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Child Protection in Ghana: Exploring the Perception and Behaviour of Radiographers

William Kwadwo Antwi

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ABSTRACT

Aim: This study, which was in two Phases, sought to explore the cultural understanding amongst Ghanaian radiographers of the concepts of child abuse and child protection (Phase 1) and how they perceived and participated in child protection within the health system in Ghana (Phase 2).

Methods: Data was collected using phenomenological methodology. Open ended questionnaires were used in Phase 1 and semi-structured interviews in Phase 2. Participants were radiographers who were selected using purposive sampling. Data was thematically analysed and managed with NVivo Version 10. Themes developed formed the basis of the discussion.

Results: Results showed that participants understood the concepts of child abuse and child protection differently. The majority of participants sought further information through history taking to gain insight into child's diagnosis. Participants were found to trade their professional values against their behavioural beliefs in culture and superstition by indicating the fear of spiritual attacks when they intervened to help a child. Participants reported barriers such as training deficits, lack of knowledge in reporting regulations, and the absence of a framework or structures in place to guide child physical abuse management. The results showed that the majority of participants were ignorant of the role of the social worker in identified child physical abuse. Additionally, there was no teamwork in the majority of the hospitals in the management of child physical abuse.

Conclusions: From the various findings, this study argues that the apparent unanimity of child abuse definition was inconclusive in this setting. The meanings assigned to child protection by participants contradicted their behaviour towards child protection. Participants' behaviour towards child protection was congruent with the theory of panned behaviour and social exchange theory. Fear, lack of direction and collaboration characterised the management of child physical abuse.

DECLARATION

I declare that *Child physical abuse: Ghanaian radiographers' behaviour and perceptions of child protection* is my own work, that it has not been submitted before for any degree or examination in any other University, and that all the sources I have used or quoted have been indicated and acknowledged as complete references.

Signature: Dr. Pauline Reeves

(Director of Studies)   Date: 9th November 2016

Signature

(Student)   Date: 9th November 2016

ACKNOWLEDGMENT

Dedication

I dedicate this work to my lovely wife Mrs Naomi Akosua Antwi and my children for your sacrifices during my journey into the PhD. The loneliness you have gone through is enough for me to acknowledge my appreciation. I dedicate this work also to my senior brother Mr Peter Alexander Owans of Tokyo and all my sisters for your support throughout my studies.

TABLE OF CONTENTS

List of Figures

Figure 1. Children Who Experience Regular Physical Harm by Adults in Ghana.

Figure 2. The Ten Administrative Regions/Capitals of Ghana

Figure 3. Relationship Between Role Problems and Role Stress Leading to Role Strain.

Figure 4. The Research Approach

Figure 5. Upward Arrow Showing the Progression of The Study Methodology

Figure 6. A Sample of Analytical Notes and Sketches.

Figure 7. The Participants' Concept of Child Abuse.

Figure 8. Participants' Concept of Child Protection

Figure 9. Theme Structure for Case Identification

Figure 10. Internal Factors in Decision Trail

Figure 11. External factors in Decision Trail

Figure 12. The Influence of Relationship

Figure 13. Radiographers' Preferred Model of Reporting

Figure 14. Child Evaluation Process.

Figure 15: Factors Impacting on Radiographers' Approach to Child Protection.

LIST OF TABLES

Table 1: Theme Clusters.

LIST OF ABBREVIATIONS

ACPF	African Child Policy Forum
ACRWC	African Charter on the Rights and Welfare of the Child
BPS	British Psychological Society
CDT	Cognitive Dissonance Theory
CFCA	Child and Family Community Australia.
CFWP	Child and Family Welfare Policies
CPA	Child Physical Abuse
CPS	Child protection Services
CRC	Convention on the Rights of the Child
CRIN	Child Rights Information Network
CT	Computed tomography
DCSF	Department for Children, Schools and Families
DOVVSU	Domestic Violence and Victim Support Unit
DSW	Department of Social Welfare
FGM	Female genital mutilation
GES	Ghana Education Service
GHS	Ghana Health Services
GNCC	Ghana National Commission for Children
GSR	Ghana Society of Radiographers
GSS	Ghana Statistical Service
HSE	Health Service Executive
IPU	Inter-Parliamentary Union
JHS	Junior High School
LGS	Local Government Service
MDG	Millennium Development Goals
MGCSP	Ministry of Gender, Children and Social Protection
MHIS	Mutual Health Insurance Schemes
MoH	Ministry of Health
MRI	Magnetic resonance imaging
NAI	Non-accidental injury
NHIS	National Health Insurance Scheme
NPEWFCL	National Programme for Elimination of the Worst Forms of Child Labour.
ODI	Overseas Development Institute
RACGP	Royal Australian College of General Practitioners
RCPCH	Royal College of Paediatrics and Child Health
RCR	Royal College of Radiologists

SCT	Social Cognitive Theory
SET	Social Exchange Theory
SHU	Sheffield Hallam University
SoR	Society of Radiographers
SW	Social Worker
TMP	Traditional Medical Practitioners
TPB	Theory of Planned Behaviour
UN	United Nations
UNDP	*United Nations Development Programme*
UNICEF	United Nations Children's Fund
WHO	World Health Organization

CHAPTER 1

BACKGROUND

1.0 Introduction

This study is centred on child physical abuse and the current Chapter offers an overview of the issue of child abuse generally. The chapter will then examine the background of the study which includes the aims and the research questions. The study was conducted in Ghana and therefore the country's profile and sociocultural behaviour is also examined to enable the reader understand the Ghanaian situation in child physical abuse.

1.1 The issue of Child Abuse

The issue of child abuse is an age old global problem with serious social, developmental, learning, and health implications for the child and those affected, in both developing and developed countries (Akmatov 2011; Pinheiro 2006; WHO 2002). Shonkoff & Bales (2011) believed that the strength and survival of any society depends largely on the enabling environment it creates for its children. They indicated that the educational accomplishment, enduring wellbeing, economic efficiency, helps children to grow into responsible members of a society. Central to the achievement of this vision is the ability to leverage credible knowledge to facilitate productive learning, adaptive behaviour, and good physical and mental health for children.

Ghana was first to endorse the CRC in 1990 (Child Rights International Network [CRIN] 2008) however, the country is yet to overcome child rights violation challenges. One key goal of WHO and UNICEF on child maltreatment (abuse and neglect) has been to stop the use of physical assaults on children (Pinheiro 2006). Physical abuse of children is particularly relevant to the practice of the radiographer as a result of the physical injuries that usually accompany such types of abuse and often require the use of diagnostic imaging. Child abuse practices have been centred primarily on the various philosophies, cultural beliefs and understandings which brought about system of laws that in turn gave children few if any, rights (Al-Shail et al. 2012). Various regimes recognise the need not only to protect children but also seek the wellbeing of children; what in the UK is known as safeguarding children. This is most significant in situations where a child's own parent/s

fall short in the provision of protection, or are themselves involved in the abuse of their children (Holzer & Bromfield 2008). In the Western world, children are noted to have the right to develop in a protected and stable atmosphere, safe against abuse and neglect, and to have their needs met for optimal growth (Holzer & Bromfield 2008). This vision of child development seeks to provide all children with the opportunity to thrive. However, the greatest obstacle to this vision may be persistent maltreatment (abuse and neglect) of children globally.

Evidence also suggests that despite its prevalence worldwide, literature on child abuse was mostly from western countries (Raman & Hodes 2012). Apart from dearth of research on the phenomenon in Africa, child protection processes were also eclipsed by several factors (Lachman 1996). These were according to Lachman, political, economic, lack of resources and research capabilities of the people and the terrible nature of abuse cases found in the continent. The African child appears more affected by abuse and neglect because the majority of the risk factors that predisposes a child to abuse are common in the continent. Moreover the protective measures adopted by the developing and some developed countries were not holistic enough to deal with the situation which led United Nations Children's Fund (UNICEF) to come out with treaties and conventions for the Rights of the Child to be accepted by all countries (United Nations Convention on the Rights of Children (CRC) 1989).

The UNICEF (2009a) acknowledges the challenges involved in attempting to quantify, the magnitude of violence against children. UNICEF clarified that the difficulty stems from the privacy under which child abuse come about in families which are normally not reported or probed. Moreover, the problem of getting a quantified figure of child abuse occurrence is complicated by lack of data collection tools in some countries (Pinheiro 2006; UNICEF 2009a). Persons or institutions aware of related problems with child maltreatment have advocated for its prevention and actions directed toward checking it have been upheld by several stakeholders, including agencies, governmental officials, and individual practitioners (Legano, McHugh & Palusci 2009). They argued that saving children from maltreatment is a task not for any particular agency, profession or programme but rather, everyone should be accountable to child maltreatment prevention.

1.2 Child Physical Abuse

Child physical abuse (CPA) is that which results in actual or potential physical harm from an interaction or lack of an interaction, which is reasonably within the control of a parent or person in a position of responsibility, power or trust (WHO 1999). Paavilainen et al. (2002) also described CPA as any destructive action directed against a child with the infliction of injuries such as bruises, slashes, burns, fractures, head and orofacial injuries, internal abdominal injuries or poisoning. There may be single or repeated incidents of child abuse (WHO 1999).

CPA committed by parents or any person is of great public health and social welfare concern globally (Gilbert et al. 2009; Allen 2008; Pinheiro 2006). The understanding and expertise of different healthcare professionals about CPA is very crucial (Lazenbatt & Freeman 2006). This is because CPA perpetrated by blood relations and other caregivers contravene human rights of children (Global Initiative 2014; Gilbert et al. 2009; Allen 2008; Pinheiro 2006). Flogging children to behave is a common practice; however arguments still exist about its helpfulness and relevance (Gershoff & Grogan-Kaylor 2016). As a result of its grave consequences, physical abuse of children requires the intervention of health professionals (Munro 1999). When any harm resulting from child abuse is identified, it is necessary that health professionals think about other potential injuries to aid in establishing whether the injuries were intentionally caused (Legano et al. 2009).

1.2.1 Child Physical Abuse in Ghana

A study on corporal punishment in schools of Ghana found that corporal punishment was believed to have moral and religious imperatives and was a motivation for learning (Agbenyega 2006). Since this study is focused on physical abuse it is appropriate to examine the situation in Ghana. Corporal punishment is permitted in schools and at homes in Ghana (including early childhood care schools, family centres, nurseries, kindergarten, youth detention homes and industrial institutions instituted under the Juvenile Justice Act 2003, (Global Initiative 2015; UNICEF 2013). Studies (Twum-Danso 2013; Kassah, Kassah & Agbota 2012; Abgenyega 2006; Boakye 2001; Ike & Twumasi-Ankrah 1999) conducted in Ghana have reported about child physical abuse and other forms of violence perpetrated against Ghanaian children. The practice of flogging children in Ghana occurs

more in schools than in homes and it has been accepted as normal (UNICEF 2012; UNICEF & Ministry of women and children Affairs (MWCA) (now Ministry of Gender Children and Social Protection -MGCSP) 2011; Twum-Danso 2013). Some children have left school as a result of use of physical force or corporal punishment on them in Ghanaian schools (Asonaba 2015).

1.2.2 Data on Child Physical Abuse in Ghana

A UNICEF (2012) country report on Ghana indicated that, approximately 90% of children reported some form of violence and placed Ghana in the 8th position in the world with serious child rights violations. The report did not indicate the top 7 countries and what was their child abuse situation. Imoh (2013) studied 153 school children on corporal punishment and found that 94 (61.4%) of the children were physically punished by their parents or whoever was assigned to take care of them at home. Also in the study, seven out of ten pupils (70.9%) found the school to be the most likely environment where they would receive physical punishment; 47 (30.4%) were found to be facing physical punishments at home and 31% claimed both physical and non-physical methods were used to correct them.

Types of corporal punishment used on children in Ghanaian schools are noted to be caning, pulling of ears, kicking, slapping and kneeling down for a period (Imoh 2013). Children with disabilities were more susceptible to bullying in Ghana and stated particularly that 15% of these category of children aged between 2-9 years were subjected to all forms of physical punishment (UNICEF 2009b). Despite these studies, national data on child maltreatment (including child physical abuse), are not readily obtainable in Ghana. The MoH (2007) in Ghana acknowledges the poor record keeping of incidence of abuse and information on violence against children. Most of these abuse cases are known through news media reports, while, statistically, the real situation of violence against children in Ghana is unreliable (MoH 2007). It is therefore difficult to ascertain the actual occurrence of child physical abuse (in figures) (MoH 2007). However there are a few studies (Ministry of Gender, Children and Social Protection (MCGSP & UNICEF 2014) have attempted to put forward some data which are not reflective of the national situation and have little impact on the child protection efforts in Ghana (please kindly see Figure 1 below).

4

Figure 1 Children who experience regular physical harm by adults in Ghana. MGCSP& UNICEF (2014).

The existence of corporal punishment in Ghana stems from the belief held by the people that the child is a possession of the parents; the acceptance of which has created the situation where parents are rarely held responsible for the mistreatment of their children (Attakorah 2013). The practice, which is common in the rural areas, is to force (rather than encouraging) the child to learn and for the child to take academic and other school activities including teachers' instructions seriously (Adinkra 2011; Edumadze 2004; Boakye 2001). As a result of the arguments about the corporal punishment of children, several studies (according to Ellison & Bradshaw 2010) have looked at the links between this practice and attitudes that support it.

1.3 Statement of the problem

Radiographers play an important role in advancing child protection in the medico-legal contest (Rigney & Davis 2004; Davis & Reeves 2006; 2004; Hogg et al 1999). Hidden fractures are revealed through the quality images radiographers produce and moreover, the images are used to estimate the age of these fractures (Carty 1997). Additionally these images may be required in a court of inquiry (Doheny, Davis & Grehan 2014; (Davis & Reeves 2006; 2004; Hogg et al. 1999). The contribution of radiographic (imaging) assessment of children suspected to have suffered physical is reported in literature (Kraft 2011; American Academy of Pediatrics (AAP) 2009; Davis & Reeves 2009; Davis & Reeves 2006, 2004; Yielder and Davis 2009; Hogg et al 1999). Critical problems solved by

imaging are questions asked in legal cases involving physically abused children (Carty 1997). These questions usually relates to the age and degree of fractures sustained or any probable indicator of the traumatic injuries of the child at different periods (Erfurt et al. 2011; Carty 1997).

There are several cases of harm sustained by children that are considered to be accidental, most often ingestion of foreign bodies by children. The ingestion of foreign bodies or poisonous substances by a child is however, sometimes intentionally caused by the parent or caregiver –a separate constituent of abuse normally referred to as Munchausen's by proxy (Meadow 1987; 1998). Munchausen's Syndrome by Proxy suggests that an offender has Munchausen's syndrome or contrived illness himself/herself and demonstrates mental disorder through the child (known as attention seeking behaviour of the parent) (Langer 2009). Most of these foreign bodies are only detected through the use of imaging techniques by the radiographer. The detected radiographic outcomes with the proposed mechanism of injury and its relationship with the child's medical status is overbearing in the assessment of alleged child physical abuse (Geller & Lin 2015).

The possibility of identifying or suspecting NAI in children, according to Barber and Sibert (2000), is primarily the most essential course of action in child protection. This is critical because it has been established that health care professionals may be invited to give reports relating to NAI (Kraft 2011). In the UK, according to Kraft, when NAI is apparent, the child will be taken over by the social welfare by court orders. This could probably explain why the standards of practice and guidelines guiding the imaging of children with suspected NAI in the UK are nested in the professional practice of radiographers (Society of Radiographers [SoR] 2005) in their policy document 'The Child and the Law. The Roles and the Responsibilities of the Radiographer'. The vital role of radiographers in child protection was previously not recognised (Davis & Reeves 2004) but has gradually gained legal recognition in some countries. In the Republic of Ireland, as per the Statute on "Persons Reporting Child Abuse", all healthcare professionals are legally considered officials to whom persons can report child abuse (Protection for Persons Reporting Abuse, Act number 49 section 2, 1998) and are employed as entitled professionals on health boards to serve notification of child abuse in Ireland (Children First, National Guidelines for the Protection and Welfare of Children 1999). Although this position has changed with the

power now resting on the Chief Executives, this law indirectly implies that if child abuse can be reported to any health professional, then the health team, in turn, cannot also conceal abuse when such is identified in the course of providing health service to children.

To date, no existing study in Ghana on radiographers regarding child physical abuse has examined their ability to recognise and report suspected or identified cases of child physical abuse. Moreover, research data about radiographers' behaviour and perceptions about their participation in child protection in Ghana is non-existent. This apparent lack of information highlighting Ghanaian radiographers' participation in the child protection efforts is a significant knowledge gap that needs to be addressed. Several studies (Rigney & Davis 2004; Davis & Reeves 2009; 2006; Hogg et al 1999; Brown& Henwood 1997) have indicated the significant role radiographers play in providing evidence in NAI through the images they produce to assist in investigating cases of child physical abuse. This is necessary because Ghana is making all the necessary efforts to protect and improve the welfare of its children.

There is anecdotal evidence to suggest that bystander effect in the practice of the radiographer and their cultural beliefs may predominate over their readiness to report abuse (Davis & Reeves 2009). They reviewed the theoretical models of the Law of Social Impact (LSI) and the model of "innocent bystander" to explicate their point. The innocent bystander assumes that someone else around may report a case and may show witness apathy. Cultural solidarity may take priority over suspicion by others regarding abuse of a specific child. This likelihood in part, serves as a backdrop for this study.

The professional mandate to report child abuse cases, in most advanced countries such as UK, Australia, and US, is well indicated in their child policy documents. The child protection legislation in Ghana under the Domestic violence Act 2007 suggest that health professional should report on suspected cases of child abuse however the Children's Act 1998 of Ghana was initially not explicit on health professionals mandated to report child abuse cases. Whereas, the cultural implications of a radiographer in Ghana to be able to recognise and report an incident of abuse remains critical, no study has been conducted to determine whether Ghanaian radiographers have been actively involved in this.

7

Problems associated with protecting children are multifaceted; for example, child abuse can be concealed because of cultural influences and the seeming danger is the mismanagement of such cases due to prejudice towards certain cultural understandings, principles, and norms (Hughes 2006). Based on these cultural influences and the role radiographers play in providing evidence of physical abuse from the images they produce, the current study sought to establish first, the understanding Ghanaian radiographers have of the concepts of child abuse and child protection. Moreover, child protection requires professional collaboration and multiagency action in order to achieve the goals of helping children at risk of abuse (Davies & Ward 2012; Munro 2011; UNICEF 2010; Davis & Reeves 2006; Lalayants & Irwin 2005; Sanders and Cobley 2005). However, there is no evidence of studies establishing such collaboration amongst health professionals in Ghana; a situation which is inconsistent with previous arguments advocating for professional collaboration in child protection activities. In furtherance of the systems approach advocated by UNICEF (2008; 2010), it is essential that Ghanaian radiographers understand how they fit into child protection concerns within the multidisciplinary health care environment. The systems approach by UNICEF describes the significance of interactive nature of parts of a system working together to achieve a common goal. For example in health several professions (parts) work together to deliver care to patients. However according to systems thinking when any one part of the system fails, the whole system becomes affected. Thus the multidisciplinary working in child protection is likened to a system where individual disciplines should work in collaboration to protect children.

The principal question this thesis seeks to address from a uniquely Ghanaian perspective was posed by Davis & Reeves (2006, p. 162) which asks that "What understanding do radiographers have of their role and input into this area" (i.e child protection)? Radiographers are integral to the multidisciplinary workforce in healthcare who renders service to child patients, and it was seen as a critical question for radiographers everywhere to answer from their own perspective and circumstances. This study seeks to answer this question from the Ghanaian perspective. This would enable them to reflect and re-examine their, strengths, weaknesses and barriers to their contribution to the child protection process. To reinforce these expectations, Reeves (2010) encouraged radiographers to be reflective, audit their practice and use research and critical analysis of practice conditions to effect change. The current study sought to find out the Ghanaian situation including policy

8

and practice implications after studying the radiographers in Ghana. The study takes into account the cultural views and beliefs held by radiographers with regard to child physical abuse and child protection aimed to identify any gaps in their practice.

1.3.1 Aims of the Study

This study, which is in two Phases, seeks to:

- explore the cultural understanding amongst Ghanaian radiographers of the concepts of child abuse and child protection (Phase 1)
- explore how radiographers in Ghana perceive and participate in child protection within the health system in the country. (Phase 2)

1.3.2 Key Objectives

- To determine the cultural understanding amongst Ghanaian radiographers of the concepts of child abuse and child protection. (Phase 1)

- To examine and assess perceptions and approach of radiographers in Ghana in handling child physical maltreatment cases. (Phase 2)

- To determine the relationship between radiographers and other health professionals with respect to child protection in Ghana. (Phase 2)

- To explore any cultural influence on the actions of the Ghanaian radiographer in managing child physical maltreatment. (Phase 2)

Having identified the problem, the next sections in the current Chapter examines Ghana the context of this study its.

1.4. Ghana- Country Background

Ghana (Figure 2) (a tropical country), was formerly known as the Gold Coast due to its abundance of gold and is situated along the coastal belt of sub-Saharan Africa (West Africa). It is a democratic country and has a unicameral parliamentary system which was

previously under British colony and became the first African nation to attain independence on March 6th, 1957.

Figure 2. The Ten Administrative Regions/Capitals of Ghana (**UNICEF 2011**)

The country covers an area of 238,587 square km (92,100 square miles) and is divided into 10 administrative regions (names in in blue) and their respective capitals (in red) which are subdivided into 216 distinctive metropolitan, municipal and district assemblies (UNICEF 2014).

The latest population census (conducted by the Ghana Statistical Service (GSS) in 2010 and released in 2012), puts Ghana's population at 24,658,823 with a female population of 12,421,770 (51.3%) exceeding the male population of 11,801,661 (48.7%) by 2.6% (Ghana Statistical Service (GSS) 2012). The population of children in the GSS document indicates that the population of children from age 0-14 is 38.6% (male: 4,988,823/female 4,943,451) and age 15-24 as 18.7% (male, 2,403,526/female 2,426,076) of the total population respectively.

Ghana's constitution (1992) defines a "child" or "children" to cover people under the age of eighteen years old. Statistics from UNICEF (2013) cited in Global Initiative (2015) states the overall child population in Ghana as 11,660,900.

The country, apart from gold deposits, is endowed with other natural resources (including bauxite and industrial diamond), and recently, significant deposits of oil and gas have been discovered in the Gulf of Guinea the production of which began in December 2010.

Agriculture (the main economic activity) employs about 40% of the people (Roberts, Mogan & Asare 2014). Agriculture also accounts for about a quarter of the Gross Domestic Product (GDP) (Index Mundi 2014). As a result of the construction, in the early 1960s, of a dam across the river Volta as part of a plan for provision of hydro-electric power, Ghana is credited with having the largest man-made lake in the world –Lake Volta which covers an area of 8,482sq km and extends 250 miles (Index Mundi 2014). This is the period where the norm in many Ghanaian societies is that children will be nurtured, guided, supported and protected and taken care of by adults. In addition, by law, it is the responsibility of the parents to register their children at birth (Ghana Children's Act 1998).

1.4.1 The Health Care Structure of Ghana

Western medicine was first brought into Ghana then Gold Coast by Christian missionaries and missionary civilisations in the nineteenth century (Berry 1994). Currently two governmental organisations are charged with management of health care provision and infrastructure in Ghana [i.e. the Ministry of Health (MOH) and Ghana Health Services (GHS)] (Pehr 2010).

The GHS, which is an appendage of the MoH was established in 1996 in connection with the Health Sector Reform of Ghana, and is specifically and fully authorised to implement the health policies of the MoH (Roberts, Mogan & Asare 2014; GHS 2004). The MoH in general deals with policy formation, monitoring and evaluation of health service provision in Ghana, distribution of resources for health services and the regulation of health services delivery (Robert, Mogan & Asare 2014). MoH is also involved in building frameworks for the regulation of food, drugs and healthcare provision (Pehr 2010).

The main priority of GHS is to oversee the delivery of health care service to clients in line with the government of Ghana's health policy to ensure that affordable but quality health care is provided to the people of Ghana (GHS 2004). In Ghana, medical imaging departments have contributed to ensuring that the goal of the GHS is attained through the provision of quality diagnostic imaging services. There has been dramatic improvement in Ghana in the last ten years in terms of imaging services. This has made the country a leader in advanced imaging services in West African sub-region with the introduction Ultrasound, Mammography, 640 slice Computed tomography (CT) and Magnetic resonance imaging (MRI) (King 2016). Moreover, conventional imaging systems are gradually being replaced with digital imaging modalities in many public and private hospitals in Ghana.

Although the government of Ghana's attention has been on socio-economic matters, health issues have also been a key area of concern of the Millennium Development Goals (MDGs) which Ghana anticipated to accomplish by 2015 (MoH 2007). The major test in attaining the health-related MDGs, according to the ministry, has been how to successfully widen healthcare to cover the disadvantaged. Ghanaian health care arrangement functions through a National Health Insurance Scheme (NHIS), which allows the operation of three categories of insurance schemes, including District-Wide (Public) Mutual Health Insurance Schemes (MHIS) to cover all the districts in the country. The scheme also includes private mutual/commercial insurance schemes which the people access for medical treatment although the scheme does not cater for all areas of the medical services delivered.

Healthcare services in Ghana are delivered by the public and private sectors (Robert, Mogan & Asare 2014) and over two-thirds is delivered by the public health institutions which form a three-tiered structure with the basic clinics and dispensaries. These constitute the primary level with the district hospitals forming the secondary level. The tertiary level consists of regional hospitals, including the Teaching Hospitals which are referral hospitals (Castro-Leal et al. 2000). The healthcare system pivots around four key types of health services: Public, Private-for-profit, private-not-for-profit and traditional medical practice (TMP) (Abor, Abekah-Nkrumah & Abor 2008). However, as a result of lack of health facilities in some parts of the country, the reliance on TMP is very strong in these areas. Although the healthcare arrangement also functions through a National Health Insurance Scheme (NHIS) it does not cater for all areas of the medical services.

All the ten regions of Ghana have a regional hospital based in the regional capital with four of the regions (Greater-Accra, Ashanti, Northern and Central regions), having teaching hospitals with polyclinics attached. The teaching hospitals were established as the result of medical, nursing and other allied health training programmes run by the public universities which are affiliated to these hospitals. There are also district referral hospitals in almost all the district capitals, some of which were established by Christian or Islamic missions or Churches and are known as mission hospitals. Other healthcare delivery is provided by private individuals or organisations. There are also hospitals owned by quasi-government agencies as well as police and the military hospitals which provide services to the general public.

There is only one dedicated children's hospital in the country located in the capital while almost all the other major hospitals have child health departments. With mental health, Ghana has three psychiatric hospitals with two located in the capital city and one along the coast in the Central region with a bed capacity of 1322 (Robert, Mogan & Asare 2014). They indicated that among the three psychiatric hospitals only one had a children's ward with 15 beds and where necessary, children were lodged in the two hospitals. The year 2011 had 57,404 patients treated for various mental health conditions out of which 14% were children and adolescents (WHO-AIMS Report on Mental Health System in Ghana 2011). There are also in Ghana, 10 informal primary healthcare facilities (known as the faith-based facilities) (Roberts et al 2013). These faith based facilities use prayers and spiritual methodologies to heal the sick.

1.4.2 Child Health Policy of Ghana

A child protection policy establishes guidelines for organisations and their staff to ensure safe settings for children (Child Matters 2016). It is a means by which children and staff are both protected by clearly describing what action is prerequisite to keep children safe (Child Matters 2016). Child Matters futher suggests that the policy should guarantee a uniformity of behaviour so that all staff go by that standards. They further agree that a child protection policy demonstrates an organisation's commitment to children and to ensure public sureness in its safe practices. Child policy can work effectively when the policy brings the various stakeholders who work with children in various capacities together to enable them share information about the right ways the needs of children could be encouraged and assist

13

children to benefit in the greater part of life (Newcombe 2016). Relating these policy issues to child abuse concerns, Doheny, Davis and Grehan (2014) indicated that hospital personnel are distinctively placed to recognise possible cases harm which necessitate personnel being exposed to the local policies and procedures to enable them to express their concerns to any significant other.

Although Ghana has a well-established healthcare structure, there are difficulties in its operations, in terms of the proper execution of policies affecting children in healthcare (Saleh 2012). These policies appear to be more of aspirations than strategic. Advanced restructuring of these policies and strategies was in progress at the time of writing. In certain circumstances, either standards have not been determined or there is no firm execution of the policies which also differ from place to place (Saleh 2012). The current update of the child and family welfare policy appears not to have been completed or is yet operational. The latest information from the MGCSP & UNICEF (2015) report suggests that the child and family welfare (CFWP) would pay attention to all actions, services and standards which supports the child in the perspective of his or her broader family setting. The child protection system (CPS) – which embraces CFW is supposed to control broadly, the legal structures including children and justice, the education and the health systems. This is to ensure that the CPS involves more stakeholders and ministries (MGCSP & UNICEF 2015). It also addresses and prevents harm to children and is established on constructive traditional values, principles and protective practices typical of the Ghanaian culture (MGCSP & UNICEF 2015).

The absence of appropriate policies in health with regard to radiography has been a problem in several areas of the practice in Ghana (Antwi 2012). The problem of health delivery policies in Ghana has been acknowledged (MoH 2007). With data on violence against children, they were yet to be gathered according to the MoH. The purpose of the data is to aid in identifying the level of violence against children and how to avert the situation. Moreover, Saleh (2012) points out that although access to healthcare has improved, quality of care is yet to be within acceptable standards. The situation generally, has child health implications who, by their varying health demands would seek medical attention.

14

In Ghana, the child health guiding principle provides a structure for setting up and putting into operation programmes that aim to promote the survival, growth and development of all children in the country (MoH 2007). The central objectives of these programmes are focused on improving population coverage with constructive child health interventions. The programme rather stresses on child illness and how it could be reduced. The programme was silent on child abuse generally. Although child abuse generally is a reality in Ghana and has health implications, it is difficult to explain why emphasis on child health intervention has been on child illness. Attention on maternal and child mortality resulting from various factors such as malaria, malnutrition and maternal socio economic situation (UNICEF 2013) seems to have taken centre stage leaving the issue of abuse covert in the intervention strategy. This could also be attributed to the increasing new born deaths which has been estimated to be 2.9 million per year with stillbirths estimated to be 2.6 million per year (MoH 2014)

Ghana's child health interventions (MoH 2007) seek to provide treatments, technologies or essential health behaviours that avert or take care of child illness and reduce child deaths in children up to age 5. Within the child health policy, it is required that healthcare providers be trained to enable them to be able to identify and deal with cases of violence or abuse against children (MoH 2007). The policy also extends to the curricula of health training institutions which (according to the policy) should include matters on violence and abuse against children in Ghana. The policy (which did not provide any details about what the curriculum should include) was also not specific regarding the category of health professionals to whom the training should be targeted. The new radiography curriculum now covers the policy details.

The MoH acknowledges the lack of clinical guidelines and health education messages and resources on the detection or handling of violence against children (MoH 2007). This shortfall is evidenced by the comments of the president of Ghana in a national newspaper which clearly suggested that Ghana was yet to formulate the appropriate policies for child and family welfare (Daily Graphic 2015) which would later be enacted as a law.

To understand the cultural issues about Ghana, it is important to further clarify the terminology 'child abuse', neglect and child maltreatment as used in the thesis. The appropriate definition of child abuse has been contested in literature (Renteln 2010).

However, in simplifying the understanding of what is child abuse and neglect and also child maltreatment, Renteln referred to child abuse as the thoughtful act of hurting a child, while neglect denotes an omission, the refusal to care for a child appropriately.

The term child maltreatment according to Renteln (2010) is broadly used to include both abuse and neglect. The issue of child maltreatment is wide (Kodner and Wetherton 2014) as such the current study centres on child physical abuse although Phase 1 generally sought to gain insight into how Ghanaian radiographers understood child abuse.

1.4.3 Radiographers in Ghana

A R call for people to provide more evidence of abuse of children for the necessary action to be taken has been established (Crichton & Ward 2006). Although medical imaging has been practised in Ghana since its introduction in country's healthcare several decades ago, there has been a consistent short fall in the number of radiographers in the hospitals. Radiographers in Ghana were initially known as radiological technicians until a degree programme was introduced in the University of Ghana in 2000. They were previously trained for 3 years by a certificate awarding health institution (School of Radiologic Technology) which was owned by the MoH.

The realisation of positive health outcomes, to a large extent would depend on the accessibility of the appropriate health workforce in their right capacities to provide the needed health care services. As of 2010, there were 256 imaging professionals in the country and out of these, 79 were females and the rest were males (MoH 2010). In terms of their geographic distribution, 154 were employed in urban areas, and the remainder in rural areas. Overall, 207 of the 256 imaging professionals as at 2010 were employed in public health facilities, with only 49 working in private institutions. Comparing this with UK with a population of 64.6 million (Office for National Statistics 2015), a study on radiographers workforce estimated that in the UK there were 26,000 diagnostic radiographers and 3,100 therapy radiographers registered with the Health and Care Professions Council (HCPC) in 2014 making a total population of 29,232 (Dumbleton 2014) .

A more recent study (Ashong et al. 2016) approximated the Ghanaian population to be 26 million and radiographers registered to be 200. According to the study, the current ratio of radiographers to the population of Ghana stood at 1:130, 000 people. This report, apart from showing increased workload by the radiographer during the official working also

16

stated that this is normally exceeded due to shortage of personnel in each department. With the changing demographic profile of the Ghanaian population and current limited workforce of radiographers and radiologists in the country, these professionals face undue pressure in their service delivery.

The MoH data (which provide an overview of the imaging professionals in Ghana) appears to be inconsistent with the current number of registered members from the regulatory body [the Allied Health Professional Council (AHPC)]. According to the AHPC, there are only 156 imaging professionals in Ghana (AHPC 2015). The reason for the disparity in figures could be that several of the radiographers were yet to register or submit their registration to the AHPC. Moreover, the AHPC data provides no information about the geographic distribution of the radiographers unlike the MoH. Current training of radiographers is limited to diagnostic and therapeutic radiography at an undergraduate level and a graduate programme in ultrasound with the award of a Master's degree.

Ghana has very few radiologists with non as a skilled paediatric radiologists. This raises the question of how children with suspected physical abuse and injuries are diagnosed with imaging techniques without the input of radiologists. Most images produced by radiographers leave the imaging departments without a radiologist's report in most hospitals to give concrete evidence of child physical abuse when it occurs. Moreover, the fact that images may be sent to distant places for radiologists' comments, with related financial implications may result in further delay or failure to gather vital evidence and possible denial of justice and treatment. The NHIS, on which the healthcare delivery revolves, does not cover access to medical reports by victims of child abuse required by the police to pursue legal proceedings. However, parents should have registered their children or themselves to cover their children in order to have access to other treatment interventions (Blanchet, Fink & Osei-Akoto 2012). This has been the practice for any assaulted individual seeking a medical report for legal attention.

1.5 Ghana's Multicultural System and Child Abuse

In conducting this study it was found necessary to investigate further into the cultural aspect of the Ghanaian life situation, the human rights issues and child protection in order to clarify the position of some aspects of the study. The cross-cultural understanding of

17

child abuse and neglect enhances the perspectives concerning the aetiology of child maltreatment and has the advantage of advancing appropriate remedies at different levels of protection, treatment, and prevention (Agathonos-Georgopoulou 1992).

A study by Goldman et al. (2003) suggested that certain family behaviours could be considered as risk factors for child abuse and neglect however they are not always present. It is also known that some cultural practices or values can create both danger and protective factors, whose bearing differ not only between cultures but also within any culture (Korbin 2002). Culture is said to be fluid and dynamic (Zechenter 1997), however in Ghana, there are static cultural practices that are yet to succumb to transformative change. For example dangerous cultural practices meted on children in some parts of Ghana and other sub-Saharan African countries such as Togo, Benin and Nigeria, can be classified as a malicious type of servitude (Ornum 2013). For example, a custom known as 'trokosi', is a practice based on a native belief and male-controlled myths that when a relative commits an offence, (from trivial stealing to murder), the family are made to provide a virgin daughter, typically from eight to fifteen years old, to a local shrine, where the innocent child will become a trokosi, (or "slave of the gods") (Dzansi & Biga 2014; MGCSP & UNICEF 2014; Ornum 2013). The witchdoctor of the shrine assumes control of the child and her liberties and beats her when she tries to escape. The child's contacts with other members of the society is monitored and often forced to succumb to the witchdoctor's sexual demands, denied education, food, and basic health services most often (Ornum 2013). People fear when they go to the aid of the child they would be cursed with calamities from the gods of the shrine. There is also the issue of child marriages which is also prevalent in the northern parts of Ghana (MGCSP & UNICEF 2014).

Given such a focus, and the fact that the Ghanaian radiographers also operate within a cultural milieu (setting), this cultural section provides some background information on the cultural landscape under which radiographers in Ghana operate. The issues of whether culture influences radiographer's decisions about child physical abuse are important given the overwhelming influence of culture on health professionals (Raman & Hodes 2012), particularly the ethnic and family kinship ties in Ghana (Kuyini et al. 2009). In addition,

such a focus also helps to clarify the human rights issues and child protection issues in the country that are relevant to some aspects of the study.

1.5.1 Ethnicity and Cultural Groupings

The ethnic makeup of the Ghanaian people is composite (Nyarko 2014). As a political entity, modern Ghana is the result of the coming together of a population with diverse social, cultural, religious and linguistic backgrounds. The differences and uniqueness of these groups, some have pointed out, constitutes a mosaic of people who share different norms and belief systems (Clarke-Ekong 1997; Amaning 1981). The many ethnic groups found in Ghana can be identified on the basis of 1) language, 2) geographical affinity or origin, and 3) social systems and cultural practices. The existence of a common language and a common way of life served to bring people of distant blood relations into a wider social relationship through the claim of a descent from a common ancestor or ancestress (Assimeng 1981).

The family, their lineage and or ethnic groups have served to give people a sense of cultural location, a broader basis of social identification, and a wider sphere of consciousness of unity, solidarity and a sense of history (Selase 2013; Clarke-Ekong 1997). On these bases, five major ethnic groups with high regional concentrations can be identified in Ghana. These are - Akan 47.5%, Mole-Dagbon 16.6%, Ewe 13.9%, Ga-Dangme 7.4%, Gurma 5.7%, Guan 3.7%, Grusi 2.5%, Mande-Busanga 1.1%, other 1.6% (GSS 2010). The Akan and Ga-Dangme areas all in the southern parts of Ghana dominates in hospitals having imaging facilities. The cultural or ethnic makeup is not determinant of where a hospital is located in Ghana however, the southern parts (particularly the Ashanti region and Greater Accra regions) which is dominated by the Akans and the Gas (pronounced 'guns' from the Ga-Dangme descent) respectively, have more hospitals (both public and private) than the northern part of the country (Netherlands Enterprise Agency 2014)

The Largest ethnic group are the Akan who are matrilineal; that is, descent groups, inheritance, and succession are traced through the mother's lineage. Among the other four ethnic groups, descent, inheritance and succession are traced through the father's lineage (i.e. patrilineal). Significant evidence (Takyi & Gyimah 2007; Takyi & Dodoo 2005) shows that differences between ethnic groups in terms of traditions, customs and values,

influence marriage, attitudes on fertility, fertility-related practices and health-related behaviours exists. The influence of these behaviours on the child is explored further in section 2.2.

Modern day Ghanaian culture – a multifaceted mélange that has evolved from adaptation, assimilation and blending of the various ethnic groups – still maintains peculiarities and specifics within the ethnic groups. Ghana has a collective rich cultural heritage expressed in the uniformity of principles and yet diversity of the peoples' ways of life. The arts of oration, drumming and dancing form a major part of glamorous practices, rituals and cultural procedures related to festivals, funerals and other social ceremonies including puberty rites, marriage and child-naming.

There are, also traditions aimed at bringing families together, instilling discipline and fostering a spirit of communality and peace among the people. For example traditional festivals bring the people together to strengthen their identity, settle scores and also inspire their people to respect elders (Selasi 2013; Clarke-Ekong 1997). The country is also noted for its culture of hospitality and warm attitude to foreigners. Indeed, the first three words noted as most frequently used in Ghana are "Akwaaba" (welcome), "Medaase" (Thank You) and "Me pa wo kyew" (Please). However, child abuse in Ghana has been a challenging encounter that explicably, results from diverse beliefs and poverty (MGCSP & UNICEF 2014). Moreover, these bodies assert that social desertion of responsibilities to the child such a child being abandoned by parents through child trafficking or involving the child in labour activities beyond their age (MGCSP & UNICEF 2014). This is also not to argue that child abuse occurs only in poor families, it happens across all family types the rich and the poor alike. Despite this Ghanaian evidence, controversy exists on the perception that poverty leads to child abuse (Jütte et al 2014).

Many practices that would qualify as abuse such as tribal marking of child's body using sharp implements are acceptable by some ethnic groups in northern Ghana. This practice is a form of cultural identify based on their beliefs. These are issues worth discussing for the society to be able to define that thin line between dangerous cultural norms and what is deemed to be acceptable globally. This is because culture is fluid and dynamic making this

thin line shift with time in order to determine and where appropriate, denounce actual acts of infringement on rights of children.

1.6 The Ghanaian Child

A child is not only considered a precious gift of life in Ghanaian culture, but is also a characteristic of a wholesome family and the ability to bear children is a manifestation of the completeness of a couple particularly the woman. Inability of a family to have children is oftentimes, albeit sometimes erroneously, blamed on the woman; and this could lead to breakup of a marriage or the man taking in a second wife; a practice not illegal in Ghana. A couple may experience pressure from friends, family and the community to bear children as soon as they are married and any sign of child bearing problems receives public ridicule. Women usually are the most affected by being blamed as the cause of the infertility (Barden-O' Fallon 2005). These values have also been reported elsewhere in Africa and other disadvantaged economies (Barden-O'Fallon 2005; Dyer et al. 2005; Dyer et al. 2004).

Barrenness is considered a dreaded "curse" on a woman in the Ghanaian and other African societies. Women are sometimes either stigmatized and/or are subjected to ridicule even by their own family members and/or the man's family could create a lot of tension between the two families. These common social problems have also been reported in Nigeria (Aroaye 2003; Hollos 2003) a neighbouring country. Out of desperation to have children and save their marriages, a barren woman may seek some form of supernatural help and, dependent on the individual's spiritual beliefs, consult with religious leaders or fetish priests and deities. Many such poor women turn out to be victims of fraud and having been taken advantage of financially, emotionally or otherwise.

Though children are well sought by couples who have no children, there is also the situation where pressure is put on the woman to have a son to inherit the father or a girl who will perpetuate the family. The complexity of these beliefs and attitudes has necessitated campaigns for educational programmes and workshops that are directed and appropriate to the ideals of each culture to eliminate the socio-psychological and economic challenges of infertility among people in developing countries (Rouchou 2013).

Children in Ghana form the largest sub-group of the population of the country with a population of 11,600,990 (UNICEF 2013 cited in Global Initiative (2015). Children are

21

born into a system having enviable cultural values and heritage woven around fertility and child-consciousness. With this in mind, it might be expected that children would be catered for in these regions. However, children in this sub-Saharan African country and in many other parts of Africa are exposed to many unfortunate situations that pose a great risk to their lives, health and development. Disabled children face more difficulties within the community (both at home and in school). Evidence suggest that such children are oppressed in schools and their teachers, apart from lacking in requisite training are not provided with materials that supports the teaching and learning of these children (Obeng 2012). Morgan (2015) in a BBC 1 documentary on the treatment of people with disabilities in Ghana questioned whether Ghana was the world's worst place for the disabled due to her observation of the inhuman treatment given to disabled people in Ghana. Kassah et al. (2012) also reports that capital abuse (killing of disabled children) are meted on disabled children in Ghana although it is a criminal offence. They ascribe this to the mutual stance in the belief system among individuals or a group. Some of these disabled children are seen as 'spirit children' from the bush and have bad omen and are killed through infanticides (Denham et al. 2010).

Ghana has in the recent past experienced ethnic conflicts especially in the northern territories. Results of such unrests worsen the already deficient condition of children in the affected areas with some ending up on the streets to fend for themselves, or worse, still falling, victim to human trafficking. Others live in deplorable conditions which are mainly due to abject poverty, further complicated by effects of rural-urban migration and lack of education, malnutrition, child labour and sometimes child slavery (Ike & Twumasi-Ankrah 1999).

1.6.1 Culture and Child Upbringing in Ghana

To fully appreciate the vulnerability of the Ghanaian child, an understanding of child rearing practices in Ghana is necessary. Child-rearing, a worldwide inescapable occurrence in all human cultures and societies is culturally comparative (Nyarko 2014). Given the admiration attached to one's cultural heritage, critical attention is required with regard to the culture, socioeconomic and political tensions of the Ghanaian society in handling child maltreatment cases in order to provide the appropriate intervention. Culture aids in

establishing a common definition of principles of child upbringing and care of children and therefore the various morals and optimism surrounding child nurturing behaviour should be given attention in any universal approach to child abuse (WHO 2002). This is because different cultures have different acceptable rules of parenting (Nyarko 2014; WHO 2002).

Child upbringing among societies globally though varies it is also private and therefore, the normative methods used by certain families in Ghana and Sub-Saharan Africa in child upbringing may appear strange to some other societies. In the name of culture and ethnic self-identification some practices encountered by children within their families and society, are difficult to prevent or be stopped no matter how painful the rituals and customs the child has to endure. The degree to which children experience violence or abuse is a critical element of the helpless situation of children which is also compounded with poverty, a key influential indicator of child protection problems (UNICEF 2009c). UNICEF, is further, of the view that abuses such as child labour, trafficking and sexual exploitation with its accompanied socio-cultural risk factors contributes to the multiple angles and complicated nature of child vulnerability.

Ghana, has historically maintained socio-cultural structures which played significant roles in providing a secure environment for the growth of the child and its maturity into a member of society. Such arrangements involved supervision and overseeing by family members and elders in society, dedication and adherence to strict and clear traditional norms and customary demands. The reason for this arrangement was that children are vulnerable human beings desirous of security and nurturing, which suggests social responsibilities and familial bond (Boakye-Boaten 2010).

It is has been reported that multiculturalism and infiltration of foreign cultures, most significantly (Western European culture), have resulted in adulteration of the rich family system of the African society (Nyarko 2014; Boakye-Boaten 2010). The traditional African culture of a family was the extended family system rather than the nuclear family practice of the western and European cultures (Madukwe & Madukwe 2012; Arowolo 2010). They asserted that the extended family system has gradually given way to the nuclear family type as the result of this external cultural influence. With the extended family system any member of the family could assist and take care of any member's problems. Moreover, the

influence of external cultures led to the adoption of foreign languages in almost all the African countries (Arowolo 2010). For example, countries colonised by the French speak French and those colonised by the British such as Ghana has English as the official language. This has weakened the the traditional languages at homes most especially where parents or a family have had formal education. There is a significant difference, in comprehension of family as an institution, between European and traditional African societies. Whereas in the United States and Canada (including nations of northern Europe), mostly, the nuclear family is, father, mother and the children (Georgas 2003), the traditional African society recognises the large extended group of relatives and relations as family (Madukwe & Madukwe 2012). They explained that the extended family system in Africa comprised not only the father, mother (wife or wives) and children but also included grandchildren, grandmothers and fathers, nephews, nieces, cousins and aunts.

The clash of the Western/European way of civilisation and traditional African culture and shared values thus gave way to unfamiliar dominant foreign culture (Nyarko 2014; Arowolo 2010; Boakye -Boaten 2010). Until recently, it was commonly accepted in Ghanaian society that a child's education and upbringing was the common responsibility of the whole community (Boakye-Boaten 2010; Kuyini et al. 2009). Every member of the community had the duty, as well as the right to call a child to order or scold him/her for unruly or inappropriate behaviour. These practices had both positive and negative effects. For example children became respectful in public and at the same time it became abusive as anybody could treat a child anyhow under the excuse that the child is being corrected. With urbanisation, such communal responsibilities became eroded and limited to the provinces and villages and reduced to almost nought. Irrespective of the varied causes of changes in African socio-cultural norms, (attributable in part to global economic hardships and financial crunch), the resultant breakdown of what knitted the family together, has the same impact.

It is worth noting that the definition of what constitutes a family has had several controversial interpretations among cultures (Carteret 2011; Georgas 2003). Despite the varying meanings of family system, one major advantage of the extended family structure was the wide range of people who could take direct responsibility of the needs of the young as well as supervision of the child's development. It was not uncommon in Ghana to find a

child transferred to an aunt or uncle for caretaking and education with the child having no problems (Kuyini et al. 2009). The child enjoyed good upbringing with the traditional foster parents without being subjected to any form of abuse or hardships.

Abandoned orphans in Ghana were normally taken care of by the extended family clan (Manful and Manful 2014). However the growth and development and rise in poverty levels and people moving to settle in other countries or distant cities and towns have also brought about problems in the family system (Kuyini et al. 2009). For example, the firm grip by the extended family on orphans and other children under their care who are not orphans has been broken and become obsolete. This relationship in fostering has gradually in most part, been supplanted in Ghana by institutional care (Armar-Klemesu et al. 2000). The institutional care system has its own challenges such as lack of resources and space. For example it is known that the SW is sometimes tasked to take care of the child without much support until the system finds a suitable place for the child (MGCSP & UNICEF 2014).

A child in any family system is important because of family procreation, as it is in the Ghanaian family system. However, children are outranked in the Ghanaian society because the generally accepted norm of the people is that the child should respect, obey and be submissive to the elderly (Adinkra 2011). Though Adinkra's assertion is not a unique situation in Ghana, gerontocracy is well established in the Ghanaian society where, for example, the elderly and adults are expected to be seated before the youth and children and in most families the aged are in full control as family heads. It is, therefore, a normal practice for a person to give up his or her seat to an elderly person of society. It is in line with such practice that children are taught at home and in school to show respect to any older person. Children normally have assigned duties and chores in the home and at school to be performed under the supervision of adults. Domestic chores are assigned dependent on the sex of the child. Thus, for example, girls are mostly given chores which help prepare them for future womanhood and family life (Chant & Jones 2005).

In a direct linkage to the extended family system in Africa, it is not uncommon to see a child transferred from its parental home to other relatives for upbringing (Boakye-Baoten 2010). In order that the death of a child's parents should not leave them deprived, another family member should take up the responsibilities for the child (Frimpong-Manso 2014).

In such case, the benefactor may not necessarily be childless; in fact, the benevolent individuals sometimes have many children or dependents themselves, which does not prevent them from taking in yet more mouths. There are other situations where children are taken away from their biological parents from remote provinces by well to do extended family members to towns and cities where chances are brighter for future career building and growth; and means of building, fostering and maintaining family ties between distant relatives. This is not to be confused with a different common practice, whereby, a minor could be engaged as a maid-servant or house help; despite possible similarities in the reasons for such arrangements, e.g. poverty.

The practices mentioned above in many instances involves young working families – with little time for housekeeping but earning enough to be able to afford a help – thus implying that there is mostly no blood relationship between the parties involved and Social Welfare Department is not involved in this arrangement. As per agreed terms, the help may be a paid a wage or sponsored through basic education with further arrangements made for him/her to learn a trade. This is purely arranged privately between the child's parents and the one seeking the help without any agency involvement. The delicate issue is about defining the intents and arrangements for transferring a child to a different home; since a child's position and situation could be compromised due to possible misunderstanding or confusion. Thus, a child may be taken in by a willing relative under the guise of sponsoring and taking charge of his/her upbringing and that child could end up in conditions of a complimentary help. Children in such predicament end up double victims since they are exploited as child labourers and in addition to that do not get paid for their otherwise improper (but locally accepted) exploitation (a modern form of slavery?). The agency system in Ghana is more effective someone has requested to adopt a child where the child is under the care of the state (details in the Children's Act 1998 of Ghana).

1.7 Religion and Child Abuse

By all indications, Ghanaians by nature are quite religious. Though technically Ghana is a secular nation, the way Christian churches, mosques, and religious paraphernalia and symbols dominate the country and the mass media, an outside observer will find it difficult to argue that Ghana is not a Christian nation. Christianity is the most dominant religion in the country, with more than two-thirds of the population from the current census conducted

Christians constitute 71.2% (Pentecostal/Charismatic 28.3%, Protestant 18.4%, Catholic 13.1%, other 11.4%), Muslim 17.6%, traditional 5.2%, and other 0.8%, none 5.2% (GSS 2010). What separated the Muslims and Christians was that when the country began to develop, most Christians took the advantage and educated themselves leaving their Muslim group behind (Sheffijl 2013). According to Sheffijl, several jobs were secured by the Christians because they had obtained formal education from the Christian missions. However, the Muslim abhorred Christian schools and their type of education thus denying their children formal education and jobs (Sheffijl 2013). The obsession about religion is such that one cannot ignore its possible influence when it comes to family and child issues.

The religiosity of Ghanaians can be assessed by a variety of measures, including for example the number of people who identify with a faith or religious organization, attendance at religious services, frequency of prayer, and those who claim religion is important in their lives (Gallup International 2012). Participation in private religious activities such as all night prayer sessions and weekend prayer camps are common events throughout the country. A study (Pomicka, Addai & Takyi, 2012) found that there has been an upsurge of religious programmes on the television and has led to more people viewing these programmes.

A previous study (Yirenkyi & Takyi 2010) observed a strong resurgence in religious activities in many parts of Africa, including Ghana. In their analysis of data from the 1988, 1993, 1998, and 2003 Ghana demographic and health surveys, they identified that very few Ghanaians claim to be non-religious. They further reported that the number of Ghanaians who claim to be nonreligious has actually been declining over the years—from a high of 12% in the late 1980s to about 4% by 2003.

As the population of nonreligious Ghanaians declines, we find a corresponding increase in respondents who claim to belong to a religious or faith-based organization—an observation that has been corroborated by a Gallup International Poll, which in 2000 surveyed 50,000 people in sixty countries on a series of questions, including their religious beliefs (Gallup International 2012; Ghana Review International 2000). This study concluded that Ghana was one of the most religious among those surveyed, as 96 percent of Ghanaians

interviewed indicated that they belonged to a religious denomination. Furthermore, 82% of the same respondents said they attended church on a regular basis.

Data from year 2000 Ghana population and housing census provides evidence to suggest that Christianity is the dominant religious form in Ghana. A most recent study on Islam and Christianity in sub-Saharan Africa, (Pew-Templeton Global Religious Futures Project 2010), identified that the greater section of the people in sub-Saharan Africa identify themselves as Christians. In a similar study (Ferrett 2005) in Africa, three-quarters of those interviewed, believed in their religious leaders and held them in high esteem. A sign of the growing influence of religion-especially Christianity, and to a lesser degree, Islam, in Ghana can be seen in the rapid spread of religious institutions throughout the country. In addition, several studies have found that religion informs several behaviours in Ghana, including for example, political behaviour (Takyi, Opoku-Agyeman & Kutin-Mensah 2009; Yirenkyi 2000 1999), HIV/AIDS behaviour (Takyi 2003), educational attainment (Addai & Takyi 2002), reproductive health decisions, (Addai 1999, 2000), use of reproductive services (Gyimah, Takyi & Addai 2006), and sexual behaviour, among others (Addai 2000).

Religion, per se, may have nothing to do with child maltreatment cases. However, It is the way in which religion is manipulated and used to, literally chastise some children or used as the basis for child training that make it relevant to the discourse on child maltreatment in Ghana. Religion, in particular Christianity, is also a key factor in understanding the prevalence of physical punishment in Ghana as many parents often refer to biblical teachings, mainly from the Book of Proverbs and other sections of the Old Testament, in order to justify and explain the use of physical methods of punishment on their children (Twum-Danso 2012). Moreover evidence from media reports also indicate that some children are deprived of medical treatment as a result of their parents' religious beliefs (The Ghana NGO Coalition on the Rights of the Child 2005). These confirm the role religious beliefs in Ghana affect children who cannot decide for themselves and most often these behaviours by parents are inherited.

1.8 Culture of Superstition in Ghana

Further to this cultural attitude and its impact on healthcare uptake, there also exists in most African countries, including Ghana, ingrained superstitious beliefs which originate from their culture. The prolonged history of profound superstitions in Africa encompasses the belief in witchcraft; suspicions, juju, gods, ancestors, black magic, sorcery, necromancy and ghost (Ofori 2014). The author asserts that this belief pattern has unfortunately led to many citizens of the continent living in perpetual dread resulting from their belief system. The irony is that such beliefs are firmly held by the people as a way of life. The issue of child rights abuses in Ghana has been linked to the held belief that one's destiny could be changed for the worse by children who are supposedly "possessed" with witchcraft. A Study (Onyinah 2009) found that about 90% of Ghanaians admitted to believing in witchcraft. Children believed to be under the influence of witchcraft are hunted, brutalised and taken to child witch camps where they suffer further abuse (Adinkra 2011) with the full awareness of the state.

In Ghana, any strange unexplained illness, poverty and premature deaths, or collapse of businesses, are attributed to irrational forces as causative agents of these problems leading to witch hunts of women and children who are particularly suspected to be behind these situations (Adinkra 2011). These kind of behavioural beliefs and attitudes have led to human rights violations which create hardship for the vulnerable women and children in some communities. For example, those labelled with witchcraft accordingly, were physically assaulted, tortured, abandoned, and in some instances murdered (Adinkra & Adhikari 2014; Adinkra 2011). Pupils, suffering from such illogical social blemishes of witchcraft also face problems in the school. For example, the child's school and the community becomes the subject of scorn and as a result, these children, (to avoid shame and vilification) drop out of school (Ofori 2014). Children, with this kind of pejorative label as witches, become psychologically affected by the persistent irrational dogmas held by the people against them. Stutterheim et al. (2009) and Meyer (2003) have proven that stigma could have a dreadful effect on the affected individual's emotional health.

Women's fertility, health and economic strength are closely tied in Ghana (World Bank Discussion Paper 403 (1999). The Paper reported that, one characteristic of the Ghanaian women is that 16 years of active life is spent in child bearing and breastfeeding at an

average age of 20. The report suggest that typically, most Ghanaian women have at least six children individually and even more in some regions with several of them at higher risk due to age of giving birth. To illustrate these high birth rates in some parts of the country, it is interesting to know that in some traditional Akan communities in Ghana, a woman is awarded with a sheep (known as *badudwan* ; *badu* means tenth child and *dawn* is sheep) by the husband in a public ceremony, if she is able to deliver a tenth child to him (Enos 2002). Ironically, twins were abhorred by some tribes in parts of Ghana. To have twins to some families or groups was to bring evil into the family (Laddzekpo 2003). These beliefs held about twins are not unique to Ghana but a belief also held by other ethnic groups in some African countries (Leroy et al. 2002).

These entrenched beliefs in witchcraft and superstition in sub-Saharan Africa have led some individuals to seek prosperity through criminal activities (Ongere 2010). Some of these criminal activities involve killing of children for ritual money known as "sakawa" in Ghana. and "juju". For events and self-confessions of using "juju" (an object used as a fetish, a charm, or an amulet in West Africa; supernatural power ascribed to such an object (The Free Dictionary 2015) to get rich has been given a detailed review in de Witte (2009) and (Meyer 1995). To prevent the ever-increasing negative human rights violations in Africa, there is the need to help reform the mind-set of traditional African societies, to enable change in attitude and convictions about witchcraft and superstitions of the people (Ongere 2010). To conclude this section, it is also interesting to note that some of these beliefs also helped children not to become destitute. For example Kaye (1962, p. 37) cited in Frimpong-Manso (2014) indicated that children of dead kinsmen were catered for by their extended family for fear of the dead visiting their anger on them and stated:

> *"The spirit of the dead parent particularly that of the mother, is watching to see how the child is treated, and will reward with misfortunes and calamities those foster-parents who neglect their charges"* (Kaye (1962, p.37).

Thus children under this dispensation would not face difficulties of childhood despite the death of their birth parents. The keys to the challenges affecting children in Ghana and Africa commonly hang on the re-examination of the concept of the child within the metaphysical context of Africa (Boakye-Boaten 2010).

1.8.1 Traditional Beliefs as a Challenge to Healthcare Uptake

The two principal, but different, medical systems which have functioned in Ghana are conventional and traditional medicine (Asante & Avornyo 2013). Traditional medicine (TM) has been in existence in Ghana long before mainstream medical practice was initiated in the country and to date has been the sole source of health care to many in the country. The World Health Organization (WHO) defines TM as a comprehensive ''set of healthcare practices, approaches, knowledge and beliefs incorporating plant, animal and mineral-based medicines, spiritual therapies, manual techniques and exercises, applied singularly or in combination to diagnose, treat and prevent illness or maintain wellbeing''(WHO 2002a). Traditional medical practitioners (TMP) in the country apply different methods in treating their patients such as the use of herbs, spiritual ideas and local knowledge and training is usually done in most cases through apprenticeship (Antwi & Griffiths 2012).

A larger percentage of the people (mostly in rural areas) in Ghana depend entirely on this form of healthcare, (Boateng 2016; Asante & Avornyo 2013). According to WHO (2005), about 70% of Ghanaian patients use this form of medicine to treat their ailments. As much as the traditional medical practices augment the conventional health care service, they also present problems to government efforts to offer universal healthcare in the country. The greatest difficulty has been those who combine TM and unorthodox procedures (i.e. herbal treatment and religious prayers). Many of these traditional medical practitioners (TMPs) maintain that they have spiritual powers for healing physical and psychological problems. The occurrence of any illness is treated by applying either herbs or incantations and other rituals, but in several ill health situations management is both natural and spiritual. As a complete approach in healthcare, the TMP thinks through the physical, mental, spiritual, and social structure of the person and is thoughtful about the source of illness (Goldstein 2000). In Ghana, the biomedical health care scheme can be viewed as operationally supreme although herbal medicine, and other traditional healing practices are also very strong (Boateng et al. 2016). TMs are applied to both adults and children some of which could be disastrous as a result of the dosage given. The government in 2001 put forth measures to regulate the use of TM by granting hospitals and pharmacies the right to prescribe and distribute approved herbal medicines (Bodeker 2001).

The government encourages the use of biomedical health services however, culture, knowledge, geographical and economic status and perception of quality of care influences the uptake of health services (Saleh 2012). According to Saleh, beside culture being a barrier, information on the use of biomedical health services is also inadequate. Evidence (Salisu & Prinz 2009) suggests that traditional beliefs, social stigma, poverty and illiteracy in certain rural areas have been a hindrance to healthcare provision in such communities. For example, a study conducted in the Kassena Nankana District in Northern Ghana showed that the people in that community were unwilling to pay for the health insurance scheme. The reason was, the community held the belief that, paying for any sickness which has not reared its head in the form of insurance scheme, was an invitation of illness (Health Research Unit 2005).

1.8.2 Cultural beliefs and maternal healthcare uptake

Cultural beliefs are known to limit women's use of health services (World Bank Discussion Paper 403, 1999). Maternal healthcare uptake is also shrouded in some beliefs and practices that affect women and the unborn child when women are in labour. It is an accepted norm, in some parts of Ghana that any delayed labour with the woman in pain, should be labelled with infidelity and this must be admitted before any assisted delivery (EngenderHealth 2004; Thaddeus & Maine 1990). EngenderHealth supported this with a report from a midwife who had a woman she delivered confess her infidelity as a result of delayed labour, by mentioning the names of men with whom she had committed adultery instead of pushing. Some families are urged to access the powers of a clairvoyant to establish the cause of a protracted delivery, a step, which discourages them from attending a healthcare facility (EngenderHealth 2004). The World Bank Disccusion Paper 403 (1999) identified that a woman's contact with biomedical healthcare in some parts of northern Ghana is determined by the family. According to the World Bank, policy mediation has not been effective to change this practice. Despite the interest to have children, this cultural influence on women in some parts of Ghana not to use biomedical health services could affect an unborn child. The behaviour can be changed through public education of such communities.

1.9 Child Marriages and Consequences

High incidence of recto-vaginal and other forms of fistula cases have been recorded resulting from early marriages of a girl child with about 2,000,000 women and children reported to be suffering from these conditions in Ghana (Quaicoe-Duho 2014b). These latter cases are also of particular concern to radiographers as most of these patients are sent to the imaging department for the assessment of the extent of their fistula (X-ray fistulography) prior to any surgical intervention; which in turn has cost implications for the economy.

1.10 Cultural Relativism and Universalism

Ghana has been battling with some cultural practices as already mentioned in previous sections. These practices though have been frowned upon by section of the Ghanaian community the practice wages on. Cultural relativists believe that the intrinsic values and practices of a culture are distinctive and therefore should be devoid of value judgments until the contextual aspect of that culture is given attention (Fluehr-Lobban 1998). Some disagree with relativism in support of transformative cultural changes into a different and usually more composite or better form (Rentteln 2010). This is by the understanding that societies are not stagnant but make changes to their customs by adopting more civilised practices in concurrence with the growth of their economies, technological and scientific competences (Zechenter 1997).

The dichotomy between schools of thought of universal human rights and cultural relativism, both generally and specifically relating to child abuse, is readily reflected as a reality in the Ghanaian society. Cultural relativism is linked with a common acceptance and respect for dissimilarity in culture; which refers to the idea that cultural context is significant in appreciating people's values, beliefs and practices (Hawson 2009). For this reason the relativists seeks to disagree with the scrutiny of culture in an objective way; and as such the values of a culture should not be subjected to criticism Rentteln 2010). The dichotomy is that the universal human rights thinkers view culture to be fluid and dynamic and should succumb to evolutionary change and criticism (Zechenter 1997). The cultural practices in some parts of Ghana (like child marriages, trokosi and FGM) that seems to affect children but are still practiced without clear actions of change could urge one to think that the relativists thinking is prevailing in the Ghanaian culture. Renteln (2010) argues

33

that cultural relativism has unduly been linked to approval of any cultural behaviours or practices. However Renteln is of the view that instead of seeing relativism as a prescriptive, it should rather be considered as descriptive- a theory that basically recognises multiple moral realities.

The existence of culture is something difficult to understand and explain. Cultural trends and attitudes of people are learned from the association with a community and family system that one has been born into which strongly shapes their interactions and practices throughout their lives (Burk et al 1995). A study (Ibanez et al. 2006) indicated that evidence on how ethnicity influences an individual and the reporting of child abuse is inadequate. They however, argued that choices to report child abuse may differ and some may report based on the ethnicity. Consequently from the above, one could infer that the culturally constructed concepts of child abuse and protection may impact on the radiographers' attitudes and behaviours towards reporting. These categories of people may find some of these cultural norms acceptable and may look on passively or may even be active in their practice.

Korbin (1991) had pointed out that the cultural perspective of the individual and value judgments are the key considerations informing the individual's classification of an abuse or maltreatment. Similarly, Brown and Keith (2003) explained that, culture impacts on one's perceptions of the world and shape the meanings people give to life experiences. This stance would imply that with these cultural values, one may not interpret all physical aggression on children as abuse from cultural considerations (Renteln 2010). He argued that some cultural practices that may initially appear to be physical punishment may not be so, and some child corrective methods may also not be injurious. Nonetheless, authorities could always protect children from permanent harm (Rentteln 2010). However, it is often unclear whether certain actions against a child could be described as child discipline or child abuse (Family Support Alliance 2016). They argued that this would normally depend on the child's age, the gravity of the discipline and its effect on the child. For example, it would be unacceptable to discipline a two year old child by subjecting him or her to severe beatings using a cane or a belt.

1.11 Ghana's Child Protection Orientation

Ghana has in recent past made great strides in consolidating the legal framework for child protection-which includes extensive laws that take into consideration, children in need of protection and juvenile justice (UNICEF 2011). However, the Ghanaian legislature in most part, was strongly influenced by the replicas of British laws [i.e British 1989 Children's Act] (UNICEF 2011; Laird 2002). This led to laws and practices which were incoherent with some disconnection between the law and social attitudes of the people of Ghana in handling matters of child protection (UNICEF 2011) as a result of the as a result of the Ghanaian culture and circumstance (MGCSP & UNICEF 2014). Moreover, due to the opposing socio-cultural setting of the two countries, the execution of the Ghana's 1998 Children's Act has been a challenge (Laird 2002).

UNICEF (2011) noted that Ghana has not been able to develop a vibrant national policy framework on child and family welfare services. According to UNICEF (2009a) report on progress for children, the restructuring of laws has rather considered issue based approaches to child protection since the declaration of the Convention on the Rights of the Child in contrast to the systems approach advocated for by UNICEF. The child protection laws seem to follow same issue based approaches to child protection with intersecting and identical strategies (UNICEF 2011). Though Ghana's child protection orientation is based on its legislation, countries generally require structures that inspire unrestricted dialogue of matters relating to child protection. This is because legal measures would not exclusively meet child protection concerns unless awareness is raised and attitudes reformed through public discourse (UNICEF 2009a).

The UK has a strong framework for appraisal of children in need and their families, and has ensured rational child and family services which safeguards and-stimulates the wellbeing of children (Hollows 2001), even though issues of child protection and safeguarding have not been resolved totally. UNICEF (2011) explains that the Ghanaian child protection legislature (The Children's Act 1998) requirements support the sequence for reporting. Failure to report any crime is an offence in Ghana, however to the researcher's best knowledge and clinical practice no professional has been sanctioned for not reporting child abuse. Child protection issues have not been talked about seriously in the hospitals for professionals to know what is expected of them. Acting on circumstances of children in

need of protection, the legislative requirement profoundly appeals to the UK emergency intervention model. In particular, this model is driven by prescribed investigative responses and interventions usually instigated by the courts which do not respond to the contextual and cultural imperatives of Ghana.

The current situation can best be described as child protection rather than safeguarding because practices are more of fire fighting than early intervention.

The crucial pointers of child protection activity as was suggested by (Bromfiled & Holzer 2008), are notifications, investigations, substantiations, orders and placements. However, these indicators are also possible when there are clear laws guiding and protecting these processes under strong policy structures. Ghana's orientation either towards child protection or family service in terms of operational policies has not been strong [compared to that in the Western and European countries (Bromfield & Holzer 2008)]. The child and family welfare policies (CFWP) in Ghana include provisions that uphold the well-being of children especially in terms of preventing abuse and protecting children from maltreatment. However, these have not been completed and are yet to be well-structured and harmonised (Donkor 2015). The unfinished CFWP framework is intended to inclusively establish an operative child and family system. This framework underscores the present Justice for Children Policy to guide the contact of children with the Ghanaian justice system. Substantial progress has been made to restructure and reinforce the child justice system: what remains is definitive policy framework to guide these reforms and a clear arrangement for the delivery of child justice services (UNICEF 2011). The policy framework currently operating in the child protection system in Ghana is centred on the rescue and removal of children as against working with families to solve problems in the home (MGCSP & UNICEF 2014). UNICEF (2011) Mapping Analysis study in Ghana found that the country has no definite national policy framework for child and family welfare

During the recent 69th Session of the United Nations (UN) Committee of the Rights of the Child (CRC) in Geneva, Switzerland in 2015, it became clear that Ghana was yet to have completed strategic policies that would seek the welfare of children and families. The country was however, on a high note by its efforts to achieve the provisions of the UN Convention on the Rights of the Child (CRC) (Donkor 2015). Having identified these setbacks in instituting operational strategic plans and policies, the current government

launched a Child and Family Welfare Policy (CFWP) in July 2015, which among other things, would establish an effective child protection system in the country to conform to current global visions for child and family welfare (Graphic.com.gh 2015). According to the report, the law would ensure that government provide resources for the smooth functioning of the child and family welfare services at all levels that the government would like it to operate. As already mentioned above, the UNICEF (2011) Mapping Analysis of Ghana identified among other issues of child protection that there was no clear national policy framework for child and family welfare services; provisions in the Children's Act 1998 (Act 560) were not tailored to the Ghanaian socio-cultural context that translate into the family and community-based approaches to child protection; several aspects of the current operating system were unregulated and lacked detailed guidelines and protocols to guide the Social Welfare officers, Probation Officers and Child Panels in performing their duties under the Children's Act 1998. Since the policy is yet to be approved by an Act of Parliament no specific periods of implementation have been provided The policy was developed by the Ministry of Gender, Children and Social Protection (MGCSP) and designed to improve the current child protection system in Ghana through child and family welfare programmes, and to undertake activities which will effectively prevent child abuse and protect children against any form of exploitation.

The previous child protection framework relied on the current child protection legislation which laid much emphasis on child care centres and adoption procedures (Children's Act of 1998), rather than laws which mandate several professionals and agencies to appreciate child protection demands and legalities. Though Ghana was the first country to sign the CRC Treaty in 1990 (Manful & Manful 2013), it is ironic that Ghana has inconclusive strategic policies which seek the welfare of children and families. This implies that the existing policies have not been effective to help children and families. When the new CFWP is implemented and enforced with public education at both community and institutional levels. The 69th UN Session on child protection again identified that the rights of the Ghanaian child were still being infringed upon because of ingrained socio-cultural beliefs and practices in Ghana (Donkor 2015). Although some beliefs and practices are coded in the country's laws as criminal, and there are constitutional requirements that prohibit them, some cases of female genital mutilation (FGM), trokosi system (young girls serving in slavery) and widowhood rites still continue in some communities (Donkor 2015).

With regard to wide-ranging legal structures addressing child protection concerns, Ghana marked high (Nicola, Ahadzie & Doh 2009). However, according to them, the worry has been its implementation which is infirm. They gave an example with the trokosi situation in the country which is proscribed by law, the police are unwilling to interfere as a result of the supremacy of traditional cultural beliefs. What they did was to help the victim. The police inability to stop this and other practices such as FGM, is fully explained in (MGCSP & UNICEF 2014, p. 69).). In this report, the police indicated that it was a challenge to prosecute family members involve in FGM. The police stressed in the report that the laws were ineffectual. The professional would not be effective in their work and children's rights will continue to be abused.On human trafficking, two Legislative Instruments (LIs) were yet to be completed and become operative for the Human Trafficking Act and the Domestic Violence Act (Donkor 2015).

1.11.1 Child protection Structures in Ghana

Ghana has put in place several important agencies and workers in place for the management of child cases resulting from abuse. These included the district-level skilled welfare personnel and trial officers, Domestic Violence and Victim Support Unit (DOVVSU) of the Ghana Police Service, Family Tribunals and Juvenile Courts (UNICEF 2011). Particularly, UNICEF is of concern that the scheme within the justice arrangements, such as the panel system required for Family Tribunal and Juvenile Court are contentiously overburdened. The Department of Social Welfare (DSW) is the main child protection agency in Ghana and its current status require attention in this study. Child abuse is both a public health and social welfare concern (Gilbert 2009a). Traditionally, the Department of Social Welfare in Ghana has evolved from the British standard as a result of its colonisation A trained professional in social welfare in Ghana is known as social worker (SW) who has the ethical responsibilities to promote and obligate to the wellbeing of clients (Local Government Service (LGS) 2014). The SW is mandated by law to handle child protection issues (Children's Act 1998). However the framework upon which the Ghanaian social welfare services operate is non-existent (UNICEF 2011; Laird 2008; Laird 2002). In Ghana, the DSW has the exclusive power in providing service to children and family, and some of their professionals work in hospitals to respond to various welfare issues of patients including children.

The arrangements for delivery of social welfare services are, apart from not being vibrant, found to be operational in some selected districts including the child justice services at the community level (UNCICEF 2011). Most children in need of welfare services and justice would not be visible in the lens of DSW. The economic environment of the Ghanaian everyday life challenges social workers with unrelated problems and differs from those of Britain where Ghana draws its legal inspiration (Laird 2002). The author identified that although the Ghanaian legislation is in tune with the CRC, the socio-economic and cultural circumstances provide several challenges to its execution.

The Ghana National Commission for Children (GNCC) (1997), indicated in a study, that while Government policy is emphatic that no child should walk more than 5 km to school, some children in actual fact walked at least 12 km to school in some communities. The consequence is that child performance has been affected in such community schools, according to the study. Moreover the study shows that parents overstretched financially in a child's education prevent the child from schooling if no benefits are seen. Under such a situation, the social worker cannot confront affected parents and charge them with neglect when their children are denied education (Laird 2002). Another identifiable problem is how professionals working with children appreciate the importance of their acquiescence to the ideas of children's rights in their everyday work. Hitherto, there was little realistic evidence that associated perception of children's rights by professionals at the strategic and operational levels in Ghana (Manful & Manful 2013). They argued that those who care for children in the foster homes do not comprehend the working legislation.

The challenges facing Ghana in its efforts to protect children are multiple (Laird 2002). The DSW is challenged with several resource constraints and training in their field which affects all areas of their practice including child protection (Manful & Manful 2013; Laird 2008). Laird (2008) in a study of Ghana's social welfare system, identified apathetic staff with poor training and lacking the necessary capacity to respond to important social issues that affect the society including services to children who are in need of support and protection. This challenge is a hindrance to their mandate to provide the appropriate services to children and families.

Most of the problems in the Ghanaian social welfare services are tied to the socio-economic, political and cultural climate of the country (Laird 2002). Until recently child labour was not featured prominently in national discourse compared to sexual abuse cases and domestic violence against children. Even though there are stringent laws, Ghana still battles with child labour and trafficking. Child labour has now received the required attention and the government is vigorously pursuing the issue. According to the CRIN (2008) there has been an on-going national programme aimed at completely eliminating child labour. The programme also includes the development of a national action plan which would study the problems and provide actions that can address child labour. These problems could also be linked to the current child protection orientation of Ghana which needs to be examined.

1.11.2 Child Protection Challenges in Ghana

Per the country's laws, the age of maturity in Ghana is 18 years. However, the Children's Act 1998 of Ghana suggests 15 years as the age at which a child can be employed. Controversially, the sub-section 560 of the same Act suggests that any parent who denies a child within the stated age the right to education, immunisation, adequate diet, clothing, shelter, health or any other needs of the child for his or her development, commits an offence and is liable on summary conviction to a fine not exceeding five hundred Ghana Cedis (GHc 500), (about £100) or to a term of imprisonment not exceeding one year or to both. This is a huge amount for the ordinary Ghanaian citizen working in public or private sector. The Ghanaian public worker is paid monthly and the minimum wage per day for the ordinary worker was eight Ghana Cedis (Ghc 8.00) as at 2016.

The complexity of this issue is that economic factors severely affecting families create what the researcher would call 'artificial neglect'; a neglect as a result of poverty. Child labour is therefore common in both the urban and rural communities despite the law and efforts to prevent child labour in Ghana. The employable age raises questions because the same law defines a child as a person under the age of 18 years. There is a free compulsory basic education in Ghanaian public schools (primary to Junior High School [JHS]), which implies that children between age 6-11years under normal circumstances should be in primary school (UNICEF 2007).

Children are seen in the urban areas involved in activities such as street hawking, cleaning car windscreens in traffic for money, as well as selling all forms of merchandise that can be carried in the street, including grocery. These unfortunate children, mostly from dysfunctional homes, or having sick or disabled parents who require special care, deem it their responsibility to make some earnings to provide for themselves and their parents.

In many households it is normal and culturally acceptable to find children engaged in farming, fishing or any other full-time adult income-earning activities – which are either characteristic of the community or form the basic source of income for the family. The relevant legislation (The Children's Act of Ghana 1998) which seeks to protect children is ambiguous in its ability to comprehensively protect the child.

Ghana in 1998 passed its Children's Act into law (Ghana Children's Act 1998; Act 560) based on the country's 1992 Constitution. The Act which was designed on the basis of Britain's 1989 Children's Act suffered in its initial implementation because the socio-economic and cultural backgrounds of the two nations were at variance and could not work appropriately in Ghana. The government had to change its direction by laying emphasis on the specific socio-economic and cultural context of the country. In view of the fact that the socio-economic, political and cultural situation of Ghana posed a hindrance to implementation of the universal child protective requirements enshrined in the UN Convention on the Rights of the Child, the Ghana government initiated different measures to protect the welfare and development of the Ghanaian child (UNICEF 2011). It also ratified the African Charter on the Rights and Welfare of the Child (ACRWC) and implemented at the Organization of African Unity (now African Union) Summit in Addis Ababa in 1990 (ACRWC 1990) and was entered into force in 1999. Ghana has since its signage to CRC and ACRWC made several strides to improve the deplorable situation of children by enacting and amending laws, drawing up policies and organising activities to promote and facilitate the realisation of the country's Child's Rights Policy. One major change has been the creation of DOVVSU of the police service which has been the first point to lodge complains about identified child abuse and domestic violence to compliment the work of the Social Welfare in their services to children.

1.12 Originality of Work

The UNICEF (2009) report on progress for children strongly encouraged the use of the evidence base on child protection and the use of information to improve laws, policies and practices. The current study is timely and important in that it is the first to explore radiographers' experiences in child protection activities in Ghana. It is hoped that the study would serve as a baseline data for the situation of child protection in health care in Ghana. It is anticipated that it would establish the facilitators and hindrances to reporting child physical abuse in relation to child protection activities in the hospitals. It is also anticipated that the study would direct future training and policies in health care in Ghana to advance child protection activities.

Child abuse concerns all and no individual agency has the full human, financial, material and training resources, or legal authority to intervene effectively in child abuse cases (US Department of Justice 2001). However, some organisations such as the Social Welfare, the police and health play a principal role in matters of child abuse. In Ghana for example, the lead agencies are the Social Welfare (SW), the Domestic Violence and Victim Support Unit (DOVVSU) of the Ghana Police Service, and Health (The Domestic Violence Act 732, 2007). The police have been the first point of people lodging complains of abuse.

The current study seeks to investigate the understanding amongst radiographers of child abuse and child protection as issues with possible cultural implications. This would help to determine their lines of action and experiences in child protection and their level of training in the imaging of physically abused children. Moreover, Raman and Hodes (2012) have indicated that how child abuse and neglect is defined seriously impacts on the approach and reaction time of local professionals to the situation. They argue that when child abuse definitions are completely subjected to the cultural norms and customs of a people, this could result in the children not getting the appropriate care and protection they deserve. Ghana, a multicultural country, has no data on health professionals (including radiographers), as to how culture impacts on their practice in managing child maltreatment cases. This study was, therefore, conducted within the broad cultural context in Ghana and in two Phases. The study aimed to establish the effectiveness of Ghanaian child protection systems and the integration of other stakeholders in health (in particular radiographers) in NAI investigation.

1.13 Summary

This chapter looked at Ghana's geographical setting, its population and healthcare system. It also examined the physical and nonphysical abuse of Ghanaian children. Child physical abuse was seen as a serious public health problem which requires a multidisciplinary approach for its identification and prevention. It was noted that the system approach to child protection supports the view that child protection is not an individual, but collective, involvement of all stakeholders who in particular handle child cases. The healthcare professionals deal with various child health situations which if not properly handled, may adversely affect the wellbeing and development of the child. Child abuse is among other health problems that confronts the radiographer. It is a public health problem which requires a holistic approach to its identification and prevention. Radiographers, by the nature of their work meet all manner of cases from various clinics involving children who have sustained various forms of injuries resulting from either physical abuse or accidents (Davis and Reeves 2004). The Chapter also indicated that imaging results are needed for evidence in a court of inquiry (Kraft 2011; Davis and Reeves 2006; 2004). Ghana, with a population of over twenty four million people, has not been free of cases of violence against children. The Chapter also addressed the cultural heritage of Ghana with particular emphasis on childhood and child upbringing in the Ghanaian setting. Childhood in Ghana is highly acclaimed by the people however it was noted that the cultural climate in Ghana, just like in other countries has several diverse consequences for child development. Though most Ghanaians were religious, the country is overwhelmed with beliefs and practices that affect its people in diverse ways including maternal uptake of health care. The laws of the country do not appear to impact on the culture of the people since abuses such as child labour and use of corporal punishment and other cultural practices are still prevalent which affects child development. Many people in Ghana are unable to draw any line between discipline, physical punishment and abuse because of different cultural ways of child upbringing.

The Chapter also examined the current position of Ghana as among the first countries to endorse the UN Convention on the Rights of the child its attainment of the tenets of the convention. The worst form of child labour can also be found in the country even though there are on-going programmes designed to reduce or eradicate it. Irrational superstitions such as witchcraft have been a problem affecting the approach to things in many African

countries including Ghana and have had a profound negative impact on the rights of the child. The beliefs surrounding healthcare uptake were discussed to throw more light on how children could be affected by such beliefs. Despite these traditions and norms child fostering in the non-formal way, has benefited many Ghanaian children.

The child protection in Ghana is still facing challenges as a result of the current child protection orientation and measures in place. The Child and Family Welfare Policy has been long overdue. The Social Welfare Department and DOVVSU of the Ghana Police Service have had difficulties executing their mandate of protecting children.

1.14 Directions of the Study

Chapter 2 reviews literature on other studies and reports about child abuse and child protection approaches generally. Chapter 3 examines the epistemological and philosophical underpinnings of the study and Chapters 4, the method used in collecting data and the analysis done in Phase 1 and 2. Chapter 5 takes the reader through the findings for Phase 1and Chapter 6 the discussion of the findings of Phase 1. The next section is the Phase 2. The findings of Phase 2 are examined in Chapter 7 on Ghanaian radiographers' behaviour and perceptions about child protection. Chapter 8 takes the reader through the discussion of Phase 2. Chapter 9 is the conclusions and recommendations and also the limitations of the study and Chapter 10 the reflexivity of the researcher in his journey through the study.

CHAPTER 2

LITERATURE REVIEW

2.0 Introduction

"In all human groups, babies depend on warm, responsive, linguistically rich and protective relationships in which to grow and develop. They cannot survive in environments that do not meet thresholds of these characteristics" (WHO 2004 p.3).

With the forgoing preamble, this chapter reviews literature on the topic area in a broader perspective.

2.1 Literature Search

An organised search of peer reviewed, published literature in English from 1990-2015 was conducted between 15th of September 2012 -18th October 2015 to categorise the various concepts of child abuse and child protection. The search was extended to literature on approaches to child protection in general, and to child physical abuse in particular. Searches were done manually and also via electronic data bases. The manual search examined lists of references, articles, books, government reports and documents of credible organisations such as the organisations formed under the United Nations. The electronic data bases searched included Cumulative Index to Nursing and Allied Health Literature (CINAHL) hosted by EBSCO, PubMed Central (PMC), and Medical Literature On-Line (MEDLINE) hosted by EBSCO including Cochrane Library. The electronic databases provided the opportunity to search wide range of credible literature covering issue of child abuse and child protection and other relevant information pertaining to the study. With the electronic search, terms used in the search included *child abuse, child maltreatment, physical abuse, child protection, health child protection, radiographers and protection.* Other search phrases included were *child protection orientation, culture and child protection, systems approach to child protection, team work, multidisciplinary working, and professionalism.* Words within the search terms and phrases were joined with "AND" and "OR". Primary evidence published in English between the periods stated above was included in the review if it related the general broad areas of the study. Unpublished articles or ordinary opinions which were not convincing were excluded. These key words were selected because of their relevance to the broader context of the study

2.2 The Conception of Child Abuse in Medicine

Child abuse, as a medical concept, originated through the studies of the paediatric radiologist John Caffey, as well as many other specialists in the field of diagnostic imaging (American Academy of Paediatrics 2000). Previously, establishing that a child's physical injury was intentionally perpetrated by the parents or caregiver was hard to believe by clinicians and was attributed to their reluctance to accept that parents can harm their children (Glick, Lorand & Bilka 2016). Indeed, in the early 20th century, the medical profession and society found it difficult to believe that violence against children could deliberately be inflicted by the child's parents (Mason 1998). This situation has changed over time due to the abundance of information from medical and sociological literature on issues of child abuse.

The American paediatrician Henry Kempe was the first to draw society's attention to child abuse in 1961 by coining the phrase "Battered Baby Syndrome" (Kemp 1962). The American Academy of Paediatricians (2000) explained that the term child abuse also encompasses other syndromes, such as Ambroise Tardieu's Syndrome, Caffey's Syndrome II, and Caffey-Kempe Syndrome. After these discoveries, several child conditions have been proven from medical assessments as resulting from violence against the child.

Ambroise Tardieu is accredited to be the first to medically investigate child maltreatment in the mid-1800s (Labbé 2005) through his forensic practice during which Tardieu revealed thirty-two incidences of maltreatment (Crane 2015). Tardieu's work covered child sexual abuse, physical abuse and neglect, infanticide (Labbé 2005). Tardieu also wrote about the working situation of young children in factories and also in mining and included in his papers the dreadful costs of the misuse of children at work (Tardieu, 1862a, 1862b) cited in (Labbé 2005). It is important to note that child abuse is generally not a solitary occurrence; it is constituted by events or actions undertaken over a period of time-(Paradise et al. 1997) and is a delicate matter for research and medical practice (Horwath & Morrison 2007).

Their study gave a strong view that prevention activities against child abuse are structured to create an environment, in which children can be safe. Moreover, Gani & Woolley (2008) argued that securing the safety of children is a shared responsibility of all whether working with children or not. However, they further argued that those who associate with children

and families in their regular activities are responsible for ensuring the wellbeing and protection of these children (Safeguarding). This assertion applies to radiographers, due to the nature of the services they provide in healthcare settings. Radiographers examine child patients in their daily work through the images they produce on children coming from several clinical areas such as the accident and Emergency unit (Davis & Reeves 2004). They argued that this positions the radiographer as part of the frontline team who meet with children suffering from NAI (Davis & Reeves 2004). Moreover, their imaging role makes the radiographer an important member of the health team who can potentially provide vital information to assist in the protection of children.

2.3 Definitional Problems with Child Abuse

There has been on-going debate on the universal definition child abuse. For clarity, this study would adopt the World Health Organisation (WHO) (1999) definition of child abuse. According to WHO, child abuse or maltreatment constitute all forms of physical and/or emotional ill-treatment, sexual abuse, neglect or negligent treatment or commercial or other exploitation, resulting in actual or potential harm to the child's health, survival, development or dignity in the context of a relationship of responsibility, trust or power.

Child abuse has been identified as an age-old social problem (Bavolek 2016; Green 1995) and has gained considerable attention worldwide in recent years. Despite this some (Reisig & Miller 2009) think of child abuse as a social construct as a result of how cultures accept or disapprove parenting practices and customs. The reason for seeing child abuse as a social construction is also captured in Reisig & Miller (2009, p.22) who stated that;

> "Just as with concepts of fear and death, parenting practices are socially constructed. Cultures construct the meaning of "proper" and "improper" practices for parents. Society imposes these constructs on individuals from the time they are children, creating deeply ingrained values and beliefs of what parents "can" and "cannot" do with or to their children… Cultural practices are socially constructed beliefs that are perceived differently between cultures."

However, historical evidence suggests that child abuse has been an age old phenomena (Green 1995; Krugman 1995). Reisig & Miller (2009) argued that while several cultures would accept that a child should not be abused, the difficulty centres on essentially defining what parenting practices and customs explicitly establish abuse. If each culture interprets

their childrearing and customs as fruitful and positive to children, conceivably it is not possible to unanimously define acceptable childrearing practices and child abuse (Reisig & Miller 2009).

The definition of child abuse has broadened according to (Fallon et al. 2010; Munro 2008). However, there are still arguments about a universal definition. According to Raman & Hodes (2012), clinicians working with children who are from racially and linguistically different societies, are entangled with the difficulty to identify whether a child has suffered abuse and neglect as defined in child protection practice. For this reason they suggest that the clinician should first inquire about the child's family culture (which can be challenging) in enable the professional give suitable child protection guidance and /or shape the treatment to suit the child.

In the case of Nadine Montgomery (a diabetic pregnant patient) versus Lanarkshire Health Board gynaecologists failed to tailor care to suit a diabetic patient who was in labour. The doctor did not explain to the patient the treatment options for diabetic patients to allow the patient to make a choice. The doctor applied a Bolam Test which the court found was inappropriate. The failure of the doctor to provide such information for the patient resulted in the patient delivering a baby with shoulder dystocia and cerebral palsy. The consequence to the hospital's board was a £5.25 million damages in favour of the patient (The Supreme Court of Scotland 2015). The failure of the doctor to provide such information for the patient to consent or disagree resulted into the patient delivering a baby with shoulder dystocia and cerebral palsy a condition associated with children of diabetic pregnant patients. The consequence to the hospital's board was a heavy fine of £5.25 million in damages in favour of the patient (The Supreme Court of Scotland 2015).

Seeking consent of the patient to apply any intervention abounds in medical literature. The radiographer could face similar challenges in cases of suspected child abuse as a result of what the radiographer may deem as child abuse. Kraft (2011) having identified the possibility of this due to the definition controversies cautioned that good communication is essential if the child requires to be investigated. In that regard, Kraft indicated that the clinician caring for the child (usually the paediatrician) has to meticulously indicate his or her concerns to the family or caregiver, explain the imaging procedures scheduled and the

disadvantages and benefits associated with the examination and indicate this in the patient's case folder.

The problems associated with child abuse definition are multi-factorial and according to Davis & Reeves (2006) the concept of child abuse can be vague because, child upbringing relies on customs and the values of a community in dealing with children. Moreover, what one culture accepts as abuse would be unacceptable to another's cultural values. In this regard, Raman & Hodes (2012) argued that culture should be considered to be clear about definitions and appreciate the features of cultural identity development. Davis & Reeves (2006, p. 162) states that "child concept of child abuse is dependent upon a society's values at a given time. As any society evolves so does its value base, which in turn is reflected in its treatment of its members such as children".

Culture is fluid and dynamic, transformational changes are possible in a society (Zechenter 1997). For example, Davis & Reeves (2006) (citing the case of children in the UK during the 19th century) indicated children were permitted to work in the mines and factories; a practice which has long been reformed because the cultural values and laws of UK changed. It has been emphasised that child abuse must be understood from the cultural context in which the phenomenon happens (Oneha & Magyary 1992; Korbin 1991).

Campbell (2005) also linked the difficulty in defining child abuse to cultures accepting their cultural values and child upbringing practices. Olson & Stroud (2012) related the problem of achieving a standard definition of child abuse to the classification and the complexity of relying on specific descriptions of the concept to provide evidence of abuse. Munro (2008) added that the disagreement in establishing what constitutes child abuse has led to serious problems in the study of the construct. To Munro, the main idea is unclear, challenged and fluid. She further argued that in examining the wide-ranging definitions, the same absence of exactness of what child abuse constitutes is found. The disagreements surrounding what constitutes child abuse led Davis & Reeves (2006) to conclude that the definition of child abuse could be an imprecise phenomenon (Davis & Reeves 2006).

The public disagreement over what forms of child nurturing pose danger is a concern according to the National Academy of Science [NAS] (2014). Besides that, is the argument

about whether it is appropriate to link child abuse to adult characteristics and behaviour and the effect on the child, environmental context, or some combination of these factors are among the contributing factors of these confusions (National Academy of Science [NAS] 2014). NAS argued that the confusions over standards of endangerment or harm to be used in developing definitions and disagreements over whether comparable meaning of abuse should be applied in scientific, legal, and clinical situations are another unsettled matter. However, the over-dependence on child protective service's standards of abuse derived from ambiguous local laws and practices have also contributed to the controversies and criticisms suffered by previous studies (Manly 2005). The disagreements of child abuse have made deducing and relating research data in the area from various countries difficult and a challenge (Gilbert et al. 2009a).

In most countries, four main categories of child abuse are mentioned in literature which is physical abuse, neglect, sexual abuse, and emotional abuse (Denham 2008). A study (Feng, Jezewski & Hsu 2005) of Taiwanese nurses' understanding of the concept of child abuse found that the majority of the nurses defined the concept as the physical abuse of children. According to the study, the nurse expressed their limited understanding of child abuse and claimed that child abuse is physical harm of children. Their reason for this definition was that it was not easy to identify psychological harm within a limited time frame and as such defined child abuse as physical damage (Feng, Jezewski & Hsu 2005). To establish that a child has been abused is a difficult decision for any profession (Tite 1993).

A WHO (2002b) report suggests the need for exploratory studies on diverse cultures to interpret the standard disciplinary behaviours of cultures. This is important in the current study whose setting is multicultural and different understandings may be given to what constitutes abuse as a result of cultural values and practices. The WHO is of the view that, the diverse forms of discipline among the various cultures could aid nations to have operational definitions of child abuse which would deal with matters of cultural differences within their jurisdictions. In the USA, the legal definition of child abuse differs from state to state (Burns et al 2000). In the African situation, definition of child abuse is besieged with problems of unclear distinction between abuse and discipline because of the differences in the cultural perspectives (Lachman 1996). The myriad of cultural practices and affiliations in Africa supports the assertion made by Lachman that, a behaviour or

50

practices considered as abuse in one culture would on the contrary be acceptable in other cultures. Abuse in Africa could be tackled through stringent laws and constant education and of the public about the consequences of the child abuse.

According to Mok (2008), child abuse involves the act of commission or omission, which directly or indirectly results in harm to the child and this may prevent a normal development of the child into healthy adulthood. Previous studies (McGloin & Widom 2001; Luthar, Cicchetti & Becker 2000) have also demonstrated that children who exhibit resilience do not develop this kind of growth despite their childhood difficulties and become strong and successful. However, irrespective of a child's outcome to adulthood, child abuse generally is unacceptable.

Korbin (1991) pointed out that a suitable cultural definition should be adopted in assessing child maltreatment and neglect. However, this could pose yet another problem because suitable cultural definitions in every different cultural environment may lead to cultural relativist point of leaving every culture intact even if that culture out of which the definition has been carved is not only dangerous but outmoded. Meadow (2002 p. 1), who shares a similar view as Korbin's, defined child abuse by taking the cultural context under which the abuse is committed into consideration and stated that, "a child is considered to be abused if he or she is treated in a way that is unacceptable in a given culture at a given time". However this will also imply that if the act against the child is acceptable by that culture then it does not constitute an abuse even if the child is harmed.

Despite the diverse interpretations, views and definitions of child abuse, the concept pivots on the cultural values of a society at a particular time, and as the society becomes multi-ethnic, it characterises the basis of its values which show the way its members are treated (Glaser & Prior 1997). The complexities of child abuse and neglect explain why the working definition of the construct has been problematic to researchers and child protection services especially when it is defined under certain specific context within which the abuse has occurred. The WHO examined the various definitions assigned to the concept of child abuse from various countries and cultures and came up with a broad definition of the phenomenon even though most of the definitions considered had similar characteristics.

The WHO (1999) on Child Abuse Prevention in Geneva defined child abuse as "any act, or failure to act that violates the rights of the child that endangers his or her optimum health, survival and development" and further reported that "child abuse, or maltreatment, constitutes all forms of physical and/or emotional ill-treatment, sexual abuse, neglect or negligent treatment or commercial or other exploitation, resulting in actual potential harm to the child's health survival, development or dignity in the context of a relationship or responsibility, trust or power". Despite this broad definition, some cultures are either contradictory to the WHO definition or do not apply it in full to protect children against abuse in dealing with child maltreatment.

In a study of nurses' definition of child abuse in Taiwan, Feng et al. (2005) discussed that the absence of agreement in the definition of child abuse among health care professionals complicated the progression of care and disclosure of child abuse cases, which often led to clashes in the nursing occupation. This situation could also be happening among other health care professionals such as radiographers. The study of Feng et al. (2005) also suggested that Chinese culture was a barrier to nurses' decision to disclose child abuse. The Ghanaian cultural influence on health care professionals has not been given such attention to conclude that it hinders the disclosure of child abuse or has resulted in conflicts among the professionals such as radiographers.

2.3.1 Consequences of child Abuse

Child abuse has been described a 'toxic stress' (Jaffee & Christian 2014); the consequences of it have been reported in literature (Asnes and Leventhal 2009; Briere and Jordan 2009; Gilbert et al. 2009a; Briere & Elliot 2005; Bergen et al. 2004). Studies (Jaffee & Christian 2014; Morgan 2013) have shown that detrimental child upbringing provokes major biological changes in children known as biological embedding. In explaining biological embedding, they argued that child abuse has been identified to be a 'toxic stress' which could affect the brain and the nervous system. A child in an environment of chronic abuse and abject hardships would be negatively affected in its growth and development (Morgan 2013). Moreover, children under toxic stress could have their immune system weakened which exposes them to several health challenges (Jaffee & Christian 2014).

This in turn alters their developmental biology and the operating balance of the body's stress responding systems (Danese & McEwen 2012; Rogosch, Dackis & Cicctti 2011). The continual activation of the stress responding systems (also known as allostatic systems), lead to progressive wear and tear which has lasting consequences on natural aging and health (Danese and McEwen 2012; Rogosch, Dackis & Cicctti 2011). Ansell (2005 p. 9) has stated that, "childhood is not a natural physical category; there are biological and physiological facts that constrain and shape children's lives, particularly in early childhood."

Children develop at different rate and in each phase of their life they could be affected by several human and environmental activities which may negatively or positively affect their progress. For example, the effect of child physical abuse (CPA) can be a short term which embraces relational disorders and psychological problems, low self-worth, desperateness and negative work coordination in adulthood (Mrug et al. 2008; Taft et al. 2008). Noted among the acute and long term consequences of CPA are behavioural problems psychopathic symptoms, prolonged physical illness (Allen 2008; Kilcommons & Morrison 2005; Lang et al. 2002). CPA also leads to both externalising and internalising problems, such as substance abuse, aggression, hopelessness and disquiet (Kiff, Lengua & Zalewski 2011; Fergusson, Boden & Horwood 2008) with high increase in threat of committing suicide among the most serious effects (Swogger et al. 2011; Pompili et al. 2009). Previous studies also showed that the individual's emotional wellbeing has a strong connection to previous childhood experiences (Cox, Kotch & Everson 2003).

2.4 Non-Accidental Injuries (NAI) in Children and Identification

Non-accidental injuries sustained by children are acts that result from child physical abuse (Giardino 2016; Child Welfare and Information Gateway [CWIG] 2014; Doheny, Davis and Grehan 2014; Hattingh 2007). According to the WHO (1999), CPA is that which results in actual or potential physical harm from an interaction or lack of an interaction, which is reasonably within the control of a parent or person in a position of responsibility, power or trust. There may be single or repeated incidents (WHO 1999). The prevalence of CPA is difficult to determine and be compared among nations; it usually occurs behind

closed doors and to vulnerable children, some of whom have been coerced into "keeping secrets" (Mok 2008).

The initial recognition or suspicion of NAI in children is the most important step in child protection process (Barber & Sibert 2008). Similarly, it had been argued that diagnostic imaging is the number one method of investigating NAI (Brown & Henwood 1997; Hogg et al. 1999). According to Brown and Henwood (1997), diagnostic imaging has played a historical role in detecting NAI. The responsibility to recognise CPA lies in the hands of all those involved in the care of children including diagnostic imaging professionals (Hattingh 2007). Notably, it is impossible to recognise any signs and symptoms which point to CPA if particularly clinicians in the emergency departments and also paediatricians fail to apply the needed clinical expertise and good decisions (Falherty and Stirlin 2010; Newton et al. 2010). The skills of the clinician are paramount in this direction (Glick, Lorand & Bilka 2016). For example, radiographers confronted with NAI cases should look for unusual bodily conditions, properly evaluate the quality of images produced (Davis & Reeves 2006; Hogg et al 1999), and correlate the identified injury with the clinical history provided to establish whether the injury was accidental or non-accidental. Moreover, incidental findings (such as rib fractures identified on a chest X-ray) with no clinical history of trauma should be taken to indicate possible physical abuse (Cary 1997).

Fractures in children indicate major traumatic events and not just falls from low heights (Robben 2006). Robben noted that fractures of high specificity for CPA are the classical metaphyseal corner or buckets handle fracture which is pathognomonic for abuse; rib fractures which are very common and highly specific for abuse in young children below two years. According to (Carty 1997) Carty (1997) indicated that fractures of the clavicle have a low specificity to identify NAI; however, this is acceptable when birth injuries are isolated. Moreover, fracture of the clavicle caused by accidents is common with infants below 2 years. Fractures of the clavicle, even if excluded, are relevant in NAI consideration (Carty 1997). A Metaphyseal fracture which usually occurs at the knees and ankles (though can occur at the upper limbs) is key signal of abuse (Carty 1995). Carty argue that metaphyseal fractures are caused by twisting and shearing mechanism and these injuries are precise to physical abuse when exceptional metabolic bone diseases are excluded. Skull

fractures occur with considerable force to the head however, spinal fractures are not commonly seen with child abuse as compared to limb and rib fractures, they do arise (Carty 1997). Even though not all fractures are indicative of abuse, it is most important to be guided by the complete medical record or information and in partnership with clinicians in making distinction between fractures consequential of accidental trauma or child abuse (van Rijn & Sieswerda-Hoogendoorn 2012). Highlighting this issue, they explained that child abuse could lead to legal tussles. With radiographic interventions, it is necessary to have adequate clinical history that fits the identified injury before conclusions can be made of the cause. Thus, the possibility of differential diagnosis should not be ignored (van Rijn & Sieswerda-Hoogendoorn 2012; Kleinman 1998).

CPA may be recognised by various groups of professionals such as healthcare providers, social workers, teachers, and non-professionals such as neighbours and families. The suspicion of NAI could result from the nature of the harm identified on the child such as an injury to any part of the body where blows are usually hit, or with a characteristic appearance (Jacobi et al. 2010). Injuries identified in NAI include but not limited to head injuries, retinal haemorrhages, failure to thrive, loop mark bruises or welts on the skin (Fraser et al. 2010; Jones et al. 2008). They further argued that abuse is probable where a child or infants present with spiral fractures, anogenital injuries, diminished rectal tone, various forms of burns made-up or induced illness, while caregivers failed to explain the injury. An in-depth description of the cause of NAI in the form of history taking should be obtained immediately after the incident has taken place and should be documented by the doctor (Kodner & Wetherton 2014; Jacobi et al. 2010) including information provided by witnesses. Moreover, Jacobi et al. (2010) suggested that meticulous physical examination of the victim is required which should be properly described and documented. The documentation should include new and old findings, all bruises and scars using the organisation's generated diagrams or body maps (Legano, McHugh & Pallusci 2009).

Misperceptions exist about fracture types and locations which can be considered to be at a higher risk of NAI in cases of physical abuse which results in fractures (Nicholas et al. 2012). They admit the difficulty involved to agree on whether an injury was accidental or not, and the challenge is depending exclusively on the appearance of fracture to make a

case as such other dynamics need to be examined when assessing the child. It has been previously suggested that when child abuse is suspected, attention should be given to every possible response ranging from a chat with all stakeholders from the child's social circle, to informing the child protection office or the police in cases of serious maltreatment (Jacobi et al. 2010).

Besides taking history and physical examination, the victim's psychosocial situation such as characteristics of the parents, child's disposition, social status and relationship biography should be established (Jacobi et al. (2010). It is also necessary for clinicians to watch the parent's warmth towards the child, (though this can be subjective and misleading as the carer or parent may not be the perpetrator) (Hecht & Hanseen 2001). They suggested that the clinician should look for any sign of inadequate empathy, and any suspicious behaviour of the parent.

Fundamental to these approaches, the clinician is also required to observe whether the caregiver aptly identifies with the child's predicament or shows any reluctance to think about the child's situation (Jacobi et al. 2010; Hecht & Hanseen 2001). The individual and family characteristics which appear to be a pointer to a child at risk of abuse should be watched (Liao et al. 2011).

2.5 Child Protection and the Systems Approach

Child protection is the heart of the UNCRC (1989). The CRC has been endorsed by several nations because child protection is a critical issue and of great concern to most countries. Child protection it is said could be enhanced when several individual professional groups and state organisation within the various countries collaborate (Lalayants & Epstein 2005). However, the acknowledgment made in the CRC by nations that children's rights be protected by laws and policies, children continue to be exploited (Mulinge 2002). UNICEF (2006), defines the term 'child protection' to denote the prevention and responding to violence, exploitation and abuse against children – including commercial sexual exploitation, trafficking, child labour and harmful traditional practices, such as female genital mutilation/cutting and child marriages. Similarly, Save the Children (2013) described child protection as a set of measures and structures to prevent and respond to abuse, neglect violence and exploitation affecting children.

Similarly, Save the Children defines the concept as a set of measures and structures to prevent and respond to abuse, neglect violence and exploitation affecting children (Save the Children 2013). Though these standard definitions of child protection could be applicable to several societies, cultural norms and societal behaviours in some communities would make its adoption a difficult venture.

The need to ensure the continuity of children's wellbeing and protection (safeguarding) efforts led UNICEF to take action on the safety of children worldwide resulting in child protection ranking high in all UNICEF initiatives (UNICEF 2008). International agreements on children's rights suggest that no child should be denied the right to get protection against maltreatment (UNICEF 2008). This agreement on protection is not targeted to a particular people, agency or professions as all those involved in the upbringing, development, and welfare of children (including health and education) have significant responsibilities in seeking the best interests of the child. However such an expectation is only possible when abuse is identified, reported and the necessary actions taken by all stakeholders responsible in child welfare issues.

With the growing knowledge and concern of child brutalities, and its attendant consequences, the United Nations (UN) was concerned about the approaches used in protecting children and consequently, established a model known as the systems approach that could help in protecting this vulnerable population of the world (UNICEF 2010).

A system is an inter-related part which is operationally structured (Booy 2005). The health care system consists of the congregation of individuals and professionals (representing the parts) who are structurally defined to provide care. The functionalists understand society as the assembly of parts or elements such as religion, education family and others that work in cohesion to produce a shared outcome (Whitcombe 2005). Booy (2005) explains that the entire system (the whole) is more important than the individual parts. However, the integrated parts of a system are influenced by each other and when the performance of any part is changed or separated, the whole system becomes disturbed and for that reason each element in the system is also remarkable (Booy 2005). Child protection systems have distinctive constructions, purposes, capabilities, and other constituents. The system

approach coined by UNICEF was aimed at guiding member nations to plan or set up appropriate child protection systems befitting their circumstances (UNICEF 2010). Central to the UNICEF (2010) model is a multiagency approach to child protection which comprises health, social welfare, justice system, and education. This was initiated as a result of the determination to create strong child protection systems in contrasts to the old issue based method (Save the Children Fund [SCF] 2010).

The change in direction to focusing attention on systems by organisations working on child protection resulted from several considerations. According to the SCF, amongst the issues that brought about the change in focus were approaches which were not harmonised in dealing with protection issues and therefore its impact were not felt, especially those articulated by the bigger child protection agencies [i.e. United Nations High Commissioner for refugees (UNHCR), UNICEF and SCF. The Save the Children further enlisted other essentials that forced change in focus to include anxieties about destabilisation of prevailing national and civic protection practices, and an increasing awareness of children's experiences- which in most part, specified a variety of interrelated protection mechanisms which did not work.

Several international organisations such as UNICEF, SCF, and UNHCR are embracing the systems approach to create, reinforce and provide a holistic approach in the child protection efforts (UNICEF 2010). Besides the systems approach, multidisciplinary training at the undergraduate and / or postgraduate level would help provide this holistic care as trainees would understand why they need to work together in child protection. The systems approach has been an unexplored area for many state policy enactors and practitioners; the approach is driven by the Convention on the Rights of the Child (CRC) in contrast with previously upheld model which had usually centred on a single situation such as child trafficking, street children, child labour, emergencies, institutionalisation, or HIV/AIDS (UNICEF 2010). Although the traditional model of child protection had produced significant benefits, it had several problems; response to child protection was not coherent and usually not well-organized and with other important necessities unmet (UNICEF 2010).

Within the umbrella of the CRC, other human rights conventions, agreements and national laws, governments are obligated to protect children (Karlsson, Stuckenbruck & Cecchetti 2010). However, they recognise that parents are exclusively accountable in nurturing their children and seeing to their growth, with support of families, and the community, as well as their unequivocal role with the protection of their children. The healthcare institution is also a system involving several parts or departments with professionals working to move the system. Radiographers form part of this system and have a stake in the bigger picture of child protection.

2.5.1 Multidisciplinary Approach to Child Protection

Though child protection is a critical issue and of great concern to most countries, it could be advanced when several individual professional groups and state organisation within the various countries collaborate (Lalayants & Epstein 2005). As a serious public health problem, the prevention of child abuse requires a multidisciplinary approach and effort (UNICEF 2010). Moreover, there is substantial similarity in child abuse recognition by health professionals and by professionals such as the police and social services (Sanders and Cobley 2005). They argued that because child abuse takes place outside the hospital environment, this necessitates the expertise of several professionals to manage the situation. This concern necessitates the consideration of UNICEF's (2008; 2010) systems' approach to child protection in the current study to ascertain how Ghana has fared in child protection. Coordination of work by professionals at all times has been an overarching subject in health and social care (Wilby 2005). As a result of having a work system that is all-inclusive where team working is the norm, several terms such as joined up working, multi-professional team working, collaborative working and working in partnership) have been used to sum up this aspiration (Wilby 2005). The advancement of patient journey through health care provision relies on several individuals and professionals working in harmony (Komet 2001). Each individual in the team is viewed as having a body of knowledge and expertise which brought together enhances patient outcome.

Child protective services (CPS) depend on frontline health professionals to conclude whether a child's injury was caused by abuse (Mudd & Finlay 2004). Accepting this fact implies that each healthcare provider has some information to aid the child protective

services (and the investigation aspect as well), to carry on with their mandate of securing the wellbeing of a child at risk and in need of protection. Radiographers are in a position to provide quality images and other relevant information to the CPS as continuity of evidence to advance the intervention in child physical abuse cases such as the quality images they produce as reported by several authorities such as (Davis & Reeves 2006, 2004. Hogg et al 1999)

Healthcare involves several professionals all working to promote the welfare of patients including children suspected to have been physically abused. Diverse roles are played by various professionals in matters related to child abuse; however, each professional has a different knowledge and competence, and hence defines and responds differently to child abuse and a decision to report (Feng et al. 2010). Rigney & Davis (2004) refer to child protection as a Jigsaw; meaning that each profession plays a role in the child's life (Phelan & Davis 2015). In borrowing their analogue, the jigsaw will not be complete in child physical abuse intervention and prosecution of culprits without the imaging role of the radiographer in such cases.

Scott (2007) is of the view that institutions that inspire collective discussion of issues inclusive of relevant staff members irrespective of their positions, promotes better outcome with more fruitful work environment for all and in particular the patient. This encourages information sharing, enhances work performance which benefits all staff including the radiographer (Scott 2007) and most importantly the patient who need the service.

The greatest cause of child admissions in hospitals has been attributed to maltreatment (Forjouh 2000). Health professionals are the initial point of contact for identifying the condition as evidence and their approach to determine children at risk of abuse is crucial to any further resolution of their conditions (Sanders & Cobley 2005). According to Glaser and Chen (2006), central to the management and elimination of abuse of young children is the ability of clinical staff to be able to diagnose, and report abuse to key stakeholders in the chain of abuse resolution when such incidences occur. The failure to communicate and collaborate appropriately between healthcare professionals and other agencies dealing with child abuse could lead to serious consequences which may be irreparable. According to the

US Department of Justice (2001), the expertise of each individual although dissimilar, is equally significant in helping children in abusive situations.

The death of Baby P in the UK who suffered multiple non-accidental injuries as a result of abuse is a typical scenario of system failure of agencies (including healthcare) working with children, as reported by the investigative panel on the case (Haringey Local Safeguarding Children Boards 2009). Professionals, as noted by the investigative panel, did not work collaboratively to safe this child even though there were opportunities to do so. Several agencies though were blamed, and the health professionals' inappropriate handling of the case when Baby P was brought to them for medical attention was highlighted because the child's injuries should have prompted further action from the professionals to secure the child's life beside the medical treatment.

What happened to Baby P-could happen to any child in Ghana which may not come to public attention for scrutiny. In response to Baby P's case in the UK, Ball (2013) indicated that once children face some threats, it is the expertise, self-assurance and decision of lead professionals which make the major difference in helping out such children. Radiographers, being experts in their field, should be seen and viewed as among the front line health professionals capable of securing the safety of children at risk of physical and other forms of abuse through collaboration with other professionals.

Laming (2010) (who chaired the public inquiry into Victoria Climbié's death in the UK and led a review of failures of social services in the wake of Baby P's tragedy indicated that in the case of seven-year-old Khyra Ishaq, who was starved to death in May 2008, various organisations did not collaborate or communicate with each other to provide the needed information to help the child. Vital information that could have been shared was thus not made available.

Drawing from the above argument, it might be concluded that inter-agency and multidisciplinary collaboration failures result in aggravating the plight of vulnerable children. Radiographers share information through providing quality radiographic images and have the opportunity to observe body marks on children undergoing imaging procedures which may raise suspicion of abuse. It is therefore relevant to this current study

61

to examine the critical role of radiographers in child protection efforts in the Ghanaian setting.

Despite these proclaimed benefits, several problems exist in multidisciplinary teams working in health care which need to be addressed by first looking at its causative agent/s in healthcare delivery. Four key areas define organisational culture: individualism vs. collectivism, low power distance against high power distance, low risk-taking versus high risk-taking, and patriarchy vs. feminism (Bialas 2009. In every human institution there is inequity and it is power distance that defines this inequity (Rafiei et al. 2013). The greater the supremacy of a group, over another (power distance) in an organisation, the outcome could be organisational injustice (Rafiei et al 2013). They argued that this kind of power or supremacy leads to undemocratic governance of the system and those at the low power level of power could become disenchanted. The high medical power of doctors over other professions allied to medicine could create disaffection among the other professions in health.

This situation could also have negative impact on a professional's motivation and capacity to identify and report a suspected child abuse incident. While the issue draws attention to professional failure in these episodes, it is appropriate to examine professions and professionalism and how it impacts on child protection.

2.5.2 Multidisciplinary Challenges in Child Protection

Healthcare occupations have reached a period of growing demand for better-quality healthcare established on inter-professional cooperation from politicians, health policy experts and intellectuals (Salhani & Coulter 2009). While these demands are necessary, individual professions are rather seeking their own interest by working to protect professional boundaries and pressing for self-rule through state support (O'Reilly 2000). In order to stimulate a unified provision of care, collaborative working among healthcare professionals has been advocated. However, collaboration does not happen impulsively (Margaret, Kate & Andrea 2016). They noted that effectual communication is key to operative coordination, particularly in a crisis situation in health care. The Institute of Medicine (2003) found that good patient outcome will be achieved when healthcare

professionals appreciate, the roles of other occupations, communicate perfectly and work as teams within healthcare delivery. This collaborative working is improved through joint education of individual professions to receive specific training, remove barriers and promote the understanding of each other's roles. The method of joint training in an establishment with the capability to advance its operations, performance and outcomes is known as organisational learning (Ratnapalan & Uleryk 2014).

Health institutions operate through several individuals and groups comprising professionals and non-professionals alike and each with different expertise, work together to achieve harmonised care for the patient (Ratnapalan & Uleryk 2014). In child protection, several professional groups agree that, child abuse is a critical issue which can best be tackled through cooperation among the groups (Glissen & Hemmelgarn 1998). While this teamwork should advance child protection with the common objective of child security, the truth is that several factors impede efficient collaboration among health professionals (Nayda 2012). Considering the wide power asymmetry within healthcare professions especially between doctors and other occupations, there is a need to examine multidisciplinary learning and how it can create changes in working together to provide safer care.

The examination of professional behaviour has been recognised to yield a better outcome in child protection activities especially in reporting of suspected child abuse (Feng & Levine 2005). Safe provision of patient care is enabled by individual professional learning, inter-professional group learning and system based organisational learning (Ratnapalan & Uleryk 2014). They argued that professionals learning together could help in changing the existing framework guiding clinical practice, and provide specific knowledge to individuals and the professional groups in a health institution (Ratnapalan & Uleryk 2014). They suggest that institutional education in health care systems is fundamental to dealing with the learning necessities in multifaceted but unified dynamics systems. They contend that under such a learning system, it is expected that mutual and contextual understanding of a common but greater awareness of roles and tasks to perform given roles are known by each and every one. This is to communicate and allow the transfer of pertinent information and together, offer safer care (Ratnapalan & Uleryk 2014). However, regardless of the benefits of collective expertise of healthcare professionals, the individual professionals are trained

separately in their own field from the others and besides, have separate roles (Engum & Jeffries 2012) which leads to separatism amongst the professions.

Due to fear of losing professional power and attempting to protect self-rule during professional collaborations, the existing attitudes of power differences thwart useful communication and group efforts in child protection within interdisciplinary team working (Feng et al. 2010). They argued that the misunderstanding surrounding who to do what, role expectations, and who to direct the team arises between disciplines in the process of child protection. They assert that group effort in reporting is essential to reduce continual questioning of victims and advance reporting effectiveness.

The care teams have to coordinate and communicate among their team members and with other teams to function in a cohesive manner to execute the highly coordinated and high risk activity that is called patient care (Ratnapalan & Uleryk 2014). Situating this argument in child protection, it requires the commitment of individuals and groups to ensure successful but better outcome for the victim. The RCPCH (2008) recognise the importance of individual contributions in dealing with child abuse cases. Moreover, the RCPCH indicated that radiologists should be conscious of the fact that evidence from imaging will add to diagnosis but that caring for the child is contingent upon the input from all participants in the clinical and broader child protection team. This also implies that inappropriate medical assertiveness and dominance of their opinion over other professions contributions, would lead to a poor outcome of care.

It is known that the actions of health care managers in providing leadership and commitment to continuing patient safety activities, setting expectations for greater performance, and showing the way with marshalled determination lead to better results (Conway et al. 2006). In contrast, Conway et al contended that with extreme power hierarchy where superiors are far to reach, the active participation and meticulous attention of the leader to committing personnel at all levels across the establishment is bound to yield greater outcome. They concluded that there should be established multidisciplinary collaborative practice frameworks at all levels of control, incorporating the practices, clinics, and programmes.

Failures in multidisciplinary team working have been attributed to the absence of shared goals and consistent staff meetings (Wiles & Robison 1994). Staff meetings bring clinicians together to share and bring out issues of mutual interest which enhances best practice to the benefit of the patient. In contributing to the discourse of inter-professional team working in the hospital, Epstein (2014, p. S295) stated that

> "teams, acting as "well-oiled machines," counteract the "silo or halo effect" (e.g. characterized by the "I am too important because I am…"), break down communication barriers between specialists, and provide better cooperation among all specialists. Utilizing such cohesive teams limits adverse events… improves patient outcomes, decreases patient length of stay, and increases patient satisfaction".

This probably, would work in a system which attempts to avoid divided attentions on goals and ensuring regular discourse through meetings.

The next section examines professions and professionalism and medical dominance and how they affect inter-professional team working in securing the wellbeing of children suffering from physical abuse.

2.6 Professions and Professionalism in Patient Care

The subject of professions is particularly a contested zone (Wilson 2012). Wilson argued that conventional medicine has been exposed to confusion as a result of universally accepted groupings of occupation-driven set of hierarchy, with its impact, negatively affecting how healthcare is provided and managed. Reeves (2002) had observed that the sociological origins of medical power explain the reasons behind the high status enjoyed by the medical profession. Occupations preserve supremacy through social confidence and/or state backing (Kent & Manca 2014). They are of the belief that for the continuous sustenance of a profession, academic scholarship is crucial. In citing Abbott (1988) they quoted that,

> "The ability of a profession to sustain its jurisdictions lies partly in the power and prestige of its academic knowledge. This prestige reflects the public's mistaken belief that abstract professional knowledge is continuous with practical professional knowledge, and hence that prestigious abstract knowledge implies effective professional work" (Abbott 1988, 53–54).

Reeves (2002), in her contribution to this discussion, explained the history of radiography and the professional restrictions they encountered in their practice. By the 1920's radiographers were prevented by radiologists from reporting on radiographic images. The accepted notion about radiographers at that time was that they were not medically trained and the fact that their work was under the supervision of radiologists, put them in a subservient position (Reeves 2002). This has also been observed in several countries such as in Australia (and in Ghana) where radiologists are the powers in authority in the imaging departments (Lewis et al 2008).

Initially, radiography was noted to be a predominantly female profession because it originated from nursing (Reeves 2002), and has to date experienced patriarchy because the medical profession was male dominated (Wicks 2005; Abbott 1988). According to Reeves, when radiography begun to admit males, the profession started to pursue the support of radiologists and this marked the beginning of the dominance of radiographers by radiologists. According to Ferris (2009) until recently, the profession of radiography was not bothered about being under the control of radiologists. Reeves(2002) explained that the profession of radiography developed from the nursing profession and later when radiographers wanted to identify themselves separately, elected to work under the radiologists with the hope of gaining recognition. Ferris (2009) argued that the professions of radiography and radiology, although synergetic, had remained in this supposedly, comfort zone of radiologists' dominance, in preference to advancing their work to the status of a profession. However, radiography has recently advanced through technology changes and as a result bringing new and advanced roles in the imaging profession. The advancing roles of the radiographer as a result of newer technologies in the practice have brought into the profession new academic and professional scholarship leading to an era of radiographers working towards a higher status and recognition (Field & Snaith 2013; Griffiths 2013).

Ferris (2009) in a study of specialism identified from radiographers she studied that professional recognition was key to their job satisfaction. However to attain this professional recognition required career development (Ferris 2009; Sim & Radolf 2008) which in the case of radiography, was tactlessly governed by radiologists who directed the confines of the radiographer's practice (Ferris 2009). The reason, according to Ferris, was

to support the principles of radiology profession rather than radiography; a practice which may have hampered the progression of radiography into a full professional status.

Radiography has advanced despite these difficulties because its practitioners are now moving into the domain of radiologists, and are seen reporting on images and performing other specialised procedures which were in the domain of the radiologists. Wilson (2012) examined medical supremacy and weakened notions of professionalism. He questioned the rationality by which the medical profession within an area of universal professions maintained such a position. Wilson further argued that medical dominance is weakening despite their attempt to maintain their power in healthcare. The worries confronting the medical governance of health systems, among others is the shifting roles of healthcare occupations other than the medical profession, who are found performing roles, which were formerly the province of medicine. Radiographers are currently found performing roles '*specially reserved for the radiologists*'. However, Ferris (2009) observed that radiographers who have assumed these new roles previously performed by the radiologists, faced difficulties particularly with radiology registrars who did not appreciate the radiographer's boundary crossing. This was not because radiographers were competing with these radiologists but rather it was/is role advancement in their career. In team working, professionals allied to medicine need to be self-confident of their expertise and bring it out to advance care outcomes. A multidisciplinary group is one in which professionals have shared objectives however, due to the numerical dimension and constitution of these experts, confusion usually occurs among them (Pellet 2005). Despite these challenges, several writers (Atwal & Caldwell 2005; Pellatt 2005; Bronstein 2003) have maintained that it is essential for all professionals within a team to identify and show fortitude in their own responsibilities irrespective of the group's make up and also show understanding of the characteristic and expected social behaviour of other team members (Caldwell & Atwal 2003).

2.6.1 Medical Dominance and Co-ordination among Professions in Care Delivery

One important aspect of child protection is the inter-professional team working through appropriate collaboration. Freeth & Reeves (2004) recognised that multidisciplinary team working among health care professionals is a gold standard in advancing health care outcomes in the Canadian health care system. However, these noble aspirations that could

be derived from several professionals working in collaborative enterprise are thwarted within the health care organisation as a result of power dominance. The last five decades of healthcare failed to recognise the significance of collaboration and doctors, besides having power over other staff had the sole responsibility of managing quality and safety with everyone else playing the subservient role (Wachter 2012).

Over two decades ago, it was found that, in most English speaking countries (including Ghana), the medical profession has established supremacy, self-governance and power across several areas of health care services (Kenny & Adamson 1992). As a result, the "lower" professions appeared disillusioned about their significant contributions to healthcare which appeared lacking the required attention. These problems have mostly resulted from power distance culture established in healthcare services by medical dominance of nursing and radiography several decades to date (Holyoake 2011; Yielder & Davis 2009; Lewis et al. 2007; Brannon 1990; Hazelton 1990). The reality of this situation is a manifestation of the Ghana's health care system where medics are heads of all the healthcare facilities including as departments of all the allied health professions (such as radiography, medical laboratory sciences, physiotherapy and others).

Medical dominance began from within medicine itself (Abbott 1988). Abbott in his seminal paper 'the system of professions', wrote that professional authority within healthcare started with mental health, where the clergy, neurologists and general medical practitioners, all claim authority on mental health. Abbott argued that occupations battle to build and protect their defined rights and interests allotted to them from other groups who themselves do not have it easy preserving and advancing their own elite assertions as a profession.

Customarily, medical supremacy has been the unifying standard in health care practice (Kenny & Adamson 1992). Currently the health system assures cooperation and team based patient centred practice (Bleakley 2011). However, medical power is established through the professional independence of doctors, their significant grip on the economics of health care delivery by their unified administrative influence and authority over professions allied to medicine (Toth 2015; Kenny & Adamson 1992). The question the researcher begs to ask is "what is important in healthcare"? Is it the struggle for autonomy and power in decision making and governance or the service to clients? In the Kenny& Adamson's study

of allied health professions which excluded radiographers, it was identified that the improved self-rule of the allied health professionals has not affected the medical governance in health services.

Yielder and Davis (2009) emphasised that the growth of an occupation demands serious enquiry of exclusive control by one group to allow the preservation of 'best practice'. This should be founded on dynamics such as service to the patient, the effectiveness of the provision, and the welfare of all the professionals involved in the service delivery and not providing care which is founded on old-fashioned models of supremacy (Yielder & Davis 2009). Similarly, the results of several health problems such as trauma care, obstetrical care stroke and others, mostly rest on the effectiveness of working together as a team rather than the cleverness of the overseeing doctor (Wachter 2012). As true as this is, professional space to ensure the togetherness of professions in the delivery of service has become tight with each struggling to get hold of good space leading to difficulties in multidisciplinary approach to care (Bleakley 2013; Wilson 2012; Holyoake 2011; Yielder & Davis 2009; Wicks 2005). Bleakley (2013) argued that while there are enough spaces for multidisciplinary training and other equally important things in health care, professional space is constricted with medical dominance.

Nurses have been cited to be compliant to doctors several decades despite their current obligation to become registered as professionals (Bleakley 2013; Wicks 2005). The situation has sparked off several clashes between the nurse and the doctor as a result of nursing coming of age to become professionals in their own right. In reporting about several ethnographic investigations Wicks (2005), showed the existence of many arbitrations, differences, agitations, and unhidden clashes as recurring features of nurse-doctor relationships at the hospital. These findings according to Wicks, demonstrates the seriousness of a major profession's power over the lesser occupations within the hospital setting.

Attention was drawn by Yielder & Davis (2009) to the risks of giving exclusive right or power to some professions in protection issues. They used the existing professional authority in child protection in their setting as an example and cited the dangers of giving special power to the police, court representatives and the social worker in child protection

matters as the sole child protection professionals. They assert that this selective right enjoyed by these professions could lead to misapplication of that power. It might also be inferred from this assertion that in healthcare, which has similar powers given to doctors over other occupations in care delivery, clashes would be expected and will continue to occur if this domineering attitude of the medical profession is not corrected by the system under which it operates.

All institutions require structure and chain of command, lack of which could lead to confusion (Wachter 2012). However, when the chain of command is extreme or wide, critical information that should reach executives from their frontline staff would either be shelved or the executives would be provided with the information they prefer to receive which may not help the situation on the ground. Explaining this further, Wachter discussed what he terms 'psychological distance' between an employee and the overseer known as authority gradient with its steepness denoted as the hierarchy of the establishment. In furthering the argument of hegemony, Wachter (2012) argued that in healthcare, this has developed some kind of attitude among other professions allied to medicine, to show unconcerned attitudes towards certain care situations. He illustrates the dangers involved in the hegemony of medics over other professions with a case of a nurse, who having assumed that something was not working well, remained indifferent in the face of a doctor's strong but inappropriate assertion. The point of importance of these scenarios is that other professions experiencing similar relationship, may exhibit same attitude of the nurse which may lead to errors and care failures.

Evidence suggest that social workers have also suffered contempt by doctor's egotism and control while doctors and nurses together perceive social workers' mistrust and unwillingness to contribute to information sharing and feedback (Goad 2008; Lalayants & Epstein 2005). This seems to contradict Hollows' (2001) position that in child and family welfare, under the UK Assessment Framework for children in need and their families, social workers will be ordering assessments from other experts (such as clinicians) while appreciating the comprehensive information they receive. However, Hollows (2001) cautioned that the SW should be fair to, and respect, these diverse views. Moreover, she argued that professional sureness is necessary to allow exceptional fusion of needs, concerns and responses to the situation which requires information sharing with other

professionals. The SW's willingness to collaborate with doctors and nurses as advised by Hollows, could however, be affected when the SW feels disrespected by these professionals as was identified in later studies (Goad 2008; Lalayants & Epstein 2005). In recognising these perceptions, Hollows (2001) also indicated that SWs, in most part were not regarded by other professionals (such as doctors and nurses) despite their capacity and skill. However, she urged the SWs to be relentless in their efforts to provide good services to rise above these perceptions and challenges. While SWs had issues with doctors and nurses (Goad 2008; Lalayants & Epstein 2005) another study (Wachter 2012) indicated that many nurses have reported having been ridiculed by doctors when they raised an alarm on issue of care importance. While other professions allied to health face similar challenges, Hollows' advice to social workers should be embraced in order to provide good services and to attain professional recognition. The adage goes that "when two elephants fight it is the grass that suffers". The truism is that when professions clash in the care delivery, it is the patient who suffers.

The current change and complexity of healthcare delivery with newer technologies, prescriptions and processes and the undisputable benefits of coordination, governs whether a patient is carefully and quickly, given the right care (Wachter 2012). A study (Lyndon et al. 2012) found that 12% of nurses were reluctant to show any concern when they felt strong indications of patient safety compromises. The findings of the study also revealed that the probable indication for harm during care was seen differently among the doctors and nurses in terms of their respective responsibilities using the Harm Index Score. In their findings, it was noted that while the possibility of speaking up with doctors about potential harm was to them a new intervention, the nurses reported recurrent subjection to contempt and coercion by doctors. The variance identified between the nurses and doctors as a reference point assessment of possible injury may in part explain the persistent problems in collaboration (Lyndon et al. 2012).

Power hierarchy is expected in health care, and it is to some extent beneficial (Wachter 2012). However, according to Wachter, there could be compromises of safety in the care delivery when taken extreme. Wachter argues that when power hierarchy prevents care providers from giving out their expert knowledge or to provide vital information for fear of intimidation from superiors, disaster should be expected. In creating a culture of safety in

71

an establishment, Wachter further noted that institutions which are safe, search for techniques to bring down pyramids of controls at all levels of the establishment, while inspiring people including patients to voice out their observations when they identify or are suspicious of unsafe situation.

Situating this argument to child protection, similar circumstances could occur between radiographers and doctors/radiologists, and other professionals. The Ghanaian radiographer's role as a health professional is consequently, pertinent to the multidisciplinary approach to child protection. In the present study, Ghanaian radiographers were therefore interviewed with the aim of understanding their relationship with other healthcare professionals in handling cases of child physical abuse.

2.7 Radiographers and Role Theory

Role theory as cited in (Brookes et al 2007), is succinctly, defined by Conway (1988, p.63) as 'a collection of concepts and a variety of hypothetical formulations that predict how actors will perform in a given role, or under what circumstances certain types of behaviours can be expected. Role theory is an analytical tool with numerous distinctions and settings that describes how individuals behave in public circumstances and how these behaviours are professed by bystanders outside (Brookes et al. 2007). They applied Conway's role concept to study community health care nurses' attitude and perception within the context of the health care organisations they encounter. Similarly, role theory positions this study to explore the behaviour and perceptions of radiographers in their interactions with doctors, nurses and social workers to deliver health care. The definition of the concept of role should apply to the description of behaviours, features and the standards or the locus of the individual (Major 2003). Moreover, understanding the undercurrents and exchanges of strategic persons in care and how care should be delivered is imperative in evolving structures, roles and the latitude of practice (Davidson & Elliot 2001).

Within the premise of role theory, the Society and College of Radiographers (2005) in the United Kingdom identified the necessity of skill development in the imaging of suspected abused children and suggested appropriate training for radiographers in all imaging departments where children are provided imaging services. When skills are developed

professionals would improve in their capacity to execute roles beyond their traditional responsibilities (such as production of images in radiography). The success of skill development had resulted in radiographers currently involved in reporting radiographic images (a role which was preserved for radiologists), performing barium studies and the operation of complex imaging modalities.

New skills imply role development for the professional; however this also goes with other checks and balances. In explaining role negotiations, Major (2003) argued that role development is not just the core individual appreciating and fulfilling the opportunities enshrined in the activity. On the contrary, Major contends that the central person and the group within the role set should enthusiastically, coordinate their work activity and outline the roles in a manner which would achieve acceptability by all.

The Social Exchange Theory (SET) explains that behaviour depends on relative costs and benefits of that behaviour (Shahsavarani 2016) such as radiographers assisting in child protection. Indeed, in making sense of SET and the views Yielder & Davis (2009), the actual cost in NAI is seen as the physical danger and court action that may befall radiographers, especially those who may involve themselves without requisite training, and for that reason would prefer to have nothing to do with such cases (Wagner 2009; Yielder and Davis 2009; Rigney & Davis 2004).

The Cognitive Dissonance Theory (CDT) (Mcleod 2014) argues that individuals possess several cognitions about the world and themselves and when they conflict, the outcome is induced inconsistencies resulting in overbearing pressures known as cognitive dissonance. Thus radiographers might weigh their professional values and prefer to drop their ethical standards in preference to their illogical culture of superstition. This is to remove tensions and attain consonance with self, if it conflicts with any other values such as parental attachments, volunteering work, cultural beliefs and spiritual beliefs. The professional who aligns his or her work with any other roles or beliefs may experience cognitive dissonance, and some roles or values must be discarded in order to achieve consonance Reeves 2015). However, forced compliance behaviour which is the situation where an individual does something against his or her philosophies can also lead to problems (Mcleod 2014). Such

considerations could occur in child protection activities which are engulfed with several legalities and inter-professional failures.

The cost could also lead to difficulties they would face as an individual in performing a role she/he lacks training. In explaining role problems, Brookes et al (2007) suggested problems that the professional could encounter as depicted in Figure (3).
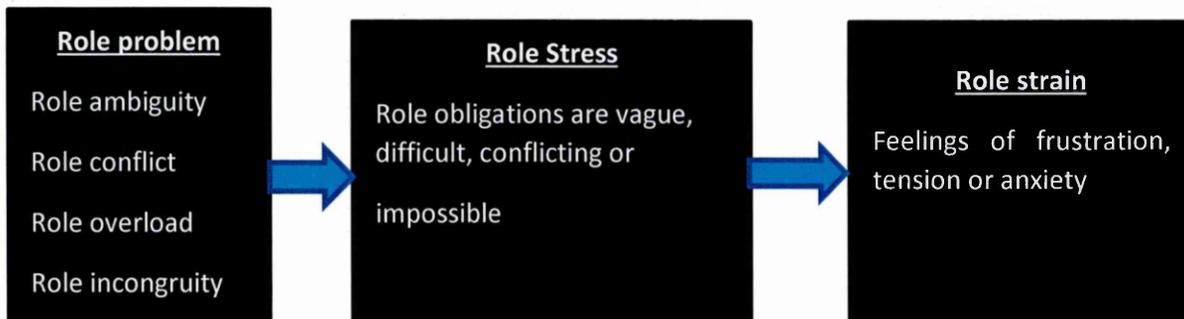
Figure 3: Relationship between role problems and role stress leading to role strain. **(Brookes et al. 2007).**

Apart from a radiologist report to support the investigation of NAI as evidence to the police, the radiographer and the referring clinician may be requested to provide a report for police investigation or court hearing (RCPCH 2008). These bodies noted that the standard imaging method for evaluation of alleged abused children is the skeletal survey and that radiographers performing the skeletal survey should be trained in paediatric radiography.

The recognised role of Radiographers in child protection is acknowledged (Davis & Reeves 2006; Davis & Reeves 2004; Hogg et al. 1999). Within this capacity, radiographers need to be aware that they create significant evidential documents when imaging a child for suspected NAI (Rigney & Davis 2004). They further argued the need for radiographers to be cognisant with child protection measures and comply with them. Similarly, understanding the legalities binding healthcare personnel regarding the management of children in health services must be known and understood by radiographers (Hancock et al. 1997). These arguments imply that radiographers would have no excuse about ignorance of the legal issues and measures in place guiding their work with children if they exist. Hancock et al. (1997); Rigney & Davis (2004) drew attention to the UK's Children Act 1989. This Act emphatically stipulates that the welfare of the child should be held supreme

in all activities that involve children. It stands to reason to suggest that radiographers should also be at the forefront to assist children and families to have solutions to their problems when confronted with child safety issues.

With the exception of Western Australia, all states in Australia mandate health professionals including radiographers to report suspicion of abuse and failure to do so in some jurisdictions attracts a fine of either $5000 or six months imprisonment (Denham 2008). In the northern territory and South Australia in particular, failure to report abuse of a child will incur a penalty of $22,000 and $10,000 respectively, regardless of one's occupation (Australia's Northern Territory Department of Health and Community Services, Community Welfare Act 1983; Southern Australia Department for Families and Communities Children's Protection Act 1993) This clearly indicates the seriousness attached to reporting child abuse in Australia by health professionals. However, in the Ghanaian legislation on child protection, mandatory reporting of suspected or identified cases of child abuse by radiographers and other health care providers has not been made clear. This situation could compromise child protection efforts within the health industry and the nation as a whole. Appropriate legislation that mandates reporting by professionals would also provide protection for these reporters who could be vulnerable to attacks of various forms by the embattled perpetrator/s of the abuse. Radiographers in Australia (as in the UK and Ireland), are entreated to be acquainted with the legislation governing child protection in the jurisdiction where they work to contribute to the protection of children (Denham 2008).

Any suspicious biological defect or injury identified through the imaging process should raise an alarm for the radiographer to serve notification of abuse. In the USA, radiographers are most often accountable to stand in as patient advocates in several case scenarios (American Society of Radiologic Technologists [ASRT] 2006). Radiographers play a key role in the campaign toward acceptable communication directly with the patient, the patient's family, radiologists and several other health care workers (Scott 2007). Good communication among staff, patients and family according to Scott, results in safer patient care. By their social and professional interaction with children and parents within the hospital setting, radiographers can be engaged to take up the minder's roles for children (Hogg et al 1999). However, it would require that, the radiographer or the clinician

involved has training. This would ensure that they have the requisite guidelines and supportive organisational arrangements to work with children and their families (Bannon & Carter 2003). They acknowledged that the key element of weakened responsiveness of child protection matters is insufficient training.

In reporting on child protection in healthcare, the Department of Health (DH) and the Royal College of Paediatrics and Child Health in the UK, emphasised the need for health professionals to possess the necessary expertise and capabilities, and work in an environment which is reassuring and guided by unambiguous governance structures. These conditions are critical issues in the UK although they may be some difficulties in respect of over tasking the professionals and the fact that their expertise are not valued for them to appreciate child protection demands. Having this in mind, Munro (2011, p.7) in her report on child abuse investigations iterated that the government of UK should do away with 'unnecessary or unhelpful prescription and focus on essential rules for effective multiagency working and on principles that underpin good practice'.

Bringing this to healthcare would mean clear rules that promote inter-professional working and good practice among clinicians in safeguarding children. Physical child abuse involves the intentional (and at times unintentional) infliction of injuries to children. Such abuse often involves the use of force such as kicking, caning, slapping, burning or forcing the child into doing some physical activity which may result in injuries, pains and emotional/psychological trauma. Clinicians are members of the health community capable of determining a suspected victim of child abuse. This is particularly true in situations where the child's mistreatment has been denied by either the culprit or the victim of abuse (Wadhera et al. 2013). In some cases, child physical abuse can lead to life changing physical injuries. Often they are actually very subtle and categorized as NAI in medical terms (Sanders & Cobley 2005). NAI resulting from child physical abuse has been defined as injury sustained by a child after being abused by a caretaker (Kraft 2011). Radiographers (and other clinicians including doctors and nurses) have a crucial role to play in identifying children at risk of maltreatment or those who have experienced NAI and provide the necessary referrals to gain support for children and their families.

By the nature of their work, radiographers who handle several patient cases on a daily basis come across children with previous history of unsuspected NAI resulting from physical abuse (Davis & Reeves 2004). Through the required quality images they produce, radiographers provide evidence of physical abuse where injury is suspected to be intentionally or unintentionally, inflicted on a child. Moreover, in reporting physical abuse to child protective agencies, the results from diagnostic imaging are considered as one of the key pieces of evidence which informs the decision of clinicians (Jones et al. 2008). Again, the final diagnosis of NAI in children is arrived at after considering the imaging outcomes based on the history available followed by assessment of findings from physical examination (Kraft 2011). It is established that diagnostic imaging is capable of determining the age difference of an injury of a healing bone fracture (Adamsbaum et al. 2010). The authors are convinced that the age difference of bone injuries in a child is suggestive of a child experiencing series of maltreatment who could only be saved from subsequent abuse and probable death, when protective legal process was initiated.

2.8 Mandatory Reporting of Child Physical Abuse

Under Section 2 of the Republic of Ireland Protection for Persons Reporting Child Abuse, all healthcare professionals including radiographers are known as designated officers to whom persons can report child abuse (Protection for Persons Reporting Abuse, Act (number 49) 1998). However in Ireland the 'Designated Officer' is now at CEO level. The implications are that radiographers may no longer bother to be active in the child protection activities aside of their imaging roles. However it is worth noting that failure to report the event regarding CPA would make it difficult to measure its prevalence.

According to Hendricks (2014), although evidence suggests that it is legally obligatory to report suspected child abuse, clinicians globally and nationally do not observe the provisions in the reporting legislature. The author noted that among the established obstacles leading to this non-compliance is the misconstruction of the child abuse reporting regulations. With this understanding, the concern is that although the regulations are unambiguous, experts who have ethical and legal responsibility to secure the wellbeing of children are not held answerable for refusal to report (Hendricks 2014).

Identification and reporting of possible cases of child physical abuse are critical precursors to intervention with maltreating families. Professionals from a variety of disciplines are mandated to report suspected cases of child maltreatment. Although, physicians could put themselves at greater risk of negative consequences such as self-reproach by refusing to follow up a suspicion of child maltreatment, unfortunately, not all physically abused children are identified or reported (Jacobi et al. 2010). Abuse cases are not reported until the child has gone through several healthcare assessments and as a result, protection services are not always alerted after a single occurrence of abuse (Newton et al. 2010). Indeed, some injuries presented at imaging departments are not identified until a later date, when the patient is brought back for further investigation.

In the UK, one of the primary roles of central government according to Department for Children, Schools and Families [DCSF], UK (2009), is to set clear expectations in legislation and guidance. Aside of these and in citing the Lord Laming's report on various child abuse investigations conducted in the UK, the Department stressed the need to have tough leadership at national and local levels (DCSF 2009). The Department contends that the leader must be trusted with unambiguous responsibilities and effectual working relationship between children's services, police, health and other agencies concerned with the protection of children. The Children's Act 1998 (part II sub-section 17, under care and protection) of Ghana's child protection legislature identifies persons to report child abuse and protection cases to include - any person with information on child abuse or a child in need of care and protection to report the matter to the Department (Social Welfare and the community child protection unit). In the UK, the Labour Party sought to introduce a new legal requirement which compels persons working in schools, hospitals and childcare to report child abuse. This legal plan is already in place in the USA and Australia (Wheeler 2015).

2.8.1 Barriers in Child Physical Abuse Reporting

Child abuse reporting generally has been a challenge among health professionals expected to identify and report suspected child abuse. The problems contributing to under-reporting of CPA have been acknowledged, and are yet to be resolved (Craft & Hall 2004; Offer-Shechter et al. 2000). The presumption is that if performing a particular role would have certain consequences, to which the individual attributes certain standards, such as

assessment of the consequences and their repercussions to the individual, the required action may not be performed (Natan et al. 2012; Davis & Reeves 2009).

Child physical abuse cannot be reported without its initial identification followed by substantiation and reporting. However, while evidence shows that the age, gender and socio-economic status of doctors and nurses have no linkage to their capacity to report abuse, their training and cultural background had a major influence on their ability to identify physical abuse of children (Shechter et al. 2000).

The approval of child discipline (which has cultural suggestions) has been adversely linked with the possibility of reporting (Ashton 2001). Thus, the method of reporting is prejudiced by reporters' characteristics, values, mind-set, cultural factors, self-confidence, as well as social and organisational supports (Goebbels et al. 2008; Ibanez et al. 2006; Alvarez et al. 2004; Yanowitz, Monte & Tribble 2003). For mandatory reporting to be effective under the law, guiding steps in handling such cases is needed. Imperatively, professionals' knowledge of regulations and procedures including their knowledge of agencies who receive the reports and their contact is what permits reporting of an incident of child abuse (Glaser & Chen 2006; Mudd & Findlay 2004).

In a Taiwanese study conducted by Feng et al. (2010) of multidisciplinary collaboration in child abuse reporting, participants of different professions perceived interdisciplinary teamwork in child protection as a relay race. Each profession was identified as a member of the relay team while mandatory reporting was seen as the baton that is handed to the next team member within a particular time and space. Each profession, according the authors, runs its own race within the team with differing style, speed and timing as with the sole aim of saving the child from additional mistreatment. In that study, doctors felt their basic responsibility was to manage any physical injuries of the child and refer the case to social workers whose primary concern was to get information suspecting child abuse. In Taiwan, social workers are the initial designation for other professionals to regularly contact when a case of child abuse is suspected (Feng et al. 2010).

Similarly in Ghana, the Children's Act 1998 stipulates that child abuse cases should be reported first to the "Department", where the department refers to Social Welfare and the

79

Community Child Protection Unit (Children's Act 1998). However, these agencies are no-existent in most of the communities in Ghana (UNICEF 2011; Laird 2002). Evidence suggests that earlier hospital attendance which mostly suggests suspicion of abuse, nonetheless, can either be unreported, missing, or improperly documented (Jones et al 2008; Flaherty & Sege 2005). This raises questions about healthcare professionals' willingness to report abuse (Craft & Hall 2004).

Until the significant role of imaging was noticed in the identification and management of child physical abuse (Kempe et al. 1962), diagnostic radiographers were typically undertaking the routine X-rays of injured children against their greater capacity in the child protection efforts (Davis & Reeves 2009). Various child protection studies have established some key obstacles among health care professionals in reporting child abuse. These studies (Lazenbatt & Freeman 2006; Russell et al. 2004) identified factors such as practitioner's uneasiness of wrong identification of the abuse, concerns about being segregated and stigmatised. fears over collapse of the professionals' relationship with their patients/clients and their families, a gap in the practitioner's awareness of contemporary facts about identifying and reporting abuse and inadequate understanding of matters related to legal process, and unwillingness to query clients about delicate child abuse issues as the contributing factors of under-reporting.

The unwillingness to report cases of child abuse also stems from stressful encounters by professionals in the field. For example, studies conducted in the UK, have shown that doctors who report child protection concerns have been exposed to several kinds of coercion (Kmietowicz 2004). Kmietowicz observed that official grievances reported to the General Medical Council UK, astonishingly worsened from 1995 to 2003 and approximately a third of the vacancies for child abuse physicians were left unoccupied. In addition to this, it is also known that an official complaint was made against 14% British paediatricians on child abuse issues (Williams 2007). Other findings such as seeming time constraints and difficulties in having an efficient health care system response, training gaps, as well as uncertainties with one's clinical capacity was noted to have influence child abuse matters (Markenson et al. 2007; Socolar & Reives 2002; Wright et al. 1999). Moreover it is important for imaging professionals to have knowledge of the legal framework as they may be called to provide evidence in court (Cameron & Rae 2007; Hogg et al. 1999.

80

2.8.2 Attitudinal Issues in Child Protection

The possibility that some experienced clinicians may fail to deal with serious instances of child abuse exist, even in the presence of clear clinical indicators. It is also possible even though, a suspicion of abuse or neglect should be treated with the same level of urgency as other potentially fatal childhood disorders (Bannon & Carter 2003). A previous study found that clinicians felt it was not in the best interest of the child to report to the child protection agencies (Marshal & Locke 1997). The effectiveness of the child protection process is contingent on prompt actions by clinicians who encounter a child in possible need of protection and make appropriate referrals to statutory agencies (Bannon & Carter 2003). Page 84 first paragraph line 10 after (Bannon and Carter 2003) is reworded to read: According to Godin (2008), the theory of planned behaviour (TPB) (Ajzen 1991), Triandis' (1979) theory of forces behind intention, and self-efficacy have been identified to answer the question of which theoretical construct can better be used to envisage the behaviour of health professionals. These theories could also be linked to the bystander attitude or behaviour where an individual or group fails to respond to a situation as a result of other factors such as looking up to others who are present to respond or intervene.

Despite these hindrances, reporting is however indispensable in guaranteeing the wellbeing of children (Legano et al. 2009). Reporting abuse, is also accompanied with legal consequences usually against the perpetrator and this alone may deter others from committing similar offence and also help in advancing activities that seeks to safeguard children. As a result of the importance of child abuse reporting in the United States of America, the past 4 decades have seen laws passed across all states directing that citizenry who deal with children in a professional capacity (such as clinicians including radiographers, teachers, nurses etc.) to report (Legano et al. 2009).

Although the criteria for reporting vary from state to state, and are often determined by medical indications, it is obligatory to report any suspicion or identification of abuse. Could there also be the possibility that the difficulty in accessing and/ or the lack of established unit to report abuse could also lead to underreporting? Irene et al. (2006) asserted that institutions which handle children should preferably have a unit with set of protocols to respond to any abuse that is exposed to the unit to enable them act promptly and

proficiently to the situation. They also recognised that it is essential for the institution to understand that the desires and wellbeing of the child or young person must take precedence over any apparent risks to the status of the establishment or the persons involved.

The health system puts radiographers in a clinical position to identify injuries through imaging, and patient interactions and body checks make them part of the chain of professionals in healthcare required to serve notification of abuse. Other studies (Flaherty et al. 2000; Gunn 2005) found that previous unpleasant experience with child protection agencies, misgivings about any child benefits when cases are reported, and concerns about hurting relationship between the professional and families are some reasons which explain the lack of physicians to serve notifications of child abuse. Irrespective of reasons deterring professionals from reporting, it is worth noting that there is 50% probability that an abused child could go through subsequent mistreatments (Vallone et al 2009) and for that reason the suspicion or recognition of abuse should be reported.

2.8.3 The Bystander Attitude of Radiographers in Child Protection

Health care professionals have been blamed for non-disclosure of abuse when identified. In a study, Bannon & Carter (2003) acknowledged that some doctors were hesitant to act on child abuse because it was someone else's responsibility. Further evidence suggests that various elements bear on healthcare professional clinical practice (Lenfant 2004). The intention to perform an act as a healthcare professional is influenced by several internal and external factors as well as the characteristics of the healthcare professional. According to Godin et al (2008) factors such as economic, political, organisational context and one's motivational predilections impacts on the healthcare professional behaviour. However, Godin et al argued that the understanding and the ideal methods required to transform the healthcare professionals' behaviour is still inadequate.

There are several hypothetical viewpoints which can be applied to ascertain what actually govern healthcare professionals' behaviour; conversely most clinical behaviours are individual professional judgements. Radiographers were studied using bystander framework (Davis & Reeves 2009). The authors examined first the law of social impact (Latane & Rodin 1969) and diverse social force fields (SFF) to determine what could

prevent the radiographers' desire to intervene in child maltreatment cases in clinical settings. In reviewing Darley & Latane (1968), Davis & Reeves (2009) developed eight reasons why non-intervention could take place among the imaging professionals. They reported that the prestige and social standing of the child, family and the professional involved may impact on judgement, and later reporting of suspicions of abuse. They noted that as a result of several individuals within the field of care, responsibilities are spread (diffusion of responsibilities) and as a result, the radiographer may feel less accountable to intervene on behalf of the child because others are present which collaborates with (Bannon & Carter 2003).

In a series of experiments on diffusion of responsibilities, Garcia et al. (2002) established that simply envisaging being part of a crowd creates onlooker attitude in the individual present in the situation. This diffusion arises from indecision where the individual would be contemplating whether he/she is the competent person to manage the situation. Davis & Reeves (2009) argued that radiographers may have good reasons to remain in a position where they feel accustomed, at ease, in control and experience little disquiet and stress (remain in comfort zone). In the Victoria Climbe's abuse case in the UK, several professionals were involved but none took action (Laming 2003). That was a typical example of bystander attitude of the professionals involved (Davis & Reeves 2009). In setting a text case of diffusion of responsibilities in an earlier work, Davis (2004) cited in (Davis & Reeves 2009) pointed out that when the issue is about child protection, the radiographer may not pass on their misgivings (a thought of division of labour sets in) after the radiography of a child with suspicious injuries. The radiographer may rather consider that the child will be back to the referring clinician whom they anticipate, will act based on their own judgements.

2.8.4 Cultural/Linguistic Competence in Child Protection in Healthcare

Multi-ethnic health concerns in primary care can pose some difficulties to the delivery of commendable service (The Royal Australian College of General Practitioners [RACGP] 2011). Incorporating culture in child protection is indispensable aspect of child protection efforts and the current demographic developments mandate an advanced standard of cultural competence (Korbin 2002). Culturally, Ghana is a varied society and the fact that child maltreatment transpires within every cultural and socio-economic groups of the

society justifies the need in this current study to examine literature on cultural and linguistic competence in healthcare in relation to the current focus on client-centred care. The current study, which drew its participants (radiographers) from diverse cultural and linguistic background, necessitated an aspect of cultural competence and how radiographers operated in the service delivery to physical abused children and their families of diverse cultural and linguistic backgrounds.

Child protection first involves recognition of abuse and serving notification for action to be taken (Bromfield & Holzer 2008). Currently, the aversion of child abuse has taken a centre stage worldwide by governments rather than reacting to children who have already been abused as a result of the yearly increase in child abuse reports (Kojan & Lonne 2012; Munro 2011).

Identification of abuse involves a holistic approach and involves seeking information through communication, by interviewing victim, parents and any significant other to ascertain the possible cause of the child's injury. This improves the judgement of the clinician and his or her decision trail about the child and family situation. Thus, language plays a key role in such interactions and the lack of which may result in wrong clinical decisions. Culture exemplifies several things and even between those with same linguistic background cultural differences exist or coming from the same country (RACGP 2011). Evidence available suggests that several professionals have been trained on matters regarding child maltreatment, particularly on how to cross-examine children, how to react to child abuse and neglect. The professionals may however not be culturally competent (Hughes 2006).

A surge in the population with different cultural/lingual background in Ghana should be a concern in the delivery of healthcare. It is essential for healthcare providers to respond to the specific needs of culturally and linguistically diverse patients who seek their services to be culturally competent (RACGP 2011). Health care delivered under cultural competency has the capacity to advance health outcomes and adeptness of health professionals, including other auxiliary personnel bringing about client contentment with service provision (Brach and Fraser 2000).

Though cultural competence has been articulated as a singular entity, it embodies several diverse issues (Korbin 2002). In healthcare, cultural competence as defined by (Betancourt, Green & Carrillo 2002, p. v) is the "ability of systems to provide care to patients with diverse values, beliefs and behaviours, including tailoring delivery to meet patients' social, cultural, and linguistic needs". Cultural competence frequently denotes practice that is directed towards knowledge of and skills in working with cultural groups outside of ones 'own (Korbin 2002). She is of the view that culture or ethnicity is commonly considered as separate variables to clarify inconsistencies in child abuse and neglect occurrences and pervasiveness. Different approaches have been adopted in reporting incidence of child abuse; this necessitates the exploration of cultural attitudes that are thought to be the cause of the diversity and rate of in reporting (Korbin 2002).

A culturally competent healthcare system is a required element for uptake of healthcare by culturally diverse populations (Anderson et al. 2003). They further argued that cultural competence is fundamental to healthcare quality, because healthcare delivery must guarantee the right services and decrease the frequency of medical errors emanating from misjudgements caused by differences in language or culture. Indeed, cultural competence goes beyond the knowledge of cultural dissimilarities, as it emphasises on the ability of the health systems to advance health by being thoughtful of cultural diversities (RACGP 2011).

Ghana is a multicultural country and that, in dealing with its diverse people in healthcare, cultural and linguistic competency is vital for health professionals. The Health Service Executive (HSE) of Republic of Ireland, having experienced multicultural influx in the past two decades, indicated in a policy document the essentiality for practitioners to be exceptionally aware of the culturally sensitive methodologies required in working with children and families from diverse circumstances (HSE 2011). The HSE policy document further cautioned that cultural differences must not be an avenue for children to be abused but rather, practitioners are encouraged to be extremely mindful of the influence of cultural issues on every aspect of child protection, from its manifestation and definition through to its management and effective prevention. The HSE was emphatic with the idea that, the process of intervention must take into consideration the cultural environment in which the situation happened to achieve any fruitful intervention, whether for data collection, prevention or improving the responsiveness of the society.

While available evidence posit that there is no linkage of gender, age and socio-economic status of doctors and nurses to their capacity to report abuse, their training and cultural background had a major influence on their capacity to identify physical abuse of children (Shechter et al. 2000). This supports the previous argument that one's cultural acceptability of child discipline through physical punishment shrouds the actor's mind-set to recognise physical abuse of children since one may see it as normal. Besides cultural influence on identification of physical abuse it also, in conjunction with other factors such as the individual's beliefs and thoughtfulness, impacts on the reporting attitude of professionals.

The approval of child discipline has been adversely linked with the possibility of reporting (Ashton 2001). For example,-several inhibiting factors which contribute to refusal to report include reporters' characteristics, values, mind-set, cultural factors (i.e. ethnicity, and corporal punishment acceptability), self-confidence, as well as social and organisational supports received (Alvarez et al. 2004; Goebbels et al. 2008; Ibanez et al. 2006; Yanowitz, Monte & Tribble 2003). Culture is linked to language and language informs communication during history taking an important aspect of child abuse recognition. In view of this, it might be argued that cultural and linguistic competence is a necessity in dealing with child abuse cases in hospitals as a result of global trend of emerging culturally diverse societies.

Ghana has about 80 languages and healthcare providers including radiographers under such cultural setting should possess linguistic aptitudes to provide appropriate services to abused clients based on arguments on culturally competent healthcare. Hancock et al. (1997) studied the influence of emotions, the law and social factors that affect radiographers in dealing with child abuse cases. While the study provides deep insight into what radiographers could experience and be wary of in handling child maltreatment cases, the study failed to address one social issue: culture and linguistic capability of radiographers and how it impacts on them. Similarly a study (Davis & Reeves 2009) identified the causes of bystander attitude of radiographers. Despite the surging multicultural influx in the UK which is an important social force field in influencing ones judgement of abuse, the study excluded their cultural competency capabilities which draws to it linguistic aptitudes.

86

What makes cultural and linguistic competency significant in the UK is the fact that within English-speaking clienteles in healthcare, difficulties exist in communication with providers (Anderson et al. 2003). While this is so, the professional may not be able to address the situation due to communication barrier which may as well prevent the professional from providing the right intervention. Cultural and linguistic competence in health care is primary to accomplishing the all-encompassing objectives of healthcare delivery (U.S. Department of Health and Human Services 2000). Language problems exist in health care delivery and it adversely affects provision of care to those from culturally and linguistically varied backgrounds (RACGP 2011). Moreover, objectionable approaches toward an individual motivated by that person's ethnicity or race establishes racial partiality (Anderson et al. 2003). Based on the above literature, the questions the current study sought to ask are stated in section 2.9 below.

2.9 Research Questions

The specific research questions formulated in Chapter One are restated for clarity of the methodology chosen.

- What do radiographers in Ghana understand by the concept of child abuse and child protection? (Phase 1)

- How do radiographers in Ghana deal with child physical maltreatment cases when they occur? (Phase 2)

- Does Ghanaian culture, and the beliefs held by radiographers, appear to influence their actions with respect to child protection cases? (Phase 2)

- What is the relationship between radiographers and other health providers who handle child abuse and protection cases? (Phase 2)

2.10 Summary

Child abuse has been a global concern which has led nations to unite and sign treaties to safeguard children using the systems approach tailored to suit the individual nations. The chapter looked at the definition of child abuse and child protection and controversies surrounding the concepts and approaches to child protection. Professional clashes resulting

from medical dominance and wide power distance in healthcare was discussed. The effect of such power hierarchy in care delivery and its impact on child protection was also examined. The chapter also reviewed literature on multidisciplinary approach to child protection and the challenges affecting reporting of child abuse cases. The role of radiographers in providing evidence of child physical abuse is an important component of this chapter as it gave credence to this current study. The reporting attitude of professionals in healthcare with regard to child abuse generally was also reviewed. Several factors were identified to militate against professional willingness to show concern in the face of doctors' assertiveness and inappropriate behaviours. The factors acting on the individual's disposition to report child abuse were also discussed.

This study explores the Ghanaian radiographers' experiences with cases of child physical abuse that has confronted them in their work setting. To achieve this, there was the need to select the appropriate methodology to achieve this goal. The next chapter examines the methodology and the philosophical underpinnings applied in this study which was conducted in two phases.

CHAPTER 3

METHODOLOGICAL REVIEW

3.0 Introduction

The preceding chapters examined the background of the study, the cultural context within which the study was conducted and a critical evaluation of appropriate literature examining child abuse and protection issues. Chapter 4 outlines the research questions, aims and objectives of the study. It then examines the epistemology guiding the selection of the method used in both phases of the current study. More specifically, it proposes the use of phenomenological methods in exploring the concepts of child abuse and child protection. This was developed to explore the lived experiences of Ghanaian radiographers in their dealings with child physical abuse cases in the hospitals.

3.1 Research Questions

The specific research questions formulated in Chapter One are restated for clarity of the methodology chosen.

- What do radiographers in Ghana understand by the concept of child abuse and child protection? (Phase 1)

- How do radiographers in Ghana deal with child physical maltreatment cases when they occur? (Phase 2)

- Does Ghanaian culture, and the beliefs held by radiographers, appear to influence their actions with respect to child protection cases? (Phase 2)

- What is the relationship between radiographers and other health providers who handle child abuse and protection cases? (Phase 2)

3.2 Aims of the Study

This study, which was in two Phases, sought to:
- explore the cultural understanding amongst Ghanaian radiographers of the concepts of child abuse and child protection (Phase 1);

- explore how radiographers in Ghana perceive and participate in child protection within the health system in the country. (Phase 2)

3.3 Key Objectives

- To determine the cultural understanding amongst Ghanaian radiographers of the concepts of child abuse and child protection. (Phase 1)

- To examine and assess perceptions and approach of radiographers in Ghana in handling child physical maltreatment cases. (Phase 2)

- To determine the relationship between radiographers and other health professionals with respect to child protection in Ghana. (Phase 2)

- To explore any cultural influence on the actions of the Ghanaian radiographer in managing child physical maltreatment. (Phase 2)

3.4 Overview of Phenomenology

Phenomenology has been conceptualized as a philosophy. Phenomenology is an umbrella term incorporating both a philosophical movement and a variety of research methodologies (Kafle 2011). It is also a research method and an all-embracing viewpoint from which all qualitative research is obtained (Streubert and Carpenter 2011; Maykut & Morehouse, 1994). There are two main schools of thought on phenomenology (i.e. Husserl's and Heidegger's phenomenology). Husserl phenomenology focuses on consciousness and essences of phenomena, while Heidegger's is centred on existential and hermeneutic or interpretive dimensions (Finlay, 2009). The prime goal of phenomenology is to pay attention to how individuals perceive the world in which they live and how they interpret it while concentrating on these life encounters (Langdridge 2007).

3.5 The Epistemological Approach Guiding the Study

Epistemology is about 'how we know what we know' and it relates to knowledge and the perception that the study is required to contribute to knowledge itself (Kafle 2011) and also, the steps by which the researcher makes the knowledge claim (Hartley 2006). Ontology and epistemology talk about truth while axiology concerns values and ethics (Mingers 2003).

90

The principles for evaluation of epistemological and ontological assertions are offered by these values (Kafle 2011). From an epistemological perspective, phenomenological approaches to research are based on a paradigm that draws extensively from the personal knowledge and subjective experiences of the study participants (Polit & Beck 2012; Streubert & Carpenter 2011; Holloway & Wheeler`2010). Phenomenologists attempt to gain insight into lived experiences and the reasons or meanings behind perceptions held by people within a particular context. More importantly phenomenological studies tend to emphasise the importance of personal perspective and interpretation as one way of gaining insights into people's behaviours and actions (Polit & Beck 2012). The central aim of this study was to bring to light, the meaning Ghanaian radiographers ascribed to their experiences in order to improve our understanding of the lifeworld of these professionals.

There are other methods that can answer all the questions in this study, however given the absence of any data on Ghanaian radiographers the research design for the study, including data collection and analyses is grounded in phenomenological epistemology. This was to enable the researcher to gain more insight into radiographers' shared experiences of child protection within their context. At its basic form, phenomenological epistemology is concerned with illuminating meanings as against debating an issue or constructing theories (Flood 2010).

Pure phenomenological research seeks essentially to describe (Streubert & Carpenter 2011) rather than explain, and starts from a perspective free from hypotheses or preconceptions (Husserl 1970). In Husserl's view the researcher should have no preconceived ideas or any suppositions either from the researcher's own experience or from the literature. What it implies is that the researcher waits in anticipation of gaining all the facts from the researched before having an opinion or making any conclusion; a stance which has also been challenged. Some humanist and feminist researchers, for instance, have challenged such an assumption. To the latter, they refute the possibility that studies can be started without the researcher's preconceptions or biases (Todres & Holloway 2010). The fundamental principle of Heidegger's interpretive school of thought has been that the researcher becomes part of the experience itself, and it is impractical for the researcher to detach from the meaning extracted from the participants' lifeworld (Reiners 2012).

91

This study goes with the school of thought that a phenomenological study should give consideration to the ideas of Husserl and Heidegger and others such as Gadamer, Merleau-Ponty, Sarte (van Manen 1990). The Utrecht (which is the Dutch school of phenomenological analysis) applies both Husserl (descriptive) and Heidegger (interpretive) phenomenology to bring to light thematically, some of the experiences of those being studied (Reiners 2012; Hazewijk et al. 2001). The description and interpretation should be viewed as a scale, by means of which phenomenological studies are measured, normally, as interpretive and that, the argument that inflexible restrictions established between description and interpretation limits the essence of phenomenology (Finlay 2009).

The researcher considered that the phenomenological understanding of Ghanaian radiographers of the concepts of child abuse and child protection and the meaning they ascribed to their practice circumstances in child protection would be better understood from the perspective of the two philosophies. The next section will explore the two main schools of phenomenological thought (Husserl and Heidegger) and establish their respective relevance to Phase 1 and Phase 2 of this current study.

3.6 Phenomenological Themes in the Study

There are some key words in phenomenology which Flood (2010) has thrown light on. These are reduction, essence and intentionality. Flood explained that reduction (epoché), is a process that involves suspending or bracketing the phenomena so that the 'things themselves' can be returned to. Husserl's main concern was returning "to the things themselves" which is the essential of all phenomenological investigations, and holding a contention that describing lived experiences is the spirit (essence) of phenomenology (Nelms 2015). Likewise, an *essence* is the core meaning of an individual's experience that makes it what it is while *intentionality* refers to consciousness since individuals are always conscious to something.

Strictly defining phenomenology is problematic and is relatively reliant on the philosophical thought from which it derives (Helm 2015). However, Berrios (1989) defined phenomenology as a set of philosophical doctrines loosely sharing; a) assumptions as to what the world is like (ontological) and how it can be known (epistemological) and b) approaches for the descriptive management of the mental entities relating to such a world.

They all attempt to capture experiential essences which are but higher forms of knowledge with which the phenomenologist expects to reconstruct reality. A more simplistic definition of phenomenology is offered by Grbich (2007) who defined phenomenology as an approach to understand the hidden meanings and the essences of an experience together. Phenomenology is resolute about the subjectivity of reality and constantly indicating the need to gain insight into how people view themselves and the world in which they live (Willis 2007).

3.7 Husserl's Philosophical Approach(Phase 1)

The understanding of the concepts of child abuse and protection of victims demand the use of a methodology that supports the application of various methods in the natural contextual environment. The fundamental concept of phenomenology is that consciousness is always intentional and inseparable from the intentioned object; it cannot be something that exists independently of the objective world (LeVasseur 2003). Intentionality has to do with 'consciousness' which is one's awareness of something and cannot be separated from the object of intention. This is as a result of our existence or engagement with the world and how things we engage with appear to the individual. Phenomenology expresses an individual's bearing on lived experience, since lived experience is, from the concept of intentionality, the source of knowledge (Prim and Cunha 2006).

3.7.1 Transcendental Phenomenology

Experiences that have not been subjected to worldly interpretations but rather, described just as it projects itself was what Husserl (1983/1913) described as transcendental phenomenology. It is the original form of phenomenological philosophy conceptualized by Husserl whose basic principle is the acceptance of the concept that experience is to be transcended to discover reality (Kaffle 2011). Husserl's phenomenology is built upon the idea of reduction which refers to suspending the personal prejudices and attempting to reach to the core or essence through a state of pure consciousness. The researcher, at this level, brackets all prior personal knowledge (also known as phenomenological reduction) to prevent personal biases and preconceptions influencing the study and to ensure scientific rigour (Polit & Beck 2012; LeVasseur 2003; Drew 1999).

A critical review of various methodologies revealed that principles of Husserl's descriptive phenomenology would ensure the realisation of the objective of Phase 1 which was to explore the cultural understanding of Ghanaian radiographers of the concepts of child abuse and child protection. In effecting a particular approach in research, it is important to consider the philosophical underpinnings of that particular methodology to avoid the situation where the research purpose is not only vague but also its construction and outcome are equivocal (Lopez & Willis 2004). Holding in abeyance the researcher's assumptions and meanings with regard to these concepts (child abuse and child protection) was appropriate to avoid introducing any biases into the study.

3.7.2 Bracketing

Husserl developed what was termed transcendental subjectivity or being in the state of transcendental consciousness (Husserl 2001). This means that the researcher, at this stage known as "bracketing", suspends all preconceived experiential knowledge of the personal lived world and biases related to the situation in order to aim at viewing the phenomena in a way that ensures that the phenomena being studied is described from its unadulterated or original form (Streubert & Carpenter 2011). According to Laverty et al. (2003) 'life world' can be known from the consciousness of the individual's experience which is not subjected to any interpretation. This means unbiased position by the researcher who attempts to suspend any held beliefs and prejudices towards the phenomenon being studied. Bracketing per se has no definite approach to enable the researcher stay in abeyance (Wall 2010). How in attempting bracketing suggestions from literature was adopted.

Husserl argued that the shared features (i.e. essence or eidetic structures) of any lived experiences could be understood through bracketing (epoché) or what Streubert & Carpenter (2011) described as phenomenological reduction and critical epistemological method of phenomenology. These features constitute the reality of the phenomena under study and guarantee credible description of the phenomena (Sadala & Adorno 2002). By the reduction process in Husserl's phenomenology, patterns of meanings and themes start to appear providing the opportunity to explore the phenomena in their entirety and purity (Frances & Wainwright 2006). In nursing research in particular, phenomenological bracketing has demonstrated rigour (Norwood 2000) and has also been used to establish validity of the data collected as well as the steps in data analysis (Ahern 1999).

As much as bracketing sounds reasonable, if pure and rich unadulterated information is to be gathered, achieving bracketing through transcendental consciousness is difficult. By transcendental consciousness, the researcher appears to be in a vacuum waiting to be filled with new and rich ideas from a source (participants) without any prejudice of previous knowledge. The idea is that previous knowledge obstructs one's capacity to research the topic comprehensively especially when the researcher intuitively carries some assumptions about the topic into the research process (Parahoo 2006). However, contrasting argument also suggests that research is mostly informed by what is already known or a gap identified in literature and ignoring what one already knows is an impossibility (Humble & Cross 2010). The approach to bracketing varies (Gearing 2004; Wall et al 2004) and is impracticable with hermeneutic phenomenology (LeVasseur 2003). How bracketing was achieved in Phase 1is discussed in chapter 5 and in the reflexive chapter of the current study.

3.7.3 Intuiting

Intuiting is particularly essential in Husserl's philosophy of transcendental consciousness. By this the researcher assumes a critical view of what a situation or experience is like. The researcher approaches the study with an open mind rather than any expectations of conformity of what is being studied to the researcher's understanding of everyday reality. To grasp the essential logic of what it might be like to be in the participants' experiences of the phenomena, an open mind towards that experience is essential (Worjna & Swanson 2007). This requires the creativity of the researcher, to transform the data to a point where common themes emerge from the participants' information (Streubert & Carpenter 2007). This is paramount at this stage to enable pure description (the last stage of being in Husserl philosophy) of the knowledge shared by participants of whose experiences the study explored.

Phenomenology as a philosophy and a methodology has extensively been applied in several disciplines such as psychology, education, and in healthcare (Connelly 2010). In that sense, phenomenological inquiry operates within the humanistic traditions with their emphasis on interpretation.

Phase 2 of this study applied the hermeneutic (interpretive) phenomenology as discussed in the next section.

3.8 Heidegger's Philosophical Approach (Phase 2)

According to Prim & Cunha (2006), the concept of intentionality takes account of the person (the radiographer) and the world (practice world). When experience is studied in depth, one would identify a link between the person and the events or situations of his or her world. Heidegger's phenomenology seeks to gain insight into how human beings give meaning to their own life world and therefore it is essential for one to be appreciative of where these individuals are coming from, ascertain whether they are enduring anything else in their lives and how they explain these experiences (Steeves 2000). Critical to Heidegger's ideas was the nature of being or reality rather than the epistemological stance of Husserl who centred on the concept of knowledge (Reiners 2012).

Heidegger argued that, instead of one concentrating on people or phenomena, the exploration of the lived experience or 'dasein' (the situated meaning of a human in the world) should rather be emphasised (Thompson 1990). Hermeneutics transcends description of the key concepts and essences to find deep-seated meanings in shared practices (Lopez & Willis 2004) – what people (Ghanaian radiographers) experience rather than what they consciously know (Flood 2010). Heidegger used the term 'life- world' to express the idea that individuals' realities are invariably influenced by the world in which they live. This exemplifies a paradigm change from an epistemological to an ontological stance, concentrating on how interpretation is intrinsic to human existence – it is not simply that someone merely has, but what he/she is (Todres & Wheeler 2001; Heidegger 1962).

Interpretivism, the hallmark of Heidegger's phenomenology, discusses the procedures which underscores the salient aspect of people's character and involvement in cultural and social relation (Elster 2007; Walsham 1995). Interpretivists aim at gaining insight into the reasons behind the activities of individuals such as their behaviour and relationships with others, the society and culture (Whitley 1984). On the basis of this understanding Phase 2 of the current study was conducted. Interpretivists support that view that the assumptions of the researcher is important to direct the research process and moreover, the researcher has the opportunity to interact with the participants involved in the investigation (Walsham 1995). As a result, according to Walsham, the perceptions of the researcher and the researched are both changed after their interactions.

In keeping with this assertion, and in situating this current study in the appropriate theoretical perspective, both Husserl's descriptive and Heidegger's interpretive ideas were considered for Phase 1 and Phase 2 respectively based on their epistemological and ontological stance. Phase 1 sought to describe radiographers' understanding of the concepts; child abuse and child protection while Phase 2 was undertaken to explore the meaning radiographers assign to their experiences and with child protection resulting from their encounter with imaging of children suspected to have been physically abused.

3.9 Which Qualitative Approach

There was the need to discuss the comparative methodological benchmarks to allow the reader to compare the current phenomenological study with others. In using qualitative approach, researchers chose from diversity of methodologies and which one to choose depends on several factors. Initially, thorough reading of the various qualitative methodologies especially the three main methodologies (grounded theory, ethnography and phenomenology,) was undertaken based on the research questions. The path taken to select the right qualitative approach in Phase 1 and Phase 2 is indicated in Figure 4 below. The three methods respond to different research questions and they originated from diverse disciplines. An appraisal of these approaches revealed that phenomenology was the best methodology to use for this research. A synopsis of the three approaches and a discussion of its appropriateness for various studies are discussed in this thesis.

The philosophical approach guiding the research draws extensively from qualitative phenomenological methodology and perspectives. Developed as a reaction to the positivistic approach to research by Husserl who lived between 1859 and 1938 (Holloway & Wheeler 2002; Sadala & Adorno 2002), the phenomenological method is not concerned too much with empirical evidences. Scholars who work within the phenomenological traditions use this qualitative method to offer some insights into the phenomena under study by examining how they are perceived by individuals in that specific situation. According to van Manen (1990), there exist multiple realities which can be subjected to various analyses. The researcher agrees with van Manen (1997), who argued that knowledge is not derivative of scientific analysis but could be attained through sharing common meaning of mutual history, culture and language. The current study was not intended to develop abstract theories but rather, to find meaning to the perceived experiences of radiographers in child

protection which could best be achieved through qualitative inquiry. Reality thus appears from what can be perceived and quantified (known as the positivist approach) (Van Manen 1997).

The positivist hypothesis is that social life can be investigated as reality as in natural science. Qualitative inquiry, in distinction, is perfectly in consonance with the interpretive paradigm which is founded on the suppositions that to appreciate the world, human behaviour should be understood by consideration of interactions between people (Topping 2010). A study that seeks to comprehend the social actions and social practices in which one is involved must adopt methodologies and techniques that permit interpretation of things as they are (Topping 2010). Unlike qualitative scholars, who often begin their studies without a theoretical framework, quantitative researchers generally start their research with a theory and try to test their hypotheses to validate or falsify their theory (theories). As a result of their emphasis on hypotheses testing, accurate measurement and statistical methods are often employed by quantitative scholars; something that is at times not possible with qualitative research which is aimed at in-depth understanding of a social phenomenon.

It should also be pointed out that both quantitative and qualitative approaches have opposing views and assumptions about the nature of reality (Topping 2010) and they do not share the same truth in the way social human behaviour may be analysed and interpreted (Simons & Lathlean 2010). For example, qualitative researchers argue that reality is based on how people give meanings to their experiences and their world. As a result, qualitative researchers contend that truth cannot be explained by a single entity but rather multiple meanings (Topping 2010). Qualitative methodologies attempt to highlight that there are multiple interpretations, truth or meaning, and as human beings differ, so do societies and norms of the people in their settings (Topping 2010). Moreover, the essential aspect of qualitative investigations rest on what is happening and not what was to be expected (Polit & Hungler 2012; Patton 2002; Creswell 1998). Following from these arguments, qualitative approach was central to the current study to understand what was happening in the world of Ghanaian radiographers' in relation to child protection resulting from child physical abuse based on the use of an interpretative approach.

Generally, scholars who work within the phenomenological traditions use qualitative method to offer some insights into the phenomena under study by examining how they are perceived by the actors in that specific situation (Polit & Beck 2010). They argue that the phenomenologist, is normally, faced with the question "what is the essence of this phenomenon as experienced by these people and what does it mean" (p. 494). The fundamental concept of phenomenology is that consciousness is always intentional and inseparable of the intentioned object; it cannot be something that exists independently of the objective world (Le Vasseur 2003).

Phenomenological inquiry has been used widely by many social scientists from several disciplines such as psychology, education, and health to describe a research perspective that is distinct from, and in opposition to, the more positivistic forms of inquiry (Connelly 2010). As the opposite of the positivistic approach, phenomenological inquiry operates within the humanistic traditions with its emphasis on interpretation. Consequently, phenomenological methods are particularly effective at bringing to the fore the experiences and perceptions of individuals from their own perspectives in order to better understand the human experience as described by participants (Polit & Beck 2012; Cresswell 2009). The goal of the current study was to construct the meanings Ghanaian radiographers placed on their experiences. This perspective was used to explore the experiences of a sample of radiographers in Ghana on the question of helping to protect children suspected to be physically abused and who presented for imaging investigation.

3.9.1 Grounded theory

Grounded theory (GT) was the first to be considered; according to Glaser 1978 GT uses the empirical data to generate concepts and theories (Glaser 1978) and this was not the focus of the current study to develop theories/hypotheses or invalidate existing theories even though GT could be used to study human experiences where little or nothing is known about the situation or phenomena.
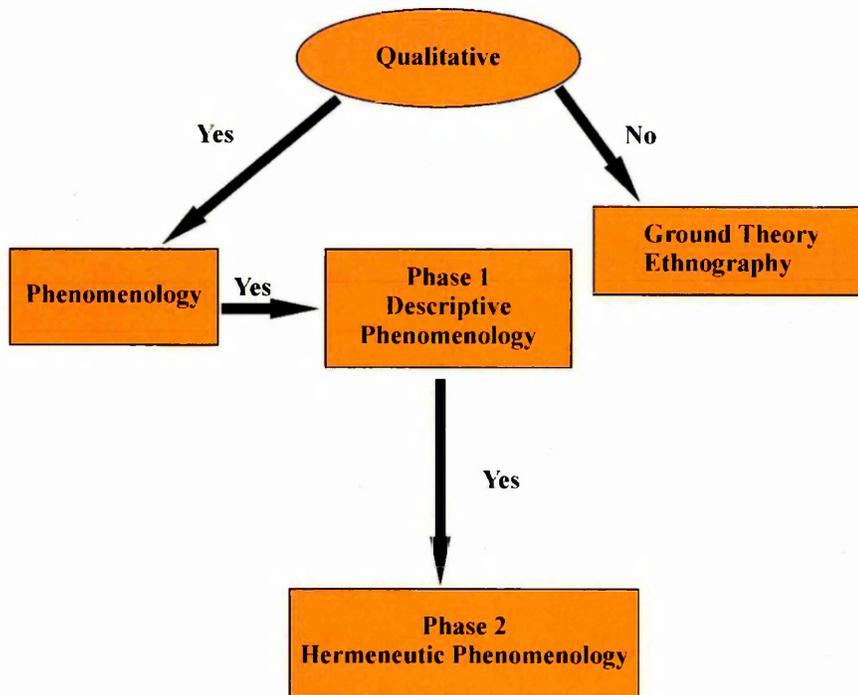
Figure 4. The research approach

3.9.2 Ethnography

Ethnography was not appropriate considering the time frame of the study, as well as the nature of the area of inquiry. Ethnography would have required that the researcher visited research sites to observe how child physical abuse was handled. Moreover, in ethnography, data is gathered mostly through participant observation and recording field notes as they observe from the side lines and/or join in the activities of those the researchers are studying (DiCicco-Bloom & Crabtree 2006). Looking at the nature of this study, which sought to explore past experience, observational studies would not have been either possible or appropriate. Phenomenology was arrived at as the appropriate qualitative approach for this current study because it has policy and practice implications. Moreover using observation to collect the data, could affect the activities of the participant if they became aware, that they were being observed. Additionally, observational approach would mean that whatever is being observed is seen from the researcher's (outsider's) perspective to the study while

interviews which pertains often in phenomenology provides thoughts of the insider (Holloway & Wheeler 2010).

3.9.3 Phenomenology

The fundamental concept of phenomenology is that consciousness is always intentional and inseparable from the intentioned object; it cannot be something that exists independently of the objective world (Le Vasseur 2003), thus, reality, and the phenomena of reality, are in essence not the same (Converse 2012). Phenomenological study is about lived experiences and therefore is a qualitative research method that describes or interprets individual's experience with phenomena in a subjective way unlike grounded theory which, though linked to qualitative process, is intended to develop abstract theories. Besides, phenomenological studies produce very rich data, give deep insight into the live world of participants and do not stay on the surface. The consideration of phenomenological research was driven by the desire to understand the perspectives of the Ghanaian radiographer about child protection. Fundamentally, the issue of phenomenological research is to understand the important viewpoints of the human beings (Holloway & Wheeler 2010) one of the reasons why ethnography was not chosen for the current study due to its observational aspect. Figure 5 below, depicts the study's progression of application of phenomenology from Phase 1 to Phase 2 of the current study.
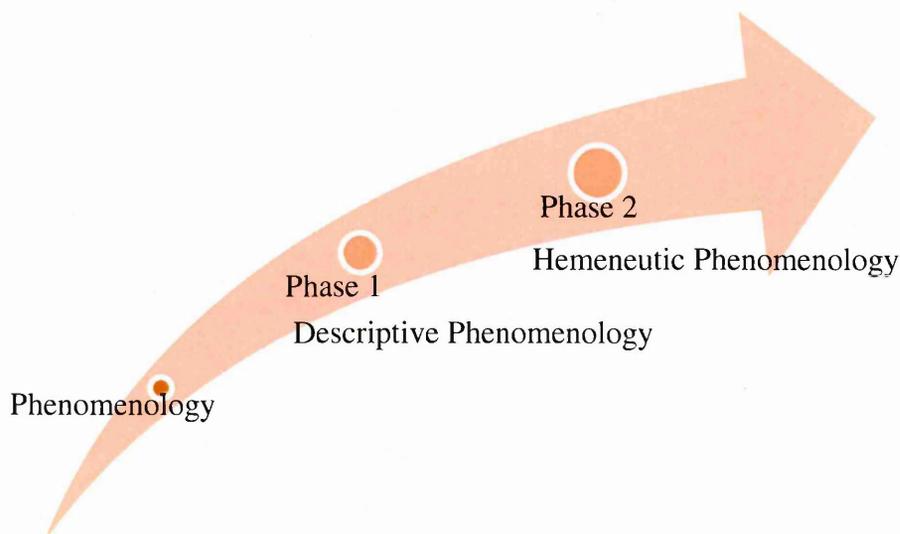
Figure 5. Upward arrow showing the progression of the study methodology

Phenomenological research is based on two premises (Morrissey & Higgs 2006): The first is that experience is a valid, rich, and rewarding source of knowledge. Secondly, experience is the source of all knowing and the basis of behaviour. They further argue that the phenomenologist does not view human experience as an unreliable source of data; they rather see it as the cornerstone of knowledge about human phenomena and particularly relevant to the exploration of people's experiences. Therefore, in order to explain the radiographers' behaviour or actions which are borne out of their experiences in managing child physical abuse, it was important also to understand their interaction with, and the meaning they assign to the larger cultural environment where they operated.

Phenomenology is a very important qualitative tool used to understand human experience (Morrissey & Higgs 2006) with its basic objective to elucidate the procedures that seek to distinguish between the objective world and an individual's experience of a phenomenon (Turpin 2008). Having a thoughtful knowledge about people's subjective experiences has several importance in the everyday life situations (Crotty 1996) because, phenomenologist belief is that knowledge and understanding are entrenched in our everyday world and do not agree with the belief that knowledge can be quantified or reduced to figures (Walters 1995). Heidegger hermeneutic phenomenology (the pivot on which Phase 2 of the study is situated) aligns with the idea of practical form of knowledge generation that goes beyond the enumeration of mathematical properties (Kafle 2011). A methodology should connect a specific philosophy to suitable research methods and should link philosophical concepts to realistic and appropriate research procedure (Walters 1995). Given that this study was purposefully centred on an area where little was known in the Ghanaian context, and no study conducted, a phenomenological form of qualitative research design was suitable.

Phenomenology, the foundation of knowledge about human occurrences, studies situations in the everyday world. It involves using logical steps to gain insight into human experiences, the significance and the meaning attached to such experiences by the individuals who have lived the phenomena. This provides reliable and rich sources of information that builds on current knowledge to advance practice and also improve situations (Morrissey & Higgs 2006).

Meanings are constructed by people as they involve with the world they are interpreting (Flood 2010). The researcher's task is to analyse the intentional experiences of consciousness to perceive how a phenomenon is given meaning and to arrive at its essence (Sadala & Adorno 2002). Social constructionism consists of the construction of meaning in a community. The idea of intentionality reveals the interaction between object and subject and therefore rejects objectivism and subjectivism (Flood 2010).

3.9.4 Descriptive and Interpretive Phenomenological Approaches

It is important that the researcher first take a position towards the nature of knowledge; either objectivism or subjectivism, which, in turn, inspires the whole research process and directs the particular theoretical perspective chosen. The theoretical perspective must be embedded in the research questions to inform the choice of methodology. The next step is for the research plan to dictate the methods that the researcher has to adopt (for example, whether to use interviews or questionnaires for information gathering) to gather data. Theoretical perspective directs the philosophical position of a research methodology and provides the steps involved which also ensures its rationality and standards (Flood 2010; Crotty 2003).

There are two main phenomenological approaches: descriptive (eidetic) and interpretive (hermeneutic) (Polit & Beck 2012). These two perspectives have different stances to the way data is generated from the outcome of the study to advance professional knowledge (Lopez & Willis 2004). Descriptive phenomenology originated from Husserl's original work and interpretive (hermeneutic) was by his student Heidegger whose interpretive stance was developed out of Husserl's but with adaptations (Wojnar & Swanson 2007). The work of both Husserl and Heidegger has been subjected in diverse ways to several analyses leading to different applications of phenomenology (Prim and Cunha (2006). However, as a research method, phenomenology has no singular approach to its use (LeVasseur 2003).

Descriptive phenomenology centres on the fundamental units (essences) or structures that make something what it is (Husserl 2001). Descriptive and interpretive phenomenologists have some similarities. They both study human experiences and the meaning individuals ascribe to these experiences. However, with descriptive phenomenology, the researchers

need to bracket any preconceived ideas about the situation being studied Chan, Fung & Chien 2013). However, in interpretive phenomenology, the researcher brings his experiences and presumptions to fore to help in the interpretation of the lived experiences of the actors and so bracketing is not compatible with interpretive phenomenology.

Phase 1 was intended to understand these essences from the participants' perspective that constitutes the basic units of common understanding of the concepts of child abuse and child protection. To achieve the aims of Phase 1, the researcher's theoretical stance about the Ghanaian radiographer's understanding of child abuse and child protection, and how these could be known, descriptive phenomenology was applied. In contrast, with hermeneutic phenomenology, the researcher understands that experience cannot be separated from the world of the researcher, who wants to realise epoché and as such, with hermeneutic phenomenology, it is not possible to describe the experiences of people without some level of interpretation (Giorgi 1992).

To provide the context of and achieve the aims of Phase 2, the researcher's theoretical stance applied to explore what could be known about the Ghanaian radiographer's experiences with child protection, it was necessary to first appreciate what to the Ghanaian radiographers constituted child abuse and child protection (Phase 1).

'Constitution' was a key word in Husserl's phenomenology (Spiegelberg (1982). The word constitution was applied by Husserl to explain the manner in which meanings have come to exist and that meaning and objects of reference are linked to one another (Sokolowski 1970). The researcher was interested in whether these meanings had any influence on their behaviour and perceptions in child protection (Phase 2).

In Phase 2, experience characterised the theoretical position of the researcher. Lived experiences (from the researcher's view) brought about understanding of what was not known for the construction of new knowledge. The researcher's initial interest in child protection was the researcher's assumptions about the world and reality. The researcher believed that Ghanaian radiographers were not engaging in child protection as required because their understanding of the concepts given consideration in in Phase 1. It was also believed that some internal and external factors might be impacting on the Ghanaian

104

radiographers' practice world in the management of child physical abuse. For example, it was the presupposition of the researcher that this may have shaped the Ghanaian radiographers' behaviour and perceptions (also influenced by their socio-cultural and work environment) resulting in a *spectator* attitude towards child protection.

3.10 The Selection of a Methodology

The philosophical approach guiding the research draws extensively from qualitative phenomenological methodology and perspectives. Developed as a reaction to the positivistic approach to research by Husserl who lived between 1859 and 1938 (Holloway and Wheeler 2002; Sadala and Adorno 2002), the phenomenological method is not concerned too much with empirical evidences. Scholars who work within the phenomenological traditions use this qualitative method to offer some insights into the phenomena under study by examining how they are perceived by individuals in that specific situation. According to van Manen (1990), there exist multiple realities which can be subjected to various analysis. The researcher agrees with van Manen (1997), who argued that knowledge is not derivative of scientific analysis but could be attained through sharing common meaning of mutual history, culture and language. The current study was not intended to develop abstract theories but rather, to find meaning to the perceived experiences of radiographers in child protection which could best be achieved through qualitative inquiry. Reality thus appears from what can be perceived and quantified (known as the positivist approach) (Van Manen 1997).

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105

statistical methods are often employed by quantitative scholars; something that is at times not possible with qualitative research which is aimed at in-depth understanding of a social phenomenon.

It should also be pointed out that both quantitative and qualitative approaches have opposing views and assumptions about the nature of reality (Topping 2010) and they do not share the same truth in the way social human behaviour may be analysed and interpreted (Simons & Lathlean 2010). For example, qualitative researchers argue that reality is based on how people give meanings to their experiences and their world. As a result, qualitative researchers contend that truth cannot be explained by a single entity but rather multiple meanings (Topping 2010). Qualitative methodologies attempt to highlight that there are multiple interpretations, truth or meaning, and as human beings differ, so do societies and norms of the people in their settings (Topping 2010). Moreover, the essential aspect of qualitative investigations rest on what is happening and not what was to be expected (Polit and Hungler 2012; Patton 2002; Creswell 1998). Following from these arguments, qualitative approach was central to the current study to understand what was happening in the world of Ghanaian radiographers' in relation to child protection resulting from child physical abuse based on the use of an interpretative approach.

Generally, scholars who work within the phenomenological traditions use qualitative method to offer some insights into the phenomena under study by examining how they are perceived by the actors in that specific situation (Polit & Beck 2010). They argue that the phenomenologist, is normally, faced with the question "what is the essence of this phenomenon as experienced by these people and what does it mean" (p. 494). The fundamental concept of phenomenology is that consciousness is always intentional and inseparable of the intentioned object; it cannot be something that exists independently of the objective world (Le Vasseur 2003).

Phenomenological inquiry has been used widely by many social scientists from several disciplines such as psychology, education, and health to describe a research perspective that is distinct from, and in opposition to, the more positivistic forms of inquiry (Connelly 2010). As the opposite of the positivistic approach, phenomenological inquiry operates

106

within the humanistic traditions with its emphasis on interpretation. Consequently, phenomenological methods are particularly effective at bringing to the fore the experiences and perceptions of individuals from their own perspectives in order to better understand the human experience as described by participants (Polit & Beck 2012; Cresswell 2009). The goal of the current study was to construct the meanings Ghanaian radiographers placed on their experiences. This perspective was used to explore the experiences of a sample of radiographers in Ghana on the question of helping to protect children suspected to be physically abused and who presented for imaging investigation.

3.11 Situating the Study in Qualitative Methodology

The word qualitative stresses the 'qualities of entities, the processes, and meaning', as opposed to quantities of, amounts, intensities, or frequencies (Denzin & Lincoln 2005). In contrast to qualitative methods with their strong emphasis on inductive reasoning and interpretation for examining social reality, quantitative or positivistic researchers tend to base their analyses on deduction and hypothesis testing using quantitative methods. Philosophically, quantitative studies are supported by assumptions that empirical truths and laws are reality (Topping 2010). As other scholars have pointed out, qualitative research seeks to comprehend, explicate and give descriptions of beliefs, behaviours and meaning based on the perspectives in which they usually take place (Wu & Volker 2009). Moreover, they contend that to understand daily human occurrences in all their complexities and in all their normal settings, qualitative methods should be used.

Qualitative methodology is associated with the interpretive and critical paradigms (Gray 2004; Henn et al. 2006). As a broad term, qualitative research design embraces several approaches for example, ethnography, grounded theory, case study and narrative research (Topping 2010; Creswell 1998). Followers of the interpretive paradigm, suggest that researchers' knowledge of the social world can develop when understood from the perspectives of the people being investigated rather than explaining their behaviour through cause and effect (Weber 1949 cited in Henn et al. 2006).

Discovering the social reality of Ghanaian radiographers regarding their experiences with child protection was only possible through meaningful interaction between the investigator and the participants by taking into consideration the socio-cultural context founded on the

interpretive paradigm (Grbich 2007; Rugg & Petre 2007). This study used a qualitative approach because its focus was to investigate experiences; understanding and interpreting behaviour and perception about child protection based on the participants' perspective as little was known in the Ghanaian setting. Qualitative methodology may be applied in a situation where little is known about a subject to explore experiences (Lacey 2010). Lacey argued that qualitative methodology requires no testing of hypothesis but seeks to explore events thoroughly by considering the context and complexity of the situation for deeper understanding (as against providing explanations).

The key issue which motivated the researcher in applying a qualitative approach, was its ability to help the researcher develop and appreciate how Ghanaian radiographers create and make sense of their world (Welch 2011). In addition, qualitative methods can be used to investigate micro-social processes as well as the cultural understandings the actors bring to the discussion of their social experiences and interactions. Qualitative methods are also somewhat flexible and afford the researcher a way to closely engage the people and groups under study. The choice of a research design or approach (quantitative or qualitative) to answer a research question often depends on which of these two approaches will reliably help the researcher answer the research questions (Benton & Cormack 2000; McPherson & Lord 2000). The value of a study is affected by the applicability and appropriateness of the method used in the data gathering process. In Phase 1, the study was intended to gain insight into the accounts of people's understanding of two phenomena (the concepts of child abuse and child protection), that made the use of the inductive approach the researcher's choice to investigate the meaning participants gave to their lived experiences. The use of such a qualitative approach was consistent with Barbour's (2014) assertion that it could aid the researcher to appreciate actions that would be seen as irrational in quantitative contexts.

van Manen (1990, 1997), an adherent of hermeneutic phenomenology, argued that there is no predetermined set of approaches in doing this type of research; however as part of qualitative investigation, purposive sampling with rich data is recommended (Merriam 1998). For data generation, several instruments can be applied that include interview, observation, and protocols however, because the aim is to bring out experiences of research participants, consideration should be given to the context and area of study to enable the researcher to apply the most suitable instrument for data collection (Kafle 2011).

3.12 Application of Phenomenology in Radiography Research

Three qualitative research methods are mostly identified in radiography literature: grounded theory, ethnography and historical approach (Ugwu, Ahamefule & Nwobi 2008). However, radiography practice is a critical area because of the practice encounter with all manner of patients including physically abused children. Radiographers encounter several people, professionals and situations in healthcare and these encounters could be studied using phenomenology (Ng & White 2005). Though limited, (compared to nursing research using phenomenology), several studies in radiography have been conducted with phenomenological approaches.

An interpretative (hermeneutic) phenomenological approach was applied to explore in-depth, real life issues, which surrounded the advanced practitioner as a solution to radiologist workforce shortages in Australia using radiographers, radiation therapists and managers (Page, Bernoth & Davidson 2014). A study exploring the ways in which diagnostic radiographers used distancing as a tool for emotional management in radiography practice applied hermeneutic phenomenology (Reeves & Decker 2012). Moreover, Keogh, Keogh & Bezzina (2000) examined nursing, radiography and primary health care within health care education in Malta using phenomenology.

This study is unique in that it combines two phenomenological approaches (Husserl's and Heidegger's) in a developmental sequence.

3.13 Summary

Phenomenology is noted as a philosophy and a method. In developing a phenomenological framework to support an exploration of radiographers' behaviour and perceptions about child protection resulting from child physical abuse, the two key phenomenological philosophies of Husserl (descriptive) and Heidegger (interpretive) were adopted in sequence. The epistemological orientation of the study was discussed and linked to phenomenology as the appropriate research method and philosophy. The chapter also discussed the rationale for adopting the two major philosophical approaches (descriptive) and (interpretive) in each phase of the current study. Husserl phenomenology was used to explore the cultural understanding of radiographers of the concepts of child abuse and child

protection in Phase 1 and Phase 2 adopted Heidegger's phenomenology to also explore the behaviour and perceptions of radiographers about child protection in Ghana. The next chapter takes the reader through the research methods for study

CHAPTER 4

METHODS

4.0 Introduction

This chapter focuses on the design for Phase 1 and 2 of the study. Phase 1 was structured in such a way as to gain some insight into how radiographers in Ghana investigate and also understood the concepts of child abuse and child protection. It was to enable the researcher to provide a holistic interpretation of the Ghanaian radiographer's behaviour and perceptions about child protection (Phase 2) with regard to the suspected child abuse cases they encountered in their clinical practice. As was stated in chapter 4, the epistemology relates to the overall study however, descriptive and interpretative (hermeneutic) phenomenology were used in Phase 1 and Phase 2 respectively to gain understanding of the meanings Ghanaian radiographers gave to their lived experiences with child protection in the management of child abuse cases in the hospital. Phenomenological investigations are mostly centred on the subjective experience of the individuals studied; they attempt to understand and describe a particular phenomenon (Gray 2009; Robson 2002).

Phase 1 was guided by the following research objectives:

❖ To determine the cultural understanding amongst Ghanaian radiographers of the concepts of child abuse and child protection.

Phase 2 was explorative in nature and it investigated the behaviour and perceptions of Ghanaian radiographers of child protection relating child physical abuse in Ghana. Three research objectives were developed at this stage and are as follows:

❖ To examine and assess perceptions and approach of radiographers in Ghana in handling child physical maltreatment cases.

❖ To determine the relationship between radiographers and other health professionals with respect to child protection in Ghana.

❖ To explore any cultural influence on the actions of the Ghanaian radiographer in managing child physical maltreatment.

4.1 Ethical Approval

Consistent with the guidelines enshrined in many research institutions, every research invariably involves compliance with ethical principles. The researcher took the advantage of a National Congress that was to be held by GSR in November 2012 to meet with the radiographers at the Congress just after returning from Sheffield to Ghana in the same month for Phase 1. In Phase 1, it was not possible to contact the radiographers in advance before they arrived at the Congress due to limited time that was available as the researcher returned to Ghana two days to the date of the Congress.

A provisional approval (Appendix A) was granted by the Research and Ethics Committee of Sheffield Hallam University (SHU). The president of the Ghana Society of Radiographers (GSR) was given an advanced notice in writing (Appendix B) prior to the researcher's arrival from the UK informing him about the study and the researcher's intention to recruit the radiographers for Phase 1 at the General National Congress. This was done because the participants could not be contacted from the UK in advance. Approval was granted by the GSR Ethics Committee and Ethics and Protocol Review Committee of the School of Allied Health Sciences (SAHS), University of Ghana (Appendix C and D respectively) before the study was commenced. The substantive approval from SHU for Phase 1 was later granted (Appendix E)

At the Congress, radiographers were briefed about the study and were provided with participants' information sheet (Appendix F) and followed with consent forms (Appendix G) which sought their voluntary participation. Participants, who agreed and were invited to take part in Phase 2 (which commenced in January 2014), were also provided with the same information sheets and consent forms before the study begun. Phase 2 was commenced after the final review and approval of the research proposal (RF1) by the various institutional Ethical Review Boards/Committees as follows: approvals from Research and Ethics Committee of SHU (Appendix H); Ghana Society of Radiographers (GSR) (Appendix I), Ethics and Protocol Review Committee of the School of Allied Health Sciences, University of Ghana (Appendix J). The final approval was granted to gain access to the hospitals and radiographers in Phase 2 was granted by the Ghana Health Service (GHS) (Appendix K).

4.1.1 Data Management Plan

At the time of conducting this study there was no approved data management plan from Sheffield Hallam University (SHU) about how participants' information or data was to be kept at SHU research archives (SHURA) and how it could be used when the need arose. However, it was then required that participants' information were saved on encrypted USB memory stick and kept under locks by the researcher. By the current SHU data management plan, the entire work and participants' data would be submitted to SHU data management archives.

4.1.2 Seeking Informed Consent

Seeking informed consent from research participants is an important aspect of any ethical process in qualitative research. This was obtained from the participants using the informed consent form (Appendix G) before each of the Phases was started. In Phase 1, because the participants were not given an advanced notice about the study, it was crucial that their consent was sought before seeking any information from them. Moreover, in Phase 2, although participants had given their consent to participate by filling in the consent form given to them before the interview, at each individual interview, the researcher sought participants' verbal consent by asking whether they were ready to be interviewed. There are aspects of participants' informed consent which is not possible with quantitative studies. Verbal consent (in keeping with best practice), was essential to be sure that they supported the use of their information as part of the interview process (Finlay & Ballinger 2006). Moreover, verbal consent was necessary in qualitative studies because ethics as argued by interpretivists is subjective by nature (Schwandt 2000). Additionally one cannot determine the direction of the interview, when issues starts to emerge, as such it is necessary that the researcher keep seeking consent as the interview progresses (Holloway & Wheeler 2002; McDonnell et al. 2000) an approach usually mentioned to as informed process consent (Ensign 2003; Behi & Nolan 1995).

4.1.3 Risk Assessment

Risk assessment was paramount in the entire study to ensure the researcher and participants' safety. Participant information sheet (Appendix F) previously was used.

4.1.4 Researcher's Safety

The initial risk consideration was about the researcher's safety especially when the researcher had to travel to the Congress ground in Phase 1 and also having to travel several kilometres to some participants in other regions during Phase 2 to conduct the interviews. The researcher personally drove throughout all the journeys to participants' sites. Colleagues at work were informed about where the journey was being made and on arrival, calls were made back home to inform them about researcher's arrival. The venue and time of the each interview during Phase 2 were also communicated to Colleagues. Similarly, they were notified when each interview was completed and time of returning home. Nothing negative happened to the researcher and all the participants were welcoming.

4.1.5 Participants' Wellbeing

The responsiveness of investigator liability for the safety of participants is very important in research involving human participants (Warwick University Research & Impact Services (n.d)). They argued that the risks to research participants could result from unwarranted stress through participation, loss of self-regard, psychological and also physical harm.

Based on ethical values of beneficence, it was essential that research participants were protected by upholding good and avoiding harm in the study; the researcher should be aware of the possible harm that is associated with studies involving human participation (Haber 2010). To guide against the possibility of any harm all the necessary measures to prevent any such experiences were handled through an in-depth explanation of the study to the participants. They were assured of their freedom to opt out of the study any time if they wished without informing the researcher of their reasons.

Psychologists give reverence to the self-governance of individuals by making rational decisions about any engagements in the course of their study that will result in some consequences of the individual's autonomy even temporarily (The British Psychological Society (BPS) 2010). Psychologists (according to BPS), always try to prevent any processes and procedures that could result in long term damage or apparent damage of autonomy of the respondent. In Phase 1, Participants were informed that the study was not intended to arouse any childhood difficulties and its attendant emotional challenges. They were told that the questions were not to test them but to gain information on what they

understood by these two concepts (child abuse and child protection) from their individual perspectives.

In Phase 2, which was an interview, the emotional stress associated with child abuse investigations was taken into consideration as against their capacity to be part of the study. They were informed that this was a follow up to Phase 1 and similar information provided in Phase 1 was repeated to them. The researcher was aware of the sensitive nature and possible emotional challenges of studies which related to potential childhood difficulties. To prevent this from happening or should it occur, during or after the interview, appropriate measures were put in place to offset this. This was done by assuring participants of professional intervention in the form of a counsellor they could access during the interviews who will respond to any negative occurrences. Participants were allowed to ask questions while the researcher also looks for any distress if the participants did not even express any such emotional problems as guided by (Haber 2010). Debriefing was conducted by the researcher after each interview to make sure participants left the interview ground safe same as they came for the interview and after a debriefing letter (Appendix L) was given to each of the participants before they departed.

4.1.6 Fair Treatment

The ethical principle of justice suggests that research participants should receive fair treatment. In Phase 2, participants were selected from those who had the experience of imaging children suffering from physical abuse who would be able to provide accurate account of their experiences and they were given the opportunity to decide when they could be available for the interview. An agreed venue safe for researcher and participant in each interview was discussed with each participant without any imposition from the researcher. The interviews in Phase 2 were conducted during daylight hours and participants were assured of leaving copies of the study findings with the office of GSR for study for anyone who wanted to have access to it either for reference for further studies or to check whether the researcher has not misinterpreted their views.

4.1.7 Ensuring Confidentiality and Anonymity

To ensure the protection of human rights, participants' right to confidentiality and anonymity was paramount in this study. Confidentiality is about guarding against associating participants' identity to any information they provided and that their information would not be disclosed founded on the principles of respect (Haber 2010). Participants were given the necessary respect by protecting their identity so they could not be linked with their responses and to any information provided (Haber 2010). To ensure their confidentiality and anonymity, identity codes (ID) such as Rad-0X (beginning from Rad 01-Rad-20) were assigned to each participant. The same ID codes also appeared on the transcribed data used for the analysis and the findings chapter to represent each participant when they were quoted to support an issue in the analysis.

4.2 Entering the Field

Access to the field in the entire study was through the granting of permission from the Ethical Review Committees as stated previously in this chapter. In Phase 1, when the researcher arrived at the GSR Congress in November 2012, the researcher had informal interaction with the participants. During the first two days the researcher attended each of the sections of the Congress as a participant radiographer. On the third day, access was granted to the researcher to meet with the radiographers in the mid-morning to formally explain the study to them after pre-arrangement with the Congress planning committee.

4.2.1 My Role as a Radiographer and Researcher

The researcher's values were recognised as impacting on how the research was conducted and what was valued in the results of the research. The researcher was both a radiographer and an academic, and acknowledgment of this was important in trying to ensure that the researcher did not introduce personal biases into the study. Several of the radiographers were aware that the researcher (apart from being a radiographer who had) previously worked with them in various hospitals, had taught and supervised a few of them as students.

In Phase 1, the researcher ensured that the environment was cordial and non-threatening through interactions and exchange of greetings, jokes and laughter during social hours such as tea breaks and when given the opportunity to talk to them before the study was conducted. This posture, adopted by the researcher, was necessary because generally in the

Ghanaian culture, people address a male or female superior with 'Sir' or 'Madam' respectively. This usually creates some kind of power and authority over the subordinate and a sense of self-importance of the superior. This could normally create some form of intimidation. This was avoided by asking all, to address the researcher with the surname and the necessary salutation 'Mr Antwi'. This is culturally the norm in Ghana to call people by their surnames instead of the first name as pertains in the UK. It was further explained to them that the entire study was for fact finding.

Despite the above precautions taken to ensure a free atmosphere where everyone's autonomy and freedom was respected, it was important to clear any misperceptions held by the participants about the researcher's role in the study (Ensign 2003). Moreover, it was also necessary to prevent a situation where participants would consider the researcher as one of their own (radiographer) (Houghton et al. 2010, Walls 2010) and have their attention diverted from the reasons for which they were asked to voluntarily partake in the research. This was important because evidence suggests that in several situations (when studying peers for example), there arises the possibility of participants presenting socially desirable responses to impress rather than genuine answers. This could negatively affect the study's outcome in terms of strength and value (Haber 2010; Armour et al. 2009). In addressing the likelihood of this occurring, the purpose of the study and the researcher's role were explained in accordance to the views of Orb et al. (2001) to create a distance from the professional self as a radiographer/academic and thus assume the image of a researcher looking for information.

As was stated above, participant information sheets were provided to all participants before the study was conducted. This also lessened any wrong anticipation that participants were entertaining (Orb et al. 2001; Smith 1999) at that time, such as providing information that could satisfy the researcher rather than true rich data demanded by the study. Despite the familiarity with some of the participants recruited, they agreed voluntarily to partake in the study without any force or influences. Accordingly those who gave their consent to participate in Phase 2, who had also been part of Phase 1, did so willingly and voluntarily. To fulfil the ethical process, participants were each given an information sheet and provided with the aims of the study stated. Participant's right to participate or withdraw from the study without notifying the researcher was made clear on the information sheet.

117

4.3 Phase One

4.3.1 Sampling and Recruitment Strategy

In Phase 1, all the radiographers who were attending the Congress were given the opportunity to take part voluntarily however, some abstained. It was not known who was willing to take part as there was no prior information available to them until the arrival at the Congress. As was mentioned previously, participants were recruited from the Congress ground due to limited time to contact them individually from their various working stations.

4.3.2 Data Collection Procedure

Two semi-structured (open-ended) questions (sample Appendix M) and the responses to which included spaces to fill in a brief demographic data (rank and years of professional experience), were administered to the radiographers who attended the Congress.

The basic concept of Husserl's philosophy of trustworthiness in descriptive phenomenology guided the study as it is associated with the description of the phenomena under study in its pure form from the perspective of participants (Sadala & Adorno 2002). Phone and email contacts were sought from participants as part of the questionnaire to seek any clarification of the information provided by them should the need arise. It was also intended for follow-ups to recruit participants for the Phase 2. It was also explained to them that by providing their contact details, they were willing to participate in Phase 2 when contacted.

Before administering the questionnaire, participants were encouraged to write freely and independently from their own perspectives and in their own words what they understood by the concept of child abuse and child protection. Open ended questions enabled the researcher to draw from participants, an in depth and varying responses for qualitative analysis of the information gathered (Sullivan-Boyai & Bova 2010). Participants had full control of the information they provided without any manipulation from the researcher which also helped in the bracketing of researcher's assumptions. Researcher's mind was opened to any responses participants would give.

The originality and reliability of the data provided by each participant for accurate description of information in its original state was gained. Participants completed the open ended questions in their own hand writing and in their own words within a period of 10-15

118

minutes. A box was placed at the entrance of the conference hall before the commencement of the study and participants were directed to place their completed questionnaire together with the signed consent forms into the box provided. To guard against the possibility of participants comparing ideas or looking for meanings of the concepts from elsewhere, they were not allowed to take the questionnaires outside to complete it at a later date. Large spaces were provided between the two open-ended questions to provide the participants enough space to write their responses without space restrictions.

4.3.3 Organisation of Data

The researcher was aware that participants involved in research studies could be apprehensive of what information they provided would be used for and how it would be interpreted (Holloway & Wheeler 1995). Therefore guarding their identities and ensuring confidentiality was paramount in this study. Identities of participants were only disclosed on the consent form but not on the questionnaire sheets so they could not be identified by the information they provided on the questionnaire. However their individual consent forms were attached to the questionnaire for the researcher to know who provided what information. Names and other identifiable information were removed from the hand written information provided by each participant and each line was numbered in accordance with Lacey & Luff (2001). Identification codes (ID) (e.g. Rad 01) were assigned to each participant to ensure anonymity and for the sake of the analysis and interpretation of data collected. In keeping with data protection policy, participant information was kept in a secured locker and copies stored in a USB memory stick with encryption software for analysis.

4.3.4 Data Analysis

Out of 120 radiographers who attended the congress 86 took part in Phase 1 achieving a response rate of 71.6%. The initial analysis began with typing in Microsoft Word format, each participant's hand written response (Appendix N) for easy analysis of the data. The next step was to assume the phenomenological attitude of descriptive phenomenology. The researcher had to bracket any personal presuppositions to have a new look at the data provided by the participants without suggesting its validity or existence in Husserl's epoché (Husserl 2008/1931). Thus the researcher viewed the data as it was in the way it presented itself without challenging it. This ensured that the researcher did not alter or critic the

119

object of intentionality (data) to affect its authenticity from the unprejudiced viewpoint (Husserl 2008/1931)

During the typing of the hand-written data, the researcher became immersed in the text to gain familiarity with the information provided by the participants. The typed data were further read several times to immerse deeply into the data Collaizi (1978) in order to get sense of meanings participants ascribed to the concepts. A thematic process, supported with Colaizzi's phenomenological analysis steps, was undertaken during the coding process of the text. At the same time, analytical notes were taken and coding schema to reduce the data (in audit file).

As an essential step in the familiarisation process, information from participants was cross checked with the aims and objectives of the study to ensure that the responses fell within the objectives (Ritchie et al. 2003). The typed data mirrors the conversion of participants' perception or understanding of the two concepts into textual language (Stubblefield & Murray 2002). However, just describing would not provide insight into meanings participants ascribed to the concepts. In-depth analysis or data conversion from the content stage of analysis to a higher level of constructs was done for generation of meanings (Stubblefield & Murray 2002). Significant statements/words that informed the concepts (child abuse and child protection) were extracted and recorded on a separate sheet noting their page and line numbers which were relevant to the concepts understudy. The typed information from the participants was then imported into NVivo for data management. The responses provided for child abuse and child protection (Appendix J and K respectively) were analysed separately using the same steps.

The formulated abstractions or themes were then organised into theme clusters of related themes to reflect the meaning of participants understanding in a wider sense which were scrutinised to explore their robustness with data. To describe the understanding of the concepts from the perspective of the participants, all the themes were included in the final description even when they did not reflect the overall meanings participants assigned to child abuse and child protection in keeping with Stubblefield & Murray (2002). They were of the view that the purpose of phenomenology is to describe the overall experience of the participants.

4.3.5 Ensuring Trustworthiness

Weak and vague research findings could result in wasted research time and effort when researchers fail to provide evidence of methodological trustworthiness (Long & Johnson 2000). As in quantitative studies where validity and reliability are paramount for the credibility of the investigations' outcome, similarly in qualitative approaches, including trustworthiness, and rigour are required for the strength, reliability, credibility and validity of findings (Streubert & Carpenter 2011; Vivar et al. 2007) and should be eminent in all stages of qualitative studies including data collection, analysis and descriptions (Mill & Ogilvie 2003; Holloway & Wheeler 2002).

Trustworthiness was achieved by applying the principles of credibility (whether results can be believed) and in keeping with this the researcher had a prolonged engagement with the area of study through thorough reading and looking at various aspects of child abuse and child protection in order to provide credible findings. Moreover two poster presentations (Antwi 2015) were made to radiographers in Ghana as a form of member checking and to enhance the study's credibility (Goldblatt, Karnieli-Miller & Neumann 2011). It also allowed the research participants to verify whether the findings were true to their experiences (Yonge & Stewin 1988). This action provides "correlation evidence to support the truthfulness and consistency of the findings" (McBrien 2008, p. 1287).

Participant hand written responses (Sample Appendix M) and the type written format (Appendix N) are kept as part of an audit trail including the analysis of the responses. Transferability compares results of studies in similar situation, dependability (repeatable) and confirmability -thus corroborated by others (Talbot 1995). The Participants hand written information was typed exclusively by the researcher and the two data sets were cross checked to ensure every detail provided by each participant was accurately captured in the type written data.

Unlike verbal interviews (where researchers on many occasions struggle with transcription and could make mistakes or introduce bias), the validity of responses was guaranteed because the responses were initially hand written by participants and it was easy to read and transcribe them into word format without any researcher bias during the coding. Both hand-written and transcribed texts were shown to local supervisors for verification and having

been cleared of any errors and biases, copies were shown to the Director of Studies and second supervisor. Whilst in most interviews, data trustworthiness implies going back to participants to verify with them the information gathered; this has been highly contested as to its necessity.

Armour, Rivaux & Bell (2009) argued that efforts to improve methodological rigour by using fixed approaches may fail to spot the distinctive threats to rigour that certainly surface when a study is examined for its specific susceptibilities. In their view, the use of predetermined approaches to enhance rigour in qualitative methods can pose several difficulties. Member checking which is applied to check researcher bias is not necessarily authentic and that participants in a research project are not free from their own biases, plans, and social limitations (Barbour 2001). Barbour is of the view that participants may portray themselves in a good light and it is essential that the researcher reflected on participants' feedback on any particular study. With member checking participants' data and the interpretations done are presented to them (Creswell & Miller 2000). They are of the view that the validity process is determined by the participants not the researcher. Lincoln & Guba (1985) describe member checks as "the most crucial technique for establishing credibility" (p. 314) and the credibility was very important to this study. Member checking was done during a workshop organised by the department of Radiography of the University of Ghana and the professional society (Antwi 2015)

Even though what participants wrote served as evidence of their own report, and despite the above arguments against member checking, the typed text was communicated to participants who left their telephone contacts for verification of what they actually wrote. Looking at the number of radiographers who participated in the study (86), it would have been a difficult task approaching all of them for verification in their various settings. Moreover participants could neither be communicated to by emails due to unreliable internet service in most of the places across the country nor by postal service due to the cost of postage. However, 52 (60%) participants, who were part of Phase 1 study, were in the national workshop and all had the opportunity to listen to the poster presentation (Antwi 2015) and questions from them were accordingly answered.

4.3.6 Achieving Bracketing

By the basic principle of bracketing, the researcher's personal experiences are not supposed to sway the participants' understanding of the concept understudy (Chan, Fung & Chien 2013). Despite the imprecision and the blankness associated with the method of bracketing (Gearing 2004) there was the need to adopt a position to ensure bracketing. The researcher in the current study assumed a no talking posture on the topic by not trying to tease or explain to the participants what actually child abuse and child protection was supposed to be before the study. This was relevant because participants were multicultural which the Ghanaian society is. Definitely taking the cultural values of the people into consideration, they might have different interpretation of the concept of child abuse and child protection which should not be contaminated by the researcher's own cultural values. These feelings in accordance with Ahern (1999) were noted in the researcher's diary including role conflicts whether the participants were going to provide their understanding based on their cultural affiliations or what was theoretically known. The researcher remained open to allow rich data to emerge from the participants (Giogi 2011; Lopez & Willis 2004) who might have been taken for granted. Participants wrote their responses individually in the same conference hall and in the quiet without any verbal interaction as would have been the case with one-to-one interviews. During familiarisation with the hand written and later with the typed data, the researcher was interested in gaining new understanding aside of what was already known to the researcher to advance the validity of the data generated and its analysis (Ahern 1999). My life story and my position as a researcher has been given a detailed description to indicate my experiences with the phenomenon in the reflexivity section (Chapter 10) of the current study to demonstrate rigour required in qualitative studies (Houghton et al. 2013) and quality (Shelton, Smith & Mort 2014). These experiences were put in abeyance to prevent those factors which place boundaries on an experience when seeking participants understanding of a phenomenon which might already be well known to the researcher from influencing the study (Ray 1985).

The establishment of an audit trail was paramount during the study and this was achieved as described in the next section.

4.3.7 The Audit Trail.

As part of the audit trail, participants were assured that the research process and findings would be presented in a scientific workshop or congress organised by the Ghana Society of

Radiographers any time. According to Holloway & Wheeler (2010), the researcher in phenomenological studies should make a selfless effort to present the study to the appropriate people. This was done during a national scientific workshop on quality assurance where the researcher took the opportunity to mount a poster presentation (Antwi 2015). Copies of the posters were also seen by researcher's supervisory team and also submitted to SHU for display and archiving. The posters, the analysis process, hand written analytical notes and maps were kept in files for reference and audit checks.

4.4 Phase Two

4.5.1 Methodological Issues and Concerns in Phase 2

Central to phenomenological hermeneutics is 'being in the world' or the lived experience (Heidegger 1962). Phase 2 used a one-to-one semi-structured interview, which provided the opportunity for the researcher to gain insight into the lived experiences of radiographers with child protection issues in their practice. The approach was driven by the researcher's ontological position - "the nature of reality" that in being in the world, the individual having experienced the world, cannot be separated from the object of attention an argument supported by various philosophical thinkers in phenomenology such as Heidegger (1962), Gadamer (1975) and van Manen (1990). "Human actions is not governed by discrete, objective patterns of cause/effect (as in positivism), but by social actors situated interpretations and meanings". (Jensen 2011, p6).

The initial concern was with the number of participants to recruit for the study. Even though the aim of phenomenological research is not geared towards generalization of the results, and for that the number of participants to recruit is not an issue in phenomenology (Converse 2012), the researcher was verbally asked by the ethical authorities of Ghana Health Service to use at least 20 participants instead of the initial 7 in the research proposal approved by SHU Ethical Committee. The granting of the ethical approval from the GHS depended upon complying with this directive. The researcher had explained to the Chairperson that for studies seeking to understand the meaning individuals give to their lived experiences, the number of participants could be fairly small (Kleiman 2004). The researcher reported the issue to the Director of Studies and SHU Ethics Committee who directed that the researcher submit a completed Major Amendment Form to review the

sample size to 20. A major amendment form from SHU was completed for approval to use a sample size of 20 which was granted later by SHU Ethics Committee (Appendix O).

The second issue of concern was with the relationship between the researcher and the participants. In this study the relationship as mentioned earlier between the researcher and participants was the fact that the researcher was also a radiographer by profession and academic. Participants and the researcher both had similar professional knowledge and there existed an ongoing professional bond. With studies involving the use of interviews for data collection, the researcher and interviewee relationship should not be overlooked and there is the need to weigh the positive and negative aspects of the study before the research process was started (Coar & Sim 2006).

The benefits of the study to the radiographers were deemed to be the awareness it would create among them about their role and practice implications in child protection to which they might not previously have given serious attention. There was also the concern of participants revealing negative reports about their situation in managing child physical abuse cases which could affect their professional image and that of the hospitals where they worked. Moreover, when a researcher was known to participants, they could disclose some information to the researcher which could lead to ethical and moral challenges for using such information as data (Silverman 2000; LeCompte & Schensul 1999a). Additionally, the bond between the researcher and participants could potentially have impacted on the dynamics of the interview process such as for example, interviewees having the notion that the interview was a form knowledge testing (Coar & Sim 2006). These concerns were addressed by demystifying this thinking before the beginning of the interview. Participants were informed that the study was purely information seeking about the protection of children when they present for imaging with a history of suspicion of abuse. The significance of identifying this possibility was to avoid any control over peers because the researcher was an academic and few of the radiographers had been taught by the researcher. However, the professional fraternity enjoyed by the researcher, seemed to enhance the recruitment, as any of them contacted appeared keen to take part in Phase 2.

Other concerns were the fact that the researcher had to travel to 5 regions in the country to interview 6 participants at their own scheduled day and time. Two sessions had to be

cancelled and rescheduled. While at the setting the researcher had to wait for the radiographer to finish all imaging cases that had to be done. In all these places the interviews were conducted in the offices of the radiographers at the time where the day's work had been completed and there were not going to be any disturbances. The researcher had to wait for long periods before staring the interview. The remaining 14 radiographers were all from the capital city where the researcher worked and resided. Two of the interviews were conducted at the premises of the participants' hospitals while the remaining 12 were in conducted in the researcher's office upon agreement with the participants. However those who had to take transport were paid their expenses from the researcher's own personal funds including lunch because all the interviews took place in the afternoon.

4.4.2 Sampling Technique and Criteria

The objective of sample selection in the application of hermeneutic phenomenology in Phase 2 strictly followed eligibility criteria. These were to have radiographers who had actually been involved in imaging children who had been or suspected to have been physically abused. Although participants in Phase 2 were selected from those who took part in Phase 1, the researcher made sure that all the recruited participants had imaged children suffering from physical abuse. As a result, it was inquired from them through the telephone numbers they provided in Phase1 to confirm. The above stated characteristic features of the population formed the basis for the inclusion and exclusion criteria in conformity with Haber (2010) who argued that research participants should be typical of the population being studied. Purposive criterion sampling was thus used to recruit the participants. Patton (2001, p.238) defines criterion sampling as "selecting cases that meet some predetermined criterion of importance".

Purposive criterion sampling is said to give consideration to the research problem and the type of information required and the qualities of the participants which ensure that participants' selection was based on defined qualities (Tongco 2007). Such participants must have had the experience themselves (having imaged abused children in this case) and be capable of recalling it and produce a rich story (Streubert 2011). Besides these selection criteria, the sample could also be taken from knowledge of previous studies (McDonald et al. 2003) in purposive sampling. All the above steps were taken to recruit the radiographers in the current study. For example participants had prior knowledge of Phase 2 because they

took part in the Phase 1 and had given their consent to participate. They constituted a homogenous sample (radiographers) in order to achieve a particular set of similar cases, reduce variation and enhance data analysis.

4.4.3 Recruitment

Recruitment of study participants requires that the researcher makes the effort to have participants who are reliable and fulfil the inclusion criteria. Participants who were far from the researcher's domain were recruited through the telephone contacts they left when they took part in Phase 1 and they were subsequently followed with a covering letter (Appendix P) inviting them to voluntarily participate. Those who were close to the researcher (especially at the premier teaching hospital which had the majority of radiographers) where the researcher's office was also located, were approached to discuss their willingness to participate. In all the recruitments, there were no incentives attached.

4.4.4 Methods of Data Collection

Data collection in interpretive phenomenology research method is usually by in-depth interview with the participants (Patton 2002, Lopez & Willis 2004) and is achieved through semi-structured interviews with the researcher's attention on occurrence as experienced by the participants (Flood 2010). In Phase 2, face-to-face individual interview was chosen instead of the use of focus group and telephone interaction for a number of reasons. For example, the study required in-depth information and insightful explanations from individual stories and examples. These normally, are provided in exhaustive individual interviews through In-depth interviewing using a small number of participants to discover their perceptions on a specific issue, program, or situation (Boyce & Neale 2006). In-depth interviews have the advantage of gaining comprehensive information according to Boyce and Neale about an individual's beliefs and behaviours or when one desires to identify fresh issues thoroughly. In-depth do offer a more comfortable environment in which to collect data from individuals compared to focus groups - individuals may also feel more relaxed having a discussion with the researcher and talk about issues as against filling out a survey (Boyce & Neale 2006).

The individual interview allowed the researcher to explore deep into the social and personal issues of the participants usually not possible with group interviews because of their open nature during the interview process (Rubin & Rubin 2005; Johnson 2002). Telephone

interview was also not ideal because the researcher needed to capture and understand the participant's setting, expressions and emotions. The semi-structured phase was critical to this study as it was necessary in the interviews to draw out rich and in-depth information of perceptual prominence to participants, rather than the researcher almost exclusively steering the entire process as would be the case with more structured methods (Barbour 2014).

4.4.5 Semi-Structured Interviews

Semi-structured interviews allow the investigator to prepare interview questions prior to the study and permit the participants the liberty to express their opinions in their own way (Cohen and Crabtree 2006). It also gives the researcher the opportunity to probe further the participants' responses, thoughts and meanings (Rigney & Davis 2004). Guided by DiCicco-Bloom & Crabtree (2006), the semi-structured interviews were organised around a set of prearranged open-ended questions (Appendix Q) as key issues. It also included other supplementary questions and probes were made to some responses as the interview went on. Prior to the actual data collection, a pilot interview was conducted with two radiographers. Findings from the pilot study were used as a guide for the actual interviews. In addition, the pilot interviews were useful as they allowed the researcher to practice interviewing skills and also evaluate the appropriateness of the questions and their feasibility for the study. The questions did not pose any ambiguities for any remedial actions to be taken. However, the researcher had to develop confidence and voice training which enhanced the fluency in asking the questions in the actual interviews.

In both the pilot study and the actual interviews, permission was sought from each participant to use a digital voice recorder VN-711PC (with 2 GB and 823 hour recording capacity) after explaining to them that there would be the need to playback after the interview for the purpose of transcription to aid in the analysis of the data. The individual participants granted the researcher the permission to use it. Additional batteries as a backup were kept during the interviews to avoid any low battery issues. Generally according to DiCicco-Bloom & Crabtree (2006), semi-structured interviews take about 30 minutes to several hours to complete. In the current study, each interview lasted from 45-90 minutes. The recorded versions of the interviews were played back and transcribed for analysis by the researcher.

In phenomenological research the researcher should appear naïve to allow the research participants to appreciate their perceptual prominence as they possess the meaning of their experience (Munhall 2012). This was achieved by allowing the participants to voice their issues without hindrance while the researcher's knowledge of issues was constrained to unearth other opportunities (Munhall 2012). This was achieved by avoiding leading questions where possible during the interview process.

All the 20 radiographers of diverse cultural lineage contacted across the country were very willing to participate and also pleased to be part of the study to fulfil the promise made during Phase 1. It is important for the reader to also note that generalisation is not possible with interviews and as a general principle on sample size for interviews, when the same information, themes, issues, and topics are developing from the interviewees, then the appropriate sample size (or data saturation) has been attained (Boyce & Neale 2006).

Before each interview, they were advised about the possible need to access counselling services where required. The first five interviews were conducted outside the researcher's domain (Greater Accra region also the capital city). The researcher had to travel to five regional hospitals to conduct the interviews at the convenience of the radiographers who had given their consent to participate. In all these regions, the interviews took place at the offices of the radiographers. Where there were other radiographers in the department the interview took place approximately 30 minutes after the researcher's arrival. In one particular regional hospital, the researcher had to wait about 3 hours for a lone female radiographer who also doubled as a sonographer to complete all the X-ray and ultrasound examinations before the interview. The rest of the interviews were conducted at the capital city where the majority of radiographers were located. One participant from northern region (whose department was a great distance away) happened to be in Accra for a programme, granted the interview in his hotel residence in one afternoon. This saved the researcher from having to travel from Accra to the north which is very far from the capital city to conduct the interview.

From their stories they were mostly motivated to take part in the study as a result of their involvement in the initial study (Phase 1) and their apparent resolute concern about violence against children and how they were handled when presented at the hospitals. They

were also influenced by the attention the study brought to bear on them about their critical roles in child protection as distinct from radiation protection concerns of the radiographer, when imaging children. None of the participants showed any sign of emotional after effects as previously anticipated in initiating such a sensitive study. Giggling and laughing characterised some of the participants' narrations or responses however, anger and frustration were identified in a few faces regarding some of the serious abuses of children they encountered in their practice as well as when a few of them came to the point where they expressed the lack of direction and poor inter professional relationships in dealing with cases of abuse generally when identified. No restrictions were placed on their responses which gave them the opportunity to share their experiences. Some gave short responses to some questions whilst others spoke at length sharing scenarios of abuses they handled.

Participants were free to ask the researcher to repeat questions that they did not hear properly or understand. Hitting of tables and hand gestures were observed to emphasise their stories. Some of the responses warranted probing to clarify issues further. Participants' lack of knowledge of some issues of child protection process was identified as well as procedural protocols of imaging abused children. One participant frequently mentioned the name of her superior to whom she often discussed child abuse cases she suspected but her attention was drawn to the confidentiality and anonymity of any significant person. Their concerns about the Ghana health care system regarding child abuse management were shared without reservation. There were good-natured remarks from all the participants interviewed who, after the interview, appeared highly relieved for being given the opportunity to share their experiences. It had hitherto not registered in their minds that those issues of child protection resulting from child physical abuse might constitute significant practice concern. After the interviews, participants assured the researcher of their readiness to respond to any calling for further clarification of any issues that came up during the interview process.

4.4.6 Analytical Notes

During the interview, brief notes were also taken (where possible) either for probing or a reflexive concern or also to note down observations. Brief notes as part of the interview process allowed the researcher to describe the setting and the various activities encountered. The notes were helpful for the familiarisation stage to record the main issues

130

without letting these dominate the decontextualisation of the data. This process of reduction is a vital part of performing qualitative analysis for the source of themes to remain rooted in the data, and also prevents the participant's reality disappearing by simply overlaying themes from the researcher's perspective (Ritchie et al. 2003).

4.4.7 Analysis of the Qualitative Data

The recorded interview from the digital voice recorder was listened to and transcribed verbatim. The transcribed data was crossed checked with the audio conversation and the analytical notes and diagrams (Figure 6) (as summaries of what was read) to be sure participants' true narrations were fully captured.
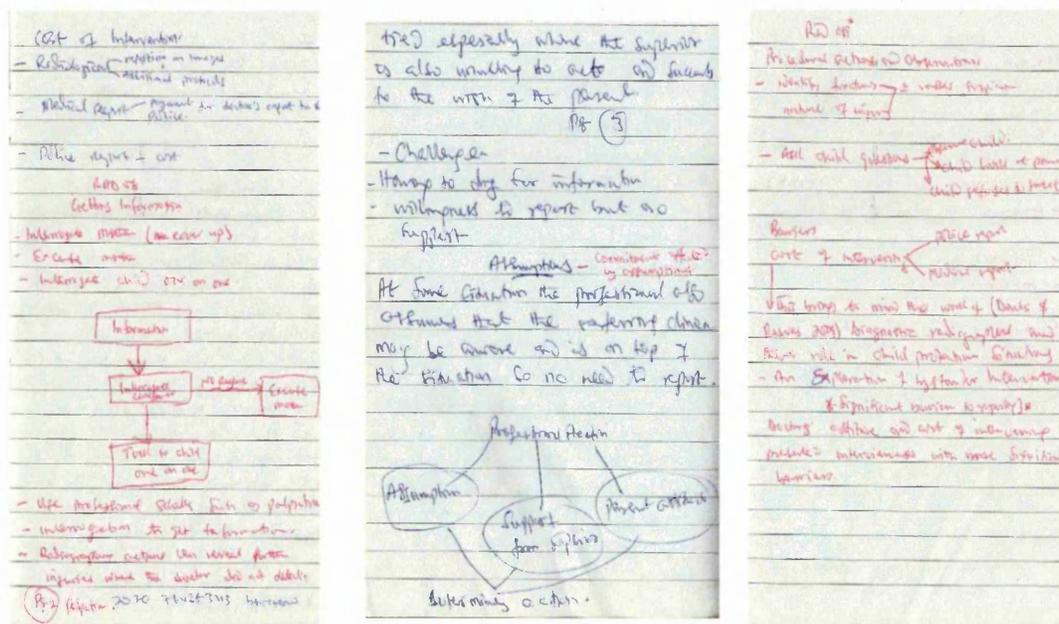
Figure 6. Analytical Notes and Sketches.

Familiarisation with data in qualitative analysis was necessary to understanding the life world of the participants in this current study. This was achieved through several readings of the transcribed text. It was followed by thematic analysis (which is not tied to any epistemology or paradigm) on all the individual textual data.

In keeping with van Manen (1990) this phenomenological hermeneutic thematic analysis followed some steps. Firstly, and in using manual coding, deep structures which

characterized the participants' stories from their lived experiences with handling child physical abuse were sought for by searching through and reading between lines of each textual data for important words and conceptions while interpreting the data including the researcher's reflective data in the form of analytic memos (Saldaña 2013). At this stage as guided by Saldaña, a careful consideration was given to language and deep reflection on the developing patterns to gain understanding of participants' meanings of their experiences. Thematic analysis necessitates the participation and interpretation of the data by the researcher to capture the niceties of the meaning within the textual data (Guest, MacQueen & Namey 2012).

The next stage involved precoding of words and short phrases by circling, bolding and highlighting or underlining and colouring participants' significant quotes of text in the passages that indicated key intents of participants' own experiences. Comments were made alongside of the participants' quotes during the pre-coding to reflect meanings of the quotes. At this stage, significant ideas were coded and grouped into keywords, categories, sub-themes and, finally into 5 themes and sub-themes (Appendix R) which were managed with NVivo software version 10 to include quotes from the participants used to support the analysis. This was followed by identifying key quotes, which were considered to be the best cases of each idea put forward by the participants and these were selected for interpretation. Participants' responses are included in the audit file for checks. The themes and their sub-themes developed out of these responses are fully described in the results section in Chapter 6 following.

4.4.8 Ensuring Trustworthiness

There are a lot of arguments about the quality of phenomenological research and four standards of quality credibility, transferability, dependability, and conformability have been attributed by Guba & Lincoln (1999) for this kind of research. In contrast, Kafle (2011) argued that this quality stance of Cuba and Lincoln may not be suitable for hermeneutic phenomenology (Kafle 2011). In support, van Manen (1997) indicated that hermeneutic phenomenology is a paradigm suitable to the study having pedagogic importance and provided four rigour criteria (i.e. orientation, strength, richness and depth) for hermeneutic phenomenology as the key quality issues that should be considered. Moreover, van Manen

further argued that hermeneutic phenomenology is a scholastic practice of textuality where the study involves text that illuminates the life world experiences of the researched.

With its data analysis, hermeneutic phenomenology applies rigorously the hermeneutic cycle in analysis of data which according to Holloway and Wheeler (2010, p228), is the interpretation of participants' narratives (text). Holloway and Wheeler, explained that with hermeneutic cycle, the researcher examines the parts of the lived experiences, then the whole and back again into the text in a spiral process to gain reasonable understanding and meaning of the text.

Demonstration of rigour in Phase 2 was centred on van Manen's (1997) rigour criteria for hermeneutic phenomenology (i.e orientation, strength, richness and depth). From van Manen's expositions, orientation is about the position of the researcher in the life world of the participants and their shared experiences which was the fact that the researcher was a radiographer and may have similar experiences of the participants, and by strength, refers to convincing fitness of the text to exemplify the central purpose of how participants are appreciative of the essential meanings articulated by them through their reports.

Recording the interpretation of data is an integral part of stages in phenomenological investigations and it demonstrates the strength in the research approach (Converse 2012). In the current study, the process of thematic analysis and the application of the hermeneutic cycle of interpretation of data were duly complied with. The analysis of Phase 2 data was circular and back and forth to achieve the depth and richness of participants' information making sure contrasting views were also captured. The aspect of richness is envisioned to aid the attractiveness of the quality of the text that recounts the meanings acknowledged by the participants. This aspect was achieved through the interpretation of participant's information and supported with quotes in the findings chapter. In achieving depth, the research text picked from participants' narrations had the capacity to illuminate the finest of the ideas of the participants. Reflexivity has generally been used to validate qualitative research activities (Kingdon 2005; Cutcliffe & McKenna 2002). Reflexivity was applied in Zitomer & Godwin's (2014) study as a measure of rigour which the current study draws from and has been provided in Chapter 10.

4.5 Summary

Thematic analysis supported with Colaizzi's phenomenological analysis steps was used in Phase 1 of the study. The descriptive phenomenological approach was necessary to understand the essences of concepts. Using a series of thematic steps, what was hidden within the radiographers with regards to the concepts studied was made known to the researcher. Phase 2 adopted the hermeneutic cycle for the data analysis to develop themes supporting participants' experiences with child protection. The hermeneutic phenomenology was not compatible with bracketing of the researcher's assumptions. Because the researcher was a qualified radiographer, there was the strong desire to know more and share participants' experiences with management of child abuse. Trustworthiness was an important component of the methods adopted and was demonstrated and in both Phase 1 and Phase

CHAPTER 5

FINDINGS OF PHASE 1

5.0 Introduction

The previous chapter discussed the methods used in Phase 1 to achieve the purpose of this study, which was to explore the cultural understanding of Ghanaian radiographers with respect to the concepts of child abuse and child protection. Husserl's descriptive phenomenological approach which requires the researcher, at this stage, to present a theoretical framework representative of the important components of what is being studied (Colaizzi 1978) was used. This is also acknowledged in Swanson-Kauffman and Schonwald (1988, pg. 104) as "a universal skeleton that can be filled in with the rich story of each informant." Following from this expectation, the significant responses of the participants who were studied are summarised below (Chapter 6) using themes that were developed. In describing the participants' reports, identification codes (ID) such as "Rad 01" was assigned to each participant to ensure anonymity.

The findings for Phase 1 are reported in two sections and to ensure that the researcher did not bring on board personal biases in fulfilment of bracketing researcher's assumptions, the meanings participants assigned to each of the concepts are presented the way they described the essences of these concepts. The first section provides the evidence about child abuse, while the second deals with child protection. Themes generated in the exploration of each concept are represented in a diagrammatic form. After presenting the Phase 1 findings, a discussion of the relevant findings are presented in Chapter 7.

5.1 The Demographic Profile of the Study Participants: A Summary.

The analyses reported here were based on the responses provided by 86 radiographers. These participants reported varying levels of work experience as radiographers. They ranged from a low of 1 year to a high of 35 years. In terms of professional rank, they ranged from a basic radiographer to an assistant chief radiographer and from various ethnic backgrounds. At the moment, a chief radiographer is the highest professional grade in Ghana.

Table 1: Theme clusters.

Ill-treatment	Negative actions	Abandonment
• Physical • Sexual • Verbal • Social	• Forced marriages • Adult responsibilities • Child trafficking	• Emotional/Psychological • Educational • Health • Physical

Table 2. Case Chart for concept of child abuse.

	Theme: Ill-treatment	Theme: Abandonment	Theme: Negative actions
Case	• Disorientation of child's stability • Deliberate actions that is detrimental to a child -without the child's consent. • Ill-treatment	• Actions that undermine the fundamental rights of the child. • Taking away a child's freedom • Denial of child's necessity • Disregard of child's rights • Desertion	• Things done which infringes on the child's right • Actions that affect the child's livelihood. • Cruel treatment • Depriving child of comfort. • Forcing child into marriage

136

5.2 Section1: The Concept of Child Abuse.

The radiographers who reported their knowledge about the concept of child abuse gave varying interpretations about what constituted child abuse. For example, some participants considered negative social factors and/or use of derogatory statements against a child as abusive while others felt otherwise. Examples of abuse were given by some participants to support their views on the concept. Participants' expressions regarding behaviours of parents or caregivers did not promote the wellbeing of children categorised these behaviours as an infringement on a child's basic rights and freedom as a human. Abandonment of a child in various forms was also cited as neglect of a child and some participants considered it as abuse.

Concerning their understanding of child abuse, from the responses provided by the radiographers studied, three main themes (Figure 7) which were noted to infringe on the rights and freedom of the child were generated.

It should be pointed out that some of the views or understanding shared by the participants were either the same or in some cases different on the concept of child abuse. These themes also had their sub themes as depicted in Figure 7 below –as a form of framework where all statements provided by participants were fitted in the form of themes. All these themes and essential structures contribute to potential instability for a child's sound development. These are summed up to provide one major theme: unfair and inhuman treatment of the child as depicted in Figure 7 below.
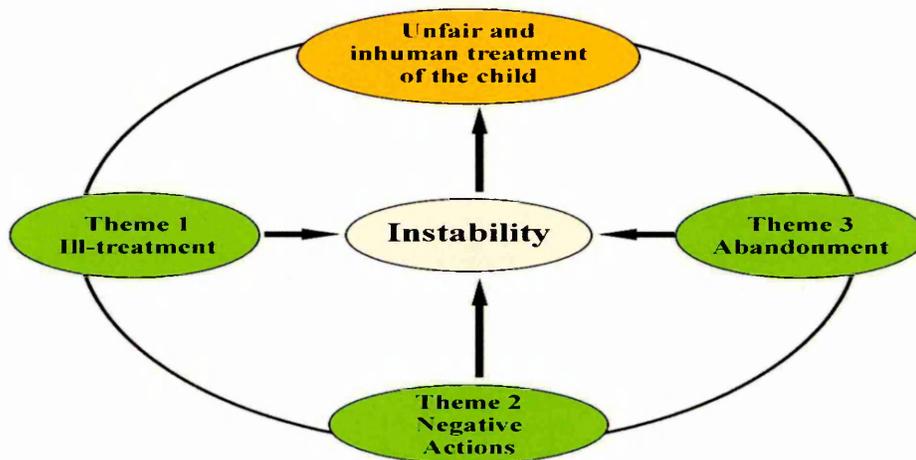
Figure 7. Participants' concept of child abuse.

The Table below indicates the sub-themes of the coding categories.

Table 3. The sub-themes of the main categories.

Ill-treatment	Negative actions	abandonment
• Physical	• Forced marriages	• Emotional/Psychological
• Sexual	• Adult responsibilities	• Educational
• Verbal		• Health
• Social		• Physical

5.2.1 Ill-treatment

Many of the respondents considered this theme as an example of physical, verbal, sexual and social abuse.

Some participants combined all these to explain their understanding of child abuse as follows:

> "The maltreatment of a child sexually, physically or psychologically" (Rad 069)

138

"The unlawful assaulting of the child whether physically, emotionally and mentally". (Rad 073)

One participant felt that apart from the parents own actions against the child and also any adult, the society is also partly to be blamed of their behaviour which affects children's freedom to thrive. Thus child abuse was understood by this participant as actions perpetrated against children by parents and society which have a negative impact on the child's wellbeing.

"Has to do with the physical, mental and emotional trauma meted unto children by adults, parents and the society at large. This causes several degrees of damage to the wellbeing of the child" (Rad 085).

General knowledge was noticed in the participants' definitions of child abuse all dominated by physical, psychological, emotional and sexual abuse:

"An act or actions that causes adverse negative effect on a person below 18years, physically, emotionally and psychologically" (Rad 047)

"It is the physical, sexual or emotional mistreatment or neglect of a child. It is any act or series of actions of commission or omission by a parent or caregiver that results in harm, potential for harm or threat of harm to a child". (Rad 053)

"The physical, psychological, emotional and sexual maltreatment of a child or any form of neglect from a parent/guardian or a caregiver to fulfil responsibility" (Rad 074)

"A violent way of handling a child which in effect causes injury to the child physically, emotionally and psychologically" (Rad 042).

"Maltreating a child who can't protect himself/herself by subjecting such a child through beatings and other wicked acts" (Rad 084).

Parental or caregiver harsh verbal attacks on children were noted less frequently, but some participants felt using harsh words on a child was not right because of their negative emotional impact. Some of the participants stated that such actions contravened the rights of the child.

"Infringement on the fundamental human rights of the child as a person. This could be in varied forms, some of which are physical, verbal and psychological" (Rad 016).

"Cruel treatment of a child. It can be ...., verbal... etc".(Rad 046)

"Indiscriminate and unlawful treatment of one's child or another's child through ....the use of insults" (Rad 057)

"...It can also be reigning (sic) harsh insults on a child for committing a small mistake (Rad 066).

The meanings assigned to child abuse under the ill-treatment category, was physical, sexual and emotional abuse. It also included verbal aggressions on the child all of which participants felt could have undesirable influences on the child's wellbeing.

5.2.2 Negative Actions

All forms of abuse have a negative impact on children, however in this study, some attitudes towards children were specifically categorised under negative actions in order create a distinction to other forms of attitudes that infringes on the rights of the child.

Taking advantage of the child's vulnerability because they lack knowledge of their rights and freedom was unacceptable to some radiographers in the study. These were categorised as negative actions against children:

"The maltreatment of a person under age who normally does not know his/her rights and freedom. It is treating a child in harsh and wicked ways" (Rad 059).

Actions against children beyond their conventional age as accepted by the society were abusive to one participant in the study.

"Child abuse is any form of action which a child is subjected to below a certain conventional age and therefore depriving the child his/her right to comfortable life" (Rad 052).

These negative actions were also extended to the situation where children were forced into activities for financial gains of caregiver or parent.

"Maltreating a child and taking undue advantage of the child as well due to financial and social issues etc" (Rad 061).

One participant felt children were more of a responsibility than an asset and explained that by their age, even if they could perform any activities, they should be cared for and not taken advantage of by needlessly using them.

"Using children in the wrong way/excessive use of children. That means, before proper/actual maturity, children should be more considered as liabilities than assets. Sadly, once a child can walk, talk and handle certain personal things on his own, some adults take advantage and make the children more of assets". (Rad 070)

One participant wrote that child abuse was a behaviour acted on children that could have the potential to harm them physically or cause psychological pain or discomfort.

"Any action taken against a child that might cause the child physical and/or psychological pain or discomfort" (Rad 026).

The situation where a child was either forced into marriage while she/he has not reached the consenting age for marriage or asked to perform an activity against their will, was undesirable action and a participant noted it as abuse:

"…when a child has not reached the age of marriage and she is forced into it… asking a child to do something against…her will " (Rad 067).
Besides forced marriages of children child trafficking (as observed by Rad 01) and engaging children into hawking activities were seen as negative behaviour by caregivers.

"The physical and mental disorientation of a child's stability by an individual …includes child trafficking and hawking" (Rad 01).

Various forms of objectionable behaviours against children were best described as inhumane treatment such as involving children in stone cracking (a form of quarrying in Ghana). Various forms of construction work and small scale mining for money were noted by Rad 053 and Rad 086 as abusive:

141

"It is any act or series of actions or omission by a parent or caregiver that results in harm, potential for harm or threat of harm to a child" (Rad 053).

"The use of a child for activities that are legally prohibited and also the involvement of a child in any activity which children are not to be part of" (Rad 086)

Any work supposed to be for adults but rather assigned to children beyond their capacity constituted child abuse. Some participants gave examples of such work that compromises the safety of the child.

"Introducing a child to work that is meant for adults such as fishing and mining". (Rad 06)

"It is when a child is subjected to responsibilities beyond his capabilities for the selfish gains of the perpetuator, which could even be his parents" (Rad 048)

"Use of child for labour meant for adults". (Rad 014)

".... involving the child in heavy duty works such as quarrying, selling etc"(Rad 051)

"When a child is asked to go to farm, sell in the street or carry loads at market places when he/she is supposed to be in school" (Rad 067)

Participants also felt children selling in the street, markets or carrying loads for money known in Ghana as "kayaye" (head porter) were all forms of abuse (social). These are known social acts against the child (as observed by participants) and were found to be inappropriate and negative:

"Actions perpetuated against a child that affect a child negatively knowingly or unknowingly". (Rad 05)

There are several parental of caregiver actions or inactions that affect children knowingly or otherwise.

5.2.3 Abandonment

Participants acknowledged that child neglect was the situation where parental or caregiver behaviours resulted in physical, emotional, and/or educational neglect. Participants asserted

142

that parental refusal to provide their children with good health, food and clothing was abusive.

> "To deprive a child of basic life needs, e.g food, shelter, education, health" (Rad 014).

> "Not giving the child food"(Rad 016).

> "Infringing upon a child's rights by denying him the right to education" (Rad, 071).

Another form of child neglect identified in the study had to do with the situation where both the physical and mental needs of children were shirked by the parent or caregiver. Physical needs are basic to human existence and because children are most often unable to cater for themselves, these needs (according to some participants) should not be ignored by parents. From this perspective one participant felt shirking such responsibilities implied denying the child of his or her basic need.

> "...the infringement on the rights of a child. It involves neglecting one's responsibilities in regards to ensuring that the child's rights are respected"(Rad 068).

> "A situation where a child's rights and freedom are trampled upon by the parents, family members, close friends and relations as well the general public as a whole" (Rad 032).

Denial of education to a child of school going age was unacceptable to some participants which they also considered as abuse because it constituted an infringement on the right of the child. Rad 06 and Rad 07 reported the following:

> "...not sending a child to school, hospital or allowing a child to go hungry" (Rad 06).

However, one definition provided by Rad-07 embraced most of what other participants described as child abuse:

"An unfair and inhuman treatment a child goes through which results in infringement on the basic rights such as dignity, care and support" (Rad 07).

From what the participants in this study understood as child abuse, it point to the argument that various acts or omissions against children negatively affects the child in several ways and constituted abuse as observed by the participants.

5.3 Section 2: The Concept of Child Protection

Moving beyond their views on child abuse as a concept (as reported in section 1 of the analyses), four major themes were developed from the participants' description of what to them constitutes child protection. This was from their different descriptions all of which pointed to measures that could be put in place to protect children.
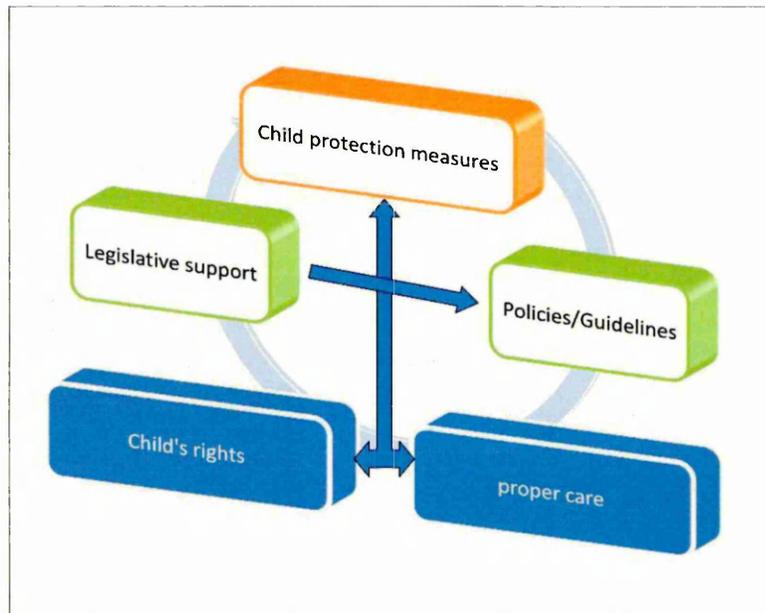
Figure 8. Participants' Concept of Child Protection.

Table 4. Themes and Sub-Themes for Concept of Child Protection.

1. Legislative support	2. Policies and Guidelines	3. Proper care	4. Child's rights
Legal backing Legal protection	Protocols/Channels	Sense of safety Shielding Shelter Sense of belonging	Education Health Food and clothing Support and counselling

5.3. 1 Legislative Support

Participants were of the view that child protection would be futile without a mechanism or framework in place to ensure the child's welfare was safeguarded. This they mostly expressed as using the law.

> "The adoption of recognized approaches aimed at ensuring a child's welfare is taken care of".(Rad 024).

> "The process of putting adequate measures in place to ensure that children are safe from abuse". (Rad 058).

> "Involves measures put in place to protect a child or prevent the child from being abused, especially by an older person. This involves protection from physical, psychological and emotional abuse". (Rad 040).

> "Protecting the rights of children according to law or a set of law set aside to safeguard the rights of children". (Rad 062).

Legal support in the child protection process was given prominence in participants' descriptions of child protection. The child's welfare (some participants felt) could be affected when there was no legislative instrument in place seeking the welfare of the child.

> "Protecting a child from physical, sexual or emotional mistreatment or the neglect of a child. This comes in the form of passing right of child law that will seek the protection of children (Rad 03).

> "It is a measure put in place to protect the child against activities that are contrary to the child's wellbeing (Rad 041).

> "When a child (below 18 years) is given a duty or assignment which is within his/her capabilities". (Rad 083).

145

Child protection was seen by one respondent as means putting measures in place to bring to deal with those found to have caused harm of injuries to children.

> "...bringing to justice all those who infringe on them and cause harm and injury to the child" (Rad 076)..

This could only be possible when there were laws covering the freedom of children as was reported by another radiographer.

> "...this comes in the form of passing rights of child law that will seek the protection of children" (Rad 03)

5.3.2 Policies and Guidelines

Policies were found to be essential structures of child protection. Appropriate mechanisms policies derived from the governing legal framework, established to protect the child.

> "Various mechanisms put in place to ensure that the safety, emotions and wellbeing are secured. These are mainly in the form of policies and laws set aside for the above purpose" (Rad 021).

Rad 04 felt that child protection is putting in place activities that promote the welfare, growth and development of the child.

> "Provisions of all the actions that promote the wellbeing, growth and development of the child physically and mentally (Rad 014).

Child protection was also understood to be acting on aggression meted out on children such as serving notification of the occurrence when identified. The understanding of child protection by this individual was stretched to provision of child programmes that promote children's wellbeing.

> "Responding to violence against children by reporting such incidences to appropriate authority or organizing child safety programme"(Rad 042).

146

This could only be possible where there were policies and guidelines for reporting suspected child abuse and also policies that guaranteed programmes such as training of personnel on child abuse and child protection.

5.3.3 Child's Rights

To some participants, the legal framework should ensure the rights of children are not trampled upon. Child protection should also embrace laws that seek and safeguard their freedom and welfare.

"Ensuring the rights of a child" (Rad 015).

Child protection is about seeking the child's freedoms and making sure the laws are applied when a child's freedom has been infringed upon.

"Ensuring the rights of the child is protected and in cases where the child's rights are abused, there should be legal remedies" (Rad 016).

"Provisions made to ensure the rights and privileges of a child are respected" (Rad 041).

"... is the act of ensuring that a child's rights are respected" (Rad 068).

Radiographers were of the view that promoting child rights were a form of protecting children and that could be achieved through:

"A law which takes care of a child, in areas such as health, education and socially" (Rad 010).

One radiographer also added that the protecting children should operational.,

"Ensuring that the child's fundamental human rights are enforced" (Rad 076).

Some participants described child protection as providing legal backing or protection to the efforts seeking to ensure that children were protected from all forms of maltreatment. Some participants felt child protection was not only about placing value on the rights of the child, but is also when parents keep children against the various forms of neglect by providing them with their basic needs.

"Child protection is a means of ensuring that the rights and privileges of the child are not infringed upon" (Rad 052).

"It is the act of ensuring that a child's rights are respected. It involves provision of basic needs for the child and making sure that the child meets his/her basic needs for existence" (Rad 068).

Some participants felt that children require protection of their internal adjustments besides the provision or protection of their physical needs such as reported by Rad 066

"The physical, emotional and psychological guidance given to a child. It can also be the parental support given to a child" (Rad 066).

The concept of child protection as understood by participants ranged from the establishment of legal framework that protects the freedom of the child. These also as reported by participants should include policies and guidelines that will ensure the proper care of the child.

5.3.4 Proper Care
Child protection was seen to embrace not only laws and policies to protect children but care given to these children. Rad 07 and Rad 077 felt that child protection was also about providing proper care through education, clothing, feeding and providing shelter to the child:

"Child has to be educated, clothed, fed and sheltered" (Rad 07).

"The proper care of a child that would prevent the child from being injured physically, emotionally, psychologically or mentally thereby enabling the child to operate at his/her maximum potential in the family or society as a whole" (Rad 077).

The process that ensures that children were safeguarded to prevent any exposure to any form of harm including hostile conditions was reported as child protection.

"The process whereby children are shielded from any kind of harm that may injure or endanger their lives" (Rad 078).

"...shielding of a child, from any harmful condition, or any unfriendly condition that can affect a child" (Rad 059)

Three participants understood child protection as safeguarding children from corporal and mental suffering, shielding the child from any form of danger and supplying the child with the basic necessities;

> "...the various ways in which children below 18 years are shielded from physical and psychological abuse" (Rad 064)

This according the understanding of one participant, is

> "Giving physical, mental and psychological care to a child to enhance his/her development and growth. Caring for a child such that he/she is well prevented from certain hazards and other activities that would hinder his/her mental, physical, psychological development" (Rad 080).

However, from the perspective of Rad 068 child protection

> "...involves provision of basic needs for the child and making sure that the child meets his/her basic needs for existence" (Rad 068).

In some participants' view, being defensive of the child resulted in the sense of safety of the child which to them was a form of child protection.

> "Any conscious effort made to protect the child and isolate him/her from things with a potential risk of endangering the child's life or adversely affecting their livelihood"(Rad 063)

> "Shielding the child against abusive conditions and allowing the child to enjoy certain basic rights" (Rad 072).

> "...building a hedge around a child to prevent any harm from befalling the child. Shielding the child from any form of danger" (Rad 074)

Child protection was also understood by radiographers as the situation where children felt that they were part of the family or society and that providing for their needs created a better environment for the child's growth.

> "Protecting the fundamental human rights of the child. Giving him a sense of belongingness and the provision of basic needs to the child" (Rad 071).

Participants in this described child protection as proper care which embodies providing shelter, education, clothing and food to the child. It also embodies shielding a child against any potential risk factors that could harm him or her. To participants, proper care was physical, mental and psychological care which enhances the child's development and growth.

149

5.4 Summary

The chapter explored the cultural understanding of radiographers of the concepts of child abuse and child protection. Participants gave various dimensions of the concepts which were wide ranging. Some of the definitions participants provided were elaborated with examples about what they understood as child abuse. Others stated the four main areas considered as child abuse without further throwing more light on it. The majority of the participants described child protection as having statutory laws that protect children. Others were of the view that child protection was about good care provided by their parents or significant caretaker. Allowing children to experience a sense of belongingness, proper care and avoiding harsh words on children were all considered to child protection. Overall the findings gave various dimensions of the two concepts. The findings regarding what constituted child abuse supported various arguments in literature about the difficulty in arriving at a common understanding of what constitutes child abuse. Child protection as defined by participants all supported the various definitions that has been attached to the securing the wellbeing of the child.

CHAPTER 6

DISCUSSION AND SUMMARY OF PHASE 1 FINDINGS

6.0 Introduction

Chapter 5 described the methods used to investigate the essences of child abuse and child protection from the perspective of the Ghanaian radiographer. Husserl's descriptive phenomenological methodology, was applied in Phase 1 to investigate the concepts from the lived experience of Ghanaian radiographers in their cultural settings. Qualitative approach using an open-ended questionnaire on the two concepts was used which enabled the researcher to gain understanding from the perspective of 86 radiographers to gain a level of consensus, their construction of reality of these two concepts.

The definition of child abuse has been very complex as a result of the various cultural contexts in which abuse occurs and whether a particular culture sees a behaviour as socially acceptable or not. Moreover, Cultural beliefs impacts on what is believed to be ideal parenting and what is regarded as child abuse (Feng & Levine 2005). The understanding of child abuse in particular is very important to professionals who handle paediatric NAI cases both in hospitals, schools, and in the communities. The current study is significant because of its policy implications. Hutchinson (1990, p61), stated that "definitions have been developed to meet four interrelated purposes: social policy and planning, legal regulations, research, and case management".

Findings from Phase 1 are discussed in this chapter which investigated the understanding of Ghanaian radiographers with respect to the two important concepts of a child's wellbeing; child abuse and child protection.

6.1 The Concept of Child Abuse

According to Raman and Hodes (2012, p. 31), "how child abuse and neglect (CAN) or 'child maltreatment' is defined critically informs how and when professionals working in the field respond". Based on the nature of the current study it was necessary to understand the Ghanaian radiographer's understanding of the concept of child abuse and child protection in Phase 1 to help explore how these understandings shapes the way they approached child protection (Phase 2).

The classical theory of concepts argues that individual concept relates to an established or assemblage of units, in which membership is all or none (Cohen and Murphy 1984). This convention could be derived from Aristotelian interpretation of concepts which suggests that each concept has a definition describing its "essence" and providing required and appropriate conditions for concept membership (Cohen & Murphy 1984). They postulate that concept elements must either satisfy all the conditions in the definition in which case it becomes part or it fails to satisfy the conditions and therefore cannot become a member. The essences provided by interviewees in the current study on the two concepts investigated (child abuse and child protection) were studied to gain insight into whether the meaning radiographers assigned to these concepts fulfils the necessary and suitable conditions for acceptability (membership) as child abuse and child protection.

Radiographers who participated in Phase 1 provided varied understanding of the concept of child abuse which suggests the difficulty and disagreements in defining child abuse (Munro 2008). Several participants used phrases such as *infringement on the rights of the child* as abuse. For example, in describing what constitutes the concept, one participant stated:

> "The infringement of a child's right either physically, mentally, emotionally, or otherwise to put a child's life or health in danger" (Rad 011)

The legal definition of child abuse has been found to differ among nations however and in most countries four main categories of child abuse have been defined namely, physical abuse, neglect, sexual abuse, and emotional maltreatment NAS (2014). Some participants felt that children had needs and were entitled to freedom as humans. When these were denied the child it was considered as abuse. Apart from using the word denial, others used the word 'deprivation' of the basic needs of the child as abusive; "To deprive a child of basic life needs" (Rad 014). A few radiographers defined child abuse in a manner that conformed to some aspects of the generally accepted categories of child abuse of (WHO 2006). For example

> "The maltreatment of a child sexually, physically or psychologically" (Rad 069).

This description also conforms to previous discussions (Royal Canadian Mounted Police [RCMP] 2008; Burns et al. 2000; WHO 1999) on what constitutes child abuse. The RCMP

152

argued that the existence, wellbeing, self-worth, and progress of children are threatened under these conditions. The diverse viewpoints of radiographers about child abuse supported the arguments of the disparity surrounding the conceptual definition of child abuse (Munro 2008). Though most of the themes appeared to inform each other, it was necessary to isolate them such that their cultural significance in the Ghanaian context would be understood. One such example was negative actions that traumatise children such as child forced marriages;

> "…When a child has not reached the age of marriage and she is forced into it"
> (Rad 026)

Child marriages have been a cultural problem particularly in some parts of northern Ghana and which Rad 026 might have witnessed. Female children, if married under age, in some communities in Ghana, sometimes experience genital complications such as fistula development. This results in girls ending up at the imaging departments for X-ray examination (known as fistulogram) by the radiographer to assess the extent of the fistula for subsequent treatment.

The mention of child physical abuse in the examples participants gave as well as the definitions they provided centred on physical abuse which concured with Feng, Jezewski, & Hsu (2005). They studied Taiwanese nurses understanding of child abuse and the majority of the nurses mentioned child physical abuse. However, the findings the current study would be expected because child physical abuse has been the main area of abuse that radiographers are professionally involved with as a result of NAI caused by physical aggression on children. It is difficult to identify any of the other forms of abuse by the radiographer under busy clinical situation. Most participants in the current study might be aware of (or have witnessed) physical discipline which is rampant in schools and at homes as a culturally accepted norm in the Ghanaian society (Imo 2013; UNICEF 2010a). A study (UNICEF 2010b) in Ghana showed that 90% of children aged 2-14 years suffered violent discipline. This could probably be the reason why most of the definitions mentioned physical abuse before any other forms of abuse. Also, uncivil verbal attacks or use of punitive words against a child was seen as inappropriate by a few of the radiographers for a child's sound development.

"...It can also be reigning (sic) harsh insults on a child for committing a small mistake". (Rad 066)

A good parent–child relationship has its corresponding positive attitude from the child to the parent (Wang & Kenny 2014). However this can be affected when child is in persistent agony of verbal abuse. Harsh verbal punishment is a form of psychological force applied with the aim of causing a child to suffer emotional agony to correct the child's naughtiness (Straus & Field 2003). This form of child discipline can differ in its gravity which could be either yelling or shouting that intends to demean the child using intemperate language (Wang and Kenny 2014). Studies (Wang & Kenny 2014; Evans, Simons & Simons 2012; Donovan and Brassard 2011; Pagani et el. 2004) have also shown that punitive verbal attacks affect children emotionally and psychologically including behavioural effects on their mental wellbeing.

Evidence (Okado & Azar 2011) suggests that when there is a wider or lesser amount of emotional distance in events of parent-child relationship, both have a negative effect on the child. Okado & Azar (2011) argued that when the emotional gap between parent and the child is extreme, there is the possibility that the parent would not provide the child the necessary attention and could miss out on any signals from the child and respond. Okado & Azar were also of the view that when the emotional detachment is not wide, it could also lead to the situation where the parent becomes over protective of the child. Emotions are determinants of individual behaviours and for that reason when parent-child interactions are characterised mostly by low or high emotional detachment, it could become a threat to the child's psychosocial advancement, especially the child's development of emotion regulation and the capacity to feel someone else feelings rationally (Soenens et al. 2007; Zhou et al. 2002). The application of tough verbal correction on children has been linked to increased conduct problems and indications of dejection irrespective of whether the method of childrearing was characterized by low, moderate, or high levels of parental warmness (Wang & Kenny 2014). These might have informed respondents in the current study to assume that harsh verbal attacks on children has negative impact and therefore abusive. The liberty enjoyed by children in their social interactions with parents and the community at large is very important for their progress and trust of their environment. Where a child was denied the warmth of caregivers and the society in general creates difficult childhood

154

experiences which were classified by one participant as abusive. For example, Rad 032 described child abuse as:

> "A situation where a child's rights and freedom are trampled upon by parents, family members, close friends and relations as well as the general public as a whole" (Rad 032).

Generally, improper early childhood social life has been identified as the cause of several negative situations for the affected children. For example Carroll et al. (2013) noted that hostile social relations in childhood where there is a genetic relationship have adverse health impact on the child's entire life. Negative actions as a theme in the concept of child abuse were noted to include taking advantage of children because they lacked knowledge of their rights and freedom. Under such conditions one radiographer expressed child abuse as being;

> "The maltreatment of a person under age who normally does not know his/her rights and freedom. It is treating a child in a harsh and wicked ways". (Rad 059)

Moreover, radiographers described child abuse in this study to mean that when a child was not given the opportunity to have a happy life they face difficulties in adulthood because their basic human rights as children were trampled upon. A recent study had indicated that when children are abused it affects their happy life and some end up gambling or have various emotional difficulties adulthood (Lane et al. 2016). Additionally a few of the radiographers were of the view that it was abusive to allow children to be involved events which may injure or affect their health and development. As a result, going against laws proscribing the use of children in such accomplishments should be seen as child abuse;

> "The use of a child for activities that are legally prohibited and also the involvement of a child in any activity which children are not to be part of". (Rad 086).

Children have needs to enable them to thrive, however if these needs are not met by parents or those in whose custody the child has been entrusted it becomes a form of rejection and as such abusive to radiographers studied. Several participants in this study defined child abuse as a form of denial; refusing the child the basic needs which they stated as food, shelter, education and health. Children's rights to education, good health, and physical care such as provision of food, clothing, shelter, hygiene, protection, or supervision have been described

in other studies (McDonald 2007). McDonald argued that any cognitive neglect or failure to put child in school constitutes abuse as well as refusal to seek medical care for the child. This assertion is debatable especially in the African contest and especially in Ghana where due to high poverty levels among some families, the inability to send one's child to school or even hospital could at times be caused by economic hardship on parents. It might be that a parent is intentionally refusing the child these basic needs for survival. Economic difficulties of parents and caregivers could lead to unintentional neglect of a child in the Ghanaian community. However, actions or inactions of parents leading to child difficulties have been classified as a form of abuse (Mok 2008). The lack of consensus overall identified in Phase 1 was further exemplified by the idea that when a child is subjected to dangerous nurturing behaviours as well as refusal to provide the child's needs, was found to be undistinguishable from abuse as it negatively impacts on child's self-worth.

> "An unfair and inhuman treatment a child goes through which results in infringement on the basic rights such as dignity, care and support". (Rad 07).

To ensure the dignity and respect of children comprehensive child policy is imperative. Melton (2005, p. 646) indicated that "A coherent children's policy would go beyond the dramatic questions of life and death and of custody and freedom to the norms by which community settings operate in their ordinary interactions with children. In that regard, the critical question is not so much whether children will be granted absolute autonomy and privacy but instead whether they will be treated with respect". This can be achieved when children are given the opportunity to express their feelings; when they are given voice. In particular, the Article 12 of the UN Convention on the Rights of the Child stipulates that: States Parties shall assure to the child who is capable of forming his or her own views the right to express those views freely in all matters affecting the child, the views of the child being given due weight in accordance with the age and maturity of the child; For this purpose, the child shall in particular be provided the opportunity to be heard in any judicial and administrative proceedings affecting the child, either directly, or through a representative or an appropriate body, in a manner consistent with the procedural rules of national law.

Growing attention regarding the necessity to offer protection and institutional responses that will lead to radical eradication of child labour illuminates the need among policy

156

makers, globally and locally, for a thorough understanding of the worst form of labour (International Labour Organization 2004). Child labour in general takes different forms in Ghana and this might have informed some participants to cite examples to buttress their understanding of the phenomenon. The various interpretations provided by participants as their understanding of the concept of child abuse (though varied) all could lead to instability in child safety and sound development. The concept of child abuse as understood by the Ghanaian radiographers surveyed pointed to infringement of the child's rights and preventing children's freedom to thrive in a stable environment. The various meanings assigned to child abuse supported arguments about the lack of consensus about the working definition of the concept (Munro 2008). The findings of the current study also supported the argument that child abuse encompasses the act of commission or omission, which directly or indirectly leads to serious consequences in the life of the child (Mok 2008). For example,

> "It is any act or series of actions or omission by a parent or caregiver that results in harm, potential harm or threat of harm to a child" (Rad 053)

It has been argued (NAS 2014) that the lack of common understanding among cultures of the definition of child abuse has resulted from disagreement about what forms of child upbringing were harmful; misgivings about the suitability of connecting child abuse to adult characteristics and behaviour, effect on the child, environmental context, or some combination of these factors (NAS 2014). From the definitions provided by the participants in the current study, adult characteristics and their influence on children were for example, included the use of children by adults in activities that could harm these children. Moreover some children were brought up to be trained into their family's livelihoods such as fishing, farming or mining; an observation that might have directed some of the definitions provided by the participants in this study.

> "The use of a child for activities that are legally prohibited and also the involvement of a child in any activity which children are not supposed to be part" (Rad 086).

> "…involving the child in a heavy duty works such as quarrying, selling etc against his/her wish" (Rad 014)

Though some of these actions have economic linkage, (i.e. by their age) children need to be in school and allowed to have their freedom to live as children. However in some parts of Ghana, a family's economic circumstances normally, influences what the child should be doing (i.e. either going to school if the family can afford the fees or working to earn income for the family) (UNICEF 2013). Korbin (1991) had argued that an appropriate cultural definition should be accepted in judging child abuse. However the problem with this assertion is arguably that, suitable cultural definitions in different cultural settings would imply that whether the culture is dangerous to children or not so far as that a society appreciates it, then it could also be suggested that the definition should be carved in a way that may exclude these cultural norms. The Organisation for Economic Co-operation and Development (OECD) stated that "the moral imperative to protect children is considered so strong that it can override the privacy of the family and the rights of parents" (OECD 2011, p. 246). That is whatever parents accept as their cultural values should not override the protection of the children.

Child abuse (as understood by participants in this study) however did not condone actions and inactions that might have affected the child negatively, in contrast with Meadow (2002) who suggested that the treatment of a child in a way objectionable to a given culture at a given time constitutes abuse. This could mean that the idea about abuse could be transient over time because practices that were considered acceptable are later considered abusive as society progresses and as changes take place in a culture values are affected (Davis & Reeves 2006).

The converse of this would be for example that a culture that condoned a practice injurious to the child (such as female child genital mutilation) did not view that practice as being abusive because that culture tolerates it. Ghana is a unicameral country and its laws are the same in all the ten regions and besides, it is multicultural. It would therefore be difficult to have various definitions which takes into consideration these different cultures and what they accept or do with their children unlike the USA, where federal definition puts minimum standard for legal definitions, the various states have their own definitions of child abuse and neglect (NAS 2014).

Despite various stances on the operational definition of child abuse, the results of this current study contribute in a meaningful way to the current body of knowledge regarding what could constitute an abuse in certain cultures. However, the fact still remains that there is no single consensus of the definition of child abuse that has been conclusively followed worldwide. The concept of child abuse has been applied to encompass or identify whatever appears to infringe upon the rights of the child as human. The diverse nature of what various as abuse of a child presents challenges. UNICEF (2006) definition attempts to encapsulate what child abuse is which nations could adopt and apply in their setting.

The differing perspectives regarding what constitutes child abuse among the radiographers in the current study concurred with Feng et al. (2005) who argued that the absence of agreement in the definition of child abuse among health care professionals challenged care progression and led to conflicts. Moreover, cultural assertiveness in the African setting towards child abuse greatly differ which has been a challenge in an attempt to define child abuse (Lachman 1996). Lachman again identified that the situation is also worsened by the inability to draw a line between child discipline and child abuse among Africans.

6.2 The concept of Child Protection

UNICEF (2006) defines child protection as, preventing and responding to violence, exploitation and abuse against children – including commercial sexual exploitation, trafficking, child labour and harmful traditional practices, such as female genital mutilation/cutting and child marriage.

Radiographers had varied perspectives of child protection and mostly described the concept as *measures required to protect the human rights of children*. This definition compares with the UNICEF (2006) definition of child protection in that preventive approaches require that measures should be put in place to ensure that children are not abused.

> "The process of putting adequate measures in place to ensure that children are safe from abuse" (Rad 058)

159

One of the eight key elements of providing a safe environment and responding to mistreatment of children is the establishment and implementation of sufficient legislation (UNICEF 2006). Participants most particularly referred to the use of laws that guarantee the wellbeing of children at home and their engagement with the larger society. UNICEF concept of child protection indicated among other things, actions that would prevent child abuse and secure the safety of children. In the current study, some participants were of the view that child protection was about putting in place structures such as policies and legal framework to ensure that the child gets protection. This was supported by one participant who added that child protection was about the laws ensuring children's wellbeing were prescribed.

> "Various mechanisms put in place to ensure that the safety, emotions and wellbeing are secured. These are mainly in the form of policies and laws set aside for the above purpose" (Rad 021).

A few of the participants felt that laws alone cannot advance child protection and therefore their understanding reinforced the necessity of policies and regulations that would guide the attitudes and behaviours towards children generally. They somehow felt that child protection lies in the hands of caregivers who they felt should shield the children against any harm. Various studies (Davis & Reeves 2006; 2004; Rigney & Davis 2004; Hogg et al 1999) failed to consider what radiographers understood by child protection. This made it difficult for the current study to compare with previous work.

In explaining child protection policy and its significance, Hart et al. (2003, p08), stated that it is 'a statement of intent that demonstrates a commitment to safeguard children from harm and makes clear to all what is required in relation to the protection of children. It helps to create a safe and positive environment for children and to show that the organisation is taking its duty and responsibility of care seriously'. This is imperative for hospitals as well to enhance practice and ensure the wellbeing of children.

Proper care of children by parents and caregivers also emerged as an important component of child protection where apart from respecting the child's right, the needs of the child are met. One participant felt that children have rights and are also in need of basic things that

will enable them to develop. In his view child protection was about the arrangements put in place to preserve the rights of the child and providing the fundamental needs.

> "It is the act of ensuring that a child's rights are respected. It involves provision of basic needs for the child and making sure that the child meets his/her basic needs for existence" (Rad 068).

Despite all preventive measures that may be put in place to protect children, Karlsson, Stuckenbruck & Cecchetti (2010) recognised that child protection is about parents being solely responsible for the child's development by seeing to their growth, with support of families, and the community. A few of the participants felt that loving a relationship between mother and child was would promote better health and prevent social risks. Glick, Lorand & Bilka 2016) have stated that risk factors of child abuse are generally characterised to include parental, child, and social characteristics. However, they further argued that these factors assist in counselling parents and develop protective policies. