and resulting conditions

Group 2: Injuries sustained. The parents did not even give an excuse

Group 3: Parents did not report changes in child

Group 4: Evidence of abuse present, claiming they do not know what happened to the child

Group 5: cracked skull. The severity of the injuries is alarming. The fact that the parents say they do not know what happened raises the question what happens to the twin whom also needs to be taken care of by these parents

Group 6: The fact that the parents say they do not know what is happening is a red flag. The extent of the injury is too severe, the child could not have injured himself to this extent. The child is a twin so the other child may also suffer abuse.

Group 7: severity of injuries

Group 8: injuries that the child sustained and that the parents did not know how it happened

Group 9: it is physically impossible for such a small baby to hurt himself to the extent of brain damage. All injuries pose red flags

B) Who would you suspect as the perpetrator on scene and why?

All groups agreed that the parents were the main suspects. Group 5 stated that the court is looking after the parents by sparring them jail time and not after the best interest of the child.

C) Nature of abuse?

All groups agreed on physical abuse

D) What subjective and objective information would you as a practitioner gather form the situation/ how do you feel about the fact that the abused child was left in the parents care?

Group1: look for abuse in the other twin and further abuse of now physically and mentally handicapped child

Group2: Observe clinical findings

Group 3: letting the parents look after the child can be riskier because as the child becomes worse and worse, the parents will get annoyed with the child and the child becomes a burden to them. This will lead them to abuse the child more.

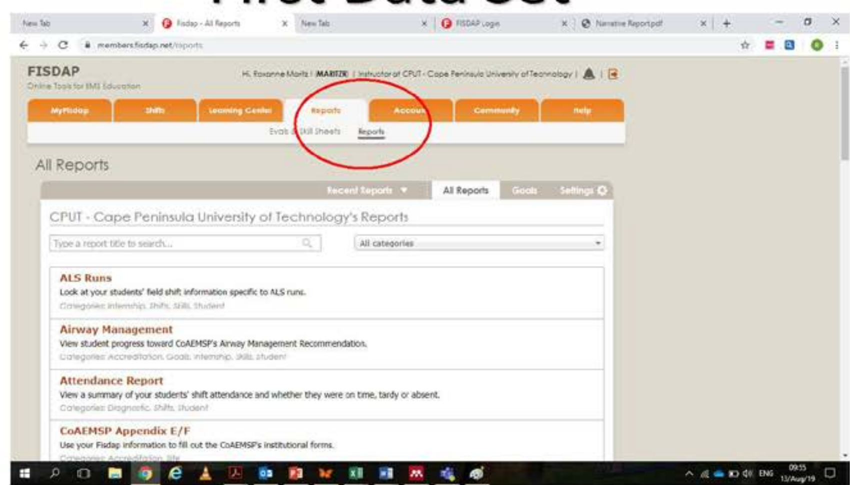
Group 4: leaving the child with irresponsible parents will just cause the child to be further abused and neglected.

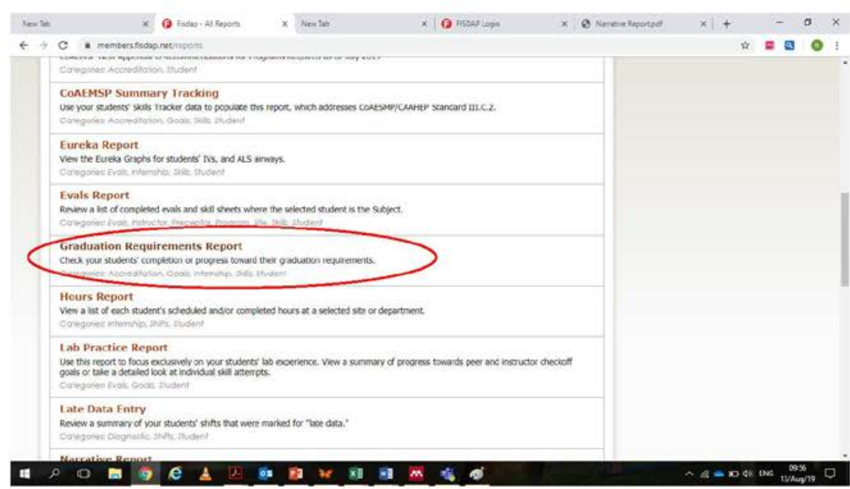
Group 5: Parents need to go for rehabilitation. They also raised the question as to how one can trust people who have caused such extensive damage to their child. They will get more frustrated because the child is mentally and physically challenged. A cracked skull on a 2 month baby is impossible to achieve on his own, someone had to cause extensive physical abuse to the child in order for this to occur.

