viii) To assure the child that he/she is now safe and would be cared for, looked after, protected;

ix) To identify areas that would / might need counselling / psychiatric intervention.

1.1 Interview setting

The more comfortable a child is, the more information he is likely to share. Also, children may be too embarrassed to share intimate details when they believe that others can overhear what they are saying. As far as possible, interviews should be conducted in a safe, neutral and child-friendly environment.

The interviewer can incorporate elements to make a room appear child-friendly, such as toys, art material or other props. Distractions like ringing phones, other people's voices and elaborate play material should be removed as far as possible.

1.2 Things to be kept in mind while interviewing a child

i) All children should be approached with extreme sensitivity and their vulnerability recognized and understood.

ii) Try to establish a neutral environment and rapport with the child before beginning the interview. For example, if the interview must be conducted in the child's home, select a private location away from parents or siblings that appears to be the most neutral spot.

iii) Try to select locations that are away from traffic, noise, or other disruptions. Items such as telephones, cell phones, televisions, and other potential distractions should be temporarily turned off.

iv) The interview location should be as simple and uncluttered as possible, containing a table and chairs. Avoid playrooms or other locations with visible toys and books that will distract children.

v) Always identify yourself as a helping person and try to build a rapport with the child.

vi) Make the child comfortable with the interview setting. Gather preliminary information about the child's verbal skills and cognitive maturity. Convey that the goal of the interview is for the *child* to talk and ask questions that invite the child to talk (e.g., "tell me about your family").

vii) Ask the child if he/she knows why they have come to see you. Children are often confused about the purpose of the interview or worried that they are in trouble.

viii) Convey and maintain a relaxed, friendly atmosphere. Do not express surprise, disgust, disbelief, or other emotional reactions to descriptions of the abuse.

ix) Avoid touching the child and respect the child's personal space. Do not stare at the child or sit uncomfortably close.

x) Do not suggest feelings or responses to the child. For example, do not say, "I know how *difficult* this must be for you."

xi) Do not make false promises. For example, do not say, "Everything will be okay" or "You will never have to talk about this again."

xii) Establish ground rules for the interview, including permission for the child to say he/she doesn't know and permission to correct the interviewer.

xiii) Ask the child to describe what happened, or is happening, to them in their own words. The interviewer should, as far as possible, follow the child's lead; however, he may have to delicately introduce the topics of the abuse.

xiv) Always begin with open-ended questions. Avoid asking the child a direct question, such as "Did somebody touch your privates last week?". Instead, try "I understand something has been bothering you. Tell me about it."

xv) After initially starting like this, move on to allow the child to use free narrative. For example, you can say, "I want to understand everything about [refer back to child's statement]. Start with the first thing that happened and tell me everything you can, even things you don't think are very important."

xvi) Avoid the use of leading questions that imply an answer or assume facts that might be in dispute and use direct questioning only when open-ended questioning/free narrative has been exhausted.

xvii) The interviewer should clarify the following:

a) Descriptions of events.
b) The identity of the perpetrator(s).
c) Whether allegations involve a single event or multiple events.
d) The presence and identities of other witnesses.
e) Whether similar events have happened to other children.
f) Whether the child told anyone about the event(s).
g) The time frame and location/venue.
h) Alternative explanations for the allegations.

xviii) However, interviewers should avoid probing for unnecessary details. For example, it may not be essential to get a detailed description of an alleged perpetrator if he/she

is someone who is familiar to the child (e.g., a relative or teacher). Although it is useful if the child can recall when and where each event occurred, children may have difficulty specifying this information if they are young, if the event happened a long time ago, or if there has been ongoing abuse over a period of time

xix) The child may get exhausted frequently and easily; in such an event, it is advisable not to prolong the inquiry, but rather to divert the child's mind and come back to the sexual abuse when the child is refreshed.

xx) Regularly check if the child is hungry or thirsty, tired or sleepy, and address these needs immediately.

xxi) Let the child do the talking and answer any questions the child may have in a direct manner.

xxii) Avoid questioning the child as to why he behaved in a particular way (e.g., "Why didn't you tell your mother that night?"). Young children have difficulty answering such questions and may feel that you are blaming them for the situation.

xxiii) Avoid correcting the child's behaviour unnecessarily during the interview. It can be helpful to direct the child's attention with meaningful explanations (e.g., "I have a little trouble hearing, so it helps me a lot if you look at me when you are talking so that I can hear you") but avoid correcting nervous behaviour that may be slowing the pace of the interview or even preventing it from proceeding.

xxiv) When two professionals will be present, it is best to appoint one as the primary interviewer, with the second professional taking notes or suggesting additional questions when the interview is drawing to a close.

xxv) Interviewers should not discuss the case in front of the child.

xxvi) Individuals who might be accused of influencing children to discuss abuse, such as parents involved in custody disputes or therapists, should not be allowed to sit with children during interviews.

xxvii) In some cases, the interviewer may consider it appropriate to allow a support person to sit in on the interview; but in these situations, such a person be instructed that only the child is allowed to talk unless a question is directed to the support person. Also, the support person should be seated out of the child's line of vision to avoid allegations that the child was reacting to nonverbal signals from a trusted adult.

xxviii) When planning investigative strategies, consider other children (boys as well as girls) that may have had contact with the alleged perpetrator. For example, there may be

an indication to examine the child's siblings. Also consider interviewing the parent or guardian or other family member of the child, without the child present.

xxix) The interviewer should convey to all parties that no assumptions have been made about whether abuse has occurred.

xxx) The interviewer should take the time necessary to perform a complete evaluation and should avoid any coercive quality to the interview.

xxxi) Interview procedures may be modified in cases involving very young, minimally verbal children or children with special needs (e.g., developmentally delayed, electively mute, non-native speakers).

xxxii) Try to establish the child's developmental level in order to understand any limitations as well as appropriate interactions. It is important to realize that young children have little or no concept of numbers or time, and that they have limited vocabulary and may use terminology differently to adults, making interpretation of questions and answers a sensitive matter.

xxxiii) A variety of non-verbal tools may be used to assist young children in communication, including drawings, toys, dollhouses, dolls, puppets, etc. Since such materials have the potential to be distracting or misleading they should be used with care. They are discretionary for older children.

xxxiv) Storybooks, colouring books or videos that contain explicit descriptions of abuse situations are potentially suggestive and are primary teaching tools. They are typically not appropriate for information-gathering purposes.

In certain situations, the interviewer may consider it appropriate to interview the child victim together with his/her parent or guardian or other person in whom the child has trust and confidence. In such cases, the following guidance may be useful:

i) When possible, interviewing the primary caregiver and reviewing other collateral data first to gather background information may facilitate the evaluation process.

ii) The child should be seen individually, except when the child refuses to separate from a parent/guardian. Discussion of possible abuse with the child in the presence of the caregiver during evaluation interviews should be avoided except when necessary to elicit information from the child. In such cases, the interview setting should be structured to reduce the possibility of improper influence by the caregiver on the child's behaviour or statements.

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iii) In some cases, joint sessions with the child and the non-accused caregiver or accused or suspected individual might be helpful to obtain information regarding the overall quality of the relationships. Such joint sessions should not be conducted for the purpose of determining whether abuse occurred based on the child's reactions to the participating adult. Joint sessions should not be conducted if they will cause significant distress for the child.

2. Children with special needs

i) It is important to understand that children may have special physical or mental needs, or a combination of both.

ii) Be aware that the risk of criminal victimization (including sexual assault) for children with special needs appears to be much higher than for those without such needs. Children with special needs are often victimized repeatedly by the same offender. Caretakers, family members, or friends may be responsible for the sexual abuse.

iii) Respect the child's wishes to have or not have caretakers, family members, or friends present during the interview. Although these persons may be accustomed to speaking on behalf of the child, it is critical that they not influence the statements of the child. If professional assistance is required (e.g., from a language interpreter or mental health professional) this should be arranged.

iv) Ideally those providing assistance should not be associated with the child. Thus as far as possible, avoid using a relative or friend of the child as an interpreter.

v) When preparing for the interview, consult with the adults in the child's world who understand the nature of his/her disability and are familiar with how the child communicates. Teachers and other professionals or paraprofessionals who have had experience in communicating with the child can be an invaluable resource to the interview team. This may include speech/language pathologists, educational psychologists, counsellors, teachers, clinical psychologists, social workers, nurses, child and adolescent psychiatrists, paediatricians, etc.

vi) Speak directly to a child with special needs, even when interpreters, intermediaries, or guardians are present. Assess the child's level of ability and need for assistance during the interview process.

vii) Note that not all children who are deaf or hard-of-hearing understand sign language or can read lips. Not all blind persons can read Braille. Be aware that a child with sensory disabilities may prefer communicating through an intermediary who is familiar with

his/her patterns of speech. Ideally, this would be someone not associated with the child, but in some cases this may be necessary.

viii) The child may experience difficulty with the concept of time, such as the concept of before and after, and being able to sequence events. The child may not be able to accurately define when something happened. It may be helpful to link events with major activities in the child's life, school events, or routines such as mealtimes.

ix) Allow extra time for the interpreter to transfer the complete message to the child and for the child to form answers.

x) Recognize that the child may have also some degree of cognitive disability: mental retardation, mental illness, developmental disabilities, traumatic brain injury, etc. Note however that not all developmental disabilities affect cognitive ability (e.g., cerebral palsy may result in physical rather than mental impairment). Be aware that a child with cognitive disabilities may be easily distracted and have difficulty focusing. Speak to the child in a clear, calm voice and ask very specific, concrete questions. Be exact when explaining what will happen during the medical examination process and why.

xi) Keep in mind that children with special needs may be reluctant to report the crime or consent to the examination for fear of losing their independence. For example, they may have to enter a long-term care facility if their caretakers assaulted them or may need extended hospitalization to treat and allow injuries to heal.

xii) While a child's special need may have resulted in him being more vulnerable to abuse, it is important to listen to his/her concerns about the assault and what the experience was like for them, and not focus on the role of his/her special need.

xiii) Assure the child that it is not his/her fault that he was sexually assaulted. If needed, encourage discussion in a counselling/advocacy setting if he/she is concerned about their safety in the future.

3. **Procedures when interviewing parents/caregivers:**

   i) Inform parents/caregivers in an open and honest way of existing concerns and reports about their child or children;

   ii) Explain how information about the case has been, and will be, obtained;

   iii) Identify the professionals who have been contacted so far;

   iv) Invite the parents/caregivers to give an explanation of their view of the concern;

   v) Show a willingness to consider different interpretations of the concern;

vi) Ensure that the parents/caregivers are fully aware of the way that information is going to be assessed and evaluated, and what expectations are held of them about the way they care for and protect their children;

vii) Explain the legal context in which the concern is being investigated;

viii) If the concern arose from an incident perpetrated by one of the child's parents/caregivers, the worker should try to gain the support and cooperation of the other parent/caregiver to facilitate ongoing protection of the child;

ix) A child should never be asked to discuss the possible abuse in front of an accused or suspected parent.

If it is considered necessary by CWC to remove a child from his/her parents/caregivers or their homes, then the following must be considered:[2]

i) In the first instance, all possible efforts should be made to place the child in a situation that is familiar, preferably with family or friends

ii) As far as possible, the timing of the move should be sensitively handled.

iii) The child's parents/caregivers should be informed of the action proposed, unless doing so would endanger the child or jeopardise the placement process.

iv) The child should be informed of the proposed action if he or she has not been involved in the decision.

v) The child's parents/caregivers should be informed of the child's location, unless otherwise directed by the Court.

vi) The child's parents/caregivers should be advised about and assisted in obtaining legal advice.

4. Best practice principles for the use of interpreters

Interpreters may be needed during both the investigation and trial of cases of child sexual abuse. They may be needed for witnesses and for parties who speak a language different from that of the Court in that State, or for witnesses and parties who have speech or hearing impairments or other communication difficulties.

[2] Rule 4(5) and (6) of POCSO Rules, 2012 state that prior to making a determination as to whether the child needs to be taken out of the custody of his/her family or shared household, the inquiry should be conducted in a manner that does not unnecessarily expose the child to injury or inconvenience. Hence, these considerations would help ascertain the same.

The police or SJPU may contact the District Child Protection Unit (DCPU), whose responsibility it is under the POCSO Act and Rules, 2012 to provide interpreters, translators, etc. Where an interpreter is not available, a non-professional may be asked to interpret for the child; however, in these cases, it must be ensured that there is no conflict of interest. For example, where there is an allegation of child sexual abuse against the child's father, the mother should not be asked to interpret.

i) Promote access to interpreter services in order to facilitate the best possible communication with the child, to ensure everything is fully explained and that there is no room for misinterpretation.

ii) Be clear with the interpreter about roles and responsibilities in the process of engagement with the family. Interpreters need to understand that their role is to translate direct communications between the police or support person etc. and the family members, not to talk on either party's behalf or act as the family's representative.

iii) Services must be planned ahead where possible to meet the child's needs.

iv) Interpreter should declare that there is no prior acquaintance or relationship with the victim/witness

v) Maintain high quality, timely, precise records along with supporting documents; as far as possible, this should be a verbatim record of the communication.

vi) There should be a record of a child's interpreter needs, including language and dialect, and whether the interpreter is required for oral and written communication. Where an interpreter is offered but declined by the child, this should also be recorded.

vii) Promote qualified interpreters who can work in partnership in the best interests of the child.

viii) Interpreters should be subject to references and background checks and must sign a written agreement regarding confidentiality.

Chapter 4

Medical and Health Professionals

(Doctors and supporting medical staff)

1. Relevant Legal Provisions in the Act and Rules and related laws:

Section 27 – Medical Examination:

27. (1) The medical examination of a child in respect of whom any offence has been committed under this Act, shall, notwithstanding that a First Information Report or complaint has not been registered for the offences under this Act, be conducted in accordance with section 164A of the Code of Criminal Procedure, 1973.

(2) In case the victim is a girl child, the medical examination shall be conducted by a woman doctor.

(3) The medical examination shall be conducted in the presence of the parent of the child or any other person in whom the child reposes trust or confidence.

(4) Where, in case the parent of the child or other person referred to in sub-section (3) cannot be present, for any reason, during the medical examination of the child, the medical examination shall be conducted in the presence of a woman nominated by the head of the medical institution.

Rule 5 – Emergency medical care:

(1) Where an officer of the SJPU, or the local police receives information under section 19 of the Act that an offence under the Act has been committed, and is satisfied that the child against whom an offence has been committed is in need of urgent medical care and protection, he shall, as soon as possible, but not later than 24 hours of receiving such information, arrange to take such child to the nearest hospital or medical care facility centre for emergency medical care;

Provided that where an offence has been committed under sections 3, 5, 7 or 9 of the Act, the victim <u>shall</u> be referred to emergency medical care.

(2) Emergency medical care shall be rendered in such a manner as to protect the privacy of the child, and in the presence of the parent or guardian or any other person in whom the child has trust and confidence.

(3) No medical practitioner, hospital or other medical facility centre rendering emergency medical care to a child shall demand any legal or magisterial requisition or other documentation as a pre-requisite to rendering such care.

(4) The registered medical practitioner rendering emergency medical care shall attend to the needs of the child, including --

- *(i) treatment for cuts, bruises, and other injuries including genital injuries, if any;*
- *(ii) treatment for exposure to sexually transmitted diseases (STDs) including prophylaxis for identified STDs;*
- *(iii) treatment for exposure to Human Immunodeficiency Virus (HIV), including prophylaxis for HIV after necessary consultation with infectious disease experts;*
- *(iv) possible pregnancy and emergency contraceptives should be discussed with the pubertal child and her* parent or any other person in whom the child has trust and confidence; and,
- *(v) wherever necessary, a referral or consultation for mental or psychological health or other counselling should be made.*

(5) Any forensic evidence collected in the course of rendering emergency medical care must be collected in accordance with section 27 of the Act.

Thus, doctors and support medical staff are involved both at the time of rendering emergency medical care as well as at the time of medical examination.

2. Emergency Medical care:

The child may be brought to the hospital for emergency medical care as soon as the police receive a report of the commission of an offence against the child. In such cases, the rules under the POCSO Act, 2012 prescribe that the child is to be taken to the nearest hospital or medical care facility. This may be a government facility or a private one.

This is reiterated by Section 23 of the Criminal Law Amendment Act, which inserts Section 357C into the Code of Criminal Procedure, 1973. This section provides that all hospitals are required to provide first-aid or medical treatment, free of cost, to the victims of a sexual offence.

2.1 Medical Examination:

Medical examination is to be conducted as per the provisions of Section 27 of the POCSO Act, 2012 and Section 164A of the CrPC, 1973 which states:

(1) Where, during the stage when an offence of committing rape or attempt to commit rape is under investigation, it is proposed to get the person of the woman with whom rape is alleged or attempted to have been committed or attempted, examined by a medical expert, such examination shall be conducted <u>by a registered medical practitioner employed in a hospital run by the Government or a local authority and in the absence of a such a practitioner, by any other registered medical practitioner,</u> with the consent of such woman or of a person competent to give such consent on her behalf and such woman shall be sent to such registered medical practitioner within twenty-four hours from the time of receiving the information relating to the commission of such offence.

(2) The registered medical practitioner, to whom such woman is sent shall, without delay, examine her and prepare a report of her examination giving the following particulars, namely:-
(I) the name and address of the woman and of the person by whom she was brought;
(II) the age of the woman;
(III) the description of material takén from the person of the woman for DNA profiling;
(IV) marks of injury, if any, on the person of the woman;
(V) general mental condition of the woman; and
(IV) other material particulars in reasonable detail.

(3) The report shall state precisely the reasons for each conclusion arrived at.

(4) The report shall specifically record that the consent of the woman or of the person competent to give such consent on her behalf to such examination had been obtained.

(5) The exact time of commencement and completion of the examination shall also be noted in the report.

(6) The registered medical practitioner shall, without delay forward the report to the investigation officer who shall forward it to the Magistrate referred to in section 173 as part of the documents referred to in clause (a) of sub-section (5) of that section.

(7) Nothing in this section shall be construed as rendering lawful any examination without the consent of the woman or of any person competent to give such consent on her behalf.

In the above legal provision, the term "woman" may be substituted by the term "child", and applied in the context of the POCSO Act, 2012.

2.2 Compensation for medical expenses:

Section 33(8) provides:

"In appropriate cases, the Special Court may, in addition to the punishment, direct payment of such compensation as may be prescribed to the child for any physical or mental trauma caused to him or for immediate rehabilitation of such child."

Rule 7 provides further details in relation to the payment of this compensation. It specifies that the Special Court may order that the compensation be paid not only at the end of the trial, but also on an interim basis, to meet the immediate needs of the child for relief or rehabilitation at any stage after registration of the First Information Report [Rule 7(1)]. This could include any immediate medical needs that the child may have. Further, Rule 7(3) provides that the criteria to be taken into account while fixing the amount of compensation to be paid include the severity of the mental or physical harm or injury suffered by the child; the expenditure incurred or likely to be incurred on his/her medical treatment for physical and/or mental health; and any disability suffered by the child as a result of the offence. Hence, the child may recover the expenses incurred on his/her treatment in this way.

3. Modalities of Medical Examination of Children

3.1 Role of Medical Professionals in the context of the POCSO Act, 2012

Doctors have a dual role to play in terms of the POCSO Act 2012. They are in a position to detect that a child has been or is being abused (for example, if they come across a child with an STD); they are also often the first point of reference in confirming that a child has indeed been the victim of sexual abuse.

The role of the doctor may include:

i) Having an in-depth understanding of sexual victimization

ii) Obtaining a medical history of the child's experience in a facilitating, non-judgmental and empathetic manner

iii) Meticulously documenting historical details

iv) Conducting a detailed examination to diagnose acute and chronic residual trauma and STDs, and to collect forensic evidence

v) Considering a differential diagnosis of behavioural complaints and physical signs that may mimic sexual abuse

vi) Obtaining photographic/video documentation of all diagnostic findings that appear to be residual to abuse

vii) Formulating a complete and thorough medical report with diagnosis and recommendations for treatment

viii) Testifying in court when required

There are at least three different circumstances when there is no direct allegation but when the doctor may consider the diagnosis of sexual abuse and have to ask questions of the parent and child. These include but are not limited to:

(i) when a child has a complaint that might be directly related to the possibility of sexual abuse, such as a girl with a vaginal discharge;

(ii) when a child has a complaint that is not directly related to the possibility of sexual abuse, such as abdominal pain or encopresis (soiling);

(iii) when a child has no complaint but an incidental finding, such as an enlarged hymenal ring, makes the doctor suspicious.

3.2 Mandatory Reporting: When a doctor has reason to suspect that a child has been or is being sexually abused, he/she is required to report this to the appropriate authorities (i.e. the police or the relevant person within his/her organization who will then have to report it to the police). Failure to do this would result in imprisonment of up to six months, with or without fine.[3]

3.3 Medical or health history: The purpose of this is to find out why the child is being brought for health care at the present time and to obtain information about the child's physical or emotional symptoms. It also provides the basis for developing a medical

[3]Section 21, Protection of Children from Sexual Offences Act, 2012.

diagnostic impression before a physical examination is conducted. The medical history may involve information about the alleged abuse, but only in so far as it relates to health problems or symptoms that have resulted there from, such as bleeding at the time of the assault, or constipation or insomnia since that time.

