

# Clinical Guidelines on Child Abuse and Neglect

First Edition 2016

Sultanate of Oman Ministry of Health

Directorate General of Primary Health Care Department of Women and Child Health

(ML-110)

# Preface

Maltreatment of children by caregivers is a health and social problem that exist in many countries that have established methodes to quantify the issue1,2. Epidemiological studies on child maltreatment in Oman is limited and not available at a national level. However, published case reports on this topic in the past two decades provide evidence on the exsistence of child maltreatment in Oman 6,8. Since 2007 the Ministry of Health (MOH) started a notification system to report susbected cases of child abuse and neglect reaching health institutions. The system was put forth for the purpose of generating data on the matter and have an understanding on the patterns of abuse in Oman.

Child maltreatment can result in death, serious injury, and long-term consequences affecting the child life till adulthood. It also affect the child family, and society in general. Recognition and reporting of child abuse is important to promote child safety, health, and welfare through the delivery of preventive, supportive, protective, and therapeutic interventions.

Hence, in order to build and strengthen the capacity of health care providers to recognize and respond to child abuse, the Department of Women and Child Health, Ministry of Health – Oman developed this Clinical Guidelines on Child Abuse and Neglect (first edition).

This guideline is not meant to replace text books. Hence, whenever detailed information is required, textbooks and other latest references should be used for gaining in-depth knowledge and understanding of the subject.

The guideline is based on the work done by the national task force of child protection (Pediatric consultants from Sultan Qaboos University Hospital and Royal Hospital, members from Ministry of Health; Department of Women and Child Health, Department of Schoold Health and Department of specialized services) and reviewed by the MOH members of the child protection comittees at the Governorate level and by the UNICEF consultant Dr.Stephen J.Atwood, M.D., F.A.A.P, Director Public Health Solutions. In addition this guideline is reviewed legaly by Dr Hamed Al Kalbani, Medical Lawyer, Office of Undersecretory for Health Affairs and the Director General of Legal Affairs, to ensure its feasibility and acceptance.

The guideline contains updated reporting system with clear algorithms of case management and referral pathway. It works as a guide for health providers on how to report and whom to contact whenever child protection is needed. We recommend to maximize the use, the guideline should be kept in close vicinity of service provision and all health care providers should read it carefully.

We are thankfull to all those who have contributed to this manual and constructive suggestions for improving and updating it further will always be gratefully recieved for the future.

We also acknowledge the continous support provided by UNICEF office on building capacity of health care providers and strengthening the area of child protection in general.

#### Dr Fatma Ibrahim Al Hinai

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# List of Abbreviations

A&E	Accident and Emergency
CRC	Convention of the Right of Children
CT scan	Computed Tomography
CPC	Child Protection Committees
DFCH	Department of Family and Child Health
DWCH	Department of Women and Child Health
RHTFCA	Regional Hospital Task Force for Child Abuse
мон	Ministry of Health
MOSD	Ministry of Social Development
MRI	Magnetic Resonance Imaging
RH	Royal Hospital
SBS	Shaken Baby Syndrome
SQUH	Sultan Qaboos University Hospital

# Acknowledgment

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# **Policy Guidelines**

- Managemnet of cases of Child abuse is an integral part of the child health services provided at all levels of health care system in all Governoartes of the Sultanate.
- This service provided to all children from age of birth till 18 years of age.
- All physicians should be aware of risk factors and common symptoms and signs of the different types of child abuse.
- Any suspected/abuse case to be reported on the assigned notification form by the treating physician at any level of health care system (primary, secondary or tertiary).
- The notification form should be kept confidential and not to be used for any legal purposes.
- Medical examination of sexually abused girls to show their virginity or not should be done by the forensic medicine only even in the event of recieving correspondences from the courts or the public prosecutor23.
- Medical Management of victims of child abuse should be carried out at all levels of health care system depends on the severity of the case.
- Treating physician at Primary Health Care should coordinate with the focal point of Regional Hospital Task Force for Child Abuse and Child Protection Comittees whenever needed to ensure child safety and provide a comprehensive care.
- Regional Hospital Task Force for Child Abuse and the Child Protection Comittees (CPC) are responsible for developing a strategic approach to child protection within the overall children's services at the Regional Hospital and overall Wilayate/ Governorate and formulating an intervention plan for suspected and confirmed cases of child abuse.

# Introduction:

Maltreatment of children by caregivers is a health and social problem that exist in many countries.1,2 Aproximately 1.5-5% of all children are reported to child-protection agencies every year for all types of child maltreatment in the UK, USA, Australia, and Canada.3 However, surveys of children, adolescents, or parents show that the annual frequency of maltreatment is much higher than is reported to child protection agencies (physical abuse 4-16%; psychological abuse 10%; neglect 1-15%; and exposure to intimate-partner violence 10-20%).1 This discrepancy is possibly due to failure to identify victims of maltreatment or to report identified cases. National data from the USA indicates that schools contribute to most of the reports from professionals (16.5%) and medical personnel report the least (8%).4 Recent reports indicate that the trend of child abuse is increasing. 11 In UK in the year 2013 a total of 50,732 children were registered on the child protection registers or subject to a child protection plan.5

In 2007 the ministry of health started a notification system of suspected cases of child maltreatment. Between 2007-2013, 560 cases were reported to DFCH, of which 484 cases were ultimately recorded as maltreatment. The trend shows an overall increase in reported cases of maltreatment, largely made up of increases in physical maltreatment reports since 2009, and a sudden increase in reported neglect cases between 2012 and 2013. These numbers, not yet representative of the overall situation in the country, are a critical start to generating hard data on the problem. Epidemiological studies on child maltreatment is lacking in Oman. However, over the last two decades there have been many published case reports on this topic 6-8.

#### **Consequences of child Abuse**

Child maltreatment can result in death, serious injury, and long-term consequences affecting the child life till adulthood. It also affect the child family, and society in general. Child maltreatment is associated with long-term deficits in educational achievement.1 It is incriminated for long lasting economic consequences for victims. Abused and neglected individuals were found to join unskilled and semi-skilled occupations more than others, and they have less chances of maintaining their jobs.1

It also increases the risk of behavior problems among victims, including internalizing (anxiety, depression) and externalizing (aggression, acting out) behavior.1,2,9 There is evidence that child maltreatment increases the risk of post-traumatic stress disorder. Consistent evidence also suggests that both physical abuse and sexual abuse are associated with a doubling of the risk of attempted suicide for young people who are followed up into their late 20s. Survivors of child maltreatment have greater risk of developing alcohol problems in adolescence and adulthood, becoming aggressive and inflicting pain and suffering on others, and often perpetrating crime and violence.1,2,9

A strong association between physical abuse, neglect, and sexual abuse and obesity is reported.1 Retrospective studies also suggest an association between child sexual abuse and eating disorders (e.g., bulimia and anorexia).1 Several large crosssectional studies have reported relations between multiple child adversities, including child maltreatment, and a range of health outcomes in adulthood (e.g., ischemic heart disease, cancer, chronic lung diseases, skeletal fractures, liver diseases, and sexually transmitted diseases).1,2,9

#### Importance of prevention of child abuse

Recognition and reporting of child maltreatment is important to promote child safety, health, and welfare through the delivery of preventive, supportive, protective, and therapeutic interventions. Thus investment in prevention, epidemiological monitoring, and training of professionals to recognize and respond to child maltreatment is widely acknowledged and recommended.