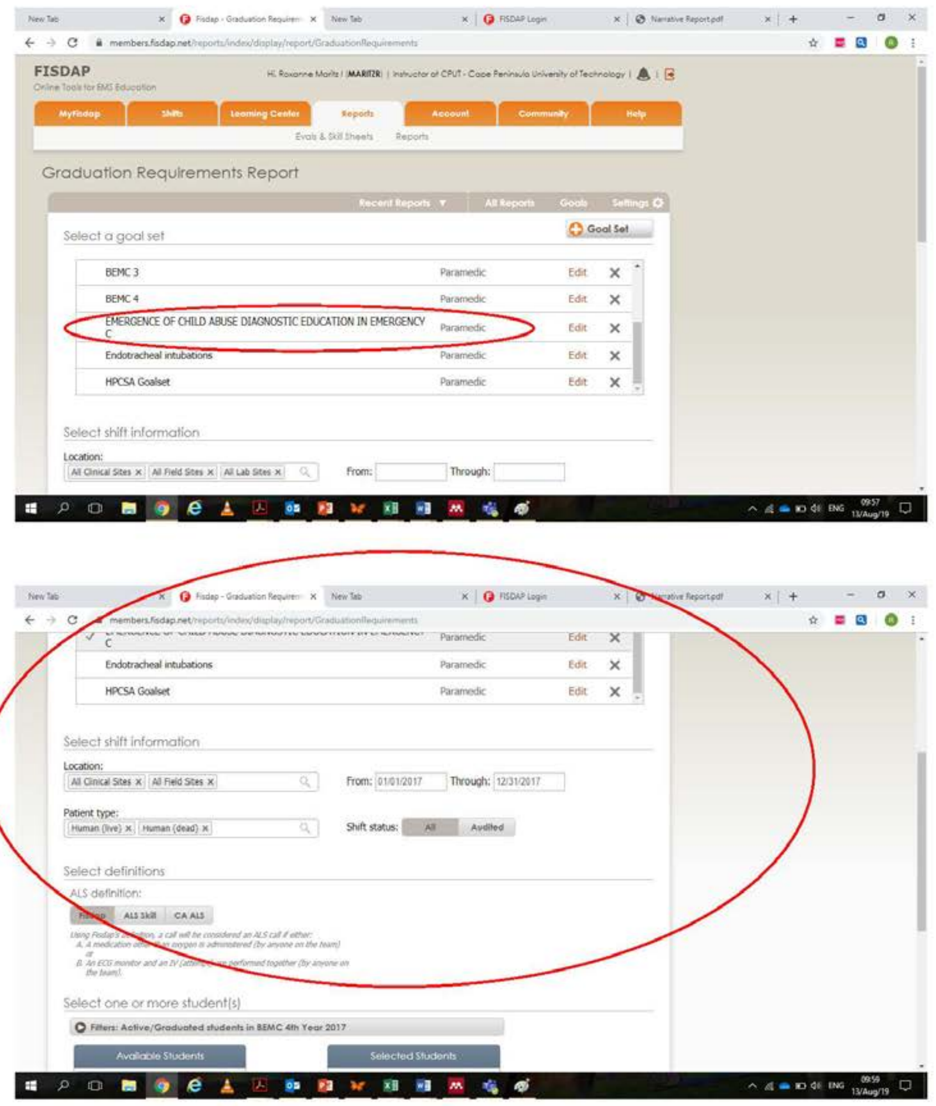
Group 6: The child will continue to be abused by parents and his twin may also suffer the repercussions of the frustration that parents may feel with his mentally and physically challenged brother.
Group 7: the child should be put into the care of loving parents and these abusive parents should be sentenced to jail
Group 8: abuse will continue to occur, the court should not see it as a punishment for the parents to look after their challenged child because it is in actual fact a punishment for the child to be left with such negligent ad abusive parents
Group 9: the living conditions should have been investigated by the court and they should have acted in the best interest of the child and his twin. 'Punishing' the parents to look at what they caused to their child just creates room for further abuse and potentially killing the child.

