# Partnership to Protect Children Malawi:
# Building Capacity of Child Protection Teams
January 11-19, 2010

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**I. MISSION:** to increase expertise and strengthen collaboration between the medical, legal, and social service agencies that respond to child maltreatment.

**Goals for Partnership to Protect Children for January 11-19, 2010:**

a) Continue capacity-building in Blantyre, Lilongwe, and Zomba to create One-Stop Centres for responding to child abuse and sexual assault.
b) Provide medical trainings in Blantyre, Lilongwe, and Zomba to physicians, nurses, and clinical officers.
c) Learn more from magistrates, police, social services, and physicians about issues in laws, policy, practice, and training.

## II. SUMMARY OF ACTIVITIES

**Blantyre**

1) Two separate stakeholder meetings at Queen Elizabeth Central Hospital (QECH) and creation of the One-Stop Centre.
    a) Attendees: QECH doctors; National Juvenile Justice Forum (NJJF); Ministry of Justice, Office of Public Prosecution (OPP); Ministry of Gender and Child Development; Social Welfare Office (SWO); Police Victim Support Unit; UNICEF; Partnership to Protect Children (PPC)
2) Two one-hour medical trainings on sexual abuse and forensic interviewing
    a) Attendees: eight doctors at Queen Elizabeth Central Hospital
3) Meeting at Child Justice Court to assess the experiences of child victims and juvenile offenders in this court versus in the adult courts.
    a) Attendees: Magistrate, NJJF, OPP, UNICEF, PPC
4) Meeting at Blantyre Victim Support Unit (VSU).
    a) Attendees: NJJF, OPP, UNICEF, PPC
5) Meeting at District Social Welfare Office
    a) Attendees: QECH, NJJF, OPP, UNICEF, PPC

**Lilongwe**

1) First-ever meeting of stakeholders to discuss collaboration and creation of a One-Stop Centre. This meeting was followed by three hours of medical and legal training by PPC.
    a) Attendees: Kamuzu Central Hospital doctors and clinicians (4), NJJF, OPP, VSU, SWO, UNICEF, PPC
2) Meeting at UNICEF to discuss Malawi government's goals for One-Stop Centres
    a) Attendees: Malawi Director of Social Services, NJJF, UNICEF, PPC

**Zomba**

1) Stakeholder meeting at Dignitas office to discuss collaboration and creation of a One-Stop Centre.
    a) Attendees: Dignitas doctor, Zomba Central Hospital doctors, local resident magistrate, VSU, YONECO, SWO, NJJF, PPO, UNICEF, PPC
2) Three hours of medical training on sexual abuse and forensic interviewing
    a) Attendees: 14 doctors, nurses, and clinical officers at Dignitas
3) Meeting at YONECO to discuss therapy modalities provided to child survivors
4) Meeting with resident magistrate at Zomba Magistrates Court and with Zomba VSU and criminal investigation department (CID) officers
5) Meeting with YONECO to visit drop-in centres and safe house

## III. ASSESSMENT OF KEY ISSUES MOVING FORWARD

### A. Medical

1) Referrals to Hospitals:
   a) Window of opportunity for HIV prophylaxis often missed. Few, if any, police and child protection workers know that there is a 72-hour window in which to start HIV post-exposure prophylaxis. Consequently, high priority is not given to ensuring child and family get to hospital as soon as possible.
   b) Schools are under-utilized resource in referring victims for medical treatment. No doctors or clinicians mentioned that school teachers referred children for evaluation. In the United States, schools are the top source for reports to Child Protective Services for suspicion of abuse.
   c) Police CID make the most referrals of children to hospital in all three cities; CID is clearly a significant stakeholder and as such CID's participation in all upcoming meetings and in the planning of the One-Stop Centres is critical.