#### Children right in Oman, Child Law

The rights of the child are guaranteed in Oman through the services provided by the different governmental authorities (e.g. health, education, and social).10 The child Law in Oman was issued by Royal Decree number (22/2014) on May 2014.22 It is composed of 13 chapters and 79 articles. The first chapter covers the definitions and general provisions in 5 articles. Chapters two to seven address the different rights of the child such as health, social, education, and cultural. Chapter eight emphasis the needs and rights of children with special needs. The last five chapters cover criminal accountability, protection measures, protection mechanisms, penalties and civil damages. The Child law will emphasis these rights more and improves the guality of child protection measures offered for victims of child abuse. It prohibited all substances, behaviors and practices that threaten child's mental and physical health. Article 62 states that "Every person shall have the right to report any incident that constitutes an act of violence, exploitation or abuse against a child, or a violation of any of his or her rights which are stipulated by the present law. Child Protection Committees must take all necessary measures to protect the reporting person and ensure his or her anonymity". Article 63 states that "Physicians, teachers and other individuals, to the attention of whom, by virtue of their profession, occupation or activities, comes a case of violence, exploitation or abuse against any child or violation of any of his or her rights which are stipulated by the present law should report such case to the Child Protection Committees".

## Aim and Objectives of the program

The aim of the program is to provide a comprehensive care for victims of child abuse through:

- 1- Strengthening the capacity of health care providers on managment of child abuse and neglect
- 2- Sandarizing the care provided to children victims of child maltreatment.
- 3- Facilitating the coordination between health facilities and Regional Hospital Task Force for child abuse and Child Protection Committees.

## **Objectives of the Program:**

#### To provide health providers with knowledge and skills to:

- 1. Define child abuse
- 2. Identify risk factors for child abuse
- 3. Identify symptoms and signs of the different types of child abuse
- 4. Manage the suspected/abuse cases.

### Service components:

The service includes:

- o **Recognition** of victims of child abuse by identifying risk factors and common symptoms and signs of the different types of child abuse.
- o Reporting suspected cases of child abuse.
- o Management of suspected and exposed cases of child abuse.
- o **Coordination** with Child Protection Committees and Regional Hospital Task Force for child abuse to ensure safety of the child whenever needed.

# Section 1 Definitions of child abuse

#### Section 1: Definition of child abuse

Child abuse or maltreatment is defined as "all forms of physical and/or emotional ill-treatment, sexual abuse, neglect or negligent treatment or commercial or other exploitation, resulting in actual or potential harm to the child's health, survival, development or dignity in the context of a relationship of responsibility, trust or power"1

#### Types of abuse

**A. Physical abuse:** Physical abuse of a child is defined as those acts of commission by a caregiver that cause actual physical harm or have the potential for harm. This includes the use of corporal punishment leading to injuries to the child and harmful traditional practices such as Wassam, Female Genital Mutilation and other harmful traditional treatment.

**B. Sexual abuse:** is defined as those acts where the abuser uses a child for sexual gratification which may involves forcing or enticing a child to take part in sexual activities. Sexual abuse can both happen by an adult or another child.

**C. Emotional abuse:** is defined as failure of a caregiver to provide an appropriate and supportive environment, and includes acts that have an adverse effect on the emotional health and development of a child. Such acts include restricting a child's movements, denigration, ridicule, threats and intimidation, discrimination, rejection and other nonphysical forms of hostile treatment.

**D. Neglect:** is defined as to the failure of a parent to provide for the development of the child – where the parent is in a position to do so – in one or more of the following areas: health, education, emotional development, nutrition, shelter and safe living conditions. Neglect is thus distinguished from circumstances of poverty in that neglect can occur only in cases where reasonable resources are available to the family or caregiver. It may involve a parent or a caregiver failing to provide adequate food, shelter and clothing, shelter including exclusion from home or abandonment, failing to protect a child from physical harm or danger, failing to ensure adequate supervision, failure to ensure access to appropriate medical care or treatment. It may also include neglect of, or unresponsiveness to, a child basic emotional need.

## Severity of abuse

**Non-Emergency cases :** This includes cases of mild-moderate neglect, physical, emotional abuse and non-emergency sexual abuse. Examples: use of discipline at schools or by caregiver, cases of neglect leading to metabolic syndrome (hypoglycemia, obesity and failure to thrive) or accidents, etc.

Child has suffered substantial amount of injury and might need to be sent to a higher level of care but does not require admission & can be managed in an out-patient basis by a pediatrician, psychologist or a family physician.

#### **Emergency cases:**

This includes cases of severe neglect, physical (shaken baby Syndrome), emotional abuse and emergency sexual abuse.

Child is suffering from severe injury or a life threatening event and needs to be immediately sent to a hospital for specialized care/admission/protection measures.

# Section 2 Recognition of child abuse

## Section 2: Recognition of child abuse

### Who could be at risk?

Child abuse does not differentiate between race or social status. It is best understood by analysing the complex interaction of a number of factors at different levels including:

#### **Risk factors in the child**

- Unwanted baby or failed to fulfil the parent's expectations or wishes.
- An infant with high needs; born prematurely, cries constantly, mentally or physically disabled, or has a chronic illness.
- Demonstrates behaviours perceived by the parent as problematic such as hyperactivity or impulsivity.
- Prodcts of Multiple pregnancies, Twins.
- First borns.

#### **Risk factors in parents and caregivers**

- Suffers from physical or mental health problems.
- Misuses alcohol or drugs.
- Domestic violence.
- Poor parenting skills as a result of young age or lack of education.
- High parity.
- Was maltreated as a child.
- Believes of physical punishment as a means of disciplining children.
- Lack of awareness of child development or has unrealistic expectations.
- Financial difficulties.

#### **Risk factors in family/relationship**

- Big size, density.
- · Family breakdown.
- Poor socioeconomic status.
- · Social isolation.

- High stress.
- Family abuse, domestic violence history

#### **Risk factors in community/society**

- Non-existent, un-enforced child protection law.
- Decreased value of children (minority, disabled, gender).
- Social inequalities.
- High social acceptability of violence.
- Media violence.
- Cultural norms.

" The eyes won't see what the mind doesn't know" (Literal, M., 2007)

## Stages of recognition of child abuse

- 1. Considering the possibility; this begins when the clinical presentation of the child does not fit with the history given and is not appropriate for the child's developmental stage. Accidents do happen but health care givers should keep an index of suspicion.
- 2. Looking out for signs of abuse; signs can be physical, behavioral or developmental. Some children may make direct disclosures but majority may not.
- 3. Recording of information: which should be documented in the notification form and filed for future reference at the health facility.

The Child	The caregiver	Child and caregiver interaction
Sudden change in behavior	Offers history not consisting with the child's injury.	Lack of interaction between caregiver and child.
Delay or lack in receiving medical attention to a problem parents know of.	Does not show interest in the child.	The child shows fear or refusal of caregiver.
The child has learning problems with no physical causes	Uses harsh discipline with the child.	State they don't like each other.
Frightened of the parent or adult and does not want to go home	Refers to the child with bad words.	
Reports injury inflicted? by an adult or other caregiver	Was abused as a child.	