Appendix O: Step by step diagram on collecting data on FISDAP®

First Data Set



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Online Tools for EMS Education
Graduation Requirements Report
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BEMC 4
EMERGENCE OF CHILD ABUSE DIAGNOSTIC EDUCATION IN EMERGENCY C
Endotracheal intubations
HPCSA Goalset
Select shift information
Location:
From:
Through:
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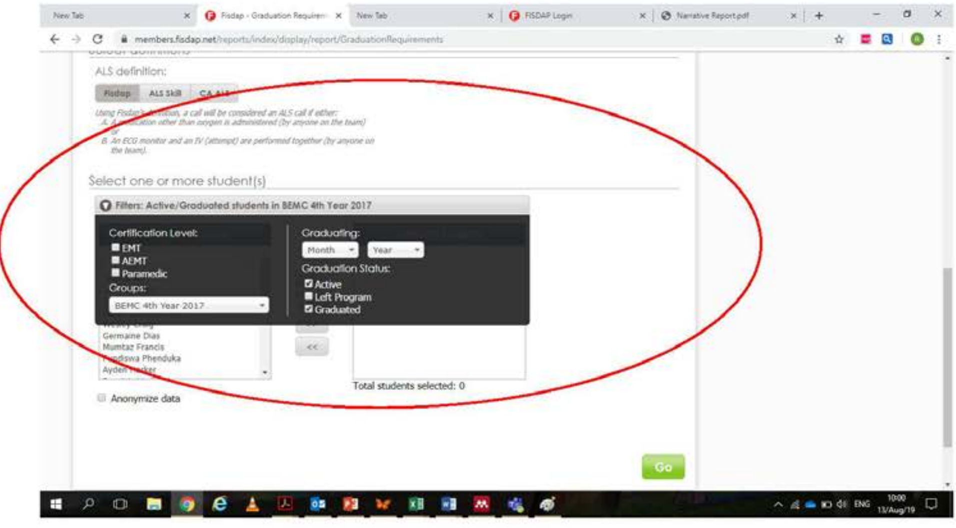
Filters: Active/Graduated students in BEMC 4th Year 2017
Available Students
Selected Students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BEMC 4th Year 2017