2) Doctors and clinical officers have poor knowledge of basic female genital anatomy. One physician told PPC after a PPC medical training session that she had been interpreting normal, open exams incorrectly for years due to belief that an "open hymen" was proof of penetration; in fact, such a medical finding is normal and not indicative of abuse. PPC found this knowledge gap was also evident at QECH prior to PPC medical trainings conducted at QECH in March 2009, during which time PPC determined that:
   a) Only 48% of medical treatment providers could correctly identify the hymen, and 43% incorrectly interpreted a photograph as showing proof of injury, when in fact the hymen depicted was normal.
   b) The forensic implications for these incorrect findings could be devastating to alleged offenders who may actually be innocent, and could gravely undermine the quality of justice resulting in these cases.

3) Queen Elizabeth Central Hospital (QECH) in Blantyre:
   a) QECH Progress:
      (i) Some sexual assault patients are not examined if they do not have a letter of referral from the police; clinicians turn them away and instruct them to return after obtaining a letter from the police. Dr. Kennedy reports having addressed this issue with staff and having largely eliminated the problem at QECH.
      (ii) Waiting times for sexual assault patients have significantly improved since March 2009 when Dr. Neil Kennedy instituted new rules for immediate registration of sexual assault patients.
      (iii) Medical evaluation and documentation have also improved since initial PPC training in March 2009.
   b) QECH Remaining Challenges:

(i) There is still little privacy for sexual abuse physical exams – a doctor conducting a sexual assault examination of a child can find her patient just a meter away from another doctor working to resuscitate a baby.

(ii) QECH sees only 115 cases of child sexual abuse in the Emergency Department each year out of 90,000 total ED visits. Sixty percent of child sexual abuse patients at QECH have injuries, much higher than the 5% noted in many U.S. studies. This suggests that only the worst-injured children are coming to the hospital.

(iii) Poor follow-up for vital HIV testing: At QECH only 15-20% of sexual assault patients return in three months to be tested for HIV; thus, the impact of HIV from sexual assault is not known. People perhaps believe that the HIV testing performed at the initial hospital visit is sufficient.

4) Zomba Central Hospital (ZCH): Sexual assault survivors have five different stops just within the hospital which are necessary to provide all the different types of testing, medical exam, treatment and registering. Dr. Graf is working to reduce the number of stops needed within the hospital.
5) None of the hospitals has a social worker who is given protected time to evaluate child or adult survivors of abuse.
6) Poor handwriting on medical records, which are often only proof offered in court case, is a problem since doctors are rarely called upon to interpret medical findings for magistrates.
7) Specific issues at Kamuzu Central Hospital in Lilongwe were not explored.
8) Mental health treatment and counseling is sorely lacking: None of the three hospitals has a psychologist, psychiatrist, or social worker trained to providing therapy to child and adult survivors of abuse. Outside NGO's are relied upon to provide a counseling in a small number of cases. Some counseling is provided by police VSU (see below).
9) Long-term medical and mental health outcomes are unknown.

**B. Social Services**

1) No unified governmental system for when and how cases are reported to Social Services. A Malawi-based NGO, Youth Net and Counselling (YONECO), operates the country's only toll-free, nation-wide child helpline.
2) Significant reform is needed in all stages of case management, information management, and long-term safety planning. Such reform could be a full-time project by itself.
3) There are no social workers who specialize in child protection in any of the cities. A designated lead in child protection would be of considerable assistance in planning, coordination of care and service development
4) There are no data available to reveal what percentage of cases the workers performed a home assessment. Anecdotal evidence, however, suggests very little follow-up is done after the first 1-2 months.
5) At the conclusion of each case, there is no standardized set of findings – i.e., categorizing a complaint of abuse as "substantiated" versus "unfounded."

Consequently, there are no data to assess trends within Malawi or to compare to other countries.
6) A child transit center is being developed to assess and address safety concerns for child victims and to determine where to send them.

**C. Police**

1) Case Volume:
   a) Blantyre VSU: 15-20 child abuse cases per month, 30% of cases involve juvenile offenders. 150 domestic violence cases per month.
   b) Zomba VSU: 10-15 child abuse cases per month.
2) CID and VSU are not trained in forensic child interviewing or specialized child abuse issues.
3) No specialized training of police prosecutors handling child abuse prosecutions.
4) Often if there are no genital injuries, police will not pursue a case, and even if they do, the case most likely will not be successfully prosecuted. Basic training is needed for police, prosecutors, and magistrates on understanding the significance of various medical findings.