#### Table 2.1 : General signs of child abuse:

#### It is important to bare in mind the following when taking history of child abuse:

- Confidnciality
- · Allocate specific time and be patient
- · Relieve anxiety and reduce fears by addressing all concerns
- Understanding of preconceptions
- · Obtain permission without coercion or deceit
- Gain trust by explaining examination and procedures
- Avoid force or restraint
- · Allow choices e.g. where to sit, who is present
- Honor privacy by allowing child to remain clothed or draped until necessary to be examined.
- Once you have confirmed the diagnosis or strongly suspecting it, you need to refer the case

# **A-Physical Abuse**

## **A-Physical Abuse**

Physical abuse includes any act that involves the infliction of a physical injury as a result of punching, beating, kicking, bitting, burning, shaking or otherwise harming the child by a parent or caregiver. It can present in many different forms including bruises, bites, wasms, fractures, symptoms of head injury or Shaken Baby Syndrome, burns and Female Genital Mutilation. The most important information leading to a diagnosis of physical abuse is obtained through the medical history.

#### **Concerning features from history:**

- Inconsistent history with the findings and does not explain the injury.
- caregiver not knowing how the injury has happened.
- History not appropriate to the child's developmental age.
- History with inappropriate caregiver response.
- Delay in seeking medical treatment.
- Previous history of unexplained injuries.

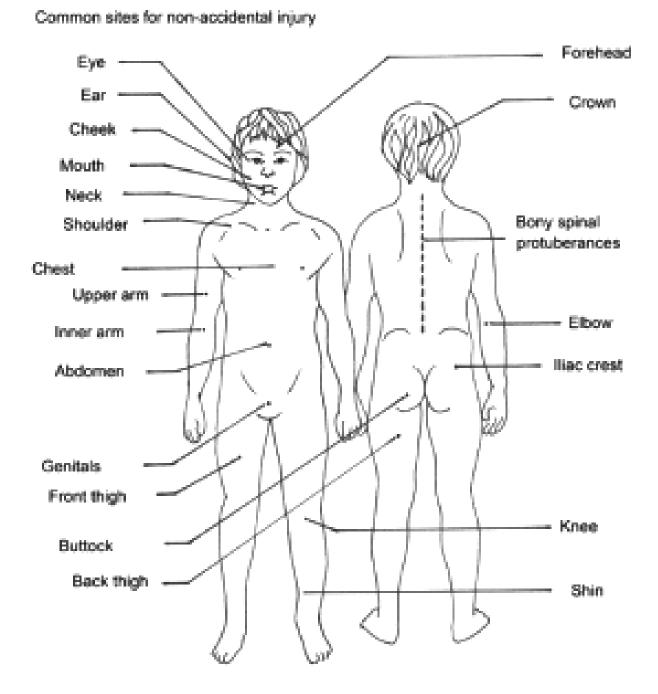
#### Concerning features from examination:

Young children are commonly injured accidentally in the course of daily activities and play. However, the patterns of injuries seen in children who are physically abused differ from injuries seen in children who are hurt accidentally.

#### Differential diagnosis (mimickers of physical abuse) :

- Birth marks.
- Meningococcal sepsis.
- · Coagulation disorder.
- · Contact dermatitis.
- Glutaric aciduria

#### Figure 2.1: Common Sites of Accidental and Non-Accidental Injury



Common sites for accidental injury

## 1) Bruises

Accidental bruises in children are directly related to their developmental age "Those who don't cruise rarely bruise".

#### **Physical examination:**

- The patterns; shape of the instrument used to cause the bruise eg;(stick, belt,..)
- Location/s.
- Bruises of different ages

The following provides a list of important sites of abusive bruises.

- Eyes, neck and mouth.
- Bruises on covered areas such as trunk including chest, abdomen, buttocks and lower back.

## 2) Bites

Bites can be caused by animals or human; adult or a child. It is not easy to differentiate between an adult bite and a child bite, however few subtle differences may be there such as the intracanine distance which is more than 3 cm in adults and less than 3 cm in children.

# Bites are always inflicted injuries.

#### **Physical examination:**

- Measurement of the bite marks.
- Location.
- Number.
- Signs of inflamation.

### 3) Fractures

Fractures are common in children, however a considerable amount of force is needed to cause them. For any fracture a thorough history is needed to be able to have a sound understanding of that cause and correlates it with the clinical picture and developmental age of the child. Most accidental fractures happen in children over 5 years old. Fractures due to injuries can be divided into three categories; Highly, Moderately and low specificity fractures for physical abuse. 13

Highly specificity fractures for physical abuse	Moderately specific fractures for physical abuse	low specificity fractures for physical abuse
<ul> <li>Metaphyseal fractures (Bucket handle fractures</li> <li>Sternal fractures</li> <li>Posterior ribs fractures</li> <li>Fracture of the scapula</li> <li>Spinous process fractures</li> <li>Femoral fractures in immobile children are highly suspicious of abuse</li> <li>Child less than 18 months old and particularly under 4 months old</li> </ul>	<ul> <li>Multiple fractures</li> <li>Fractures of different ages</li> <li>Epiphysis separation</li> <li>Vertebral body</li> <li>Digital Fracture</li> <li>Complex skull fractures. Skull fracture especially if it is: occipital, depressed fracture, growing fracture, wide (more than 3.0 mm on x-ray), crosses the suture line, associated with an intracranial injury, history of fall less than 3 feet</li> </ul>	<ul> <li>Clavicle</li> <li>Long bone shaft</li> <li>Linear skull fracture</li> <li>In infants, simple linear skull fracture may result from a minor accidental fall (fall from a height of 3-4 feet or less)</li> </ul>

#### Table 2.2: Categories of Fractures due to injuries.

NOTE: It is important to consider the age of the child, developmental abilities, the height, force of fall, and the exact surface that the child lands on.

#### **Physical examination:**

- A complete general examination to look for other signs of injuries.
- Abdominal examination for an intra-abdominal injury.
- Ophthalmic examination for the fundus and retinal hemorrhage.

#### **Differential diagnosis:**

- 1- Accidental injury.
- 2- Birth injury.
- 3- Pathological fracturs including: Osteogenesis imperfecta, Rickets, chronic disases and malignancy.

# 4) Shaken Baby Syndrome (SBS)

Shaken baby syndrome (SBS) is a collective term for the internal head injuries a baby or young

child sustains from being violently shaken. 27 It is most commonly seen in infants less than 6 months old but can go on to older ages. Infants may present with a wide range of symptoms ranging from poor feeding, lethargy, vomiting, fits, respiratory difficulty and sudden death. Presentation may vary from being acutely ill or with a mild form of localized illness. However, doctors should keep a high index of suspicion and investigate for it, if the clinical presentation of the infant does not match the history. Mortlality from SBS is high and can reach up to 30%.28

#### **History:**

- It's very important to take a careful history covering; timing of the onset, history of injury or trauma.
- When was the child last well.
- Birth and Developmental history, Family and detaild social history
- Past medical history including previous or recent history of injury.

