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Indore, Madhya Pradesh

INDIA

MODULE PLAN

- TOPIC : **CHILD ABUSE AND NEGLECT**
- SUBJECT: PEDODONTICS
- TARGET GROUP: UNDERGRADUATE DENTISTRY
- MODE: POWERPOINT – WEBINAR
- PLATFORM: INSTITUTIONAL LMS
- PRESENTER: DR. BINTI RANI CHAND

CONTENTS

- Introduction
- Definition
- Prevalence
- Historical background
- Consequences of CAN
- Predisposing factors
- Types of child abuse
  - Physical abuse
  - Sexual abuse
  - Emotional abuse
  - Child neglect
- Oral manifestations of child abuse and neglect

- Identification of CAN
- Management of CAN
  - Documentation
  - Reporting
- Role of pedodontist
- Indian legal system
- Prevention of child abuse and neglect
- Conclusion
- References

INTRODUCTION

- Childhood should be a care-free time filled with love, and the joy of discovering new things and experiences.
- However, it is a dream for many children.
- Child abuse and neglect is an increasing social problem.
- Effects of child abuse and neglect are not limited to childhood but cascade throughout life, with significant consequences for victims (on all aspects of human functioning), their families, and society.

- CHILD ABUSE

words or overt actions that cause harm, potential harm, or threat of harm to a child.

- CHILD NEGLECT

can be conceptualized in a broad sense as harmful acts of omission or the failure to provide for a child's basic physical, emotional, or educational needs or to protect a child from harm or potential harm.

- Child abuse, as defined by *Gill* (1968)

  "nonaccidental physical injury, minimal or fatal, inflicted upon children by persons caring for them."

DEFINITION

- Dental neglect

"willful failure of parent or guardian to seek and follow through with treatment necessary to ensure a level of oral health essential for adequate function and freedom from pain and infection."

American Academy of Pediatric Dentistry, 2010

DEFINITION

Dental neglect

"the failure of a parent or other person legally responsible for the child's welfare to provide for the child's basic needs and an adequate level of care."

Nester, 1998 & Kaplan and Labruna, 1999

PREVALENCE

- 25-50% of children around the world suffer from physical abuse.
- 5-10% of boys and 20% of girls experience sexual abuse.

(Summary report of 'Workshop on International Epidemiological Studies' : XIXth ISPCAN International Congress on Child Abuse and Neglect, Sept 2012)

- Acc. To WHO A quarter of all adults report having been physically abused as children.

- One in 5 women and 1 in 13 men report having been sexually abused as a child

PREVALENCE

- 2006: US dept of Health and Human Services:
  - 65% of child maltreatment encompasses neglect
  - 16% involves physical abuse
  - 9% involves sexual abuse
  - 7% involves emotional abuse
  - >2% involves medical neglect

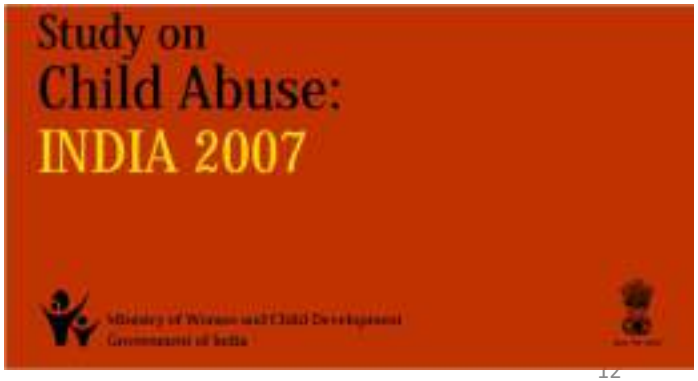
- Average age of identification of maltreatment victims: 7.4 years

- Infants ˜2 years : victims of child neglect

PREVALENCE IN INDIA

- India is the home of 19% children in the world.
- 440 million people in India are below 18 years.
  - Physical abuse – 69%
  - Sexual abuse – 53%
  - Emotional abuse- 49%

- 71% girls reported facing neglect within the family



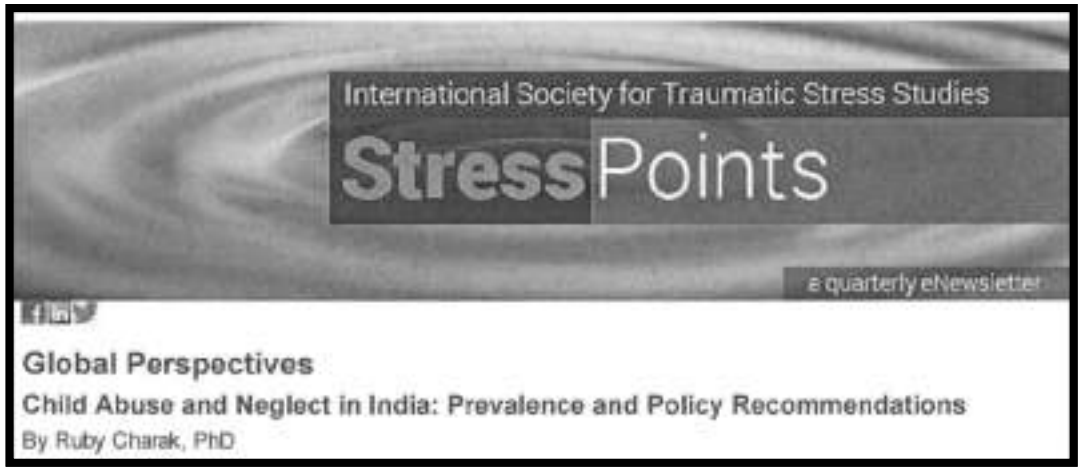
PREVALENCE IN INDIA

- 69% of Indian children are victims of physical, emotional, or sexual abuse.
- New Delhi, has an over 83% abuse rate.
- 89% of the crimes are committed by family members.
- More than 70% of cases go unreported and unshared even with parents/ family.

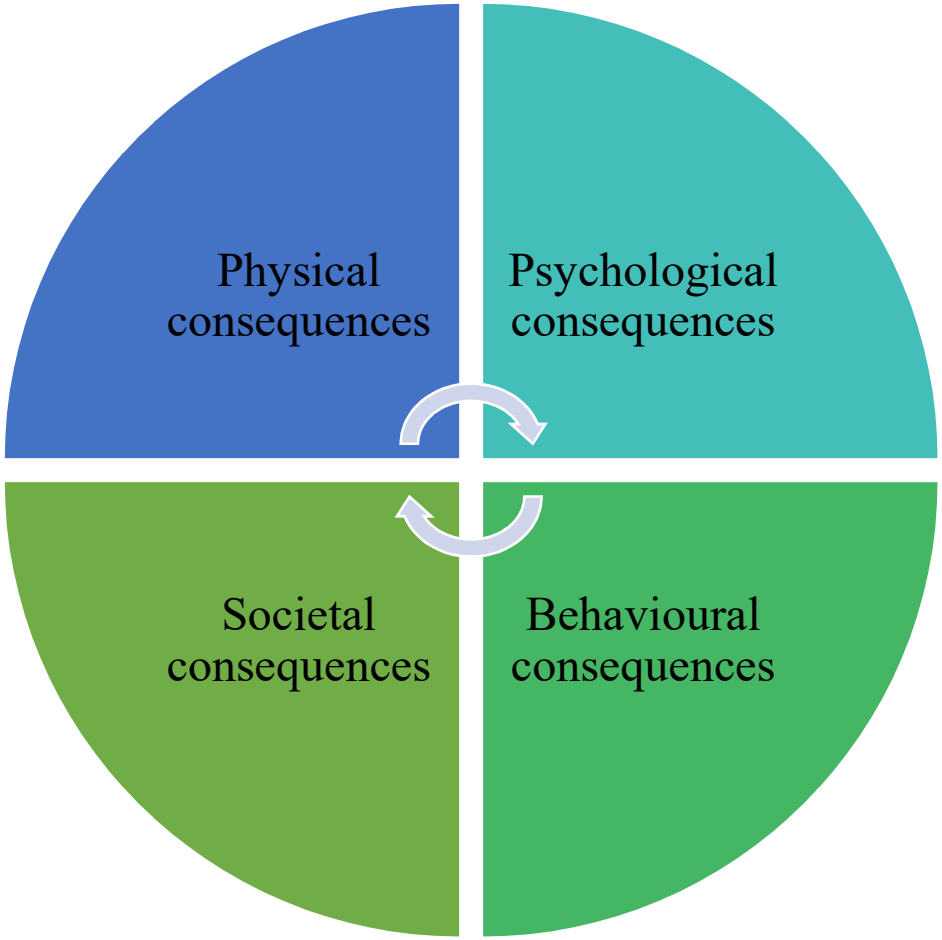
- Acc. To Asian centre for human rights (2013) stated that 48,333 child rape cases were recorded during 2001-11 in India.

- 3 fold higher rates of abuse among adolescents in India as compared to western world.

- Role of parental education



CONSEQUENCES OF CHILD ABUSE AND NEGLECT



Factors Affecting the Consequences of Child Abuse and Neglect

- The child's age and developmental status when the abuse or neglect occurred
- The type of maltreatment (physical abuse, neglect, sexual abuse, etc.)
- The frequency, duration, and severity of the maltreatment
- The relationship between the child and the perpetrator

Physical consequences

- The immediate physical effects of abuse or neglect can be relatively minor (bruises or cuts) or severe (broken bones, haemorrhage, or even death).

Abusive head trauma

- Abusive head trauma, an inflicted injury to the head and its contents caused by shaking and blunt impact, is the most common cause of traumatic death for infants.

Impaired brain development

- Child abuse and neglect have been shown to cause important regions of the brain to fail to form or grow properly, resulting in impaired development.

- These alterations in brain maturation have long-term consequences for cognitive, language, and academic abilities and are connected with mental health disorders (Tarullo, 2012).

Poor physical health

- Several studies have shown a relationship between various forms of child maltreatment and poor health.

- Adults who experienced abuse or neglect during childhood are more likely to suffer from cardiovascular disease, lung and liver disease, hypertension, diabetes, asthma, and obesity.

Psychological Consequences

- The immediate emotional effects of abuse and neglect—isolation, fear, and an inability to trust—can translate into lifelong psychological consequences, including low self-esteem, depression, and relationship difficulties.

Difficulties during infancy

- Children who experienced maltreatment exhibit some form of cognitive delay and have lower IQ scores, language difficulties, and neonatal challenges compared to children who have not been abused or neglected

Poor mental and emotional health

- Experiencing childhood trauma and adversity, such as physical or sexual abuse, is a risk factor for borderline personality disorder, depression, anxiety, and other psychiatric disorders.

- 54 percent of cases of depression and 58 percent of suicide attempts in women were connected to adverse childhood experiences (Felitti & Anda, 2009)

Psychiatric problems: Mood and anxiety disorders, Unipolar depression, bipolar disorder, panic attacks, phobias and post-traumatic stress disorder.

(Agid et al 1999, Famulrao et al 1992, Heim and Nemeroff 2001, Hill 2003, Kendler et al 2000).

Increased risk of schizophrenia, reactive attachment disorder, eating disorders and personality disorders.

(Ackard and Neumark-Sztainer 2003, Agid et al 1999, Felitte et al 1998, Saunders et al 1992, Zeanah et al 2004)

Link between child abuse and later substance abuse : Briere and Wow 1991, Burnam et al 1988, Kendler et al 2000)

Childhood trauma: increases the risk for later suicide attempts.

Cognitive difficulties

- Children with substantiated reports of maltreatment are at risk for severe developmental and cognitive problems.

- More than 10 percent of school-aged children and youth showed some risk of cognitive problems or low academic achievement, 43 percent had emotional or behavioural problems, and 13 percent had both (ACF/OPRE, 2011).

Social difficulties

- Children who experience neglect are more likely to develop antisocial traits as they grow up.

- Parental neglect is associated with borderline personality disorders, attachment issues or affectionate behaviors with unknown/little-known people, inappropriate modeling of adult behavior, and aggression (Perry, 2012).

Behavioural consequences

• Not all victims of child abuse and neglect will experience behavioural consequences.

• However, behavioural problems appear to be more likely among this group.

• More than half of youth reported for maltreatment are at risk for an emotional or behavioural problem

Difficulties during adolescence

- more than half of youth with reports of maltreatment are at risk of grade repetition, substance abuse, delinquency, truancy, or pregnancy

Juvenile delinquency and adult criminality

- Several studies have documented the correlation between child abuse and future juvenile delinquency.
- Children who have experienced abuse are nine times more likely to become involved in criminal activities (Gold, Wolan Sullivan, & Lewis, 2011).

