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SHONETTE STACY CRYSTAL GOODRIDGE

Nurses' Experiences when caring for the Abused Children at the Georgetown Public Hospital Corporation

Ribeirão Preto

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SHONETTE STACY CRYSTAL GOODRIDGE

Nurses' Experiences when caring for Abused Children at the Georgetown Public Hospital Corporation

Thesis presented to the University of de São Paulo at Ribeirão Preto College of Nursing to obtain the title of Master of Science, Nursing.

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Supervisor: Profª Drª Adriana Moraes Leite

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Dissertation presented to the University of de São Paulo at Ribeirão Preto College of Nursing to obtain the title of Master of Science, Nursing.

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DEDICATION

I dedicate this thesis to all the hardworking nurses of the Georgetown Public Hospital Corporation. I would like to thanks to the Almighty God for sustenance and strength to carry on to the end. Thanks to my family and friend for their never-ending support. I am grateful to my supervisor Dr. Adriana Moraes Leite for your guidance during the thesis, the countless drafts of my thesis, and constant talk about my research to bring to a standard. Your support was vital to me finishing this thesis. Special thanks, the Coordinators of this scholarship Programme, Professor Lucila Castanheira Nascimento & Professor Carla Aparecida Arena Ventura, without your initiative and directions, this would not have been possible.

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ABSTRACT

GOODRIDGE, Shonette Stacy Crystal. **Nurses' Experiences when caring for Abused Children at the Georgetown Public Hospital Corporation.**2021. 77 p. Dissertation (Master) – University of São Paulo at Ribeirão Preto College of Nursing, 2021.

Objective: Child abuse has major consequences on the child's psychological development. Healthcare workers play an intricate role in detecting and reporting child abuse. In most cases they are the first person to come into contact with abused children and therefore, are solely responsible to report this abuse immediately to the relevant authority. The objective of this study was to understand registered nurses' experiences during the care of children who were victims of abuse at the public hospital in Guyana. **Methods:** This study was qualitative approach. Sixteen registered nurses who work in Georgetown Public Hospital cooperation (GPHC), Accident and Emergency Department (A&E), Intensive Care Unit (ICU) and Pediatric Department were interviewed individually. The study used a semi-structured interview questions as research tool, in order to allow freedom and spontaneity to the interviewee and capture the desired information. An interview guide (topic list) for interviews was prepared. The interview guide was, therefore, used to ensure that all relevant topics were covered. All interviews were recorded in audio files and then later transcribed by the authorized researcher. These interviews, transcribed by the researcher, provided useful input to the analytical process. The qualitative data was subjected to content analysis and thematic modality. Ethical approval was granted from the Ethical Review Committee, Ministry of Public Health, Guyana and the Georgetown Public Hospital Corporation, Medical & Professional Services, Research Committee. **Results:** The mean(±SD) age and clinical experience of the nurses were 30.1(±4.0), 8.4(±6.9) respectively. The nurses were aged between 25 and 55 and most of them had five to ten years of clinical experiences. The majority of nurses (87.5%) were female and 12.5% were male. Furthermore, 93.8% were Christian, 50.0% were single and 43.8% belong to Afro-Guyanese ethnic group. Most nurses (62.5%) in this study were station at the Accident & Emergency Department. Table 1 shows the demographic information of the participants. Five categories were organized from the analytical process, namely: 1. Types of Abuse; 2. Knowledge; 3. Aroused feelings; 4. Protocols and actions; 5. Suggested changes. The nurses feared the consequences for the child and the family and most nurses were emotionally taken away with the depth of child abuse although they had varying experiences with the abused children's family; most nurses mentioned the family being irresponsible. Many nurses pointed out the gaps and flaws in the abused child treatment at the hospital. All the nurses felt the need to improve the abused child care while at the hospital. Education, awareness and training were some of the suggestions mentioned to better manage the affected child. **Conclusion**: Registered nurses demonstrated gaps in knowledge and awareness of child abuse, due to their limited experience and training. Training stands out to be most crucial in improving documentation of such victims and to provide appropriate care to those victims. Nurses go through various emotional feelings as they care for child abuse victims. Therefore, it is necessary to implement support strategies that look to emphasis on support for the professionals. The nurses need training, counselling and experience to properly manage all of the complexity that exists in the situation of violence against children. Nurses are the first health care provider to deal with an abused child, therefore it's important to have awareness, responsibility and education to encounter child abuse cases.

Keywords: 1. Child abuse. 2. Registered Nurse 3. Experiences 4. Nursing.

5. Qualitative research

Resumo

GOODRIDGE, Shonette Stacy Crystal. **Experiências de enfermeiras que cuidam de crianças vítimas de abuso no Georgetown Public Hospital Corporation**.2021. 77 f. Dissertação (Mestrado) – Escola de Enfermagem de Ribeirão Preto, Universidade de São Paulo, Ribeirão Preto, 2021.

Objetivo: O abuso infantil tem consequências importantes no desenvolvimento psicológico da criança. Os profissionais de saúde desempenham um papel complexo na detecção e denúncia de abuso infantil. Na maioria dos casos, eles são a primeira pessoa a entrar em contato com crianças abusadas e, portanto, são os únicos responsáveis por relatar esse abuso imediatamente à autoridade competente. O objetivo deste estudo foi compreender as experiências de enfermeiras durante o atendimento de abuso infantil em o hospital público da Guiana. **Métodos:** Este estudo teve uma abordagem não experimental, exploratória, descritiva e qualitativa. Dezesseis enfermeiras que trabalham na cooperação do Hospital Público de Georgetown (GPHC), no departamento de emergência, terapia intensiva e pediátrica foram entrevistadas individualmente. O estudo utilizou a entrevista semiestruturada como instrumento de pesquisa, a fim de permitir liberdade e espontaneidade ao entrevistado e captar as informações desejadas. Todas as entrevistas gravadas foram posteriormente transcritas pela pesquisadora autorizada e os dados qualitativos foram submetidos à análise de conteúdo e modalidade temática. Um guia de entrevista (lista de tópicos) para entrevistas foi preparado. O guia de entrevista foi usado para garantir que todos os tópicos relevantes fossem cobertos. As entrevistas foram gravadas em arquivos de áudio e posteriormente transcritas pelos próprios pesquisadores e forneceram subsídios úteis para o processo analítico. A aprovação ética foi concedida pelo Comitê de Revisão Ética, Ministério da Saúde Pública, Guiana. **Resultados**: A média (± DP) de idade e experiência clínica dos enfermeiros foi de 30,1 (± 4,0), 8,4 (± 6,9), respectivamente. As enfermeiras tinham idades entre 25 e 55 anos e a maioria delas tinha de cinco a dez anos de experiência clínica. A maioria dos enfermeiros (87,5%) era do sexo feminino e 12,5% do masculino. Além disso, 93,8% eram cristãos, 50,0% eram solteiros e 43,8% pertenciam à etnia afro-guianense. A maioria dos enfermeiros (62,5%) deste estudo eram postos de pronto-socorro. A Tabela 1 mostra as informações demográficas dos participantes. Cinco categorias foram organizadas a partir do processo analítico, a saber: 1. Tipos de Abuso; 2. Conhecimento; 3. Sentimentos despertados; 4. Protocolos e ações; 5. Mudanças sugeridas. As enfermeiras temiam as consequências para a criança e a família magoada e a maioria das enfermeiras ficou emocionalmente arrebatada com a profundidade do abuso infantil, embora tivessem experiências variadas com a família da criança, com a maioria das enfermeiras mencionando que a família era irresponsável. Muitas enfermeiras apontaram as lacunas e falhas no tratamento da criança abusada no hospital. Todas as enfermeiras sentiram necessidade de melhorar o atendimento à criança maltratada durante a internação. Educação, conscientização, treinamento são algumas das sugestões citadas para melhor manejar a criança acometida. **Conclusão:** Há falta de conhecimento e conscientização das enfermeiras sobre o abuso infantil, devido à sua limitada experiência e treinamento. As enfermeiras passam por vários sentimentos emocionais enquanto cuidam das vítimas de abuso infantil. Portanto, é necessário implementar estratégias de apoio que busquem ênfase no apoio aos profissionais. Faz-se necessário treinamento para administrar

adequadamente toda a complexidade que existe na situação de violência contra a criança, pois os enfermeiros são os primeiros prestadores de cuidados de saúde a lidar com uma criança vítima de abuso, por isso é importante ter consciência, responsabilidade e educação para encontrar casos de abuso infantil.

Palavras-chave: 1. Abuso infantil. 2. Enfermeira. 3. Experiências 4. Enfermagem.5 Estudo Qualitativo

Resumen

GOODRIDGE, Shonette Stacy Crystal. **Experiencias de enfermeras que cuidan a niños maltratados en Georgetown Public Hospital Corporation.** 2021. 77 h. Tesis (Maestría) – Escuela de Enfermería de Ribeirão Preto, Universidad de São Paulo, Ribeirão Preto, 2021.

Propósito: El abuso infantil tiene consecuencias importantes para el desarrollo psicológico del niño. Los profesionales de la salud desempeñan un papel complejo en la detección y notificación del abuso infantil. En la mayoría de los casos, son la primera persona en entrar en contacto con niños abusados y, por lo tanto, son los únicos responsables de denunciar tal abuso de inmediato a la autoridad correspondiente. El objetivo de este estudio fue comprender las experiencias de las enfermeras durante la atención por abuso infantil en un hospital público de Guyana. **Métodos:** Estudio cualitativo. Se entrevistó individualmente a dieciséis enfermeras que trabajaban en cooperación con el Hospital Público de Georgetown (GPHC), el departamento de emergencias, cuidados intensivos y pediatría. El estudio utilizó la entrevista semiestructurada como instrumento de investigación, con el fin de permitir libertad y espontaneidad al entrevistado y captar la información deseada. Todas las entrevistas grabadas fueron posteriormente transcritas por el investigador autorizado y los datos cualitativos fueron sometidos a análisis de contenido y modalidad temática. Se preparó una guía de entrevistas para entrevistas. La guía de entrevistas se utilizó para garantizar que se cubrieran todos los temas relevantes. Las entrevistas fueron grabadas en archivos de audio y luego transcritas por los propios investigadores y proporcionaron un apoyo útil para el proceso analítico. La aprobación ética fue otorgada por el Comité de Revisión Ética del Ministerio de Salud Pública de Guyana. **Resultados**: La media (± DE) de la edad y la experiencia clínica de las enfermeras fue 30,1 (± 4,0), 8,4 (± 6,9), respectivamente. Las enfermeras tenían entre 25 y 55 años y la mayoría de ellas tenía de cinco a diez años de experiencia clínica. La mayoría de las enfermeras (87,5%) eran mujeres y el 12,5% hombres. Además, el 93,8% eran cristianos, el 50,0% solteros y el 43,8% pertenecían a la etnia afro-guayanesa. La mayoría de las enfermeras (62,5%) de este estudio eran puestos de urgencias. La Tabla 1 muestra la información demográfica de los participantes. Se organizaron cinco categorías a partir del proceso analítico, a saber: 1. Tipos de abuso; 2. Conocimiento; 3. Sentimientos despertados; 4. Protocolos y acciones; 5. Cambios sugeridos. Las enfermeras temían las consecuencias para el niño y la familia heridos, y la mayoría de las enfermeras estaban emocionalmente abrumadas por la profundidad del abuso infantil, aunque tuvieron experiencias variadas con la familia del niño, y la mayoría de las enfermeras mencionaron que la familia era irresponsable. Muchas enfermeras señalaron las lagunas y fallas en el tratamiento del niño abusado en el hospital. Todas las enfermeras sintieron la necesidad de mejorar la atención al niño maltratado durante la hospitalización. Educación, sensibilización, formación son algunas de las sugerencias mencionadas para gestionar mejor al niño afectado. **Conclusión:** Las enfermeras registradas demostraron lagunas en el conocimiento y la conciencia del abuso infantil debido a su experiencia y capacitación limitadas. La capacitación se destaca como la más importante para mejorar la documentación de estas víctimas y brindar una atención adecuada. Las enfermeras experimentan diversos sentimientos emocionales mientras atienden a las víctimas de abuso infantil. Por tanto, es necesario implementar estrategias de apoyo que se enfoquen

en apoyar a los profesionales. Las enfermeras necesitan formación, asesoramiento y experiencia para gestionar adecuadamente toda la complejidad que existe en la situación de violencia contra los niños. Las enfermeras son los primeros proveedores de atención médica que tratan con un niño abusado, por lo que es importante tener conciencia, responsabilidad y educación para encontrar casos de abuso infantil.

Palabras clave: 1. Maltrato infantil. 2. Enfermera. 3. Experiencias 4. Enfermeria. 5 Estudio cualitativo

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.

LIST OF ABBREVIATIONS

EERP-USP	University of São Paulo at Ribeirão Preto College of Nursing
GPHC	Georgetown Public Hospital Corporation
USP	Universidade de São Paulo

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1 Introduction

1.1 Definition of child abuse

Child abuse is defined as a physical or emotional abuse, sexual abuse, negligent treatment, or maltreatment of any form on a child under age 18 ((*Maine Department of Health and Human Services Office of Child and Family Services, Child Protective Services. Annual report on referrals.*, 2008; Becker, 2020a). Globally, it is estimated that up to 1 billion children aged 2–17 years, have experienced physical, sexual, or emotional, violence or neglect in the past year (Hillis *et al.*, 2016; Becker, 2020b).

1.2 Types of child abuse

Most of the child abuse falls under 6 main categories that occur at different stages during the child's growth.

Physical abuse is any kind of impulsive reaction that could cause minor physical injuries like bruises or cuts to major injuries like fracture or brain damage to a child (LaSala, KB; Lynch, 2006).

Emotional abuse or psychological abuse is a very difficult one to identify since it involves with a child's unmet emotional needs. The child might be put under constant fear, ridicule or extortion which is difficult to express or understand unless the child explains it.

Sexual abuse is most affected among girls under age 18. Sexual abuse is identified as any form of sexual contact between the child and the offender (Kotch *et al.*, 2008). Most times the perpetrator is male, but females also sexually abuse children, both with and without coercion by their partner. Anyone who knows that sexual abuse is occurring to a child is considered as guilty as the perpetrator in a court of law.

Neglect occurs when the child physical needs are not provided or when the child gets no proper care and supervision as per his/her developmental stage (Kotch *et al.*, 2008). Child needs could include food, shelter, clothing, and heat, and also health related issues. Somes studies says that for families living in poverty, this definition of neglect includes choosing not to take advantage of community services

such as food stamps and emergency shelter, and leaving children with inappropriate supervision (Lyden, 2011).

1.4 Consequences of Child abuse

In addition to short term physical trauma that the child get as a consequences of abuse, there are some long term consequences (Caneira; Myrick, 2015; Child Welfare Information Gateway, 2019). Such long term consequences can be detrimental and could pose a tremendous increase in incidence of depressive conditions, anxiety disorders (such as post-traumatic stress disorder), cardiovascular diseases, diabetes, alcohol abuse, abusive head trauma, spinal cord and neck damage, impaired brain development and social difficulties (Nemeroff, 2016; Child Welfare Information Gateway, 2019).

1.4 Prevention of child abuse

Furthermore, child abuse could result in death of the child- homicide, causing severe injuries as a result of violence and assault. Some victims cannot cope with the abuse aftermaths and indulge in health risk behaviours like smoking, substance abuse, alcohol misuse and high-risk sexual behaviour. Female child abuse results in unintended pregnancies, gynecological problems and sexually transmitted infections (STI) like HIV. Such child abuse victims are more likely to drop out of schools leading to unemployment and falling into the same route. They contribute to wide range of non-communicable diseases (Becker, 2020b).

WHO claims that violence against children is preventable with systematical efforts at all four interrelated levels of risk (individual, relationship, community and society). Ten international agencies under WHO's direction came together, developed and endorsed an evidence-based technical package called *INSPIRE: Seven strategies for ending violence against children*. This aimed on ending violence against children and each letter of the word INSPIRE stands for one of the strategies. These strategies have been shown to have preventive effects across several different types of violence, as well as benefits in areas such as mental health, education and crime reduction. The seven "INSPIRE' strategies are (Becker, 2020b):

- **I**mplementation and enforcement of laws (for example, banning violent discipline and restricting access to alcohol and firearms);
- **N**orms and values change (for example, altering norms that condone the sexual abuse of girls or aggressive behaviour among boys);
- **S**afe environments (such as identifying neighborhood “hot spots” for violence and then addressing the local causes through problem-oriented policing and other interventions);
- **P**arental and caregiver support (for example, providing parent training to young, first time parents);
- **I**ncome and economic strengthening (such as microfinance and gender equity training);
- **R**esponse services provision (for example, ensuring that children who are exposed to violence can access effective emergency care and receive appropriate psychosocial support); and
- **E**ducation and life skills (such as ensuring that children attend school, and providing life and social skills training).

1.5 Role of health care providers

A multidisciplinary team approach (physicians, advanced practice nurses, pediatric nurses, school nurses and social workers) is important in caring a pediatric patient. Since child care is very delicate and need each team members role in the health and well-being of the child and its family. Since many caregivers who come in repeated contact with children at risk for child abuse and their role in intervening, these caregivers need to be trained adequately to manage cases of child abuse and to provide the victims with proper care (Caneira and Myrick, 2015). A nurse's vigilance in the pediatric care can identify cases of abuse that might otherwise be missed.

According to “The Child Care and Protection Agency (CCPA)” Guyana has a total of 1,117 cases of child abuse reported for 2013 and 2532 cases of child abuse recorded in Guyana between January and August 2019 (*Inews Guyana Article*, 2013; *Inews Guyana*, 2019). The Child Care and Protection Agency (CCPA) was launched in July 2009, by then Minister of Human Services and Social Security Ms. Priya Manichand, geared towards creating a more protective, healthy and conducive environment for Guyana’s children. The Child Care and Protection Agency legislation

was passed on January 8, 2009 and was later accented to by the then President of Guyana, Mr. Bharrat Jagdeo. The Legislation states that the Agency has the power to implement the policies and make decisions in relation to the laws governing children: the monitoring of childcare facilities; to intervene in cases where a child is abused or neglected and to protect vulnerable children (*Inews Guyana Article*, 2013).

In most developing countries, healthcare providers are not trained in child abuse expectations within their scope of practice and are unsure of what their primary responsibility is as mandatory reporters (Jordan and Steelman, 2015). Lack of health care providers expertise in child abuse could be because of insufficient training and knowledge on child abuse, and a lack of standardized guidelines for reporting these cases (Saifan, Alrimawi and Bashaireh, 2015).

Lack of education and care is one of the most important barriers that leads to low rates of reporting. Nurses need to be educated especially on the common signs of child abuse and also to investigate the relationship between injury patterns and how they occurred (Caneira and Myrick, 2015; Lynne *et al.*, 2015). Lack of continuing education programs on child abuse is equally important along with lack of basic child abuse education could create barriers for nurses in reporting. It is important to have knowledge and to consistently build upon based on the country's case scenario and prepare guidelines accordingly (Jordan and Steelman, 2015).

Additional expertise and skills are required to identify and manage child abuse. One strategy is to encourage health care provider or nurses to collaborate and work with child abuse experts to get a better hold of identifying and managing abuse (Goad, 2008). Not having a standard protocol or guideline on child abuse reporting system is also a barrier in reporting child abuse by nurses hence experts in this field also view each cases differently from their colleagues (Saifan, Alrimawi, & Bashayreh (2015); Levi & Crowell (2011).

Some other barriers include a lack of consensus on what is considered child abuse or sometimes not being sure about the observed symptoms (Barlow, 2011). Due to uncertainty, some nurses fear that they might be wrong and therefore choose not report any suspected case.

Another strong barrier in reporting child abuse is the fear of getting involved in legal matters, its long term future involvement with litigation and the negative impact in their work and practice (Russell et al., 2004; Herendeen et al., 2014; Caneira and Myrick, 2015).

Hence, it is important to identify barriers to recognize and report child abuse so the victimized children could be provided proper care (Nemeroff, 2016). Having understood the complex situation of child abuse and the complexity of reporting system, it is important to learn what the registered nurses' experiences are on the situation of child abuse and management in Guyana.

1.6 Child abuse in Guyana

The alarming rate of violence, abuse and neglect against children is not sufficiently addressed in Guyana. UNICEF reports that children and adolescents in contact-with-the-law do not always receive holistic support geared towards complete rehabilitation and reintegration into their communities (UNICEF, 2020).

Child Care and Protection Agency (CCPA) disclosed that that 3129 children in Guyana faced some type of abuse in 2020. Most incidences reported among the types of abuse are sexual abuse and neglect. CCPA found that of the total 688 girls sexually abused, 382 were between the ages of 14 and 18 and abused right at their home. Reports also disclose 632 girls face neglect, while 258 were physically abused, 104 were verbally abused, 12 witnessed abuse and four were abandoned (*Guyana Times*, 2021). In contrast to the year 2020, Guyana has recorded more than 300 cases of child abuse in initial month on top of in excess of 3,000 reported in 2020 (Chabrol, 2021).

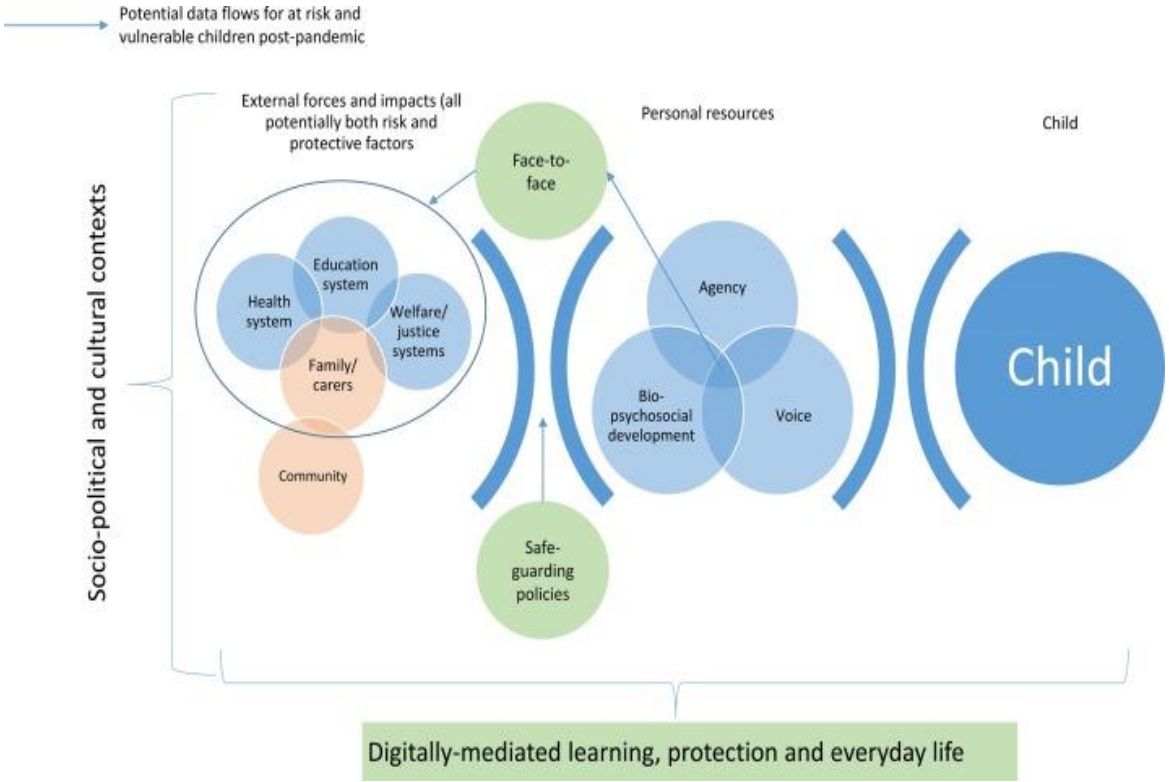
This prevalence of child abuse has been recorded in Guyana by Henry in her report 2012-2016 which claims child neglect as the most prevalent reported form of child abuse in Guyana, accounting for half of the total number of reported cases of child abuse during this period (Henry, 2017).

Although Government of Guyana, in 2015 implemented a three 'Bs' Programme, through which buses, bicycles and boats are provided to children in need of support. Other supports of education, free meals were initiated, still the cases are at high. The most observed reason of neglect was directly related to the lack of finances, unemployment, separation of parents, drug and alcohol abuse. Often parents with inadequate finances, particularly those without the support of extended family, found difficulty in providing the basic physical needs of their children. Stress due to their inability to provide for their children cause to became physically abusive to children which reinforces that child neglect can potentially lead to other forms of abuse. The study highlighted that of the families surveyed, 46% earned less than US $1.90 per capita income per day, suggesting that these families

can be characterized as poor (Henry, 2017). Therefore, child abuse in Guyana is multifactorial and needs multi-specialized integrated efforts in dealing with the matter.

1.7 Theoretical Frameworks for Child Abuse

Theories have been formulated to help understand and explain the phenomena of child abuse which could be widely used in different child abuse scenarios. These theories include attachment theory, social learning theory/intergenerational transmission of violence, general strain theory, self-control theory, filicide typology, and three-factor theory.



The framework highlights the importance of interconnected sectors and multi-agency working as well as the need for resilient and adaptable support systems (Levine, Morton and O'Reilly, 2020).

Healthcare workers play an intricate role in detecting and reporting child abuse. In most cases they are the first person to come into contact with abused children and therefore, are solely responsible to report this abuse immediately to the relevant authority.

Healthcare workers experiences, their knowledge, attitude and practices in properly detect, delivering care and effectively report child abuse at Georgetown public hospital corporation has never been properly researched and documented.

2 Objectives

3 Objective

This study is to explore the experiences of nurses when caring for abused children at Georgetown Public Hospital Corporation (GPHC).

A Method

4.1 Theoretical framework

The theoretical framework of choice for this research is the Health Belief Model. The Health Belief Model (HBM) is a psychological model that attempts to explain and predict health behaviors. This is done by focusing on the attitudes and beliefs of individuals. The model was developed in response to the failure of a free tuberculosis (TB) health screening program. Since then, the HBM has been adapted to explore a variety of long- and short-term health behaviors. HBM is a popular model applied in nursing, especially in issues focusing on the knowledge, attitude and practice of health care work to detect and report child abuse.

4.2 Study design

This study was a descriptive and qualitative approach (Minayo, 2014). The qualitative approach is based on different comprehensive approaches that they have in common: the recognition that human realities are complex; contact with people, which occurs in their own social contexts; and the highlight of the intersubjective meeting between researcher and participating subjects. Also, in this type of approach, the results are presented as the rationality of the contexts and the internal logic of the various actors and groups under study. Reality is viewed dynamically, highlighting the perspectives of the various actors facing a social project in constant creation. The conclusions in this type of approach cannot be generalized, but the in-depth study of reality allows broader inferences (Minayo, 2014).

4.3 Setting

Georgetown Public Hospital cooperation (GPHC) is the main referral Hospital in Guyana. The nurse patient ratio is severely challenged. Children care is done at the Pediatric outpatient clinic, and Accident and Emergency Department. These Children when admitted are housed at the Intensive Care Unit, Pediatric Medical and Surgical wards and the Pediatric High Dependency Unit. Nurses expedite ward rounds with the physician/surgeon, perform physical assessment, and formulate nursing diagnosis, carrying out investigations and special procedures, and other nursing routines. Nurses are the frontline contact with patients in this institution.

4.4 Participants

The study participants were defined as follows: a) permanent registered nurses working at the accident and emergency or the pediatrics unit at Georgetown Public Hospital Corporation for over 1 year. b) must be above 18 years old and can speak English.

4.5 Data collection

The study used a semi-structured interview questions as research tool, in order to allow freedom and spontaneity to the interviewee and capture the desired information in order to grasp the meanings emerged from the speeches that allowed the registered nurses to narrate the facts and particularities of her experience naturally. For (Minayo, 2014), the semi-structured interview in qualitative research is the most usual procedure in field work, through which the researcher seeks to obtain as much information from the speech of the respondents. Its further possible to characterize the semi-structured interview to discuss the proposed theme, without being conditioned to answers or conditions prefixed by the interviewer.

The first step was to have a casual/preparation talk with the registered nursed for the interview. This was done with the intention of helping the registered nurses to prepare for a conversation, that is, for a reflection on the issues.

The preparation talks were held with each nurse individually and constituted scheduled meetings through the phone (when they are free). This gave interviewer an opportunity to introduce herself and to appreciate the nurses to participate in the study.

After explaining the goal of the study and clarifying any queries, the nurses were given an opportunity to accept or to reject their participation. Once they accept to participate, they sign the Informed Consent (Appendix 1).

Nine questions on demographic background and 8 interview questions were asked to assess experience of registered nurses on child abuse. Interviews will be recorded with the registered nurse's consent in a private place, lasting an average of 40 minutes, and transcribed in full into MS Word.

All nurses were identified by a codename to preserve anonymity and subsequently analyzed as speeches. The first question in the beginning of the interview will be "please tell me about your experience (s) in caring for a child who

was a victim of abuse and/or neglect". In addition to the interview, some impressions of the researcher occur during a conversation.

The following guiding questions were used to perform the interviews:

1. Tell me your experience when you cared for a child who came into your (work setting) with a child abuse situation.
2. Tell me about your experience of being a nurse who cares for children at GPHC.
3. Tell me about your experience with the families of children with abuse.
4. Tell me about a significant event that you remember caring for an abused child.
5. What is the process you would have to go through as you care the abused child?
6. In your view, what more can be done while taking care of abused child?
7. What more the institute could do to help those abused children?
8. Do you think your current qualification/training is adequate for abused child care? Would you suggest for any additional training in the field?

4.6 Data analysis

All recorded interviews were later transcribed by the authorized researcher and the qualitative data was subjected to content analysis and thematic modality. An interview guide (topic list) for interviews was prepared. It was made clear that informants could speak as freely as possible in order not to overlook important information.

The interview guide was, therefore, used to ensure that all relevant topics were covered. The interviews were recorded in audio files and then transcribed. The interviews were transcribed by the researchers themselves, and provided useful input to the analytical process.

4.7 Ethical consideration

Ethical approval was granted from the Ethical Review Committee, Ministry of Public Health, Guyana. The objectives and conduct of the study were explained to individual participants and voluntary informed consent of the registered nurses were obtained. Nurses were assured that personal information would not be disclosed to a third party and also assured their anonymity and protection of their answers.

Participation in the project was voluntary and the participants received prior oral and written information about the project. None of the nurses withdrew during the study and all nurses did signed consent forms.

5 Results and Discussion

Sixteen qualitative interviews were conducted, guided by a semi-structured script, and conducted through online meetings (Google Meet®), with an average duration of 40 minutes. To organize and analyze the data efficiently, they were distributed into 5 categories, namely: 1. Types of Abuse; 2. Knowledge; 3. Aroused feelings; 4. Protocols and actions; 5. Suggested changes.

Among the categories found, it was possible to identify aspects relevant to the three publics involved - nurses / health professionals, children who are victims of abuse and parents / relatives of these children -, making it possible to understand, as a general overview, the role of nurses facing this issue and how they deal with the care of these patients.

5.1 Sociodemographic status

The mean(±SD) age and clinical experience of the nurses were 30.1(±4.0), 8.4(±6.9) respectively. The nurses were aged between 25 and 55 and most of them had five to ten years of clinical experiences. The majority of nurses (87.5%) were female and 12.5% were male. Furthermore, 93.8% were Christian, 50.0% were single and 43.8% belong to Afro-Guyanese ethnic group. Most nurses (62.5%) in this study were station at the emergency department. Table 1 shows the demographic information of the participants.

Table 1: Sociodemographic status of the registered nurses

Variables	**n (%)**
Gender	
Female	14 (87.5)
Male	2 (12.5)
Religion	
Christian	15 (93.8)
Hindu	1 (6.3)
Marital status	
Single	8 (50.0)
Married	5 (31.3)
Separated	2 (12.5)
Common Law	1 (6.3)
Ethnicity	
Afro-Guyanese	7 (43.8)
Indo-Guyanese	2 (12.5)
Amerindians	1 (6.3)
Mix	6 (37.5)
Department	

Emergency	10 (62.5)	
ICU	2 (12.5)	
Paediatrics	4 (25.0)	
	Mean±SD	**SE Mean**
No. of children	0.9±1.0	0.3
Age	30.1±4.0	1.0
Experience	8.4±6.9	1.7

5.2 Overview

Nurses, as health professionals present in the most diverse care environments, have a privileged position regarding the identification and care of cases of child violence, one of the great global health challenges (Taylor & Harris, 2018).

The interviews showed that, even with many cases of these types of violence, most of the knowledge on the subject is acquired in daily practice, with experience being the professionals' great ally. The recognition of cases of violence/abuse, for example, is often done by nurses who, in their daily work, witness the same scenarios from different angles. However, sometimes the low affinity for serving children can make it difficult to provide care and establish a relationship with the family/patient, resulting in the loss of fundamental information for understanding each case and each need of the child being assisted.

Thus, the feelings aroused by each interaction could change the outcome of the story. Observing the reaction of the family, the communicator (who seeks the health service) and the child, allows the professional to choose the most appropriate approach for each case, as well as contact superiors and/or other members of the health team to better handle the case and, if necessary, triggering the available protocols.

Thus, knowing the context being worked on, the reality of the local and global health scenario in relation to child abuse and acting in these scenarios, allows nurses to act based on scientific evidence, delivering a safe care to children and their caregivers.

5.3 Types of abuse

When asked for reports of cases of assistance to child victims of child abuse, most nurses affirm that, in short, the number of assistances to cases of

sexual abuse exceeds, by a large percentage, any other type of abuse, such as physical abuse and neglect.

> *"(…) we really done get these physical abuse most time when we think of a…of abuse or we have reports it does usually be like you uhm….like sexual abuse."* **Interviewee 1**

Child maltreatment is therefore associated with deprivation or impairment of different basic human needs essential for development, such as sleep, hunger and the development of cognitive activities. The harms of these acts to the future adult range from mental health problems to heart disease, lung disease and cancer (Lavigne et al, 2017).

Sexual abuse, in turn, consists of any type of activity aimed at the pleasure of the adult (abuser) or older child, carried out with children younger than that necessary for legal consent. There are several forms of sexual abuse, which may or may not involve the genitals, penetration, touching, the requirement to show private parts or even the exhibition of pornography to children.

There is not enough epidemiological data to precisely define which ages, genders or vulnerabilities predispose such an occurrence. However, it is a fact that the traumas caused by this abuse will last for a lifetime, and may result in future relationship problems, mental illness or any other damage to the current and adult life of these children. It is estimated that, on the African continent, the prevalence rate of sexual abuse in rural areas is 39.1% for women and 16.7% for men, both under 15 years of age. For women, sexual abuse is generally related to physical contact, while boys are exposed to abuse without contact, i.e., through pornography (Ward et al, 2018).

A study carried out in 2017 used the "Juvenile Victimization Questionnaire" to assess the prevalence of sexual violence among children in South Africa, as well as identify the effectiveness of national laws on the subject and seek a definition of the term sexual abuse (Ward et al, 2018). Among the risk factors for greater exposure of children to this type of violence, living in an urban area, having a discharge, having some type of disability, being a poor girl, having one of the main parents/caregivers hospitalized by a longer period, attending school and having a weakened relationship with the caregiver (female). The girls interviewed also reported, together with sexual abuse, the prevalence of post-traumatic stress. In

addition, about 1/3 of the cases of abuse were accompanied by substance abuse by children (Ward et al, 2018).

The recognition of cases happens, in most cases, by the nurse himself, present in the screening and first care of victims and/or their families. The cases usually occur with children in early or second childhood, a time of greater vulnerability and interaction with family members.

> *"(…) the father spends most of the time with the child……so that opens my thinking box because…which father would want to spend most of the time with a ten-year-old"* **Interviewee 4**

> *"(…) while cleaning her vagina, we noticed that the whole of it was….big then……..so well…. We were curious…all of us…..and the midwife was there and then she came and she was like this doesn't look right….and the doctor came and when they actually came they heard the child was actually abused….like sexual intercourse abuse"* **Interviewee 5**

Studies show that the younger the victim is, the more difficult it will be to obtain a report on what happened, which can often lead to a delay in identifying and starting the necessary protocols and treatments. (Meinck et al., 2017)

> *(…) children of all types of abuse…..but the one that stand out to me is a sexual abuse and this child was just eleven years old (…) that childs no longer want to…what should I say?.....participate in giving information to the healthcare or even giving information to me.* **Interviewee 3**

Sexual abuse is a multi-stage process, with the victim being exposed to feelings such as fear, anger, guilt and confusion, thus including stages of reluctance, denial and the need for reassurance. In most cases, this plurality makes the child tell what happened to someone they trust, in an environment where they feel safe, such as their parents, friends and teachers (Meinck et al., 2017). Thus, one of the main identifiers/reporters are those with whom the child lives most: the mother.

> *"(…)the ones that come with the report of abuse ahm….most time the family members"* **Interviewee 6**

> *"(…) the most recent case that I've dealt was this three year old child….the mother claimed that…uhhhhm….she leaved the child*

with her thirteen year old step-son…..when she return home from work….the child would keep crying out for pain to the anal region and she seh when she took the child to the washroom or to the bathroom shower…she notice that there were bruises…there were abrasion all over…….she then decided to bring the patient to the hospital" **Interviewee 4**

5.3 Nurses' knowledge

The preparation of professionals in the emergency services that receive these children is still scarce. Most knowledge is gained through daily practice and lived experience. However, when the working nurse is young and does not yet have a background that allows them to know all the protocols and actions necessary for each case, the approach and management of the case is based on the basic "2+2=4" and sharing the experiences of other more experienced professionals, rendering the dealing and caring processes even more challenging.

"(...) and we're having new staff in the department also…..so yes there are you…..are room for improvement and training will be….would also because a lot of times….sometimes we have these abused…..uhhhhm…..patients would approach the emergency department and you…..you would find that colleges would come to you and say well uhhhmm….what do you think?....you know….I should do…….and so forth because all of us probably didn't had the training" **Interviewee 4**

"I feel very pathetic (..) however, I know there's some sort of care and there is a process and there is a treatment plan also to help with the pay uhhm……the parents and also the children and even to the victim….right?..." **Interviewee 4**

"(…) maybe because it was my first experience working with a child like that it was kinda hard but with senior nurses giving you the….guidance or the guidelines to use when dealing with these children" **Interviewee 7**

"(…) there is no training or qualification that can prepare you mentally to deal with a child who's been abused…uhhm…no one in their right frame of mind can actually could actually uhhm……..sit

with no amount of training and deal with that within a comfort level….uhhhmmm….but training is always important….uhhmmm…..it basically prepares you" **Interviewee 11**

Thus, knowledge about the subject allows cases to be better identified and conducted. The practice allows that, through physical examination and/or observation of the behavior of the child and their caregivers in health services, cases of violence are identified and referred to the responsible bodies/professionals.

"(…) it had this baby but this one was more like neglect and he….it was a twin actually and one of the twin like died the night before and the other came and basically it,s more like, for him, is like being neglect….so baby was like really dehydrated, malnourish, you could see that baby is not being taken care" **Interviewee 9**

It is estimated that around 12% of cases of violence are related to emotional abuse and neglect in children under 15 years of age. Among the associated risk factors, it is important for nurses to pay attention to the child's family environment, asking them or their caregivers if they live in the midst of violence, if they have witnessed cases of violence or if they have been exposed to any other type of violence (Ward et al, 2018).

When dealing with this type of case, the approach to obtaining information or consenting to the physical examination must be done in a delicate manner. Often, the child feels withdrawn and fearful of reprisals from family members if they tell or find out about the violence being suffered (Meinck et al., 2017). The identification of such behaviors by the nurse allows, while welcoming the victim, to discover more details about the case, ensuring that the child is treated in the most correct way (Hornor & Zeno, 2018).

"(…) and this baby was like so hungry, just keep sucking away on anything that goes to the moth and the grandmother would just sit there….she's sipping on her coffee and not….like….literally to me…that's just my perception….like she just didn't care (…)" **Interviewee 9**

"(…) usually these children are…are kinda ahm….you know shy…they don't communicate much with you……ahm..some of them can be aggressive" Interviewee 6

> *"(…) they would actually blame what have occurred on the child rather than blame the individual that would've committed the act"* **Interviewee 3**

After identifying or reporting the violence, most of the times, it is found that the aggressor is someone from within the child's intimate circle, who knows their habits, family members, routine... Studies show that 61% of victims were abused by relatives, 38% by strangers and only 1% by strangers. Generally, the main caregivers' routines, such as the need to work and leave the child with someone, spending many hours away from home, are factors that facilitate the occurrence of such facts (Carlson et al. 2015).

> *"(…) most of the time it's usually like another sibling or another relative that does this, so we try to be empathetical with them"* **Interviewee 2**

> *"(…) we had a ten year old….which the person that abused her was her father….and wasn't a step-father…was her real father"* **Interviewee 4**

> *"(…) well we had one of them parents I think she was….str…..parents claimed to say that she was….she had hanged herself….which in that was not true…the father hanged her"* **Interviewee 5**

> *"(…) you might find the family tryi…trying to protect them most of the time or all of the time…so is like they have something to hide and…and thy don't want this child to tell"* **Interviewee 6**

However, "basic" knowledge can sometimes be a confounding factor in determining the facts presented, since, in common convention, it indicates that, in most cases, aggression only occurs in disadvantaged socioeconomic environments, being the only male aggressors (even if these are the majority) who are generally unknown people. (Hornor & Zeno, 2018). In fact, the numbers of deaths from abuse in rich countries are staggering: In Germany and the UK, two children die from abuse and neglect every week, three a week in France, four a week in Japan, and 27 a week in the USA (UNICEF, 2003).

To avoid biases arising from such preconceptions, it is essential that nurses involved in daily practice know the laws of their respective countries/states

and the bodies responsible for monitoring and referring these children. Such knowledge allows the professional to feel more secure, if identified, in reporting such a case. Furthermore, divestment of personal beliefs and opinions is necessary so that factors such as “what I consider abuse/violence” do not confuse what really was/is abuse and violence for that specific context (Dahlbo, Jakobsson & Lundqvist, 2017). The ability to recognize the signals given by victims and their families, however, is a fundamental tool for early intervention. In hospital environments, such as the one in this study, the daily and prolonged contact, on different shifts, with these children and their companions, allows the observation of family dynamics, detecting risk factors related to abuse and symptoms related to abuse/neglect (Lavigne et al, 2017).

> *“(…) while the child was being examined..you know uhmm……..doctor and everyone was there examining this child and this was literally you know?.....she not really…you know how a child a….a normal child would react?....she’s not the kind of person that would scream to say anything she was really traumatized and the fact that she wasn’t speaking…saying anything…whatever was happening is like….you know…was like she was numb to the pain of whatever that was happening”* **Interviewee 6**
>
> *“ (…) those children who are physical abused they already have a fear of people touching them”* **Interviewee 8**
>
> *“(…) while the child is actually talking….the child is actually looking back at the parents…..so that too uhmm……create another challenge for me because you can see uhhm…fear is been exhibited….the child is fearful”* **Interviewee 3**
>
> *“(…) they all have different vybez that they would bring to you some of them would be a little bit scared to talk….some would be very bold….and some would just be normal children that you would just see from a day to day basis”* **Interviewee 3**

In most interviews, it was reported that, together with the conduct of the case and, even before its outcome, counseling, active listening and welcoming of these victims and their families is essential so that they do not feel lost and helpless. Such counseling follows both the direction of these caregivers to which paths and

decisions to take, which places to look for what to do, as well as the emotional counseling of children and family members.

In order to carry out this counseling, however, the need to improve the nurses' level of knowledge is highlighted once again, as specific knowledge in the area allows for assertive and effective communication to resolve or mitigate feelings and doubts. The importance of the professional nurse is more than recognized as essential, and, therefore, its improvement is one of the keys to success in acting in such cases (Lavigne et al, 2017).

> *"(…) the counselling should start with that nurses…you counsel both relatives…the relative and the….the…….the…..you don't just…the victim along gah get counseling (…) but the main thing you need to focus on is getting counselling for the victim"* **Interviewee 7**

> *"(…) like not just have it there but if these people need like counselling and some sorta…*clears throat*… support that they could assist with to me that would be great because some of these family do not have anyone to talk to or they're too ashamed to talk to anyone about"* **Interviewee 9**

Interaction with the child is thus fundamental for the correct follow-up of these topics. The little affinity with the pediatric area can sometimes lead to believe that the child audience is a miniature portrait of adults. However, the particularities of children, their neuropsychomotor development, the way they perceive and relate to the world and the interference of their current experiences in their adult "I" make care challenging. Overcoming these obstacles is possible through gaining knowledge and training in specific skills.

> *"(…) at first it was like really difficult having to deal wih kids cause totally different from adults (…) as time goes by it didn't get easier….I just learn different way of actually coping or like I wouldn't say cope is like distract myself….."* **Interviewee 9**

> *"(…) you would still feel the same way but you just learn how to handle it. (…) focus on the child and not so much the parents (…) be there and be positive"* **Interviewee 9**

"(…) its always very heart rending dealing with those cases because there are obviously children and to know that somebody is taking advantage of them is very hard…….it's usually very hard for us. (…) it's a very wonderful experience I must say, uhhm when I…I…..when I first started it was a bit challenging, right?….uhhm however as the years progress, I was able better to learn them, I was better able to care for them, I was better able to understand and communicate them….. their mode of communication is mostly non-verbal, so it take a time to adapt to (…)" **Interviewee 2**

"(…) but for me uhm…..children is not really…pediatric nursing then in general is not really my uhm preference (…) Because I don't really don't interact with them…especially those who are like toddler" **Interviewee 1**

In addition, the nurses' personal lives can interfere with the levels of empathy shown, as well as with the feelings aroused by the cases and their action against them. The psychological monitoring of these professionals, as well as the sharing of experiences, can help them to better deal with these situations. *"(…) it's a very traumatic experience (…) for the nurses and the doctors that are dealing with it (…) so I think that we should also have counselling from uhm with the social worker as well"* **Interviewee 3**

"(…) and I don't really like dealing with it cause I have children of my own and….I would never ever want it to go……them to go through these thing things that these….these patients are going through". **Interviewee 8**

Dealing with suspected cases of abuse is also a challenge for nurses. It is necessary that the approach to parents or caregivers is made free from such personal biases. Communicating the suspicion and following up on the case is one of the major difficulties reported in a study conducted in Switzerland (Tingberg et al., 2008).

"(…) when I actually heard about this tears actually came to my eyes because you remember….i have a child and I woulnt like for that to happen to her." **Interviewee 5**

"(…) how could you leave the child at the hospital , just because the child would've stated who would have committed the act….that wasn't nice at all….and as a mother……I don't think no mon should've done that to a child." **Interviewee 3**

"definitely training would be an asset….would be a plus in dealing with these cases…uhhm….but…..at the end of the day….I don't think nothing prepares your mind for that." **Interviewee 11**

"(…) it was hard because I have a cousin at home and I wouldn't want anything like that to happen to him or her…you know….and……it was a little emotional at first….but…..maybe because it was my first experience working with a child like that it was kinda hard" **Interviewee 7**

5.4 Feelings aroused by cases of violence

A 2003 study by the United Nations Children's Fund (UNICEF) reported that, in first world countries, around 3500 children under the age of 15 die each year as a result of maltreatment. sometimes children between 1 and 4 years of age, either due to physical and/or mental vulnerability (Barret et al, 2017).

Taking care of these children and their families is exhausting due to the great emotional load involved on both sides. Maintaining professionalism and calm in the face of situations of violence against vulnerable beings requires emotional control from the nurse, since he is the professional responsible, among many things, for reducing the burden on the victim and his family. Taking care of children in situations of violence can often seem like being swimming "against the tide", after all, how to take care of those who are not taken care of in their own environment? Such weight inevitably leads to stress and can also trigger problems such as Burnout Syndrome. (Barret et al, 2017).

In these cases, feelings such as anger, hopelessness, impotence and stress are common to nurses. Furthermore, as stated above, one's own personal beliefs and experiences can collaborate with the appearance of such feelings. Taking care of a fragile and injured child awakens the need for protection, as well as feelings of justice and disbelief that such a fact can actually happen to an innocent being. (Roney & Acri, 2018; Barret et al., 2017).

On the other hand, following the positive evolution of the case, with the physical and mental recovery of the victim while hospitalized, can arouse feelings of satisfaction and reaffirmation of their roles as professionals. Added to these factors are the workload, the work environment, collaboration between professionals and the style of leadership to whom this nurse reports, which may be points of positive or negative influence during each case (Roney & Acri, 2018).

> *"(…) its always very heart rending dealing with those cases because there are obviously children and to know that somebody is taking advantage of them is very hard…….it's usually very hard for us (...) . However, she had beaten him very badly and we were angry….I was angry at one point but you know we try not to blame……...you try not to blame and you just try to do the best that you can do for that patient"* **Interviewee 2**
>
> *"(…) it's a very traumatic experience, not only for the patients and the relatives, but for the nurses and the doctors that are dealing with it because some of it is very gruesome"* **Interviewee 3**
>
> *"(…) I feel very pathetic….I feel very……very worried towards these patients"* **Interviewee 4**
>
> *"I always want to run away from pediatrics but….in your profession you have to….you have to….you can leave them…..you can't leave them to…to…to be more in pain and suffering so is so kinda hard that you just wanna help to make things better and…….when you actu…when I actually put forward myself to do it….at the end the day you feel satisfied that you know…this child have hope…this child have another chance to live again….to be healthy again…..to be strong again….to live life….at that purpose that they that…that they come to this earth to do……so…when you actually do it you feel satisfied"* **Interviewee 8**

Most of the victims' caregivers are involved in this process, as reported in the interviews and in line with what is reported in the studies, the mothers. As trainers responsible for the development of these children, parents are, in most cases, between two extremes: guilt for what happened, for the lack of protection or for the excessive work and the fear for the future, since the aggressor is often a member of the caregiver's family, being his brother, husband, stepson... he can also be the

family provider. Such fear can be expressed in anger, defensiveness, and indignation.

> *"(…) some relatives will be aggressive…some would be even try to not say anything because of shame you know…"* **Interviewee 7**

> *"(…) the mother was in…between a rock and a hard place…because I think it's her brother…..and her child….of course a mother would *weak signal* to always protect her child"* **Interviewee 7**

> *"(…) they show a bit nonchalant attitude towards that situation…especially if it was a partner of them that would've committed the act…..they would actually blame what have occurred on the child rather than blame the individual that would've committed the act….and I find that very very what should I say…..unacceptable"* **Interviewee 3**

In addition, as reported by the interviewed professionals, the parents' reaction and their relationship with the child victim of abuse is essential for the development of cases, since the younger the child, the lower their ability to understand and externalize their feelings and experiences, being the parents responsible for the "translation" of these. The ability of parents to understand their children's signals and knowledge of their usual behaviors allows them to be protected from their own fears, while, depending on the caregivers' response to these feelings, the effect can be the opposite expected, arousing guilt and fear in the victims (Ensink et al., 2017).

> *"Well with the families…..most of the time there's a lot of anger and there a lot of betrayal because like I mentioned earlier uhmm….the perpetrators for these acts they're usually like a relative. So there's a lot of confusion and there's a lot of anger uhhmm…. And a lot of hurt with those parents (…) some persons like to blame themselves saying its they're fault"* **Interviewee 2**

> *"(…) while the child is actually talking….the child is actually looking back at the parents…..so that too uhmm……create another challenge for me because you can see uhhm…fear is been exhibited….the child is fearful"* **Interviewee 3**

“some parents would come and they would just act like they don’t care they just come and……oh because we think duh is the right thing….we doing the police report and…yeah…and just come hurry up and….and ….is like they’re not consoling the children…they’re not comforting them or….what you would expect a parent should do….I…I hardly see that so…that support…that ….you would expect…..i don’t …...I don’t …..I don’t see that as much as it should” **Interviewee 8**

“(…) Majority of the times the family are usually ahhmm…..they would ask a…a variety of questions because for them I would underts…..to me for them it’s something like a shocking experience…something that they’re….they weren’t expecting so they would usually be asking a lot a questions…they would be very much emotional” **Interviewee 12**

5.5. Protocols used and nurses' actions

The interviews carried out evidenced the existence of a care protocol for abused children, highlighting the steps taken in cases of sexual abuse, as shown in the figure below:

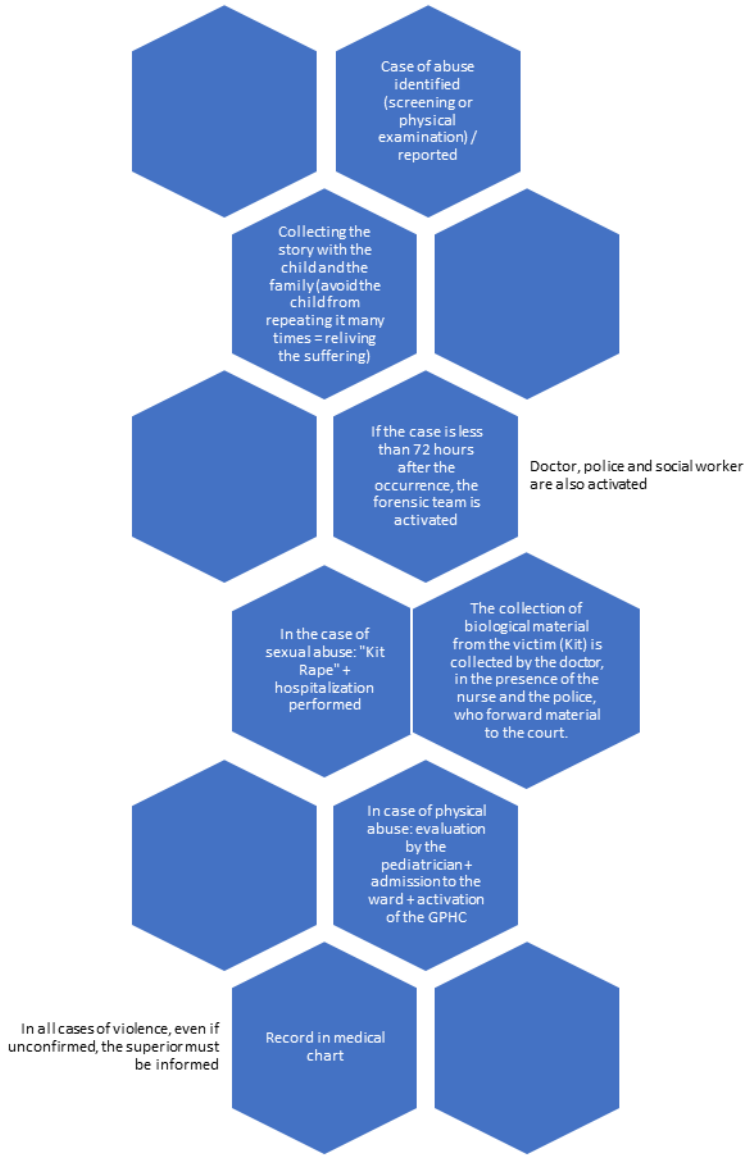


Figure 1: Protocol for assistance to child victims of violence

It is important to highlight, however, that among the 16 nurses interviewed, 4 (25%) did not know the specific institutional protocol for the follow-up of these children, reporting or unaware of its existence or that the protocol to be followed was only the professionalism in dealing with the situation. This fact demonstrates the need, once again, for more specific knowledge to provide care in the area. In addition, the professional's proactivity in seeking to know what tools are available can collaborate to increase the quality of care.

> *"(…) you need to maintain professionalism…that is one….and secondly you need to uhm…ensure that the patient's information are not handed over to un…handed over to persons that are not staff…so I think uhm…the main procedure would be professionalism"* **Interviewee 12**

> *"(…) Well….we normally like inform….we would inform the doctors and they would actually like talk to the relative them…I'm not exactly sure what happens after there….I think police would've……would get involved because of this situation also…..cause they uhhh….time and time again you see that police would come and check on these children"* **Interviewee 5**

> *"(…) if…..I guess if they have a specific protocol or a specific way how we should approach these patients…..in terms of…from the time the patient hit the gate or hit the emergency door….not only for myself or for college….it can be more of a smooth procedure or more of a helpful procedure"* **Interviewee 4**

As for the actions performed by nurses in child care, the approach, communication and establishment of a relationship with them and their families stand out. Professional support for these children is a determining factor for their openness and exposure to facts and feelings. When they feel that they are not supported or understood, children and adolescents tend to close themselves off in anticipation of the negative reactions they can get from their reports. These negative feelings are often expressed through fear, either by themselves, due to the possibility of family repression and accusation, or by the aggressors who are often family members, being loved and/or feared by the victim. On the other hand, direct questioning about the abuse, the establishment of non-violent communication and counseling on the subject are facilitators performed by nurses, promoting information and providing them with their own cases (Lemaigre, Taylor & Gittoes, 2017).

Support and counseling for parents, as mentioned above, are also essential actions for understanding the situation experienced and following up on the case, promoting support and security for them.

> *"Explain to the parent what care an so and what treatment you are going to give to the child…..right?...and ensure that they're comfortable (…) Answer questions once uhm…they have any and so"* **Interviewee 1**

> *"(…) we try to be very empathetical with them, not also with them but with the parents as well (…) we try to counsel them and make them comfortable and uhhhm…..just be a little more sympathetical with them (…) you know we try to let them know that it's not their*

fault and things like in that area we get the social worker involved to try to counsel them and you know just be there for them and let them feel comfortable" **Interviewee 2**

"One of the things that we would've learn…learnt in the workshop is that we're not supposed to ask the child what happened…..we're supposed to wait until the forensic team would've gone through that because it is very traumatizing for them to have to relating the same information over and over, every time a different nurse ask" **Interviewee 3**

"(…) because if a child comes to you and tell you that "I have been hurt" or this would've happened to me…at that point in time the parents supposed to reassure that patient or that child or their child that its ok…you offer open communication with the child (…) I ask them just to hold on outside once the child is of age or if there not hold on outside just to step back a few steps….so that the child would feel safe….the child is…will feel safe….the environment is safe…you reassure the child that there is nothing that can happen at this moment…mommy can't do anything…just speak to me" **Interviewee 4**

" (…) sometimes like if is like the mother you would have to do a lot of counseling….you have to try and explain to them what is really …..or what to expect from the child (…) for small children like the seven year old…you would try to stoop at the bed so they can see……you …you know…basic…….try and talk simple words and you try to get them more involved in conversation…the more they talk to you…the more open they get…" **Interviewee 8**

"(…) my role would be to maintain professional realism when caring for the child by….he has to show empathy (…) caring for them in such a way that they're…that they're comfortable so my interventions were slightly different when compare to a child that was abused so….my interventions were different because kids are mostly sad they lack trust….so my approach would mostly be unbyass and would try to comfort them as much as possible (…) with an abused child I would not say that this is Panadol and I want

you to drink it….I would either cuddle…if is a two year old and she left alone in the world…I would cuddle that child a little bit hug her up and bit by bit attempt to feed that child that Panadol" **Interviewee 12**

5.6 Proposed changes

Finally, changes considered necessary for a more adequate care of these children in the hospital context were reported, especially in the emergency ward, the sector in which most respondents worked.

Among the proposed changes are those related to: 1. Knowledge; 2. Service and; 3. Follow-up, which are described below.

1. **Conhecimento =**
    - **a.** Training of professionals by the social service, as, as they are more used to these cases and with more experience, they can teach the team about protocols, approaches and follow-up, in addition to allowing other professionals to be able to follow up on cases if they do not. have social workers available, such as on night shift (Interviewee 2)
    - **b.** Promotion of formal training by the hospital, with updates and protocols and use of the Rape Kit (Interviewee 4/7)
    - **c.** Training and education on specific child care, whether in a general or specific context of violence (Interviewee 5)
    - **d.** Promotion of workshops for training and reinforcement of basic techniques such as hand washing, puncture... Often neglected by the nurses' work overload. (Interviewee 7)
2. **Assistance =**
    - **a.** Distribution of hygiene/personal use items, such as clothes, soap and toothbrushes, to caregivers, in order to prevent children from being alone during hospitalization, when they are already fragile and feeling insecure. (Interviewee 2)
    - **b.** Establishment of a visitation protocol for children, aiming at greater safety and less exposure to other risks.(Interviewee 2)
    - **c.** Counseling of victims and their families through the social service, aiming at greater knowledge and ammunition for them in relation to other situations, also advising on what should be done / what could

happen during hospitalization and after hospital discharge (Interviewee 2)

d. Removal of the child from the risk environment, aiming, once again, for their safety, either placing them in the care of a close trusted family member, or through temporary institutionalization, preventing them from returning to the environment where the violence occurred. (Interviewee 3)

e. Promoting the child's privacy for data collection and physical examination, since, as most of the times the emergency service is full, it is common for other patients and their caregivers to know about the case and to keep observing the child and their caregiver, weaving comments, and looking for information. These facts contribute to the victim's withdrawal, making it difficult for them to express their feelings and for nurses to obtain data (Lemaigre, Taylor & Gittoes, 2017). (Interviewee 1)

f. Increase the number of nurses per shift, allowing the team to have time to sit down and discuss with the child their information and feelings (Interviewee 4)

3. Follow-up

a. Promote therapy and counseling sessions, aiming to avoid the occurrence of damage to mental health and the recurrence of cases. (Interviewee 3)

b. Inform the population about the reality of the country and what to do in these cases, with the aim of preventing and intervening early in situations of violence, whether through leaflets, website or television advertisements promoted by the GPHC (Interviewee 4)

c. Follow children after hospital discharge, together with the Social Service/GPHC, making periodic visits or calls, in order to supervise and monitor the context in which they are inserted (security) (Interviewee 5)

7 Conclusion

To conclude, this study identified child abuse a significant challenge in Guyana. The cases are increasing everyday with negative consequences. Registered nurses demonstrated gaps in knowledge and awareness of child abuse, due to their limited experience and training. Training stands out to be most crucial in improving documentation of such victims and to provide appropriate care to those victims. Nurses go through various emotional feelings as they care for child abuse victims. Therefore, it is necessary to implement support strategies that look to emphasis on support for the professionals. The nurse needs training, counselling and experience to properly manage all of the complexity that exists in the situation of violence against children.

Moreover, the attitude towards prevention of child abuse need to be changed and more focused on family and relatives. Since most children were abused by either the family member or the relative themselves, as mentioned by the nurses in the study. Community, state, and national levels involvement is also important to prevent such abuse.

Children from lower income families or single parents are most vulnerable as such widespread campaign to educate such parents, caregivers, children and youth would help in prevention of sexual abuse. Social health workers and teachers of vulnerable communities could play a very important role in tracing and monitoring child abuse. Lastly, impletmenting programs are not sufficient but continuous monitoring and deciphering matters are equally important.