#### **Physical examination:**

- · General examination.
- Lethargy or signs of encephalopathy.
- Prsence of bruises or laceration on the face, head or trunk.
- Depressed Skull fracture.
- Signs of raised intracranial pressure and bleeding.
- Subconjuctival hemorrhage and fundoscopic examination to look for retinal hemorrhage in one or both eyes .
- Signs of neck or cervical cord injury.
- Signs of external injury including the mouth.
- Signs of internal injury such as abdominal distnsion or tenderness.
- Signs of neglect.

#### Investigations:

- CT Scan of the head as soon as child is admitted.
- If initial CT was abnormal then perform MRI of the head and spine.
- Skeletal survey after 1-2 days of admission.

## 5) Burns

#### Burning a child can present in a number of forms:

- Contact burn with a hot object (coal, fire, match or cigerate).
- Wasam.
- Immersion scalds with hot water, or thrown hot liquids.

#### History:

- Detaild history of how the child was burned, time and onset of burn
- Who has witnessed the incident

#### **Physical examination:**

• Patterns, Location, extend and degree of burn

#### Investigations:

If clinically indicated.

# **B** - Sexual abuse

## **B- Sexual abuse**

Sexual abuse is defined as those acts where the abuser uses a child for sexual gratification which may involves forcing or enticing a child to take part in sexual activities. Sexual abuse can both happen by an adult or another child.14

#### **Concerning symptoms & signs**

- Vaginal bleeding
- Rectal bleeding
- Vulvo vaginitis with or without dysuria
- Anogenital warts
- Recurrent Genitourinary Infections
- Foreign body in anus/vagina
- Soiling/bowel disturbance/enuresis in a previously toilet-trained child
- Behavioural presentation: Abused children often appear scared, anxious, depressed, withdrawn or more aggressive, Fear of going home or school, change in appetite, sleeping problem or nightmares, Changes in school performance and attendance, Inappropriate sexual behaviorso; use explicit sexual language or masturbation.

#### **History:**

A full history is needed include the following:

- Bowel and urinary history.
- History of genital/anal symptoms.
- Behaviour changes.
- · Menstrual and sexual history in adolescents.
- If the child presents with a disclosure, then the medical assessment usually follows a formal Police/ Children's Social Care interview.
- If the Police and Children's Social Care have already interviewed the child in detail, there is no need to repeat this, but check the history with Police/ social services. Only essential details need to be confirmed with the child.

Since misdiagnosis of sexual abuse can be traumatic for everyone involved, differential diagnosis of sexual abuse must be carefully considered in children particularly those who present with nonspecific genitourinary complaints or behavioral disturbances and do not volunteer a history of abuse.

# Table 2.3: Diffrential diagnosis of sexual abuse

Genital injuries	Infections
<ul> <li>Straddle injuries that typically involve anterior structures, like clitoris, clitoral hood, mons pubis and labial structures and even posterior fourchette .In few cases straddle injuries can be penetrating.</li> <li>Zipper injuries or hair tourniquet injuries.</li> <li>Vaginal foreign bodies.</li> <li>Fresh Female circumcision can present with bleeding and perineal adhesions and scars Is a long term consequences</li> </ul>	<ul> <li>Streptococcal vaginitis</li> <li>Candida infections</li> <li>Varicella</li> <li>Pinworms</li> <li>Perianal cellulites.</li> <li>Molluscum contagiosum can mimic warts caused by human papilloma virus (condyloma acuminatum).</li> </ul>
Dermatologic conditions	Anal conditions
<ul> <li>Nonspecific vulvovaginitis (poor hygiene, bubble bath).</li> <li>Seborrheic, atopic or contact dermatitis including diaper dermatitis.</li> <li>Lichen sclerosus, lichen simplex chronicus or lichen planus.</li> <li>Psoriasis.</li> <li>Bullous pemphigoid.</li> <li>Behecet's disease.</li> <li>Perineal hemangiomas.</li> <li>Mongolian spots can look like bruises.</li> </ul>	<ul> <li>Any condition that can be associated with perianal bleeding, bruising or laxity must be considered in the differential diagnosis e.g.:</li> <li>Hemorrhoid.</li> <li>Crohn's disease.</li> <li>Chronic constipation.</li> <li>Rectal prolapse due to medical conditions.</li> <li>Hemolytic uremic syndrome.</li> <li>Rectal tumors.</li> </ul>
Rectal erythema caused by:	Perineal swellings caused by:
Encopresis.	Caruncle.
<ul> <li>Poor hygiene.</li> <li>Pinworm infestation.</li> <li>Group A streptococcal or staphylococcal infections.</li> </ul>	<ul> <li>Partial or complete urethral prolapse in pre-adolescent girls that may cause bleeding.</li> <li>Sarcoma botryoides seen in infants.</li> <li>Ureterocele.</li> </ul>

### **Physical examination:**

• **Emergency sexual abuse:** Rape cases are considered as emergency sexual abuse and Child Proection Committee and Regional Hospital Task Force of Child Abuse should be involved immediately.

Rape victims should be notified to Royal Oman Police and forensic medicine (if available) through patient service to prevent loss of evidence for rape. Treating doctor should only perform general examination and provide emergency care if needed.

- **Non-emergency sexual abuse:** cases presenting with genital infections or pervaginal discharge +/- suspicious of child abuse, examination is to be done by the treating physician. The examination should include:
  - o Oropharynx: forced penile –oral contact may leave palatal petechiae, ecchymoses, and torn labial frenululm.
  - o Neck: ecchymoses, petechiae, bite marks.
  - o Breasts: abrasions, ecchymoses, bite and finger nail marks.
  - o Buttocks and thighs : ecchymoses and bite marks.
  - o Genitalia: bleeding, p/v discharge, echymoses, briuses.

Notes: forensic medicine examination should be considered to confirm the diagnosis.

# Investigations:

### All suspected cases of sexual abuse should have the following tests done:

- Urine Pregnancy Test
- VDRL.
- HIV.
- Hepatitis
- Per-vaginal / anal swab
- Other tests recommended by forensic medicine.

# **C-Emotional abuse**

# **C-Emotional abuse**

Emotional abuse is the persistent emotional maltreatment of a child causing severe and persistent adverse effects on the child emotional development 29. Emotional abuse may occur at the same time with other forms of abuse.

In general , all physically or sexually abused children are also emotionally abused. In addition, emotional abuse can occur when physical needs are excessively provided. Emotional abuse can damage the child emotionally, behaviorally and intellectually. It may be difficult for a health care professional at a health facility to detect emotional abuse and these cases of emotional abuse are difficult to prove.

It may involve conveying to child that he/she is worthless or unloved , inadequate or valued only if they meet the needs of another persons. It may also include giving the chance for the child to express their veiws or making fun of what they say or how they communicate. This may include overprotection of children, overfeeding leading to obesity and excessive care or Munchausen Syndrome by Proxy(described below). Also diagnosis of emotional abuse is made when the lack of caregiver stimulation results in developmental delay such as social and language delay. For some children with emotional abuse, they have impaired thinking and concentration which will have an impact on their educational achievement. School absentees or lateness may be a persistent pattern.

### The most common parental risk factors are :

- · History of childhood abuse
- History of mental health problems
- Violence between parents
- Alcohol or substance misuse

#### Munchausen Syndrome by Proxy:

The diagnosis of the Munchausen Syndrome by Proxy is rare. This condition results when a parent or a caregiver fabricates or induces illness in a child. It is also called "medical abuse".

The child may present with common medical problems such as apnea, seizures, bleeding disorders, hypoglycaemia and somatic symptoms such as headaches and abdominal pain. The caregiver presents as a perfect parent and will stay obsessively by the child side throughout the assessment and hospitalization. In this condition, the keys to diagnosis are to be alert to the signs of deception, consider the possibility of induced illness when the medical tests and examinations do not support the history. In addition, review all medical recods to look for patterns of presentations.

#### Signs and symptoms:

Emotional abuse commonly results in failure to thrive and often misdiagnosed as intellectual disability or physical illness. The emotional effects on children usually become obvious at school age as children find difficulties in forming relationships with teachers and peers. This is due to child replacement to another environment.

#### Indicators of emotional abuse:

Emotionally abused children are often more withdrawn and emotionally disengaged than normal peers. Emotionally abused child exhibit a range of symptoms and signs (see table 2.4). A combination or pattern of indicators should alert the health worker to the possibility of emotional abuse.

# Table 2.4: Indicators of Emotional abuse.

Child characteristics		
Physical indicators	Behavioral indicators	Caregiver characteristics
<ul> <li>Physical symptoms: frequent headache, stomach pain, diarrhea.</li> <li>Pain in arms, legs and back.</li> <li>Speech disorders</li> <li>Learning problems</li> <li>Lag in physical development</li> <li>Developmental delay such as social and language delay</li> </ul>	<ul> <li>Feel unhappy, frightened and distressed</li> <li>Antisocial and aggressive behaviors at school age.</li> <li>Find it difficult to make friends</li> <li>Sudden changes in behaviors . Children suffering may also display extreme behaviors such as becoming extremely demanding or complaint.</li> <li>Changes in school performance/ achievement and attendances.</li> <li>Low self-esteem/ feel worthless.</li> <li>Eating disorders .</li> <li>Emotional or intellectual developmental delay.</li> </ul>	<ul> <li>Blaming the child</li> <li>Ignoring the child</li> <li>Demonstrates a negative attitude toward a child</li> <li>Seems unconcerned about child's problems</li> <li>Has unrealistic expectations of the child based on child's developmental capability</li> <li>Has a history of domestic violence</li> </ul>

#### Assessment and Diagnosis

Assessment of emotional abuse focuses on general appearance and behaviors to determine if the child is failing to develop normally. Teachers and social workers are often the first ones to recognize this type of abuse. The physician may notice a pattern of missed appointments and vaccinations that are not updated. Medical neglect of chronic diseases such as asthma and Diabetes can lead to subsequent increase in emergency or clinic's visits and poor adherence with recommended treatment. Assessment of a child with suspected emotional abuse should include Physical, Emotional, Behavioral, Educational effect on the child and Peer relationships. Parental factors such as Domestic violence, Drug and alcohol use, Mental health problems and History of abuse as child should be considered



# **D- Neglect:**

Neglect is the persistent failure to meet a child's physical and/or psychological needs, likely to results in the serious impairment of child's health or development 29.

Neglect may include the following forms:

- a) Neglect of a child's physical needs, e.g. nutrition/hygiene/clothing.
- b) Neglect of a child's medical needs.
- c) Neglect of supervision and lack of awareness of safety issues.
- d) Neglect of a child's social needs, e.g. child not given opportunities to mix with peers.
- e) Neglect of child emotional needs; failure to provide affection and appropriate nurturing.
- f) Failure to ensure the child receives stimulation and education appropriate to their age and level of development.

Although neglect is usually chronic, on occasion episodic neglect may occur. This is often associated with a crisis in the family such as divorce or mental illness such as parental depression. It is important to note that disabled children are particularly vulnerable to neglect. In addition, while neglect is commonly associated with poverty it can also occur in more affluent families

# **Presentations of Neglect:**

- Frequent A&E attendance (e.g. for injuries). These are often associated with accidents through lack of supervision.
- Untreated medical conditions and not giving essential treatment regularly or consistently for serious illness and/or minor health problems.
- Poor uptake/casual attitude to immunizations.
- Physical care and presentation of the child outside acceptable norms for the population (e.g. inappropriate clothing for the weather).
- Parent/ caregiver does not have the ability and/or motivation to recognize and ensure the needs of the child are met.

### Assessment:

- A Neglected children may present with consequences arising from situations of danger accidents, assaults, poisoning, other hazards (lack of safeguarding).
- Additional risks of neglect may be present for children with disability and chronic illness. These may be associated with the child's environment, lack of service provision, family circumstances and society's attitude towards disability.
- Parenting issues may impact on the parent/ caregiver's ability and motivation to meet the needs of the child. (Refer to section 2, recognizing child abuse, and risk factors).

# History:

- Assess parents/caregiver's knowledge and understanding of child's health, development and needs.
- Family and social history assess the parents' personal, social, financial resources, health, support (both formal and informal networks) and their availability to the child both physically and emotionally.
- Consider the relationships within the family and particularly in relation to the identified child. Consider whether the child was planned or welcomed? Does the caregiver treat other children in the family any differently? Was the child the wrong sex, born at the wrong time, or born at a time of crisis within the family? Does the child have specific needs that make them vulnerable to neglect, for example, complex health needs or disability?
- Assess the child's health, development, behavior, past illness and accident history, schooling.
- Specific vulnerabilities (e.g. parental substance abuse and family violence or racial harassment).
- Consider whether the parent/caregiver's has the ability, motivation and opportunity to meet the needs of the child.

# **Examination:**

Use the whole consultation to observe the parent/caregiver and child and their interaction.

- · Parent/ caregiver
  - ► How do they care for and control the child?
  - ► How do they interact with the child?
  - ► Do they focus on the child and the child's needs?
  - ► Do the parent/caregiver own needs come first?
- Child play, attention, relationship with adults and siblings. Observe the child's general demeanor and behavior pattern, craving attention or ambivalent towards adults, or may be very withdrawn.
- General physical examination (smelly, unwashed, dirt under nails, nappy rash, unkempt, infestation, untreated skin, eye or other conditions, signs of anemia (iron deficiency) and measure hemoglobin.
- Child's growth as child may present with failure to thrive through lack of understanding of dietary needs of a child or inability to provide an appropriate diet; or they may present with obesity or teeth decay through inadequate attention to the child's diet.
- Development assessment (language, social, fine motor). Delayed development and failing at school (poor stimulation and opportunity to learn).
- Difficult or challenging behavior (failure of parenting).

Section 3 Management of suspected child abused cases and care pathways.

# Section 3: Management of Suspected/Abused Cases

**Non-Emergency cases :** This includes cases of mild-moderate neglect, physical, emotional abuse and non-emergency sexual abuse. Examples: use of discipline at schools or by caregiver, cases of neglect leading to metabolic syndrome (hypoglycemia, obesity and failure to thrive) or accidents, etc.