- Alcohol and other drug abuse

- Abusive behaviour

Societal Consequences

Direct costs

- The lifetime cost of child maltreatment and related fatalities in 1 year totals $124 billion, according to a study funded by the CDC.

Indirect costs

- Indirect costs represent the long-term economic consequences to society because of child abuse and neglect. These include costs associated with increased use of our health-care system, juvenile and adult criminal activity, mental illness, substance abuse, and domestic violence

CONSEQUENCES OF CHILD ABUSE AND NEGLECT

Table 1 Long-Term Consequences of Child Maltreatment: (Increased Risk)

Injury, Illness, Disability	Risky Health Behaviors	Social, Emotional Cognitive Impairment
Chronic obstructive pulmonary disease (COPD)	Alcoholism and alcohol abuse	Depression
Ischemic heart disease (IHD)	Illicit drug use	Risk for intimate partner violence
Liver disease	Promiscuity	Suicide attempts
Adolescent pregnancy	Smoking	unemployment
Health-related quality of life	Early initiation of sexual activity	Less likely to own place of residence, bank account, stock
Fetal death	Sexually transmitted diseases (STDs)	Criminality/incarceration
Skeletal Fractures	Early initiation of smoking	Lower educational attainment

Sources: 1. Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, Division of Violence Prevention (January 18,2013)

2. Child Maltreat. 2010 May; 15(2): 111–120.Long-Term Consequences of Child Abuse and Neglect on Adult Economic Well-Being

Janet Currie and Cathy Spatz Widom

HISTORICAL BACKGROUND

- First documented and reported case of CA/CN occurred in 1871 with a child named, Mary Ellen.

- 1949: Medical discovery of child abuse was documented by Caffey on observing children with multiple bone fractures and children with trauma unsubstantiated by parents.

- 1955- Wooley and Evans observed that many chilhood traumas were willfully inflicted

- 1960: Term ‘Battered child syndrome’ by Henry Kempe

- 1974: Child Abuse Prevention and Treatment Act

- 1978: Mclain: coined CAN: Child abuse and neglect

- Contribution of dental profession in CAN

PREDISPOSING FACTORS

- PARENTAL CHARACTERISTICS
- CHILD CHARACTERISTICS
- ENVIRONMENTAL CHARACTERISTICS

PARENTAL CHARACTERISTICS

- Violence,
- Poverty,
- Parental history of abuse,
- Socially isolated,
- Low self esteem,
- Less adequate maternal functioning.

CHILD CHARACTERISTCS

- Unwanted or unplanned child
- No. of children in the family,
- Child's temperament,
- Position in the family,
- Additional physical needs if ill or disabled,
- Activity level or degree of sensitivity to parental needs.

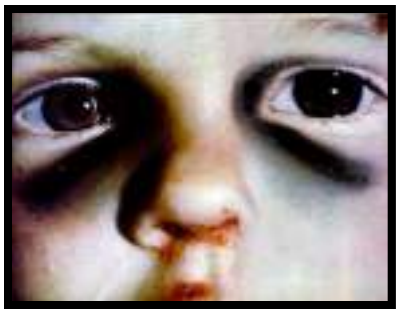
ENVIRONMENTAL CHARACTERISTICS

- Chronic stress,
- Problem of divorce,
- Poverty,
- Unemployment,
- Poor housing,
- Frequent relocation,
- Alcoholism,
- Drug addiction.

TYPES OF ABUSE

- Physical abuse
  - Shaken Baby Syndrome
  - Munchausen syndrome of proxy
- Sexual abuse
- Emotional abuse
- Child Neglect

PHYSICAL ABUSE



INCLUDES:

- SHAKING
- HITTING
- BURNING/ SCALDING
- FEMALE GENITAL MUTILATION
- FABRICATED AND INDUCED ILLNESS
- DROWNING
- SUFFOCATING

- Most easily recognizable form of maltreatment.
- <u>Battered child syndrome:</u>
  - Initially described by Dr C Henry Kempe and colleagues in 1962
  - Elaborated further by Kempe and Helfer in 1972
  - Clinical picture of physical trauma in which the explanation of injury was not consistent with the severity and type of injury observed.

Evidences for suspecting child abuse

- Any injury unusual to a specific age group
- History of previous or recurrent injuries
- Unexplained injury
- Excessive bruising in an area other than usual traumatic contact.
- Evidence of poor supervision
- Evidences of neglect

IDENTIFYING PHYSICAL ABUSE IN CHILDREN

- Often, the abuse stems from an angry response of caretaker to punish the child for misbehaviour.

- Most commonly recognized by clinical findings, but history is a helpful tool when child reports with non-descriptive findings.

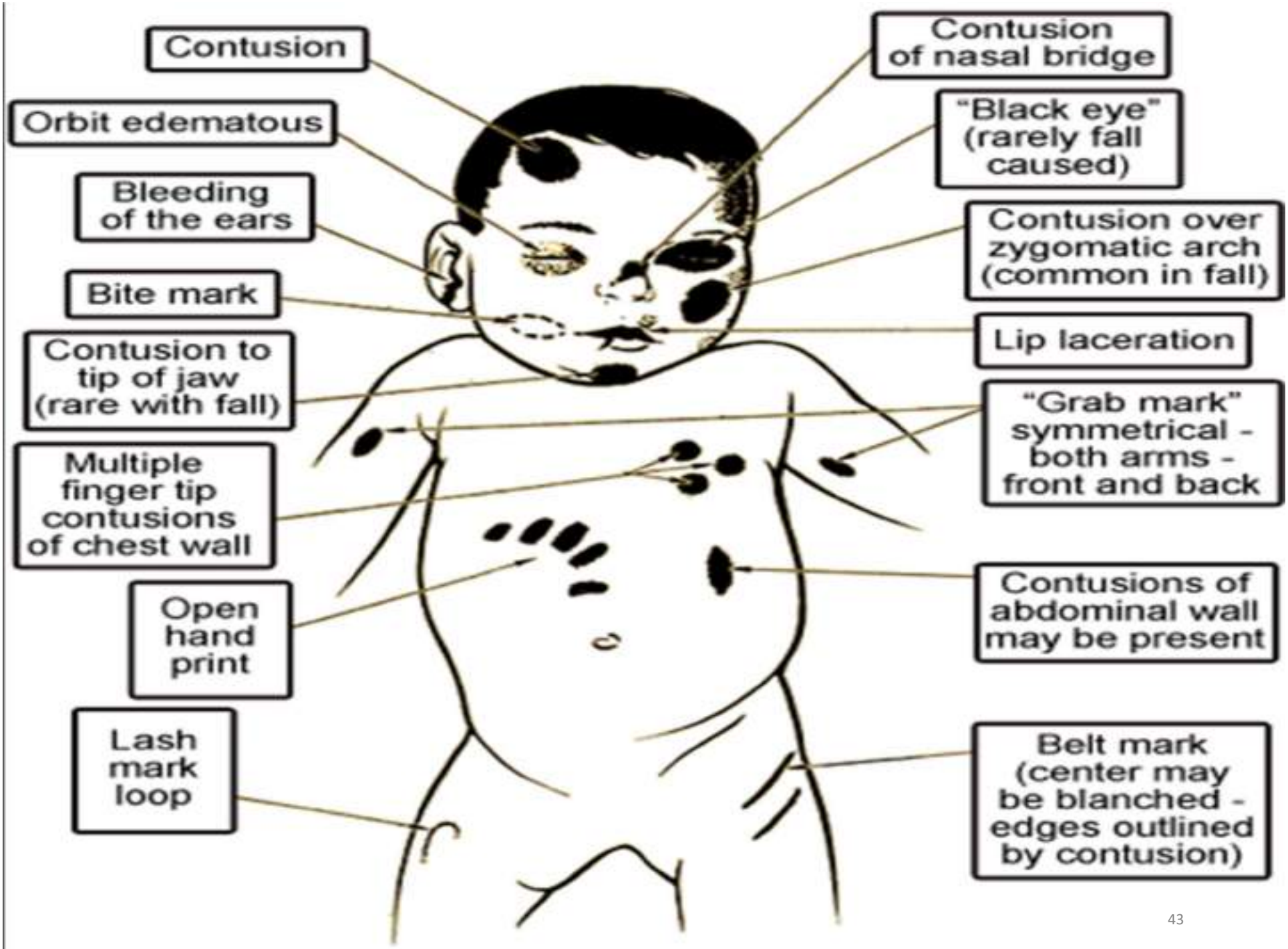
- Identifying factors elucidated in history and clinical examination.

HISTORY

- Correct questions to be asked.
- Eyewitness history:
  - Child states that injury is caused by parent.
  - Parent accepts that one of the many injuries is caused by him but not all.
  - One parent accuses the other about the injury.
- Unexplained injury
  - Denial
  - Vague explanation
  - No explanation
  - Inconsistent explanation
  - Alleged self-inflicted injury
- Delay in seeking medical care

CLINICAL FINDINGS

- BRUISES
- MARKS
- BURNS
- LACERATIONS AND ABRASIONS
- FRACTURES AND DISLOCATIONS
- MUTILATION INJURIES


Contusion
Orbit edematous
Bleeding of the ears
Bite mark
Contusion to tip of jaw (rare with fall)
Multiple finger tip contusions of chest wall
Open hand print
Lash mark loop
Contusion of nasal bridge
"Black eye" (rarely fall caused)
Contusion over zygomatic arch (common in fall)
Lip laceration
"Grab mark" symmetrical - both arms - front and back
Contusions of abdominal wall may be present
Belt mark (center may be blanched - edges outlined by contusion)

CLINICAL FINDINGS

- Bruises and Welts
- Burns- on sole of feet, palms of hand, back or buttocks. Patterns descriptive of object used, such as sound cigar or cigarette burns, immersion in scalding water, rope burns on wrists.
- Absence of ' splash' marks and presence of symmetric burns.
- Fractures and dislocations-

  Skull, nose or facial structures.

  Multiple new or old fractures in various stages of healing.
- Lacerations and abrasions-

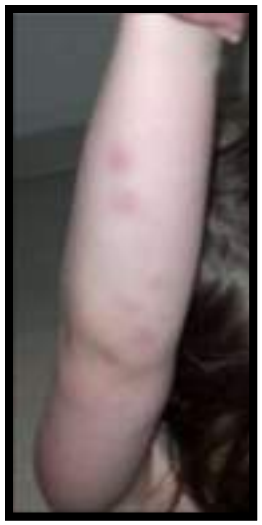
  On back of arms torso, face or external genitalia.

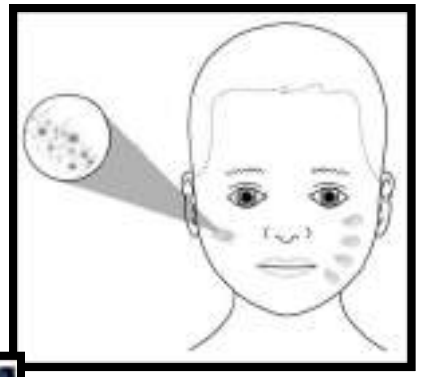
  Descriptive marks such as from human bites or pulling hair out.
- Chemical-

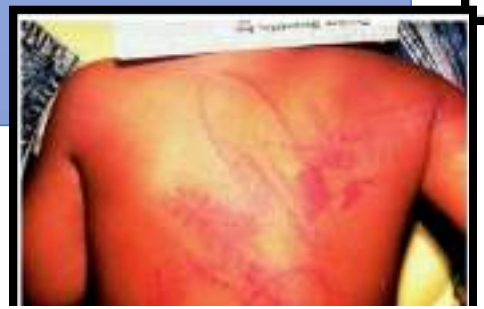
  UN explained repeated poisoning, especially drug overdose.

MARKS

- **HUMAN HAND MARKS:**
  - Grab mark: oval shaped mark that resembles fingerprints due to holding of child in violent shaking.
  - Important to differentiate from non-abusive marks like when the parent holds the child's legs to help him walk or on the cheeks, when an adult squeezes it in an attempt to feed food or medicine.
- **STRAP MARKS**:
  - 1-2 inches wide, sharp-bordered, rectangular bruises of various lengths.
  - Caused by a belt.