Where a child is brought to a doctor for a medical examination to confirm sexual abuse, the doctor must:

i) Take the written consent of the child. The three main elements of consent are information, comprehension and voluntariness. The child and his/her family should be given information about the medical examination process and what is involved therein, so that they can choose whether or not to participate. Secondly, they should be allowed enough time to understand the information and to ask questions so that they can clarify their doubts. Lastly, the child and/or his or her parent/guardian should agree to the examination voluntarily, without feeling pressurised to do so. In some situations it may be appropriate to spend time with the child/adolescent alone, without the parent/guardian present. This may make it easier for the child to ask questions and not feel coerced by a parent/guardian.

ii) Where the child is too young or otherwise incapable of giving consent, consent should be obtained from the child's parent, guardian or other person in whom the child has trust and confidence.

iii) The right to informed consent implies the right to informed refusal.

iv) To be able to give informed consent, the child and his/ her parents/guardian need to understand that health care professionals may have a legal obligation to report the case and to disclose information received during the course of the consultation to the authorities even in the absence of consent.

v) Document who was present during the conversation with the child.

vi) Document questions asked and child's answers in the child's own words.

vii) Conduct the examination in a sensitive manner. It is important that the exam is never painful. The exam should be done in a manner that is least disturbing to the child.

viii) Focus on asking simply worded, open-ended, non-leading questions, such as the "what, when, where, and how" questions, which are important to the medical evaluation of suspected child sexual abuse.

ix) Reliance should be placed as far as possible on such questioning as "tell me more" followed by "and then what happened?"

x) Do not ask uncomfortable questions related to details of the abuse, but try to find out more about the medical and family history of the child

xi) Using the child's words for body parts may make the child more comfortable with difficult conversations about sexual activities.

xii) Using drawings may also help children describe where they may have been touched and with what they were touched.

xiii) Ensure that the child has adequate privacy while the examination is being conducted

xiv) Do not conduct the examination in a labour room or other place that may cause additional trauma to the child

xv) Always ensure patient privacy. Be sensitive to the child's feelings of vulnerability and embarrassment and stop the examination if the child indicates discomfort or withdraws permission to continue.

xvi) Always prepare the child by explaining the examination and showing equipment; this has been shown to diminish fears and anxiety. Encourage the child to ask questions about the examination.

xvii) If the child is old enough, and it is deemed appropriate, ask whom they would like in the room for support during the examination. Some older children may choose a trusted adult to be present. *Sexual abuse of children is usually not physically violent. In the* large majority of children the physical exam is normal. A normal or non-specific exam does not rule out sexual abuse.

xviii) As a minimum, the medical history should cover any known health problems (including allergies), immunization status and medications. In terms of obtaining information about the child's general health status, useful questions to ask would be:

a) Tell me about your general health.
b) Have you seen a nurse or doctor lately?
c) Have you been diagnosed with any illnesses?
d) Have you had any operations?
e) Do you suffer from any infectious diseases?

xix) Carefully collect and preserve forensic evidence

xx) Clothing collection is critical when evidence is collected. Clothing, especially underwear, is the most likely positive site for evidentiary DNA.

xxi) Scene investigation, including collection of linens and clothing should be done early. Evidence from clothing and other objects is more likely to be positive than evidence from the patient's body.

xxii) Children often report weeks or months after the abuse event, and physical injuries to the genital or anal regions usually heal within a few days. This is why the medical provider should always consider differential diagnosis and alternative explanations for physical signs and symptoms.

xxiii). In the case of a child with special needs, ensure that the procedures are explained to the child in a manner which he/she understands and that he/she is asked what help he/she requires, if any (e.g., a child with physical disabilities may need help to get on and off the medical examination table or to assume positions necessary for the examination). However, do not assume that the child will need special aid. Also, ask for permission before proceeding to help the child.

xxiv) Recognize that it may be the first time the child is having an internal examination. The child may have very limited knowledge of reproductive health issues and not be able to describe what happened to them. He/she may not know how he/she feels about the incident or even identify that a crime was committed against him/her.

xxv) Wherever necessary, refer the child for counselling

xxvi) Wherever applicable, refer the child for testing for HIV and other Sexually Transmitted Diseases

3.4 If the child resists the examination

i) If a child of any age refuses the genital-anal examination, it is a clinical judgment of how to proceed. A rule of thumb is that the physical exam should not cause any trauma to the child. It may be wise to defer the examination under these circumstances.

ii) It may be possible to address some of the child's fears and anxieties (e.g. a fear of needles) or potential sources of unease (e.g. the sex of the examining health worker). Further, utmost comfort and care for the child should be provided e.g., examining very small children while on their mother's (or caregiver's) lap or lying with her on a couch.

iii) If the child still refuses, the examination may need to be deferred or even abandoned. Never force the examination, especially if there are no reported symptoms or injuries, because findings will be minimal and this coercion may represent yet another assault to the child.

iv) The child should not be held down or restrained for the examination (exception for infants or very young toddlers).