Child has suffered substantial amount of injury and might need to be sent to a higher level of care but does not require admission & can be managed in an out-patient basis by a pediatrician, psychologist or a family physician.

# Emergency cases:

This includes cases of severe neglect, physical (shaken baby Syndrome), emotional abuse and emergency sexual abuse.

Child is suffering from severe injury or a life threatening event and needs to be immediately sent to a hospital for specialized care/admission/protection measures.

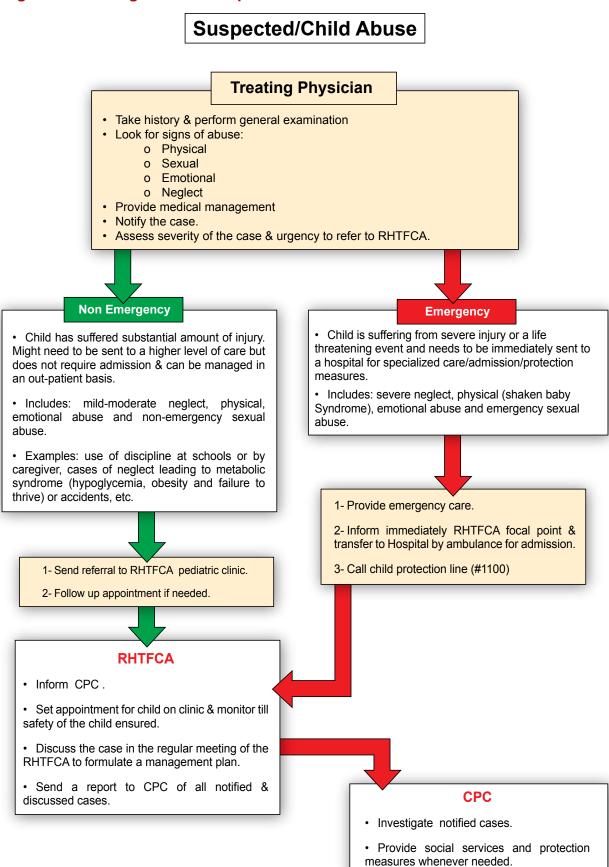
For penetrating sexual abuse: Prophylactic treatment must be started within 72 hours of the assault 24, 25, 26:

- Prophylactic antibiotics for the treatment of gonorrhea, Chlamydia, trichomonas and bacterial vaginosis to be given. Recommended Regimens (Ceftriaxone 250 mg IM in a single dose + Azithromycin 1 g orally in a single dose + Metronidazole 2 g orally in a single dose)
- Emergency contraceptive pills: two tablets given immediately and two tablets given 12 hours later for adolescent girl.
- Postexposure hepatitis B vaccination (without HBIG) if the hepatitis status of the assailant is unknown and the survivor has not been previously vaccinated. If the assailant is known to be HBsAg-positive, unvaccinated survivors should receive both hepatitis B vaccine and HBIG.
- Recommendations for HIV Prophylaxis is individualized according to risk, consult an expert.

### Note:

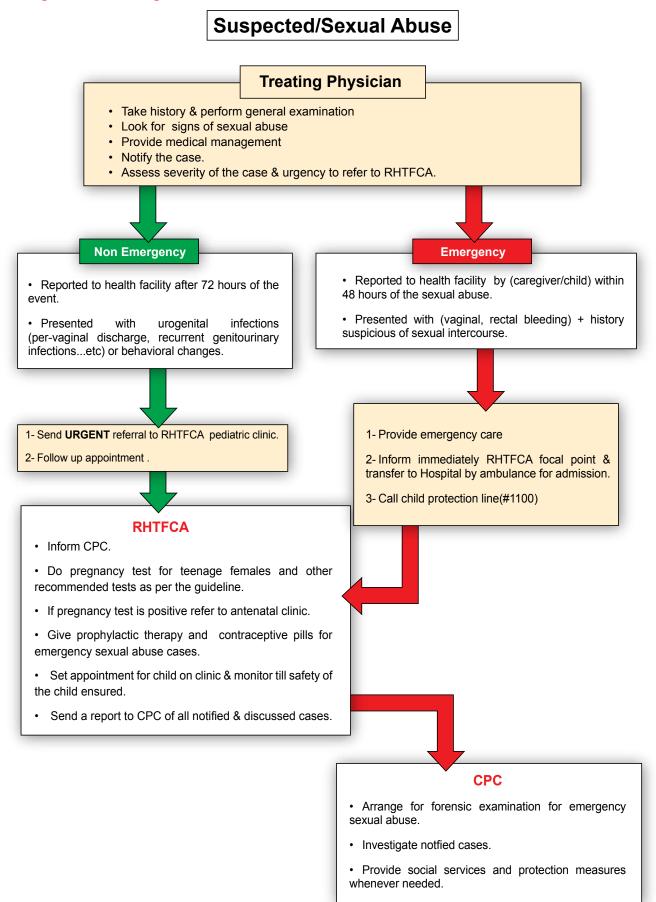
- At any level/categery of severity, referral to RHTFCA and informing CPC should be considered if the child safety can not be assured or a life threatening insult is anticipated
- All notifyifed cases should be reported to the CPC by the women and child health section in the governorate.

#### Figure 3.1: Management of suspected/child abuse cases.



**NOTE:** If the child safety can not be assured or a life threatening insult is anticipated, refer to RHTFCA and inform CPC at any level / category of severity.

#### Figure 3.2: Management of Sexual Abuse



# Section 4 Reporting of suspected cases of child abuse.

# Section 4: Reporting of suspected cases of child abuse.

Any suspected case of child maltreatment reaching health facility should be notified using child maltreatment notification form.

# Notification form for suspected cases of maltreatment of children and adolescents [up to 18 years], (H/P 29).

- The form should be filled including personal data of the child, the date, timing and details description of the events as well as examination findings, investigations and action taken.
- Preferably the form should be reported within 48 hours of presentation.
   The original copy should be sent to the Head of Women and Child Health Section and the duplicate copy (pink copy) will remain in the reporting institutions, (in a confidential file/register).

# Acknowledgement to Complete the Treatment of a Child at another Hospital (HP-259), annex 3

This form has been designed based on article (21) of Child Law: 'the specialized physician may, up on the request of the guardian, authorize the child patinet to be discharged to complete the treatment to another health institution, and release the child to his or her guardian provided that the later undertakes in writing to complete the treatment for the child and transfer him or her with an appropriate means'.

This form is available in all hospitals. It should be signed by the treating physician and the Administration Deputy staff. It has three copies, the white copy (original) should be kept on child file, pink copy (duplicate) should be sent to head of women and child health section in Governoarte and green copy (duplicate) should be given to the parents.

Then the form should be sent by the head of women and child health section in Governoarte to Child Protection Committee who will be taking the responsibility to follow up the case.

# **Responsibilities of Head of Women and Child Health Section:**

- Recieve all notified cases and ensure confidentiality of the these cases.
- Discuss all the notified cases with the Regional Hospital Task Force for Child Abuse (Senior Pediatrician and MOH representitive of RCPC) in their periodic meeting of the task force. The task force will assess the quality of reporting, classify the reported cases according to the type of abuse and formulate a management plan for them.
- Report all notified cases to the representitive of CPC
- Recieve any feedback and follow up of the cases when needed in coordination with MOH member, the (RHTFCA) and CPC.

## **Responsibilities of MOH representitive (annex 2) of Child Protection Comittees:**

- Coordinate with Head of Women and Child Health Section to arrange for a periodic meeting of the RHTFCA to discuss the notified cases.
- Participate in the discussion of the notified cases in the periodic meetings of the (RHTFCA).
- Kepp a register of the discussed cases and follow up the management plan of the cases as recommended by the (RHTFCA).
- Submit a periodic report of the discussed cases to Child Protection Comittees (CPC) and participate in the discussion of the reported cases in the committee meetings
- Laise with the CPC annex (1) whenever consultation or child protective measures are needed.

# **Responsibilities of Physicians Attending Suspected Child Abuse**

- Provide medical management for the patient as needed.
- Counseling of parents and care giver.
- Reporting of the case on the assigned notification form.
- Arrange a follow up visit for the patient if needed.
- Referral of cases to secondary care level if needed.
- Contact the focal point of the Regional Hospital Task Force for Child Abuse and CPC whenever needed to ensure child safety and provide a comprehensive care.

# Responsibilities of child protection delegate (مندوب الحماية )

Child Protection Delegate: An employee nominated by a decision of the Minister, who enjoys judicial enforcement powers in the implementation of the provisions of the present law. The requirements, duties and ethics of the child protection delegate function shall be specified by a decision of the Minister. Communication with child protection delegate through child protection line (#1100)

Article (64) of child law states that: A child who was victim of violence, exploitation or abuse shall be placed in a temporary care home pursuant to a decision of the public prosecution on the recommendation of the child protection delegate.

Hence the Child Protection Delegate has the judicial enforcement powers, the treating physician should contact him whenever an emergency case of child abuse is encountered to ensure child protection measures.

### **Responsibilities of Child Protection Committees :**

Committees for child protection against violence, exploitation and abuse called (Child Protection Committees) are formed based on article (60) of child law.

Article (61) states that: The Child Protection Committees shall be competent to receive complaints and reports about child rights violations and cases of violence, exploitation or abuse against children, as prescribed by the regulation.

The main responsibilities of Child Protection Committees are:

- Recieve any complaints and reports about child rights violations and cases of violence, exploitation or abuse against children and take the necessary actions.
- Study the reported cases of violence, exploitation or abuse against children and follow up the management and rehabilitation plans.
- To coordinate with child protection delegate and public prosecution whenever a child who was victim of violence, exploitation or abuse shall be placed in a temporary care home and follow up.
- To conduct home visits for children victims of abuse and their families to find out the causes of abuse, assess the severity and put management and rehabilitation plans.
- To register all reported cases of child abuse through the assigned notification forms and prepaire periodic reports and statistics of reported cases.
- Increase the awareness of the community about children rights, child protection and rules of child protection committees.

Section 5 Formation of Regional Hospital Task Force for Child Abuse.

# Section 5: Formation of Regional Hospital Task Force for Child Abuse Mission:

- To develop a strategic approach to child protection within the overall children's services at the Regional Hospital and overall Wilayate/Governoarte.
- In collaboration with other health institutes is committed to provide patient centered care in an environment that support continuous improvement in child protection.

# Role of Regional Hospital Task Force for Child Abuse (RHTFCA)

- Develop a strategic approach to child protection within the overall children's services at the Regional Hospital and overall Wilayate/Governoarte.
- Formulate intervention plan for suspected and confirmed cases of child Abuse.
- Initiate the process of child protection to ensure prevention of premature return of child to unsafe environment or repeated abuse.
- Focus on patient and family rehabilitation.
- Liaise with Child Protection Comittee to ensure that proper management and follow up is provided for abused cases.
- Develop a register system of the reported cases is the responsibility of the Head of Women and Child Health Section in the DGHS.

# **Policy:**

- All suspected cases of child abuse and neglect must be notified.
- Children who are subjected to severe physical, emotional abuse and neglect or emergency sexual abuse must be referred and evaluated by the (RHTFCA) immediatly.
- Mild to moderate physical, emotional abuse and neglect and non-emergency sexual abuse cases to be notified and discussed by the task force on their regular meeting.
- Regional Hospital Task Force for Child Abuse will meet on regular basis, evaluate all referred cases and set a management plan.
- Full confidentialityshould be maintained to protect the privacy of the patient and family.
- All reported cases of child abuse should be kept in a specific register.
- The Senior Pediatrician and the MOH member of Child Protection Comittee are the focal point of the Regional Hospital Task Force for Child Abuse.
- Contact numbers of the focal point should be circulated to all health facilities of the catchment area for easy referral.
- The focal point of the Task Force & representative of patient service should liaise with the Child Protection Committee for further management of the cases.
- · The Head of Women and Child Health Section in the DGHS is responsible of

recieving all notified cases, arranging the task force meetings and sending the task force reports (minutes of meeting and discussed cases) to the Departemnt of Women and Child Health, Ministry of Health on querterly basis.

Regional Hospital Task Force for Child Abuse should contain the following members:

- 1- Pediatrician
- 2- Pediatric A&E doctor (if not available, Adult A&E).
- 3- Social worker.
- 4- Representive of Patient service
- 5- MOH member of the Regional Child Protection Comittee.
- 6- Head of Women and Child Health Section in the DGHS.

It is preferable to have the following members on the task force if available on the same hospital, otherwise to assign a focal of each of those speciality at Governorate level to be invited for the meeting of the task force whenever needed and to liase referral of cases:

1- Psychiatrist.

2- Ophthalmologist.

3-Radiologist

4-Consultant physician (to deal with adolescent patients).

# **Procedure of Management**

Management of suspected case involves:

- Referral
- Assessment
- Initial response
- Intervention

### Referral

- Referral should be made by attending physician to the Regional Hospital Task Force for Child Abuse depends on the urgency. The referral letter should be directed to the focal point by name.
- Adolescent patients must be referred to the Regional Hospital Task Force for Child Abuse consultant physician.
- The Regional Hospital Task Force for Child Abuse will review all referred cases and classify them.
- Report of all cases should be sent to Child Protection Committee, except those cases who were excluded from being subjected to maltreatment.
- Notification form of Ministry of Health should be filled by the attending physician

& forward it to Head of Women and Child Health Section in the DGHS. This form should not be used for any legal puposes.

# Assessment

- Patient presenting to pediatric/adult emergency department or health centres with severe form of abuse and whenever child protection is needed regardless of the severity of abuse, the focal point of the task force should be informed immediatly. Those patients will be transferred by abmulance to the regional hospital for admission after stabilization and providing the medical manegement.
- Interviews related to abuse, psychosocial assessment & examination of the abused child should be done for all admitted cases.
- History, events, clinical examination and outcome of investigation should be well documented in the case file.
- All notified cases of child abuse should be discussed in the meeting of the Regional Hospital Task Force for Child Abuse by (Paediatrician, social worker + MOH member of the Child Protection Comittee + Head of Women and Child Health Section in the DGHS).