Recommendations

Child neglect is the most common form of child abuse in Guyana. There are multiple factors that leads to child abuse in a society. Successful preventive strategies are myriad and require effective implementation. Prevention becomes more complex since family members are the most times the culprit. To prevent child abuse in the society a very efficient preventive measure is required.

As such the model proposed by Center for Disease Control (CDC) and Prevention is an effective way to move forward to prevent child abuse (Center for Disease Control and Prevention (CDC), 2012). The model signifies out the following four levels (Center for Disease Control and Prevention (CDC), 2012):

1. defining the problem
2. identifying risk factors and protective factors
3. development and testing of prevention strategies,
4. assuring widespread adoption of these strategies.

Prevention Approaches

1. Primary preventions: This would be the most important approach to prevent such abuse even before it could happen. Even though this would take some time from its initial implementation but the long-term effect would provide a healthy environment for Guyanese children. Social health workers can take the charge to be extra vigilant to capture any vulnerable families.

This includes educating children especially sexual education, making them recognize potentially harmful situations, what they should in a case they fall in any inappropriate situation. Educating to respect once body. Involvement of spiritual leaders, teachers and social workers in primary prevention. Widespread media involvement. Education girls and women of the benefits of family planning and providing good education and health care for children.

2. Secondary prevention/early intervention: This is where nurses play a significant role. To report, care and address the child abuse issues to prevent short-term, negative impact on survivors of abuse.

3. Tertiary prevention: It aims at mitigating the consequences of abuse and minimizing secondary consequences. Relocating abuse victims to safer environment and to strengthen the psychological and physical health of victims.

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Attachments

Ministry of Public Health
Guyana
Institutional Review Board

Research Proposal Form

(Must be submitted typewritten with each proposal)

Date Received by Board: ..... (office use)

Please complete all sections of this Form

1. Title of Project: Nurses' Experiences when caring for abused children at the Georgetown Public Hospital Corporation.

2. Investigators:

Primary investigator (PI): Shonette Goodridge

Tel No.: +592 603 0896

Address: 515 Eleventh Street Paradise Housing Scheme, East Coast Demerara. E-mail: shongood.sg@gmail.com

Collaborators/Co investigators

Name: NIL Contact Information: NIL

Sponsors/Agencies/Organization: NIL

Contact Information: NIL

3. Expected dates of:

Sample collection/field work: 29TH February 2020

Analysis: 30TH April, 2020

Writing final results/thesis/publication: 31ST July, 2020

4. Purpose and objective of project.

To determine the knowledge, attitude and practices of healthcare workers to properly detect and effectively report child abuse at the Georgetown Public Hospital Corporation (GPHC).

The objectives are to:

- Analyze the knowledge and experience of healthcare workers at the GPHC in relation to identifying children who are abused
- Identify the current perception of healthcare workers at the GPHC to effectively report child abuse.
- Establish whether healthcare workers at the GPHC are utilizing the protocol to identify and report child abuse

5. How many subjects will be used?
15-25 Subjects (participants)

6. Who are being recruited and what are the criteria for their selection? (2) Nurses at the GPHC
- Registered Nurses

7. How are subjects being recruited? If with written materials, attach a copy. If verbally state exactly what they will be told, by whom, and when and where this will occur.
By contacting subjects in the clinic setting, who are eligible for the study face to face and provide printed consent forms

8. Describe the study methodology and procedures. Include details of all medical devices or tests, interviews, questionnaires, or use of medical records.
A prospective study will be used to conduct this research. The prospective study will be suitable due to study time limitation and is the best selection to analyze the knowledge, attitude and practice of health care workers to detect and report child abuse at the GPHC. Data regarding, knowledge, social influences, will be collected and analyzed using the random sampling, double blinded method

9. What is known about the risks and benefits of the proposed research? Do you have any additional opinions on this issue?
No risk is foreseen, but the benefits will be great since the research will identify the areas for improvement in Knowledge deficit, attitude and practice of the Healthcare workers so as to provide better quality of care

10. What discomfort or incapacity are subjects likely to endure as a result of their participation?
Some subjects may experience a feeling of exploitation if they do not comprehend the study

11. What provisions are made to protect confidentiality? Who has access to coded and uncoded data?

 The study will account and address all subjects as anonymous. No form of identification will be required; and all information will be stored in a secure place under lock and key

12. How much time will a subject have to dedicate to participating? Thirty minutes (30-45 minutes) max/min

13. What are plans for future use of data or samples, beyond what is already described?
Future reference in other study

14. How will informed consent be obtained? If by written forms, please attach copies. If informed consent will be verbal, state who will be involved and provide a written statement of information that will be given to subjects, and to nurses or other intermediaries.
Written forms. Please find attached copy

15. Do you agree to provide a statement of significant findings (not more than one page in laypersons terms) to the MOPH Committee when writing your paper/thesis, and to copy such information to participants who request it? Yes

16. If the study is a part of your requirement for training, list the members of your supervisory committee and their affiliated institutions:
Profª Drª Adriana Moraes Leite
Associate Professor
University of São Paulo at Ribeirão Preto College of Nursing
WHO Collaborating Centre for Nursing Research Development
Department of Maternal-Infant and Public Health Nursing
Avenida Bandeirantes, 3900. Ribeirão Preto - São Paulo - BRAZIL
Zip code: 14040-902
Phone: +55-16-3315053

17. I certify that this statement is true. I agree to submit any subsequent changes in study design that bear on living subjects to the IRB for review. I will report to the IRB any concerns brought to me by the study participants about their roles or treatment in the project.

Signed:_____ Date _____

(Principle Investigator)

_____ Date _____

(Supervisor/Other)

Please submit seven (7) completed forms along with seven (7) copies of the Study Proposal and other relevant documents printed three (3) weeks prior to the Statutory Board meeting which is the 2nd Saturday of every month to:

Dr. Shamdeo Persaud, CMO
Chairman, IRB/Ethical Review Committee
Ministry of Public Health, Guyana

Lot 1 Brickdam, Stabroek
GEORGETOWN
Guyana

Tel: 592 226 1224
Fax 592 225 6271
E-mail: cmoguyana@gmail.com or
cmo@health.gov.gy msmith@health.gov.gy

Institutional Review Board FWA00014641

Ministry of Public Health

Brickdam, Georgetown, GUYANA

Telephone: 592-22-61224

e-mail: cmoguyana@gmail.com/cmo@health.gov.gy

Memo

To: Shonette Goodridge
From: The Chairman, IRB Ministry of Health
Date: 13/08/2019
Re: IRB Approval of New Protocol # 636/2019

The Ministry of Public Health's IRB has reviewed the request for approval of protocol # ***636/2019*** entitled "***Knowledge, attitude & practices of healthcare workers to detect & report child abuse at the GPHC",*** and has approved the protocol for the maximum allowable period of **one year**. This IRB approval expires ***July, 2020.***

As a reminder, the IRB must review and approve all human subjects' research protocols at intervals appropriate to the degree of risk, but not less that once per year. There is no grace period beyond one year from the last IRB approval date. It is ultimately your responsibility to submit your research protocol for continuation review and approval by the IRB. Please keep this approval in your protocol files as proof of IRB approval and as a reminder of the expiration date. To avoid lapses in approval of your research and the possible suspension of subject enrollment and/or termination of the protocol please submit your continuance request at least six weeks before the protocol expiration date.

Upon completion of your research a Report **MUST** be submitted to the Board.

Any problems of a serious nature should be brought to the immediate attention of the IRB and any proposed changes to the protocol should be submitted as an amendment to the protocol for IRB approval before they are implemented.

If you have any questions please contact the ***IRB Administrator*** or the ***IRB Chairman*** on **226-1224**.

Chief Medical Officer
Ministry of Public Health Guyana

Dr. Shamdeo Persaud
Chief Medical Officer/
Chairman, Institutional Review Board

Dr. Narine Singh

Chairman, Institutional Review Board

Ministry of Health

Brickdam, Georgetown, GUYANA

December 20TH,2020

Dr. Singh

This letter serves as a request for a six (6) months extension in my research study on "Nurses' experiences when caring for Abused Children at the Georgetown Public Hospital Corporation". My previous IRB approval expired in July,2020. The Covid-19 pandemic has gravely affected me in my data collection, and thus I have approximately 10% of my data collection to be completed.

The research project is linked to the Master in Postgraduate Program in Public Health at the School of Nursing of Ribeirão Preto-University of Sao Paulo.

S Goodridge

……..

Shonette Goodridge
Ward Manager, Georgetown Public Hospital Corporation
Student of the Postgraduate Program in Public Health at EERP-USP

Supervisor
Prof. Dr. Adriana Moraes Leite
Professor at the Department of Nursing (Advisor)
Maternal Child and Public Health of EERP-USP
CPF: 118828988-85

Institutional Review Board FWA00014641

Ministry of Public Health

Brickdam, Georgetown, GUYANA

Telephone: 592-22-61224

e-mail: cmoguyana@gmail.com/cmo@health.gov.gy

Memo

To: Shonette Goodridge
From: The Chairman, IRB Ministry of Health
Date: 30/12/2020
Re: IRB Approval of New Protocol # 636/2019

The Ministry of Public Health's IRB has reviewed the request for approval of protocol # ***636/2019*** entitled "***Knowledge, attitude & practices of healthcare workers to detect & report child abuse at the GPHC"***, and has approved an extension the protocol for the maximum allowable period of **six months**. This IRB approval expires ***January, 2021.***

As a reminder, the IRB must review and approve all human subjects' research protocols at intervals appropriate to the degree of risk, but not less that once per year. There is no grace period beyond one year from the last IRB approval date. It is ultimately your responsibility to submit your research protocol for continuation review and approval by the IRB. Please keep this approval in your protocol files as proof of IRB approval and as a reminder of the expiration date. To avoid lapses in approval of your research and the possible suspension of subject enrollment and/or termination of the protocol please submit your continuance request at least six weeks before the protocol expiration date.

Upon completion of your research a Report **MUST** be submitted to the Board.

Any problems of a serious nature should be brought to the immediate attention of the IRB and any proposed changes to the protocol should be submitted as an amendment to the protocol for IRB approval before they are implemented.

If you have any questions please contact the ***IRB Administrator*** or the ***IRB Chairman*** on **226-1224**.

Chairman
Institutional Review Board
Ministry of Health

Dr. Narine Singh
Chief Medical Officer (ag)
Chairman, Institutional Review Board

Ministry of Public Health
GUYANA

Regulation in accordance with the MOH Act

ETHICAL PRINCIPLES & POLICIES GOVERNING RESEARCH INVOLVING HUMAN SUBJECTS

The Guyana Institutional Review Board, Ministry of Public Health requires that all research projects or studies involving human subjects comply with the principles and procedures for protecting human research subjects specified below.

1. ***Ethical Principles Governing Human Subjects Research***

The Guyana Institutional Review Board, Ministry of Public Health is guided by the ethical principles regarding research involving human subjects set forth in the Declaration of Helsinki. These ethical principles must guide individuals, groups and institutions in the conduct of all studies in which human subjects participate.

2. ***Policies Governing Human Subjects Research***

The policies below are to be compiled with by all Researchers.

a) Researchers acknowledge and accept their responsibilities for protecting the rights and welfare of all human subjects involved in research which they sponsor or conduct.

b) Researchers encourage and promote a research atmosphere that safeguards the rights and welfare of human subjects.

c) Researchers agree that before human subjects are involved in research which they sponsor or conduct, proper consideration must be given to:

1) Risks to the subjects

2) Anticipated benefits to the subjects and others

3) Importance of the knowledge that may reasonably be expected to result

4) Informed consent process to be employed

d) Researchers agree that, whenever appropriate, they will consider special safeguards for protecting research subjects who may be vulnerable to coercion or undue influence, such as children, prisoners, pregnant women, refugees, mentally disabled persons, rural populations and economically or educationally disadvantaged persons.

e) Researchers agree to provide appropriate administrative overview to ensure that these principles are applied effectively.

3. The Guyana IRB, Ministry of Public Health may implement appropriate mechanisms to ensure that these regulations are complied with.

.....
Chairman
Institutional Review Board

Date: 2020-12-30

.....
Investigator(s)

Date: 2020/12/30

ESCOLA DE ENFERMAGEM DE RIBEIRÃO PRETO
UNIVERSIDADE DE SÃO PAULO
CENTRO COLABORADOR DA ORGANIZAÇÃO MUNDIAL DA SAÚDE PARA O
DESENVOLVIMENTO DA PESQUISA EM ENFERMAGEM
Av. Bandeirantes, 3900 – Campus Universitário – Ribeirão Preto – CEP 14040-902 – São Paulo – Brasil
Fax: 55–16– 3633-3271 / 55–16–3630-2651 – TELEFONES: 55-16-3633-0379 / 3602-3382

Ribeirão Preto
September 10, 2019

Dr. Fawcett Jeffrey
Director of Medical & Professional Services,
Georgetown Public Hospital Corporation,
New Market Street,
Georgetown

Dear Dr. Jeffrey,

We have forwarded the project entitled: "Nurses' Experience when caring for Abused Children at the Georgetown Public Hospital Corporation", for purposes of study in this department and subsequent referral to the Research Ethics Committee. We emphasize that the project is linked to the Master in Postgraduate Program in Public Health of the School of Nursing of Ribeirão Preto-USP.

Regards,

Prof. Dr. Adriana Moraes Leite
Professor at the Department of Nursing (Advisor)
Maternal Child and Public Health of EERP-USP
CPF: 118828988-85

S. Goodridge

Shonette Goodridge
Student of the Postgraduate Program in Public Health at EERP-USP

Cc. Brigadier Ret'd George Lewis, CEO, GPHC
Mrs. Elizabeth Gonsalves, Deputy CEO, GPHC
Mrs. Celeste Gordon, Assistant DNS, GPHC

Georgetown Public Hospital Corporation

Director of Medical & Professional Services

New Market Street, Georgetown, Guyana
Tel: 226-6712; Fax: 225-3346; Email: medicaldjefgphc@gmail.com

We Care

27th April, 2021

Dr. Adriana Moraes Leite
Professor at the Department of Nursing,
Maternal Child and Public Health of EERP-USP.
Ribeirao Preto College of Nursing
University of Sao Paulo,
Brazil

Dear Dr. Moraes,

Please be informed of the change of topic for Sister Shonette Goodridge research paper which was approved.

The previous topic was an oversight on the IRB approval letter. The new topic is entitle.

"Nurses' experiences when caring for Abused Children at the Georgetown Public Hospital Corporation".

The previous letter dated 18th January, 2021 is hereby amended.

Sister Joan Stewart, Nurse Mentor, Nursing services will supervise this research on behalf of the Georgetown Public Hospital Corporation.

Please be reminded of the following:

- That permission needs to be sought for any publication of information gathered using our data.
- Copies of the **final** research papers **must** be submitted to the hospital through my office upon completion of the research.

Regards,

.....
Dr. Fawcett Jeffrey
Director, Medical & Professional Services

Copy: Brigadier (Ret'd) George Lewis, C.E.O
Dr. Narine Singh, Chief Medical Officer, Ministry of Health
Ms. Shivani Ramdihol, Assistant Director Nursing Services
Dr. Zulfikar Bux, Consultant/Head, Accident & Emergency Department
Sis. Joan Stewart, Nurse Mentor, Nursing Services

Researcher: Sister Shonette Goodridge, Ward manager,
Accident & Emergency Department.

Appendices

ESCOLA DE ENFERMAGEM DE RIBEIRÃO PRETO

UNIVERSIDADE DE SÃO PAULO

Participant Information and Verbal Consent Form

Title of Study: Nurses' Experience when caring for Abused Children at the Georgetown Public Hospital Corporation: A Qualitative Study

Principal Investigator: Shonette Goodridge, BScN, M.Sc. Candidate

You are being asked to participate in a research study about your experience with children who were victims of abuse, also referred to as Child Abuse. Before you give your consent, it is important that information in this form is explained so that you understand what is being asked of you. Please let me know if there is anything that you do not understand or anything that needs further explanation.

Why is this study being done?

The purpose of this study is to speak with nurse to gain a better understanding of their experiences when delivering nursing care to abused children in the Accident & Emergency and Pediatrics Departments of GPHC. The information collected by this research will be used to build knowledge on the issue, which will hopefully be used to improve initiatives and programs in eliminating this problem.

What is required of you?

With your permission, I will interview you about your experiences, challenges and outcomes when delivering care to children who were victims of abuse, service provision and related policies. You are eligible to participate if you are a Registered Nurse working in the mentioned departments. You will be asked a series of general questions about these topics. The interview should last 45 – 60 minutes and will be conducted virtually by videoconference or telephone. I will be digitally audio recording this session because I do not want to miss any of your comments. I will be using this audio recording for a transcript. By providing verbal consent, you are agreeing to be interviewed. If at any time you want me to stop recording, the recording will be stopped and you will not be penalized in any way.

What if I change my mind?

You can change your mind about participating in the study at any time, and you may stop this interview whenever you wish and without any negative consequences. **If you decide to withdraw from the study, your transcript will be removed from**

the data set or your specific quotations will not be used, according to your preference.

What are the Potential Harms of Participating?

This is a sensitive issue and answering questions about child abuse and associated policies may elicit feelings of discomfort, anger, or sadness. If any questions cause you to feel uncomfortable, you are not obligated to answer them. Contact information for local psychological services will be distributed if at any time after the interview you are in need of support.

Limit to Confidentiality: If you report that there is a threat to your life or that you would like to harm yourself or someone else, I am required by law to report this to the appropriate authorities.

What are the Potential Benefits of Participating?

There is no tangible benefit for participating in this study, however, I am hopeful that your participation in discussing this issue will shed light on how our current policies add to the quality of care we give.

How will my Privacy and Confidentiality be Protected?

If you decide to participate in this study, the researcher will collect personal information about you for the purposes of the study. Identifying information will be collected directly from you at the beginning of the interview and will not be audio recorded. Instead you will be given a participant number that will be used during the recorded interview. All recordings of this interview and transcripts created from the recordings will be kept secure on encrypted and password protected storage devices accessed by the researcher. Recordings will be destroyed once transcripts are created and reviewed by the researcher.

If you provide verbal consent to participate in this study, you will be asked to complete a

demographic survey. The demographic survey will be read to you by the researcher and your answers will be recorded. This survey is anonymous. You do not have to complete the survey if you are not comfortable doing so. The information collected from the survey will be transferred into an electronic format and hard copies will be destroyed.

Depending on the topic of the interview question, if anyone enters the room where you are while we are talking, I may stop the interview or change questions. I do not want you to feel any pressure to talk to me, especially if you become uncomfortable.

Who Will Have Access to this Information?

This data is the property of the researcher. This data will be used as part of the researcher's MSc dissertation and may be published or used to make public presentations. Prior to any publications, a summary of the research results will be available to all participants. Please contact the researcher at the email address below for this information.

Questions?

If you have any further questions or concerns regarding this study please contact: Shonette Goodridge, Bsc, Msc Candidate at shongood.sg@gmail.com or (592) 603-0896.

I would like to provide you with a copy of what we've talked about today. This will include your name and the study title and the other information we have discussed. Can I send this to you by email or mail?

□ Mail.
Mailing Address:
_____

X Email
Email Address: _____

Participant:
By providing verbal consent, you confirm that:

- The study has been explained
- All of your questions have been answered
- You understand what is required of you
- You understand the potential harms and benefits of participating in this study
- You understand that you can withdraw at any time if you change your mind
- You don't have to answer any questions that you are not comfortable with

Print Name of Participant: _____

Date of Participant Verbal Consent:
_____

Interviewer:

By signing this form, I confirm that:

- I have fully explained this study to the participant
- I have answered all questions asked by the participant

Print Name of Interviewer / Person Obtaining Consent: _____

Signature of Interviewer / Person Obtaining Consent:

_____ Date: _____

Demographics:

Please circle the appropriate ones

1. What is your gender?
   a) Male
   b) Female

2. Ethnicity
   a) a. Indo-Guyanese b. Afro-Guyanese c. Amerindian
   b) d. Mixed e. Other

3. What is your relationship status?
   a) a. Single b. Never married. b. Married
   b) c. Separated d. Divorced e. Widowed

4. Do you have children?
   a) Yes
   b) No

   How many? _____

5. What is your religion?
   a) a. Christianity b. Muslim c. Hinduism
   b) d. Buddhism e. Other: _____

6. How old are you? _____

7. Your qualification?

   _____

8. How many years have you practiced nursing? _____

9. Where do you currently practice? _____

Interview questions

1. Tell me your experience when you cared for a child who came into your (work setting) with a child abuse situation.
2. Tell me about your experience of being a nurse who cares for children at GPHC.
3. Tell me about your experience with the families of children with abuse.
4. Tell me about a significant event that you remember caring for an abused child.
5. What is the process you would have to go through as you care the abused child?

Closing

1. In your view, what more can be done while taking care of abused child?
2. What more the institute could do to help those abused children?
3. Do you think your current qualification/training is adequate for abused child care? Would you suggest for any additional training in the field?
4. Is there anything we haven't talked about that you would like to tell me?