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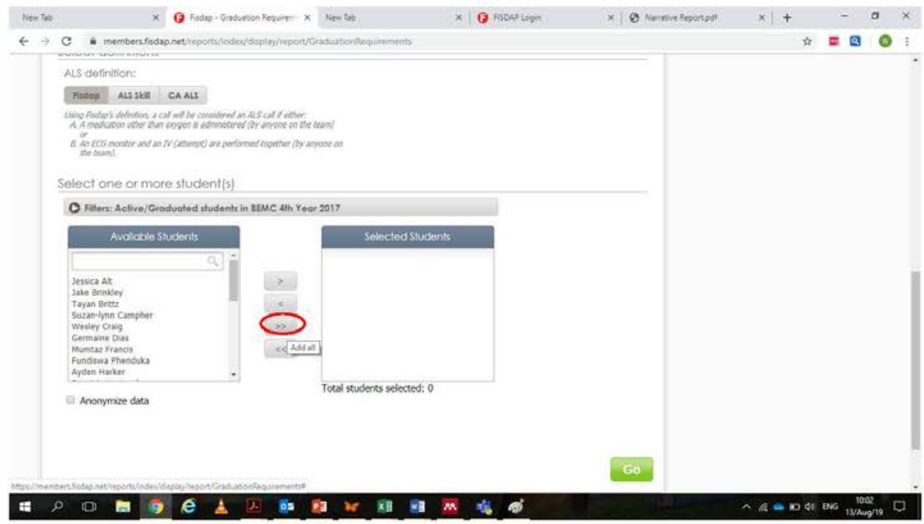
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Available Students
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Tayan Brittz
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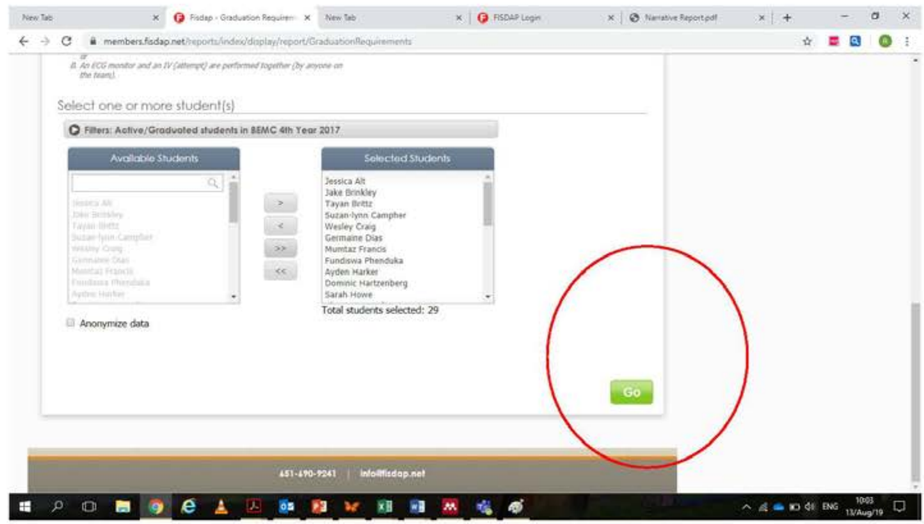
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Mumtaz Francis
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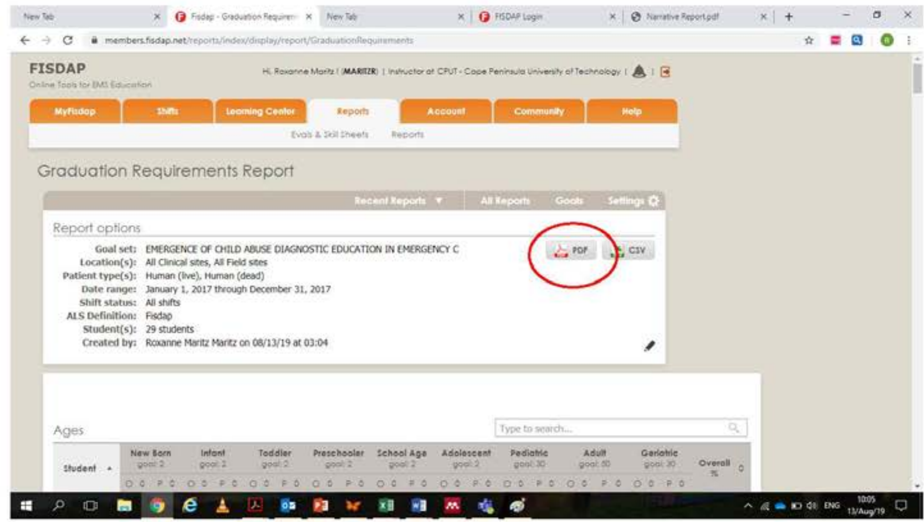
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Online Tools for EMS Education
MyFisdap
Shifts
Learning Center
Reports
Account
Community
Help
Graduation Requirements Report
Recent Reports
All Reports
Goals
Settings
Report options
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Patient type(s): Human (live), Human (dead)
Date range: January 1, 2017 through December 31, 2017
Shift status: All shifts
ALS Definition: Fisdap
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Created by: Roxanne Maritz Maritz on 08/13/19 at 03:04
PDF
CSV
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Toddler
Preschooler
School Age
Adolescent
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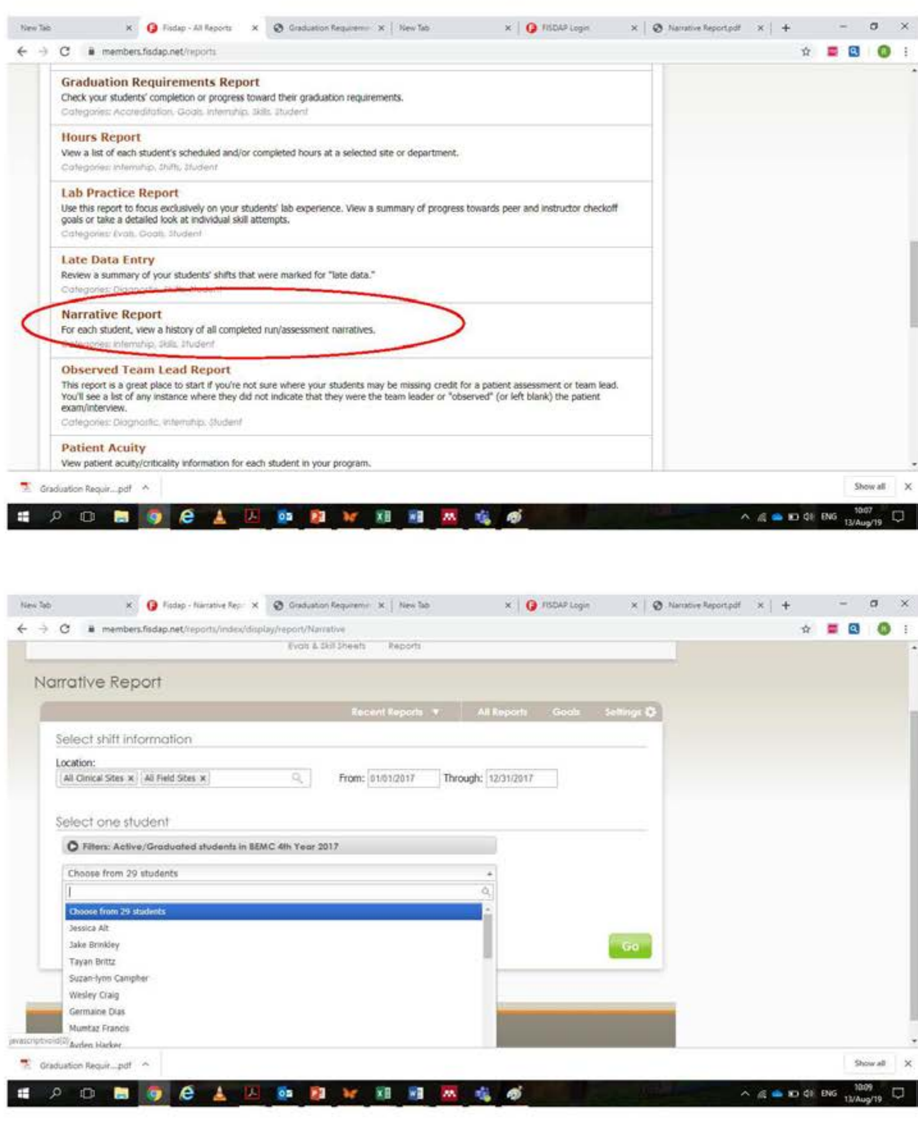
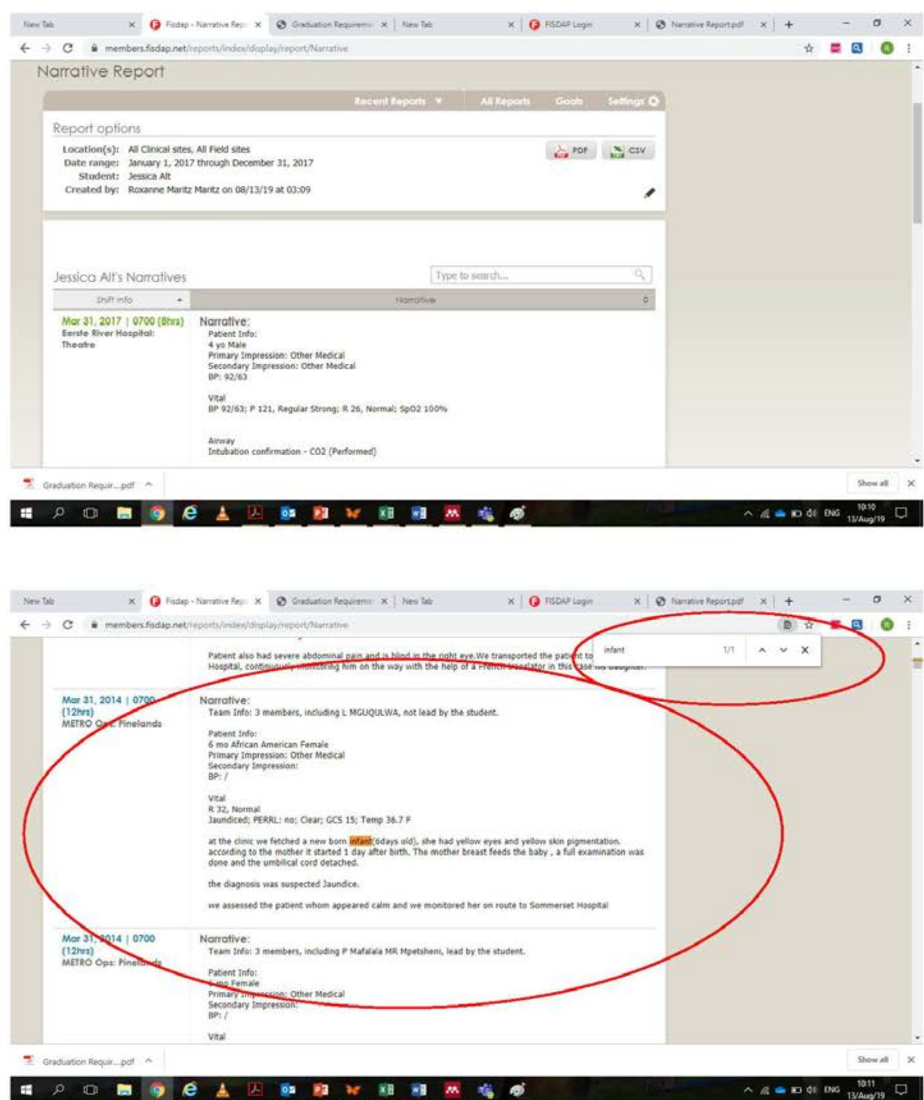
Adult
Geriatric
Overall %

Second Data Set





Do all these steps for the year 2018 as well and fill in the excel sheet with needed requirements.