# **Initial response**

- If patient need admission, should be admitted under the focal point of the RHTFCA and further expert opinion (medical, surgical....) should be obtained.
- Referred cases that require an outpatient management should be given an urgent appointment.

# Intervention

- An intervention plan should be formulated by the task force team after gathering all the information and ensure prevention of premature return of the child to unsafe environment or repeat abuse, and focus on patient and family rehabilitation.
- If the child is admitted or referred with risk of a life threatening insult, the focal point will call the task force members for a meeting within 48 hours to formulate a multidisciplinary plan.
- Detailed medico-legal report and summary of task force meeting should be well documented in the patient file.
- Medical and psychosocial follow up should be arranged.
- Regional Hospital Task Force for Child Abuse should liaise through the MOH representative with the Regional Child Protection Committee to ensure safe environment for the child.
- Communication with other governmental agencies should be done through the patients' service department in Hospital.

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# Annexes:

Annex (1): list of members & contact details of the Child Protection Committees at all Governorates.

النقال	الهاتف	لمتابعة البلاغ		يوجه البلاغ	المحافظة	م
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كشف بجهات تحويل بلاغات الاساءة والعنف ضد الاطفال من المؤسسات الصحية للجان حماية الطفل

Governorate	MOH member	Contact #
Muscat	Dr. Noora Al Hosni Dr. Khoula Al Said	99898282 99254748
Dakhilyia	Dr. Amal Al Nabhani	97990506
Musandam	Dr. Eida Al shihi	99244302
Dhofar	SN. Ibtisam Ramadan	92060644
Al Sharqia South	Dr. Samya Al Hattali	99888302
Al Sharqia North	Dr. Fatma Al-Hudifi	99337758
Al Batinah North	Dr. Salama Al.Jabri	98993666
Al Batinah South	SSN. Bushra yousef	92060809
Buraimi	SSN. Afra Ali	96367722
Dhahira	Dr Mutairah Al yaqoobi	99464712
Wusta	Dr Yasser Abdelhamid	93273654

# Annex 3: Acknowledgement to Complete the Treatment of a Child at another Hospital (HP-259)

سلطنة عمان	HOSPITAL No. :		
	Name :		
SULTANATE OF OMAN MINISTRY OF HEALTH	Age :Nationality :		
Hospital :	Clinic/Ward :Unit		
Acknowledgement to Complete the Treatm of a Child at another Hospital	تعهد باستكمال علاج الطفل في مستشفى أخر nent		
I, the undersigned, and the parent/guard			
registered with hospital number	المسجل برقم ملف المسجل برقم ملف		
adhere to complete his/her treatment in a hospital within/out of	f Oman داخبار) خارج السلطنية دورد خروجه من مستشف		
after discharge my child from Hospital by an adequate transportation bas			
my request and I will be fully responsible			
decision in terms of medical and legal as The medical and legal consequences have	تحاه الطفل نتبحية لقراري هذا سرماء من الناجبية		
explained to me by the medical team			
administration officer according to Article			
(21) & (68) Of the Child Law. I also declare	و (٦٨) من قانون الطفل ، كما أنني قد استلمت كافة		
have received all relevant medical docu related to my child's health.	uments المستندات الطبية الخاصة بالطفل .		
Full Name:	الإسم الثلاثي :		
ID:			
Address:	عنوان المنزل :		
Governorate: Wilayate:	المحافظة :		
Mobile No: Signature:	رقم الهاتف :		
Date:	التاريخ :		
Doctor's Name:	اسم الطبيب :		
Signature:	التوقيع :		
Adm. Deputy Name:	الموظف الإداري المناوب :		
Signature:	التوقيع :		
Hospital Stamp:	ختم المستشفى		
Please attach ID copy of parent/guardian	ترفق نسخة من البطاقة الشخصية لولي الأمر /الوصي مع الاستمارة		

Note: See backside of this form for Article No. (21) and (68) of the Child Law.

#### Royal Decree No 22/2014 Child Law

#### Article (21)

The guardian shall ensure the child undergoes the necessary medical examinations and enters the governmental health institutions, or those licensed by the Ministry of Health, to receive treatment or medical care and shall not take him/her out of the institution unless his/her health condition allows according to the concerned doctor's advice.

The concerned doctor may, on the guardian's request. discharge the child patient to get the treatment in another health institution and may hand over the child to him after obtaining a written pledge stipulating continuation of treatment and provision of proper transfer. In all cases, the concerned health institution shall provide the guardian with all information, tests' reports medical examinations and the treatment plan of the child's own case.

#### Article (68)

In case of intended breach of any of his obligations stipulated in articles (19) and (21) of this law, the guardian shall be punished by imprisonment of minimum (6) months and maximum (3) years and by fine of minimum (100) OR and maximum of (500) OR. In case of neglect or dereliction, the punishment shall be a fine only, In case of repeated breach, the punishment shall doubled in minimum and maximum.

مرسوم سلطاني رقم ٢٢ / ٢٠١٤ قانون الطفل

المادة (٢١)

على ولي الأمر إجراء الفحوصات الطبية اللازمة للطفل وإدخاله المؤسسات الصحية الحكومية ، أو المرخص لها من وزارة الصحة ، لتلقي العللاج ، أو الرعاية الطبية ، وعدم إخراجه منها ما لم تكن حالته الصحية تسمح بذلك حسبما يقرر الطبيب المختص .

وللطبيب المختص بناء على طلب ولي الأمر - التصريح للطفسل المريسض ، أو المصاب ، بالخسروج للعسلاج فسي أي مؤسسة صحية أخرى ، وتسليم الطفل إليه بعد تعهده كتابة بإستكمال علاجه ، ونقله بوسيلة مناسبة ، وفي جميع الأحوال على المؤسسة الصحية المعنية تزويد ولي الأمر بكافة المعلومات ، والتقارير الخاصة بنتيجة الكشف ، والفحوصات الطبية والإجراءات العلاجية الخاصة بحالة الطفل الصحية .

المادة (٦٨)

يعاقب بالسجن مدة لاتقل عن (٦) ستة أشهر ، ولا تزيد على (٣) ثسلاث سنسوات ، وبغرامة لا تقسل عسن (١٠٠) مائة ريال عماني ، ولا تزيد على (٥٠٠) خمسمائة ريال عماني ، أو باحدى هاتين العقوبتين ولي الأمر الذي يخل عمدا بأي من التزاماته المنصوص عليها في المادتين (١٩) ، (٢١) من هذا القانسون ، وتكسون العقوبة الغرامة فقط إذا وقعت الجريمة بإهمال أو تقصير ، وفي جميع الأصوال تضاعف العقوبة بحديها الأدنا والأقصى في حالة التكرار .

Note:

- \* White copy (original) should be kept in child file
- \* Pink copy (duplicate) should be sent to Head of Women and Child Health Section in governorate
- \* Green copy (duplicate) should be given to the parents.

الملاحظات:

- + النسخة البيضاء ( الأصلية ) تحفظ في ملف الطفـل
- + النسخة الوردية ( نسخة ) ترسل لرئيسة قسم صحة
   الـمــراة والطفــــل بالحافظــة
- \* النسخية الخضراء (نسخة ) تسلم لولى الأمر