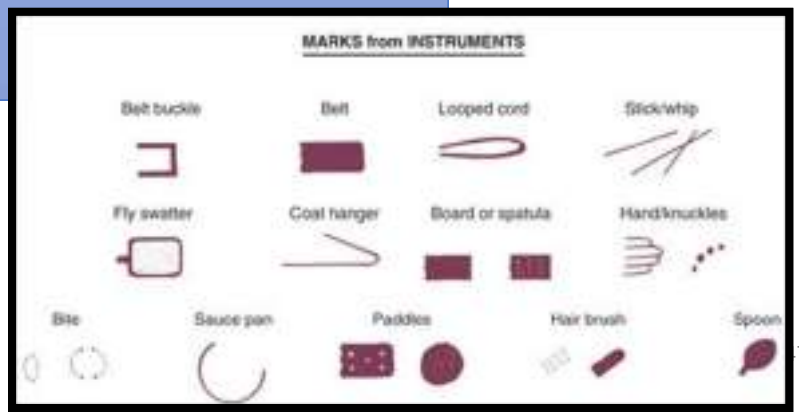
- **LASH MARKS**:
  - Narrow, straight edged bruises or scratches caused by thrashing with tree branch or stick.

- **LOOP MARKS**:
  - Secondary to being struck with a doubled over lamp-cord , rope or fan-belt.
  - The distal end of the loop strikes with maximum force and leaves loop shaped scars.

- **GAG MARKS**:
  - Abrasions near corner of mouth.

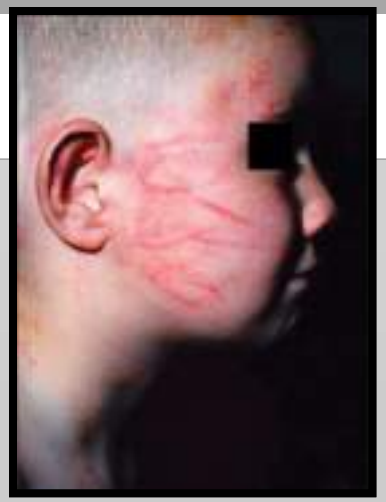
- **CIRCUMFERENTIAL TIE MARKS**:
  - On ankles or wrists when a child is restrained.
  - Narrow rope/ cord: circumferential cut
  - Wide/ broad strap of cloth : friction burn or rope burn that encircles the extremity.

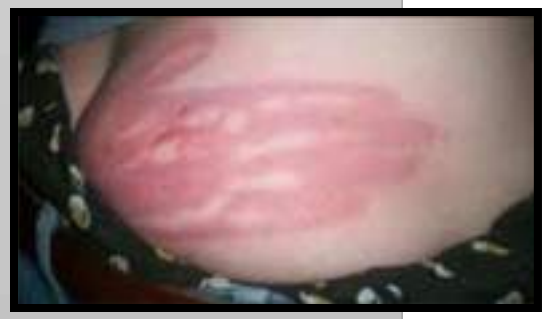
- **BIZARRE MARKS**:
  - Blunt instrument is used in punishment.
  - Marks resembles the inflicting instrument in shape.

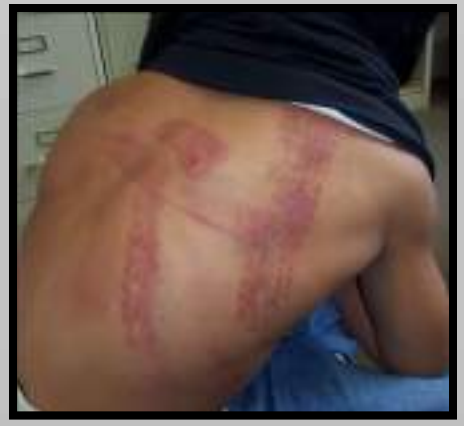


BRUISES

- Sites for inflicted bruises:
  - Lower back and buttocks (Patting)
  - Genitals and inner thighs
  - Cheek (slap marks)
  - Ear lobe (pinching)
  - Upper lip and frenum (forced feeding)
  - Neck (Choke marks)







BURN INJURIES IN CHILD ABUSE

2 general patterns:

Immersion

- Child falling or being placed into a tub or other container of hot liquid.
- In a deliberate burn, depth of the burn is uniform.
- Clear line of demarcation

Splash

- When a hot liquid falls from a height onto the victim.
- Burn pattern: irregular margin and non-uniform depth.

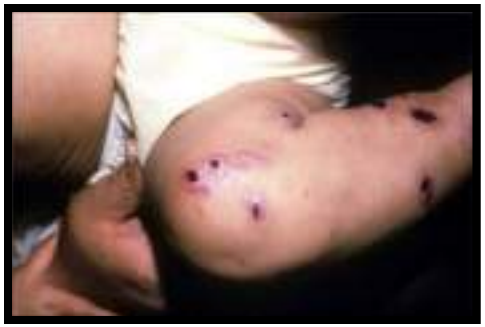
BURN INJURIES IN CHILD ABUSE

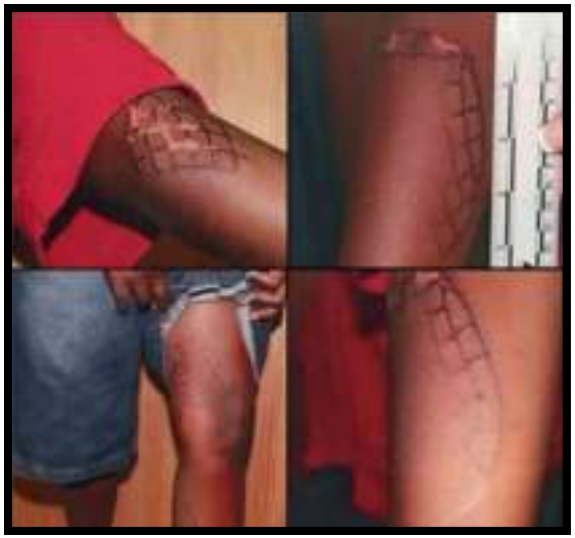
Third category of type of burn: **CONTACT BURN**

- Caused by flames or hot solid objects
- Accidental contact burns: lack of pattern since the child quickly moves away from the source.
- Cigarette and iron burns

To distinguish accidental contact burns from deliberate burns:

- Location :
  - Cigarette burns on back and buttocks: unlikely to be accidental.
- Accidental burns: more shallow, irregular and less well defined than deliberate burns.



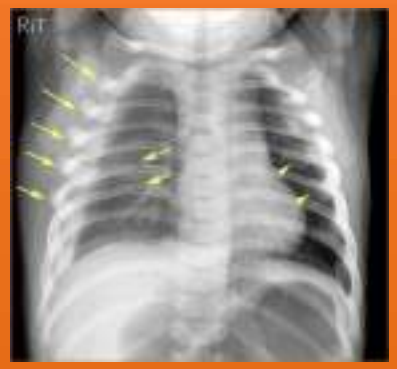


When to suspect as abuse:

- Clear dileneation between the burned and healthy skin,
- Has uniform depth,
- Mainly sock or glove distribution.
- Absent splash marks,
- Symmetrical burns ,
- Pattern burns.

FRACTURES

- Are diagnosed in up to third of children who have been investigated for physical abuse.
- Often occult fractures.
- 80 % of all fractures from abuse are seen in children under 18 months. (Merten et al)
- 25-50% of fractures in children under 1 year of age resulted from abuse. (Feldman et al 1984, Belfer et al 2001, Day F et al 2006)
- A child with rib fractures has a 7 in 10 chance of having been abused.
- Mid-shaft fractures of humerus are more common in abuse than in non-abuse children.
- Commonly seen
  - Ribs
  - Skull
  - Long bones



Merten DF, Radlowski MA, Leónidas JC. The abused child: a radiological reappraisal. Radiology 19S3;1A6:377-S'I
Feldman i<W, Brewer DK. Child abuse, cardiopulmonaiy resuscitation and rib fractures. Pediatrics 198'i;73:339-42.,

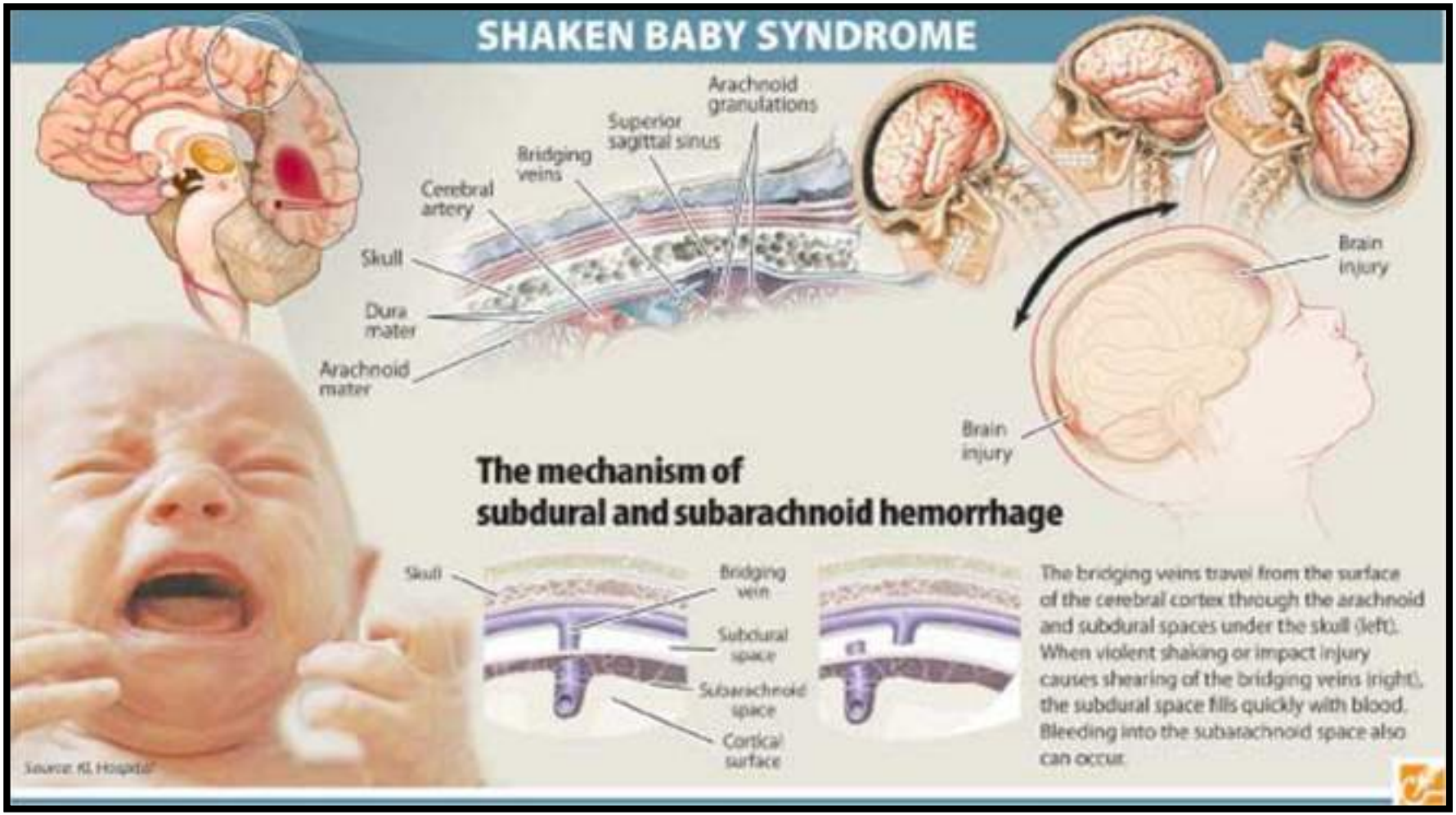
SHAKEN BABY SYNDROME

- Also called:
  - Slam syndrome
  - Shaken-impact syndrome

- **John Caffey**, a pediatric radiologist popularized the term 'whiplash shaken baby syndrome' in 1972, to describe a constellation of clinical findings in infants that included: retinal hemorrhages, subdural and/or subarachnoid hemorrhages and/or external cranial trauma.

- Serious form of child maltreatment most often involving children younger than 2 years but may be seen in children upto 5 years.

SHAKEN BABY SYNDROME



- **Mechanism of injury:**
  - Whiplash forces cause subdural hematomas by tearing cortical bridging veins. (Guthkelch 1971)

- **Clinical features:**
  - Signs may vary from mild and non-specific to severe.
  - Non-specific signs:
    - Moderate ocular or cerebral trauma
    - History of poor feeding, vomiting, lethargy and/or irritability occurring for days or weeks.
  - Non-specific signs are sometimes attributed to viral illness, feeding dysfunction and colic.

Guthkelch AN. Infantile subdural haematoma and its relationship to whiplash injury. Br Med J. 1971;2:430–431
Jenny C, Hymel KP, Ritzen A, Reinert SE, Hay TC. Analysis of missed cases of abusive head trauma. JAMA. 1999;281:621–626

- **Diagnosis**:
  - History
  - Physical findings:
    - External injuries, fractures should be documented.
  - Radiology: CT scan and MRI
    - Triad of subdural hemorrhage, retinal hemorrhage and encephalopathy.
  - Shaken baby is also seen to be mildly to moderately anemic.

MUNCHAUSEN SYNDROME BY PROXY

- "Munchausen syndrome' described by British physician, Richard Asher in 1951.
- Munchausen syndrome by proxy: term coined by Roy Meadow in 1977.
- Referred to as 'illness induction syndrome' and 'pediatric symptom falsification'
- Diagnostics and Statistical Manual (DSM-IV) : 'factitious disorder'
- Term 'factitious' describes symptoms that are artificially produced rather than the result of a natural process.
- Findings:
  - Fabrication of subjective symptoms
  - Self-inflicted conditions
  - Exaggeration of pre-existing medical disorders.

MUNCHAUSEN SYNDROME BY PROXY

- MSbP is a strange combination of physical abuse, medical neglect and psychological mistreatment that occurs with active involvement of the medical profession.

- Carter et al
  - An often misdiagnosed form of child abuse in which a parent or caregiver, usually the mother, intentionally creates or feigns an illness in order to keep the child (and therefore the adult) in prolonged contact with health providers.

- Perpetrators systematically misrepresent symptoms, fabricate signs, manipulate laboratory tests or even purposefully harm the child.

- The goal is to create symptoms or induce illness so that the child will receive unnecessary and potentially harmful medical care.

Carter KE, Izsak E, Marlow J. Munchausen syndrome by proxy caused by ipecac poisoning. Pediatr Emerg Care. 2006;22(9):655-656.

MSP - both pediatric and psychiatric entities

a. focus on child victimization
   – Pediatric Condition Falsification

b. parent s' psychiatric disorder psychiatric disorder
   – Factitious Disorder by Proxy

MSP – Two Components

Child Victim – Pediatric Condition Falsification (PCF)

Adult falsifies physical signs and/or symptoms in a victim, causing victims to be regarded as ill / impaired

Falsification includes:
1) directly causing conditions
2) over or under reporting signs or symptoms
3) creating false appearance of signs and
4) coaching the victim or others to misrepresent the victim as ill

The perpetrator – Factitious Disorder by Proxy (FDP)

Persons who intentionally falsify a history, signs or symptoms in a child to meet their own self their own self-serving psychologic serving psychologic needs

Types of self-serving psychologic needs:

1) The need to be perceived as devoted parent
2) The need to covertly control, manipulate or deceive authority figures or deceive authority figures
3) External incentives in FDP may be present, but they are not the primary motivation for but they are not the primary motivation for the MSP behavior

The perpetrator:

98% biological mother
2% adoptive mother
1.5% paternal collusion
Unusual that father is perpetrator

117 cases from the literature
Males = females
• Age at diagnosis 39.8 months
• Time from onset to diagnosis 14 9 months

MUNCHAUSEN SYNDROME BY PROXY: Severity

DISEASE SEVERITY	EXAMPLES
MILD, SYMPTOM FABRICATION	Claiming the child experienced symptoms such as apnea or ataxia.
MODERATE, EVIDENCE TAMPERING	Manipulating laboratory specimens or falsifying medical records.
SEVERE, SYMPTOM INDUCTION	Producing actual illness or injury including diarrhea, seizures and sepsis.

Laura Criddle. Monsters in the closet: Munchausen Syndrome by Proxy. Critical Care Nurse 2010;30(6):46-55

MUNCHAUSEN SYNDROME BY PROXY: Methods of inducing illness

METHOD	EXAMPLES
POISONING	Ipecac, Salt, Laxatives, Lorazapam, Diphenhydramine, Clonidine, Amytriptyline
BLEEDING	Hematuria, Gastrointestinal bleeding, Bruising
INFECTIONS	Applying fecal matter to wounds, rubbing dirt and coffee grounds into wounds, Injecting urine into the child, spitting or introducing feces into intravenous catheters.
INJURIES	Suffocation, Osteomyelitis, Non-healing wounds, Recurrent conjunctivitis, Fractures that fail to heal.

Laura Criddle. Monsters in the closet: Munchausen Syndrome by Proxy. Critical Care Nurse 2010;30(6):46-55

Warning Signs

- Unexplained extraordinary illness
- In congruous signs, symptoms when mother is present
- Ineffective treatment
- Numerous alleged allergies
- Inappropriate maternal affect
- Numerous family medical problems

Management

- Cessation of unnecessary medical tests
- The physician must not become part of pathological process
- Balance delay in confrontation with risk to the child
- Confirm historical events with eyewitnesses
- Examine temporal relationship of events with presence of mother history
- Interview other family members Interview other family members

- Look for a motive
- Document meticulously
- Perform toxicological examinations Perform toxicological examinations
- Type and match blood samples with child and parents
- Separate child and parents
- Notify child protection agencies
- Increase surveillance

SEXUAL ABUSE

•Prevalence had increases dramatically but reporting is less due to following reasons:

- •Cultural morals: stigma for the victim and family.
- •Doesn't have visible physical signs.
- •Inability of clinician to identify correctly.
- •Victims are often young children whose fear, lack of awareness, or lack of language skills makes them easy prey.

•**National Centre on Child Abuse and Neglect** :
sexual abuse include contacts or interactions between a child and an adult when the child is being used for the sexual stimulation of the perpetrator or another person.
•It can also be defined as any sexual activity with a child under 18 years of age by an adult.

SEXUAL ABUSE : VICTIM

- Most often a female; ratio of male: female = 1:9
- Most offenders are family related, some are family friends and least common are strangers.
- Effects seen on victims:
  - Emotional effects
  - Guilt
  - Anxiety
  - Preoccupation with genital area
  - Functional disturbances

SEXUAL ABUSE : evidences

- Reports by the patient of sexual activities by parents
- Early or exaggerated awareness by the patient of sex or fearful avoidance of close contact with others
- Tearing, bruising or specific inflammation of the mouth, anus or genitals
- Pregnancy
- Behavioural problems

SEXUAL ABUSE : Consequences in adult life

- Drug dependence
- Alcohol dependence
- Major depression
- General anxiety disorder

EMOTIONAL ABUSE

- It is maltreatment which results in impaired psychological growth and development.
- Involves words, actions and indifference.
- Examples:
  - Verbal abuse,
  - Excessive demands on a child's performance,
  - Discouraging caregiver and child attachment,
  - Penalizing a child for positive, normal behaviour.
- Overlaps with physical abuse

EMOTIONAL ABUSE: Etiology

- Stressful life of parents
- Reduced capacity to understand children
  - Alcoholism
  - Drug abuse
  - Psychopathology
  - Mental retardation
- Controlling personality of parents
- Family stress
  - Unemployment
  - Poverty
  - Isolation
  - Divorce
  - Death of spouse

A single factor may not lead to abuse, but in combination they can create social and emotional pressures that lead to emotional abuse.

EMOTIONAL ABUSE: Effects

- Psychopathologic symptoms are more likely to develop in emotionally abuse children.
- Lifelong pattern of depression, estrangement, anxiety, low self-esteem, lack of empathy

Battered baby syndrome

non accidental, physical, emotional, sexual, or other forms of injuries that are made deliberately by parents or other care-takers that violate the community standards concerning the treatment of children.

The battered-child syndrome may occur at any age, but, in general, the affected children are younger than 3 years.

Many parents have criminal records or psychiatric problems with the background suggesting, battering parents were „battered children“ themselves.

In addition to physical injury, there may be non-accidental deprivation of nutrition, care and affection.

They are brought to the doctor with vague history, narrated by the parents, for sustaining the injury like, fall from a stair, bed or a table or that the baby “bruises very easily

Subdural hematoma. with or without fracture of the skull, is,, an extremely frequent finding even in the absence of fractures of the long bones

The characteristic distribution of these multiple fractures and the observation that the lesions are in different stages of healing are of additional value in making the diagnosis.

The classical features of syndrome are obvious discrepancy between the nature of the injuries and explanation offered by the parents, and delay between the injury, and medical attention which cannot be explained.

The constant feature is repetition of injuries at different dates, often progressing from minor to more severe.

A particular feature is the denial by the parent of any injury

J Indian Acad Forensic Med, 31(2)

Review Article

Battered baby syndrome: The extreme case

Parteek R. Patel & Digvijay Vaghela***

Abstract

In India, it has been found that physical injuries, punishment or neglect of the child by parents or guardians is too common to be overlooked, unlike developed western countries, where law and order is so organized particularly for children. As forensic medicine expert, we have seen hundreds of cases of battered child, but, the case, which we are presenting here, is so different to be forgotten. A 4 yrs old female child was physically abused by her own father since her birth, ultimately killed her by strangulation. Before strangulating her, he tried to electrocute her to kill.

J Indian Acad Forensic Med. Jan-March 2015, Vol. 37, No. 1 ISSN 0971-0973

Case Report

Battered Baby Syndrome: A Barbaric Act

[1]Rajendra Singh, [2]Yogesh Sharma, [3]PN Mathur, [4]Nimish Khatri

Abstract

Battered baby syndrome is a heinous crime and brutish act. Knowledge of such cases gives us the thought that we are still living in barbaric era. By the thought of such cases one gets goose bumps. The battered child refers to the child usually less than three years of age, though it may occur at any age, who suffers repeated non- accidental injuries, sometime fatal, caused through episodes of violence by a parent or guardian. Physicians have a duty and responsibility to the child to require a full evaluation of the problem and to guarantee that no expected repetition of trauma will be permitted to occur. Forensic expert also has an important role to play in uncovering the cases of battered baby syndrome. We present two incidences of battered baby syndrome aged 12 year and 5 year. The first was a male child who committed suicide by hanging after beaten repeatedly by her mother. The second case was a female child, admitted in our hospital pediatrics side beaten repealedly by her father.

Fig. 3: Hypo-pigmented Scar on Forehead

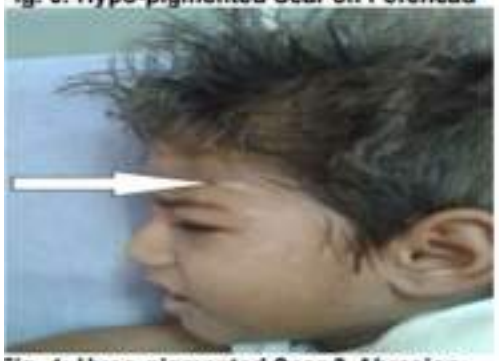


Fig. 4: Hypo-pigmented Scar & Abrasion

Fig. 5: Burn lesion by 'Cigarette burn'

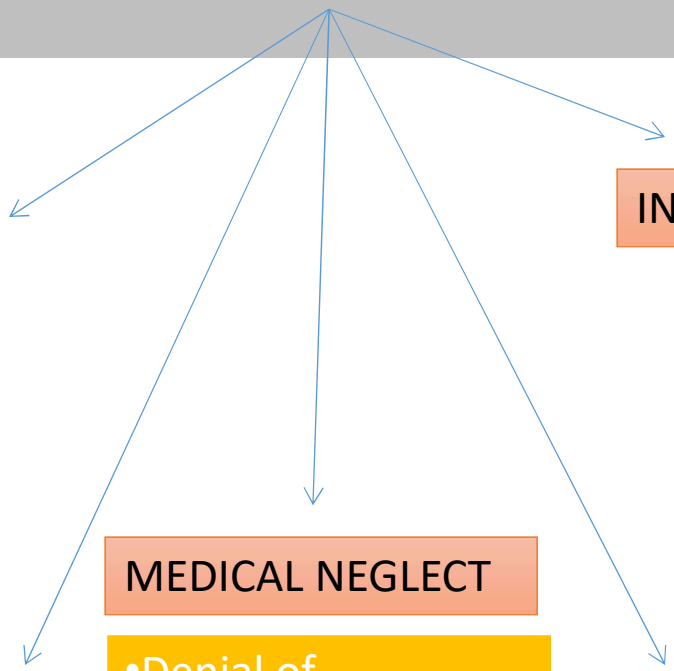
Fig. 6: Fracture of left Humerus

CHILD NEGLECT

- Inattention to basic needs of a child: food, clothing, shelter, medical care, education and supervision.

- Types:
  - Physical
  - Medical
  - Inadequate supervision
  - Educational
  - Emotional

CHILD NEGLECT



PHYSICAL NEGLECT

- Abandonment
- Expulsion
- Shuttling
- Nutritional neglect
- Clothing neglect

INADEQUATE SUPERVISION

- Lack of appropriate supervision
- Exposure to hazards
- Inappropriate caregivers

MEDICAL NEGLECT

- Denial of healthcare
- Delay in health care

EDUCATIONAL NEGLECT

- Permitted habitual absenteeism
- Failure to enroll
- Inattention to special education needs.

EMOTIONAL NEGLECT

- Inadequate affection
- Chronic or extreme spouse abuse
- Permitted drug or alcohol abuse

DENTAL NEGLECT

"willful failure of parent or guardian to seek and follow through with treatment necessary to ensure a level of oral health essential for adequate function and freedom from pain and infection."

AAPD, 2010

Three distinct signs of child dental neglect are:

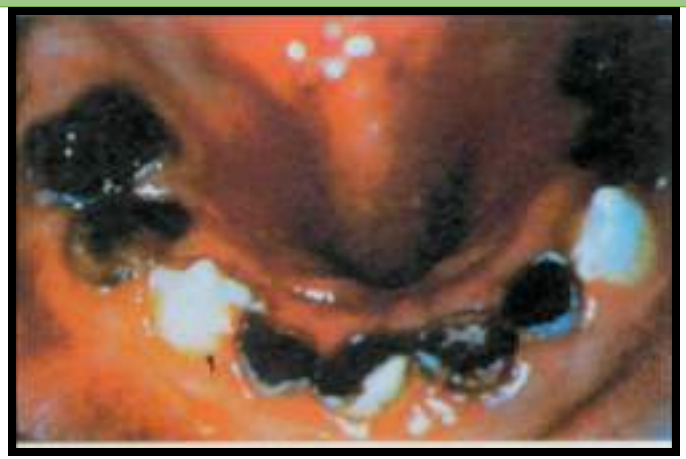
1) oral manifestation and history;

2) social determinants;

3) characteristics of parents or caregivers

ORAL MANIFESTATIONS

- Untreated rampant caries,
- Untreated pain, infection, bleeding or trauma affecting of orofacial region,
- History of lack of continuity of care in the presence of identified dental pathology.



SOCIAL DETERMINANTS

- poverty,
- unemployment,
- homelessness,
- family isolation,
- illness,
- overcrowded housing,
- poor housing,
- economic status

CHARACTERISTICS OF PARENTS OR CAREGIVERS

- Delayed attendance and repeated missed appointments for scheduled dental assessment,

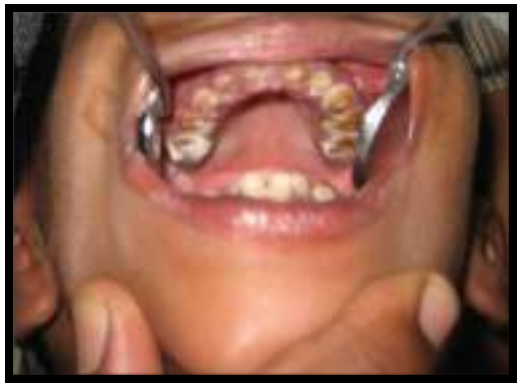
- No interest for oral hygiene education,

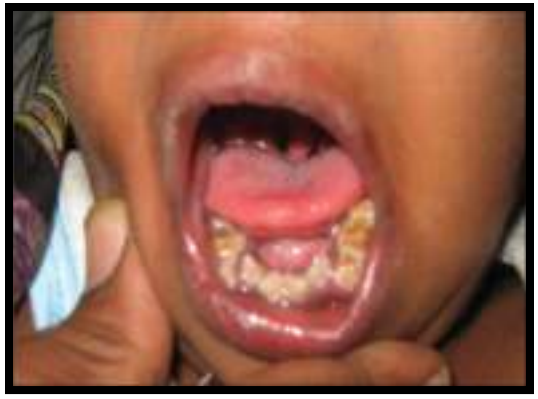
- Repeated attendance for emergency pain relief,

- Failure to access dental treatments and rehabilitation services,
- Failure to complete treatment plans,

- Poor dental status,

- Poor knowledge and attitude in respect to oral health and inadequately performed home oral hygiene





K Kiran, 2011
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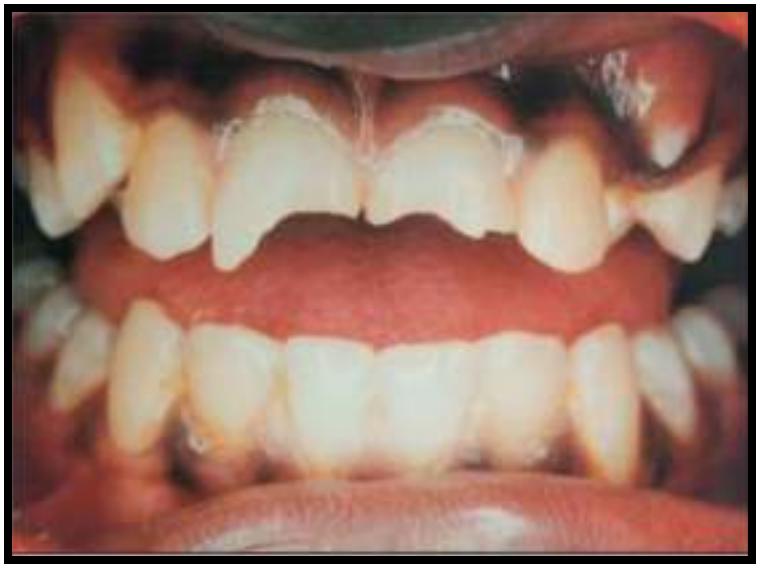
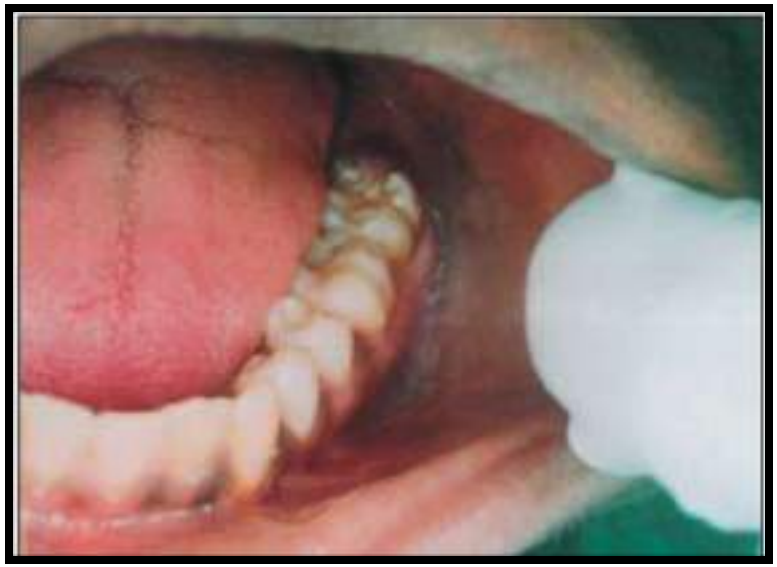




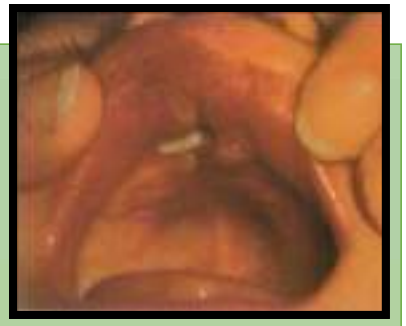
ISSN 0970 - 4388

Neglected child with substance abuse leading to child abuse: A case report

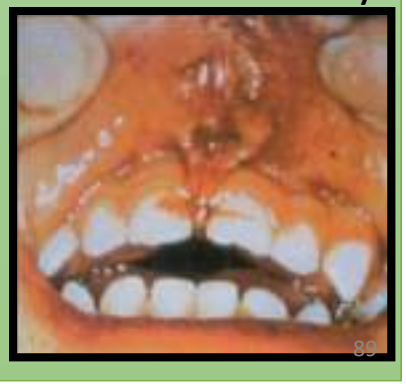
Subramanian E. M. G.,[a] Subhagya B.,[b] Muthu M. S.,[c] Sivakumar N.[d]

12/F , 2005

ORAL MANIFESTATIONS OF CAN: Physical abuse



- Lips:
  - bruises,
  - lacerations,
  - scars from persistent trauma,
  - burns caused by hot food or cigarettes,
  - Bruising, scarring or erosion at corners of mouth (gag trauma)
- Mouth:
  - Tears of labial or lingual frenum caused by either a blow to the mouth, forced feeding or forced oral sex,
  - Burns or lacerations of gingiva, tongue, palate or floor of the mouth caused by hot utensils of food.
- Teeth:
  - Fractured,
  - Displaced,
  - Mobile,

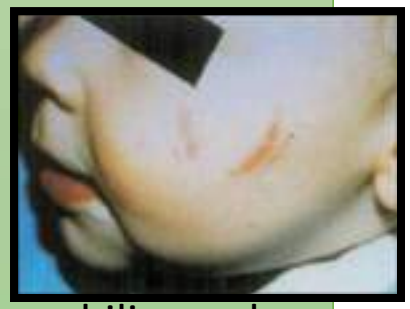


- Avulsed,
- Nonvital and darkened,
- Multiple residual roots with no plausible history to account for the injuries,
- Unaccountable malocclusion.

- Maxilla/ Mandible:
  - Signs of past or present fracture of bones, condyles, ramus or symphysis,
  - Unusual malocclusion resulting from previous trauma.

ORAL MANIFESTATIONS OF CAN: Sexual Abuse

- Gonorrhea:
  - symptomatically on lips, tongue, palate, face and especially the pharynx in forms ranging from erythema to ulceration and from vesiculopustular to pseudomembranous lesions.
  - Positive culture for Neisseria gonorrhea.
- Syphilis:
  - Papule on lip or dermis at the site of innoculaiton.
  - Papule ulcerates to form the classic chancre in primary syphilis and a maculopapular rash or mucous patch in secondary syphilis.
  - Rarely found in children.
- Erythema and Petechiae:
  - At the junction of soft and hard palate or floor of the mouth : signs of forced fellatio.



IDENTIFICATION OF CAN

- Doctors of Medicine are expected to practice 4 Rs,
  - Recognize
  - Record
  - Report
  - Refer

- Clinician should be able to recognize the specificities of oral and dental status, since it could be the first indications of abuse.

- All members of dental team: Administrators, Assistants, Nurses, Hygienists etc play an important role in recognition and prevention of abuse.

- First indication usually comes during clinical examination,
  - Physical indicators
    - Trauma of head, face, neck, hands.

    50-75% of all physical trauma occurs in the area of head and neck.*
  - Behavioral indicators

PHYSICAL INDICATORS

- Bruises, welts, or bite marks
  - Different colors or in various stages of healing
  - Back, buttocks & back of legs
  - Groups, clusters or patterns , Not common for age & activity level of child
  - Defense wounds to back of arms and hands
  - Shape of bruise ie: shape of an object
- Burns
  - Scald and immersion burns
    - Sock-like, glove-like, doughnut shaped on buttocks or genitalia
    - Splash burns
  - Contact burns
    - Cigar, cigarette especially on the soles, palms, back, buttocks
    - Patterned like electric iron, electric burner, fire place tool, etc.
    - Rope burns on arms, legs, neck and torso

- Fractures, scars or internal injuries
- Lacerations, abrasions or unusual bleeding
  - Loop type lacerations from belts, straps and extension cords
  - Lacerations to the backside of the body (whipping)
  - Series or groups of straight line lacerations or welts
- Head trauma
  - Black eyes
  - Split lips or loose teeth
  - Lumps on the head
  - Facial bruises, or bruising behind the ear

DISTINGUISHING ABUSE FROM ACCIDENT

BEHAVIORAL INDICATORS

Indicators in the victim

- Child is extremely loyal to the parent: fear of being punished
- Child's behaviour is either more mature or immature for his/her age.
- Uncooperativeness
- Destructive or antisocial behaviour
- Emotional indicators
- Lack of friends
- Lack of self-confidence
- Inability to react with emotion

Indicators in the care taker

IDENTIFICATION OF CAN

- Interaction between the parent and child is assessed on entry into dental office.
- History:
  - Taken from child as well as from parents/ custodians regarding:
    - Nature of trauma
    - Type of trauma
    - Time of trauma.
  - Differences in history and lack of consistency between severity of the trauma and the story told by parents may point to abuse.

IDENTIFICATION OF CAN

- Physical examination:

  Physical signs of injury: bruise, black marks, abrasions, lacerations, burns, bites, eye trauma and fractures.

  - Recognition of abusive bruises/ marks
    - Colorimetric scale
  - Intraoral signs:
    - Forked frenum
    - Petechiae and scars on lips
    - Lacerations on lips/ tongue
    - Jaw fractures
    - Avulsions of teeth
    - Multiple root fractures

According to Naidoo et al.abuse is most frequently located on the oral structures such as lips (54%), followed by oral mucosa, teeth, gingiva and tongue.

COLORIMETRIC SCALE FOR BRUISES

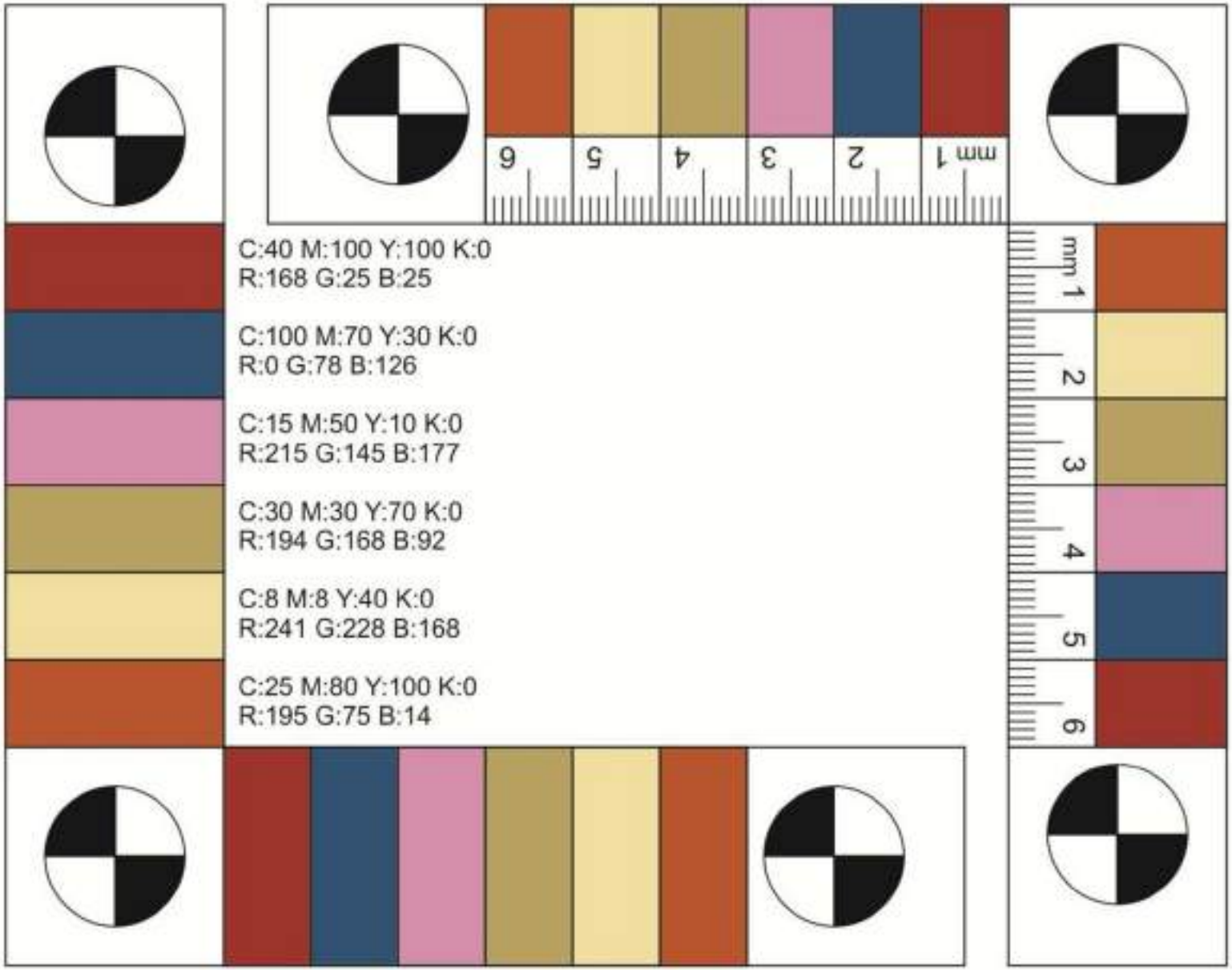
- June 1996, the US Dept of Justice developed a pamphlet
  - "Recognizing When a Child's Injury or Illness is caused by Abuse"
  - Dating of bruises:
    - Red: 0-2 days
    - Blue or Purple: 2-5 days
    - Green : 5-7 days
    - Yellow: 7-10 days and
    - Brown: 10-14 days

- Exact age of trauma from photogrpahic evidence remains controversial due to the fact that it is dificult to identify the precise colour sequences of healing process in each individual.

COLORIMETRIC SCALE FOR BRUISES

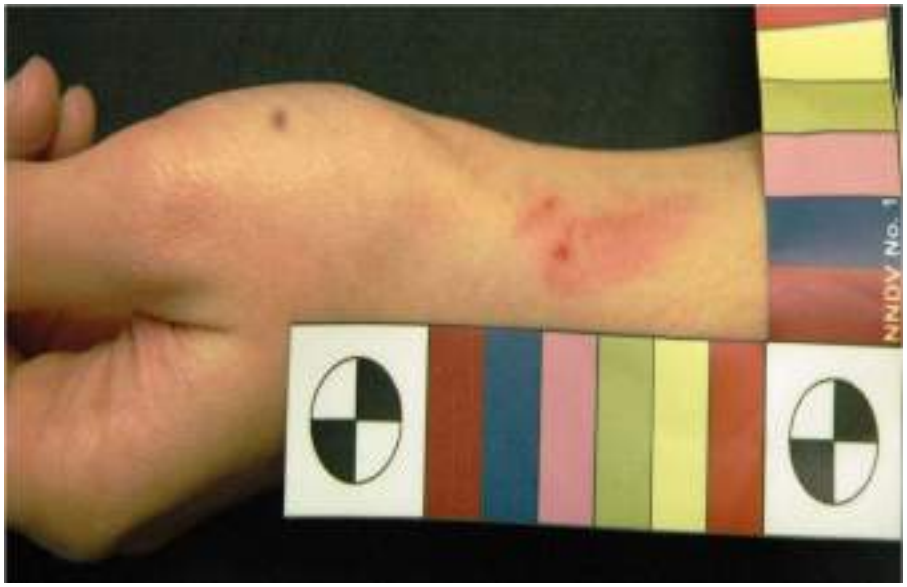
- E. Nuzzolese and GD Vella proposed two prototype colorimetric scales for forensic photography of epidermal injuries
  - NNDV scales
  - Both scales consist of L shaped ruler provided with double references, both dimensional and colorimetric.
  - Linear references: 6 cm scale per side and three circles (1 inch diam)
  - Each circle: divided into four black and white sectors for black and white levels.
  - Both scales have same dimensions: scale no 2 has cm reference on both sides.
  - Colorimetric references: 6 colours
    - Dark red, Bluish, Purple, Greenish, Yelllow, Light Brown.

E. Nuzzolese, Gdi Vella. The Development of a colorietric scale as a visual aid for the bruise age determination of bite marks and blunt trauma. Journal of Forensic Odontostomatology Dec 2012;30(2): 1-6.

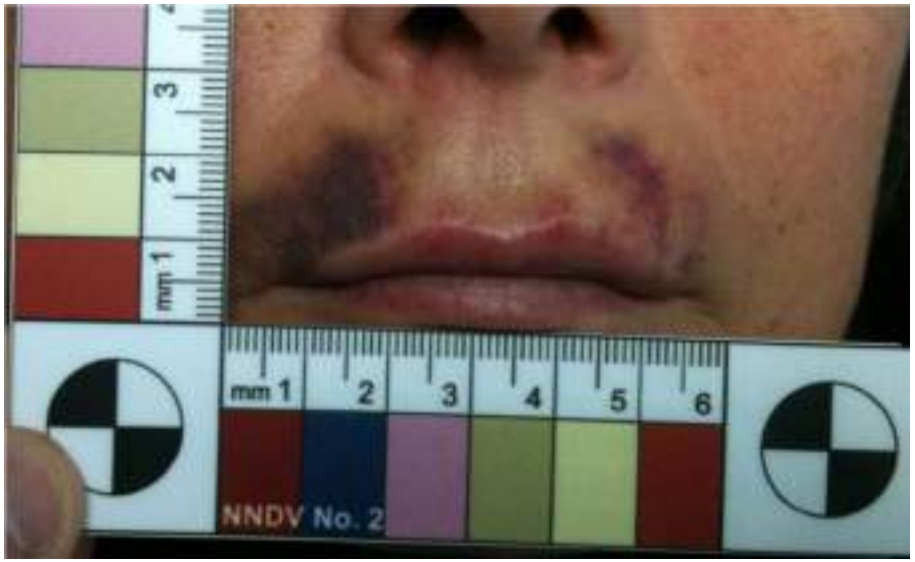


E. Nuzzolese, Gdi Vella. The Development of a colorietric scale as a visual aid for the bruise age determination of bite marks and blunt trauma. Journal of Forensic Odontostomatology Dec 2012;30(2): 1-6.

- Different bruises and bite marks of differing ages may also be an indication of child abuse revealing continual or regular violence.



- But these colorimetric scales need to be validated through the observation of a large sample of blunt trauma and bite mark injuries.



DOCUMENTATION

- HISTORY
- PHYSICAL EXAMINATION
- RADIOLOGY/ LAB
- PHOTOGRAPHS

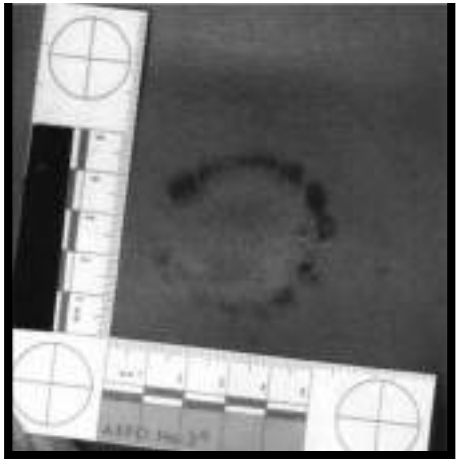
DOCUMENTATION

•All the data collected in medical history and physical examination must be documented in complete and objective manner.

•Positive and negative findings should be included.

•Actual comments and behaviour should be recorded.

•Lab tests and findings should be mentioned.



•For visible injuries photographs should be taken if possible.

•A tag with date and reference number

•Millimeter reference scale placed close to the area being photographed

•Reference scale most widely used and accepted by forensic odontologists in the no.2 ruler of the Americal Board of Forensic Ododntologists.

REPORTING

The dentist is obligated to report suspected findings of the child abuse to appropriate authorities

Reporting can be initiated simply with a telephone call to appropriate protective services.

No further involvement is necesssary on the part of dentist

In most sitiuations, parents should be told of the concerns about possible child abuse and neglect and the legal requirement to report it to legal authorities.

Role of pedodontist

Bipolar disorder:

- Bipolar disorder is characterized by cyclic **depressive** as well as manic or **hypomanic** episodes
- The **depressive** phase of the bipolar disorder appears identical to unipolar depression.
- Causes unusual shifts in mood, energy, activity levels, and the ability to carry out day-to-day tasks.

UNIPOLAR DISORDER

- Unipolar Disorder is characterized by severe episodes of Clinical Depression
- True to its name in that they only have symptoms at one end of the spectrum (the low end).
- Depressed people are typically unaffected by happy moment.
- They often remain apathetic and emotionally unresponsive.

Schizophrenia

- Schizophrenia is a mental disorder that usually appears in late adolescence or early adulthood.
- Characterized by delusions, hallucinations, and other cognitive difficulties
- schizophrenia can often be a lifelong struggle.

Christian Nordqvist , Understanding the symptoms of schizophrenia, europian journal of psychiatry, volume 24:issue 12, 2016 pg. 324-333

Occult fracture:

- A **fracture** is a broken bone.
- **Occult** means hidden.
- An **occult fracture** is one that does not appear well on an X-ray.
- A possible **occult fracture** is a suspected **fracture** that needs to be confirmed with other imaging tests.
- **Occult fractures** can occur because of a fall or other type of sudden (acute) injury.

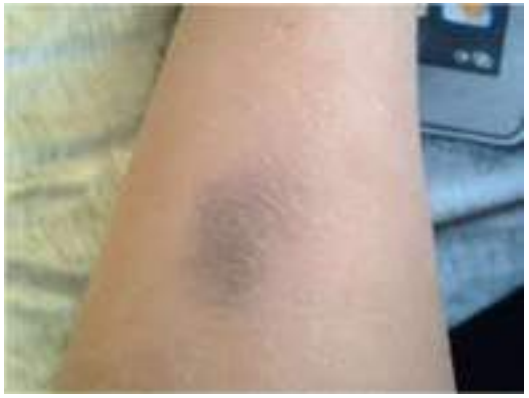
Abrasion

- Abrasion is destruction of the skin, which usually involves the superficial layers of the epidermis only.

- They heal without scar formation

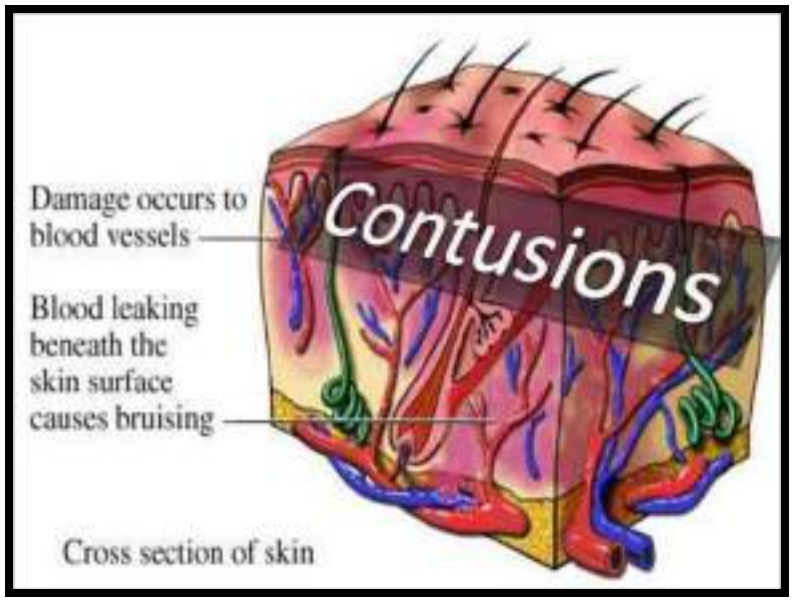
Bruise

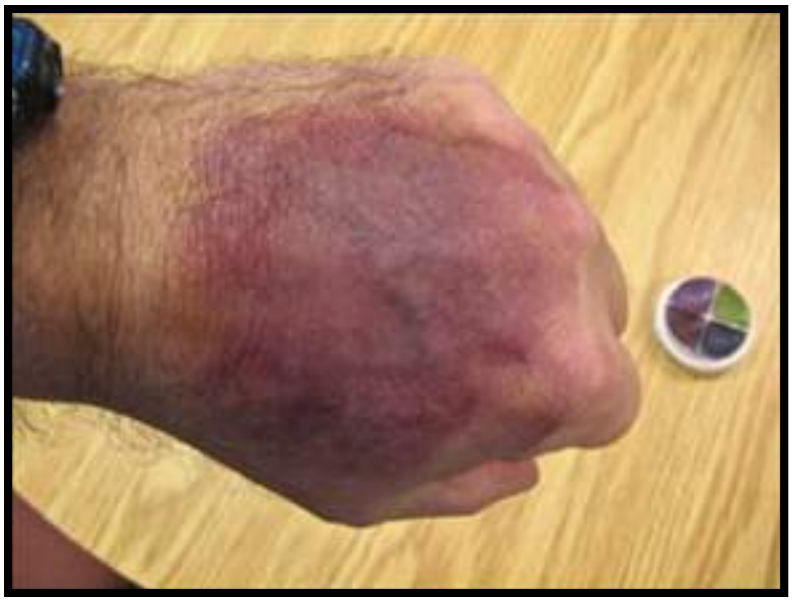
- an injury appearing as an area of discoloured skin on the body, caused by a blow or impact rupturing underlying blood vessels.



CONTUSION

A contusion is an **effusion** of blood into the tissues, due to the **rupture** of blood vessel, caused by **blunt trauma**





Ptosis

is a drooping or falling of the upper eyelid.

The drooping may be worse after being awake longer when the individual's muscles are tired.

ROLE OF PEDODONTIST

By providing continual care, dentists are in a unique position to observe the parent-child relationship as well as changes in the child's behavior.

- **At Reception:**

  - Routinely observe children for unusual behavior.

  - Evaluate
    - ✓ Hygiene
    - ✓ Nourishment
    - ✓ Clothing
    - ✓ general health.

- Wounds or bruises in the child's face or body.

- Evaluate how the child respond to others

- Attain a detailed history, both from the Patient, and parents separately

- Observe the relationship that the patient and the parent share.

•**<u>Extraoral examination:</u>**

- **Head and neck**:
  - Asymmetry
  - Swelling
  - Bruising

•**Scalp**: signs of hair pulling

•**Ears**:

- Scars
- Tear
- abnormalities.

•**Bruises/ abrasions**:

varying colour → indicates different stages of healing.

Distinctive pattern marks on skin left by objects.

•**Middle third of face**:

Bilateral bruising around the eyes

Petechiae in sclera of the eye

Ptosis of eyelids

Deviated gaze

Bruised nose

Deviated septum

Blood clot in nose.

- **Bite marks**: especially in areas that cannot be self-inflicted.

- **<u>Intra-oral examination:</u>**

  - Burns/ bruises near commissures of the mouth

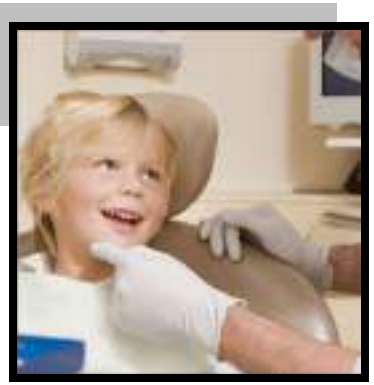
  - Scars on lips, tongue, palate or lingual frenum

  - Labial frenum

  - Lingual frenum

- Hard tissue injuries:
  - Fractured
  - Missing tooth
  - Jaw fractures

ROLE OF PEDODONTIST



- **Legal aspects:**
  - Dentists should know the definitions of child abuse and existing related laws proposed, to protect himself and apply it correctly in such cases.

- **Informing the parents**

  "Based on my training, I am concerned that this injury could not have happened this way. Because of this, I am required by law to make a report to child protection services."

FLAWS IN INDIAN LEGAL SYSTEM

•In India, there is not a single law that covers child abuse in all its dimensions.

•The Indian Penal Code (IPC) neither spells out the definition of child abuse as a specific offence; nor it offer legal remedy and punishment for it.

•In Indian legal system, the child has been defined differently in the various laws pertaining to children. Therefore, it offers various loops in the legal procedure which is used by the guilty to escape punishment.

FLAWS IN INDIAN LEGAL SYSTEM

•The IPC defines the child as 12 years of age

•The Indian Traffic Prevention Act, 1956 defines a ‘minor’ as a person who has completed the age of 16 yrs but not 18 yrs.

•**Section 374 and 376 of IPC**, (punishment for rape)

:defines the age of consent to be 16 yrs of age

•**Section 82 and 83 of IPC**

:states that nothing is an offence done by a child under 7 years, and further under 12 yrs, till he has attained sufficient maturity of understanding the nature of the Act and the consequences of his conduct on that occasion.

•Differential definition for ‘boys and girls’ as seen in the Juvenile Justice Act, which defines:

- male minor as being below 16 years
- female minor as being below 18 years of age.

CURRENT MEASURES TO PREVENT CHILD ABUSE IN INDIA

The legislative framework for children's rights is being strengthened with the formulations of new laws and amendments to existing laws.

The legislative framework for children's rights is being strengthened with the formulations of new laws and amendments to existing laws.

1. The Food Security Act (2013)
2. The Protection of Children from Sexual Offences (POCSO) Act, 2012
3. Right to Free and Compulsory Education Act (2009)
4. Prohibition of Child Marriage Act (2006)
5. The Commissions for Protection of Child Rights Act (2005)
6. Juvenile Justice (Care and Protection of Children) Act 2000, amended in 2006, Right to Information Act (RTI) 2005
7. The Child Labour (Prohibition & Regulation) Act, 1986 (two notifications in 2006 & 2008)
8. The Information and Technology (Amendment) Act 2008.

Integrated Child Protection Scheme (ICPS)

The Ministry of Women and Child Development, Government of India has launched an Integrated Child Protection Scheme (ICPS) (2009)

It is meant to institutionalise essential services and strengthen structures, enhance capacity at all levels, create database and knowledge base for child protection services, strengthen child protection at family and community level and ensure appropriate inter-sectoral response at all levels and raise public awareness.

The guiding principles recognize that child protection is a primary responsibility of the family, supported by community, government and civil society.

The ICPS is an important initiative, but is still in its infancy.

Until 2012, there was no appropriate legal framework in India which deals with child sexual abuse.

Earlier sex crimes against children were protected by section 354, 375, 377,509 of Indian Penal Code, 1860.

Section 354 → "*Assault or criminal force to woman with intent to outrage her modesty,"*

Section 374→ deals with rape

Section 509→ any person who intends to insult the modesty of a woman through word, gesture or act

Section 377 → unnatural offence

The pornography was dealt with young persons (harmful publication) act, 1956.
In the year 2012, the parliament of India has passed the protection of children against sexual offences act (POCSO) for the victims of child sexual abuse below 18 years of age

Features :

- Gender neutral.
- The consent of the child is immaterial under this act.
- Section 19(1) of the posco act makes it compulsory to report the offence.
- Section 3 : “a person is said to commit “penetrative sexual assault” if (a) “he penetrates his penis, to any extent, into the vagina, mouth, urethra, or anus of a child or makes the child to do so with him or any other person”
- Since the words “any other person” are used in section 3(a), women may also be offenders or victims under the second part of section 3(a)”.

Provisions of POCSO

1) Within 24 hours of being reported , the case should be presented before the child welfare committee.

2) statement of the minor recorded

3) speedy trial and in camera proceedings to ensure confidentiality.

4) minor not be called in the court repeatedly. Testified through video from home.

5) medical examination, by a female doctor. In the presence of a person whom minor trusted. (Consent of the parents or guardians if present, otherwise the consent of medical professional on the behalf of a minor is required.)

6) defense should route all the question through the judge and cannot ask any aggressive or character assassination questions to the juvenile.

7) minor should not be exposed to accused in any way during the recording of evidence.

Punishment enumerated under POCSO

1.For penetrative sexual assault→ seven years extended up to life imprisonment along with fine under section 4 of the POCSO Act.

2.Aggravated sexual assault committed by a person of trust or authority like police officer under section 6→ ten years and extended up to rigorous life imprisonment and fine.

3.For the non-penetrative sexual assault committed by a person with sexual intent → three years and extended up to 5 years of imprisonment under section 10 of the POCSO Act.

4.Under section 10, if the aggravated sexual assault is done by the authority or by the person of trust → five years and extended up to seven years of imprisonment.

5. For sexual harassment under section 12 of the POSCO Act, prescribes a punishment of 3 years along with fine.

"As per section 42 of the POCSO Act, where an act or omission constitutes an offence punishable under this Act and also under sections 166A, 354A, 354B, 354C, 354D, 370, 370A, 375, 376, 376A, 376C, 376D, 376E or section 509
of the Indian Penal Code, then notwithstanding anything contained in any law for the time being in force, the offender found guilty of such offence shall be liable to punishment under this Act or under the Indian Penal Code as provides for punishment which is greater in degree."

Retrieved on https://indiankanoon.org/doc/203036/
Retrieved onhttp://www.legalservicesindia.com/article/article/crusading-against-child-sexual-abuse-through-law-introspecting-the-posco-1908-1.html

CHILDLINE INDIA ORGANIZATION

- Platform that brings together the
  - Ministry of Women and Child Development, Govt of India,
  - Department of Telecommunications,
  - Street and community youth,
  - Non-proft organizations,
  - Academic institutions,
  - The corporate sector and
  - Concerned individuals.

MANAGEMENT AND PREVENTION OF CHILD ABUSE AND NEGLECT

- Management of manifestations of abuse:
  - Physical: Dental and Medical treatment
  - Emotional : Psychological counselling
  - Review

- Educating the school-children and making them comfortable to confide in their parents, teachers etc.

Family counselling and education:

- Reduce the impact of child abuse
- develop strategies of personal safety
- protective healthy ways of children and young people.
- focus on enhancing behaviour, such as developing and practicing positive discipline techniques

•learning age-appropriate child development skill (Parent Education Programs)

REPORTING CHILD ABUSE TO THE AUTHORITIES

Various Child care authorities and helplines all over the world.

- In US, National Child Abuse Hotline : 1-800-422-4453

- PANDA: Prevention of Abuse and Neglect through Dental Awareness, active in North America

- India: CHILDLINE 1098

CHILD HELP FOUNDATION ®

Help Line Nos : +91 9819900180 / 022 65352220 / 65352221

PAN No : AABTC2577M

Contact Details	
Email: contact@childhelpfoundationindia.org	

Helpline No. +91-9819900180	PAN Card No: AABTC2577M
Mumbai Office 1	**Mumbai Office 2**
403/404, Sai Arpan, Near P.G.Vora school, Mira Road East, Thane - 401107.	4/F1, 35, Court Chambers, Near – SNDT Women College, New Marine Line, Mumbai - 400020, India
Delhi Office	**Bengaluru Office**
E4 B1, Mohan Cooperative Industrial Estate New Delhi-110044	No-26, 2nd Floor, Shri Complex, Bendre Nagar, Subramanyapura Main Road, Kadirenahalli, Bengaluru - 560070
Chennai office	**Telangana**
No:6A, 2nd Floor Mahalakshmi Nagar, 2nd Main Road, (opp.G K Shetty School Primary Section) Adambakkam, Chennai -88 Tamil Nadu.	H.No.2-18-24/A, first floor, Prahsanthi Nagar, Uppal.opp survey of India, Hyderabad -500039.Telangana. landmark: Dr. Reddy's Dental Clinic Building.

arpan

Towards Freedom from Childhood Sexual Abuse

Vision and Mission

Our Vision

Arpan's vision is to have a world free of Child Sexual Abuse.

Our Mission

Arpan's mission is to empower individuals, families, communities and society with prevention and intervention skills to reduce the occurrence of child sexual abuse and heal its psychological, social, sexual and physical consequences.

All of Arpan's strategies and programs are guided by the above Vision and Mission.

Contact info

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Phone
022 2686 2444

Email
info@arpan.org.in

https://www.savethechildren.in/sciin/files/60/60c56fc8-e492-4cdd-916e-028e33503902.pdf

Save the Children

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Gurgaon 122003, Haryana, India. Ph: +91 124 4752000

www.savethechildren.in

www.facebook.com/india.savethechildren

@stc_india

www.instagram.com/savethechildren_india/

GET READY, GET SAFE: COMMUNITY PREPAREDNESS SAVES LIVES

THE URBAN DISASTER RISK REDUCTION (DRR) PROJECT, KOLKATA, WEST BENGAL

Project Name: Building Safer and Resilient Communities in Urban Slums of India

H-E-L-P embedded in Disaster Risk Reduction

The Urban Disaster Risk Reduction (DRR) intervention is based on the HELP model pioneered by Save the Children, India in West Bengal. The project looks into the broad target of building resilience of communities by identifying risks, planning how to mitigate them, strengthening community collectives like Children's Groups to raise their voice, innovating no cost or low cost adaptation strategies and presenting the intervention in front of civil society and the government as a replicable model.

OUR VISION

A world in which every child attains the right to survival,protection, development and participation.

OUR MISSION

To inspire breakthroughs in the way the world treats children, and to achieve immediate and lasting change in their lives.

OUR VALUES

Guide our behavior and are the principles by which we make decisions. These are: Accountability, Collaboration, Integrity, Ambition and Creativity.

In 2016, Save the Children reached 29.65 lakh (2.9 million) people out of which 13.64 lakh (1.3 million) were children. We worked in 74 districts of 19 states in India.

Together, with the tremendous support of our donors, partners and all champions for children, we are transforming children's lives and the future we share.

Thank you!

OUR 2030 AMBITION

We will be the world's largest child rights movement for and with children, and a catalyst for India to be among the top 5 countries achieving the greatest improvement in child indicators related to survival, protection, development and participation.

We won't inspire breakthroughs for children on our own. We will work hand in hand with them, their communities, our partners and donors, to transform the lives of children. We will do whatever it takes to ensure all children survive, learn and are protected by achieving three global breakthroughs by 2030.

THEMATIC REACH

THEME	Direct Reach (Children)	Indirect Reach (Children)	Total Reach
Child Protection and Poverty	2,44,545	3,29,680	5,74,082
Education	55,941	1,23,346	1,79,287
Health and Nutrition	1,46,101	1,81,046	3,27,147
Humanitarian Response and DRR	1,63,723	1,20,329	2,84,052
Total Reach	6,10,310	7,54,258	13,64,568

Protsahan

- Child abuse
- Incest
- Education & Schooling
- Child Marriage
- Gender Based Violence
- Menstrual Hygiene
- Body Shaming

Most children do not report abuse to any one. Join us as we fight child abuse and dream of a world where childhood receives the love it deserves.

107, Hastsal Rd, Vikash Nagar JJ Colony, Uttam Nagar, New Delhi, Delhi 110066

info@protsahan.co.in

+91 954-078-1011

VISION

To empower every at-risk adolescent girl with Creative Education and Entrepreneurial Skills Training so that she can break the cycle of extreme poverty and abuse.

MISSION

To empower, educate and mobilise all the stakeholders of society against Child Abuse and create an environment that protects the child, not the abuser.

THEORY OF CHANGE

Education of adolescent girls is the most crucial element in order to break the cycle of extreme intergenerational poverty and abuse in the life of a woman.

info@protsahan.co.in (+91) 954-078-1011

Chennai

Address : CRY – Child Rights and You, No. 14, 4th Lane, McNicholas Road, Chetpet, Chennai – 600 031

E-Mail : cryinfo.mds@crymail.org

Tel : 044-28365545/47/49

Fax : 044-28365548

Delhi / NRI / Foreign Donor

Address : CRY – Child Rights and You, 632, Lane No.3, Westend Marg, Near Saket Metro Station, Saiyad-ul-Ajaib New Delhi – 110 030

E-Mail : cryinfo.delsb@crymail.org

Tel : 011-29533451/52/53
011-29531835

Mumbai / Pune

Address : CRY – Child Rights and You, 189/A Anand Estate, Sane Guruji Marg, Mumbai – 400 011

E-Mail : cryinfo.mum@crymail.org

Tel : 022- 23063647/3651/1740
022-23098324/6472/6845

Fax : 022-23080726

Bengaluru

Address : CRY – Child Rights and You, Madhavi Mansion 12/3-1, Bachammal Road Cox Town, Bengaluru – 560 005

E-Mail : cryinfo.blr@crymail.org

Tel : 080-2548 8574/4952/4065

HUSU

Home Background About Us Donate Us Projects Engage Contact Us

Organization Name - Hamaari Ummeed
Registered- In Indian trust Act
Registration date: 15/July/2009.
Settler – Mrs. Vineeta Sharma
Trustees – Mr. Karan Paul, Mr. C.L. Sharma.
Income Tax Registration- Contributions in India are tax exempted u/s 80G.

Address of the Organization:
Hamaari Ummeed
Flat Number C2, Banda Bahadur Apartment,
Rohini Sector – 14, New Delhi-110085.
Website- www.hamaariummeedhu.org , www.husud.org , www.spashtuddeshyasu.org
Email – hamaariummeed@gmail.com, dineshaman2005@gmail.com, karanummeed@gmail.com, spashtuddeshya@gmail.com
Contact Numbers - 09868753175, 09278699367, 9899276059.
Office Phone Number- 011-27561184.

Objectives

1. To open sustainable residential educational Home with Livelihood, life Skills & Confidence building Programme for street & working children & neglected youth in various area.
2. To develop a National Resource Centre for Life Skills, Confidence Building & Sustainable Livelihood Training Programmes.

ww.humaariummeed.org

Year Established 1980

About **AAS**

"AAs- which in Hindi means "Hope"-was established in May 2005 to establish the hope for positive change in the society."

It is the endeavour of AAS to serve the society and make it more capable to facechallenges of deprived groups especially women and children. AAs works for child development, women empowerment and improvement of society.

About Us

AAs is the organization working for the women empowerment and child development throughwarious projects like CHILD LINE, Conjunctive Water management and entrepreneurship development of women in slums.

Recent Posts

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Contact Us

H-33, MIG, RSS NAGAR, INDORE

0731-4089521,0731-2570073

info@aasindore.org

60922


CHILDLINE INDORE
1098
AAS
Collaborative Agency
www.aasindore.org


AAs
"Aim for The Awareness of Society"
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Waseem Iqbal 9827300186
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Orphanages , NGOS ...more
Send Enquiry By Email
www.aasindore.org

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Madhya Pradesh
Phone:
Mobile: 91-94074 09332
Email: matrachaya1993@gmail.com
Website: http://www.matrachhayamms.webs.com
Contact Person: Bhawna Singh Baghel
Purpose : Social works, and work for women and child development, pollutation, plantation, global warming.
Aims/Objectives/Mission : NGO Right to work is constituted as non-governmental, non-politically sided, non-profit and humanity organization, that resolves problems of woman

CONCLUSION

AWARENESS

IDENTIFICATION

DOCUMENTATION

TREATMENT AND NOTIFICATION

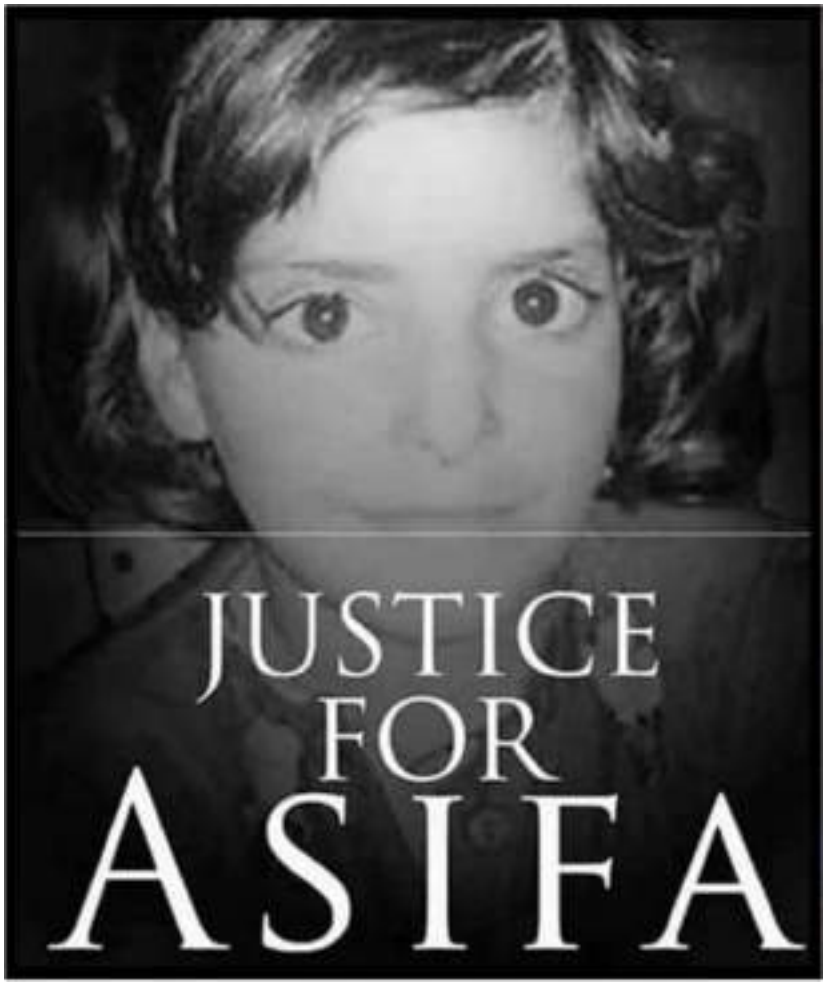
PREVENTION

the future of the world begins with our children

CAN-PREVENT TASK FORCE

Child Abuse and Neglect Prevention

www.canpreventnv.org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Juvenile Justice Rules 2016 Gazette Notification

Child Abuse Happens.
April is
Child Abuse
Awareness
Month
Child Abuse Hurts.
Stop Child Abuse.
Save a Child.

THANK YOU

Frequently asked questions

1. Child abuse and neglect
2. Child abuse and role of pedodontist

Short notes

1. Detection of child abuse
2. Child abuse and management
3. Manchausen syndrome by proxy
4. Battered baby symdrome
5. POCSO
6. Provision in indian legislature against child abuse and neglect
7. Identifying child abuse and neglect
8. Dental neglect
9. Child abuse and role of pedodontist
10. Emotional abuse