**D. Courts**

1) Magistrates court is often traumatic for child complainants. They may wait in queue next to violent criminals. Courts are often open-air, allowing casual passersby or those aligned with a defendant to heckle or intimidate the child. Even if the child is permitted to give testimony in a magistrate's chambers, the room is often small, and the child victim may find herself sitting face-to-face with her abuser just a meter or two away from her as she testifies.
2) No prosecutors or magistrates are specifically designated or trained to handle abuse cases.
3) An estimated seventy percent or more of defendants are estimated not to have an attorney.
4) Trials often are finished within 1-2 months of the arrest.
5) Courts only require reports from Social Services in evaluating alleged child perpetrators; however, no report is ever required assessing the child victim, their family, and the conditions that contributed to the abuse occurring.
6) No impact statement taken from victim in sentencing reports prepared for court.
7) Doctors are rarely called to testify, and if a subpoena is sent, there are some clinicians who do not show up to testify; prosecutors virtually never seek to enforce an unanswered subpoena.
8) Physical abuse cases can sometimes be closed if the alleged abuser parent agrees to pay a fine.
9) Intra-familial child sexual abuse is rarely reported.
10) Short- and long-term safety issues for children: "stay away" orders of protection are not available after a case concludes, even if defendant is convicted.
11) Additional important procedural issues beyond the scope of this summary were identified and could be addressed in future visits.
12) Opinions from magistrates meeting with PPC:

a) Increased education needed on interpretation of medical evidence. Heavy reliance on medical evidence by courts, yet there is lack of education on what that evidence means.
b) Increased education on proper forensic interviews. Magistrates report often suspecting that a child witness has been coached by police and prosecutors, but the courts have no education on what constitutes a proper forensic interview or line of questioning for a child witness.
c) Much room for improvement in quality of police interviews of children.
d) Prosecutors need more education on how to evaluate evidence before them and to be more discriminating when evaluating it.
e) Would like to see judicial workshop on all these issues so magistrates can be better informed and better able to fairly administer justice in these case.

**E. Laws**

1) There is no mandated reporting system. Such a system would force professionals across all sectors to be responsible in terms of reporting cases to social services and law enforcement for investigation when a child is suspected of having been abused.
    a) Minimum age of consent for marriage is 15.
    b) Minimum age of consent to have sex is 13. Therefore, many cases are not prosecuted with victims age 13 and above because there is question of whether it was consensual and thus legal.
2) Establishing a child's age is difficult because there is yet to be a bill signed (as of January 12, 2010) that requires newborns to receive birth certificates. Thus, alleged perpetrators have sex with 11 and 12-year-old girls and claim they are 13, and when there is no certificate to prove them wrong, the case is dropped.
3) Inadequate social service laws: social workers and child protection workers do not appear to have statutory authority to perform their roles adequately. For example, if they go to home to assess the safety of a child in the home, but the family tells them to go away, the workers cannot compel entry or access to the child or the child's siblings.
4) Children and Young Persons Act (Cap: 26:03) (aka. "Child Rights Bill") has been pending in Parliament for several years. There appears to be momentum for the bill this year; however, there are people in Malawi who would prefer to improve the bill first, because it deals mostly with child offenders and contains virtually no provisions to address common forms of sexual and physical abuse that children suffer at the hands of adults.

**F. Additional Coordination Issues**

1) Malawi Supreme Court Justice Twea states that he is aware that many victims are still being bounced between police, the hospital, social services, and back to police to the detriment of children, the investigation and the prosecution of cases, and ultimately undermining the best interest of the child and the interests of justice.
2) Simply stated, outside of recent improvements in Blantyre, there is very little communication or coordination between agencies in Malawi.

3) Blantyre: Since initial PPC visit in March 2009, Dr. Kennedy notes improved connections and less isolation of stakeholders. The Blantyre Child Protective Team is still unique in Malawi in how they follow up abuse cases with phone calls to contacts at the police and social services. They also have held case review meetings every other month to discuss specific children and forming safety plans.

## IV. NEXT STEPS

1) Build One-Stop Centres (OSC's) in Blantyre, Lilongwe, Zomba, and Mzuzu.

2) Create Standard Operating Procedures for OSC's addressing issues of:
   a) which children and adults will be referred to the OSC.
   b) how much police and/or social service investigation should be done prior to referral to OSC.
   c) who will take lead in coordinating patient-intake and coordination.
   d) who interviews the patient and the guardian(s) in the OSC.
   e) how often team case review will take place.
   f) coordination of case follow-up after initial evaluation.

3) Create Memoranda of Understanding (MOU's) between hospital, police, social services, and relevant NGO's.

4) Resources:
   a) Fuel allowances for Community Child Protection Workers and VSU.
   b) UNICEF to supply a vehicle for each One-Stop Centre.
   c) Phone-call credit ('air-time') for coordination phone-calls.
   d) Institutionalize work at QECH by addition of specialist nurse (although no existing establishment or funding for such a post).

5) Trainings were requested by stakeholders at every meeting with Law Enforcement (VSU, CID, magistrates, judiciary, Ministry of Justice), Department of Social Welfare, and hospitals:

   a) Recommended trainings for Law Enforcement:
      (i) Forensic interviewing best practices, including age appropriate types of questioning and sensitivity to child development considerations.
      (ii) Understanding medical records.
      (iii) Dynamics of child abuse, understanding delayed disclosure, recantations of abuse, and recognizing familiar patterns.
      (iv) Investigatory and prosecution approaches for successful handling of acquaintance sexual assaults.
      (v) Investigatory and prosecution approaches for child assaults without positive medical findings.

   b) Recommended trainings at hospitals:
      (i) Sexual abuse recognition, physical exam, and treatment
         (a) Class room setting: train more health providers.

(b) Develop local specialists: work side-by-side in clinical setting with key staff, evaluating real patients, in order to develop stronger expertise which can be passed on to other clinicians in the future.

(ii) Physical abuse recognition, physical exam, and treatment

(a) Since March 2009, Blantyre is the only city in which PPC gave lectures to pediatric health providers on child physical abuse – only two hours total. Orthopedic surgeons need to be involved in these trainings as they are often the only doctors involved in the care of children with fractures.

(b) Develop local specialists: work side-by-side in clinical setting with key staff, evaluating real patients, in order to develop stronger expertise which can be passed on to other clinicians in the future.

(iii) Emotional abuse and all forms of neglect will be incorporated into the above trainings.

(iv) Creating clearer and better forensic medical records for prosecutors and courts.

(v) Continue to include recognition of child abuse in undergraduate and postgraduate medical curricula.

c) Recommended trainings for Social Welfare Office

(i) Identify key Community Child Protection Workers and Social Workers in each city who will be involved in the OSC and include them in the trainings for forensic interviewing, dynamics of child abuse, and safety planning. These trainings should be held together with these trainings for Law Enforcement in order promote and enhance OSC team development.

6) Promote policy reform: Meet with country-level leaders in law enforcement, the judiciary, social services, and hospitals to determine which policies can be reformed within the existing statutory framework versus which policies would require legislative or regulatory changes.

7) Identify key stakeholders in Mzuzu and bring them together for first round of meetings to provide trainings and discuss creation of OSC.

a) Identifying medical stakeholders: due to heavy workload issues for doctors in Blantyre, Zomba, and Lilongwe, there currently is no Malawi-based health provider to spend time in Mzuzu to provide medical trainings or consultation in creation of a multidisciplinary team or OSC.

8) Additional needs for future consideration:

a) More outreach through schools to educate children and teachers on child sexual assault and encourage disclosure/treatment/reporting.

b) Consider data collections systems to measure outputs and outcomes of new One-Stop Centres.

c) Interdisciplinary training on Mental Health Treatment that includes the victim, siblings, non -offending caretaker and the offender in individual, group and/or family treatment.

d) Violence Prevention Campaign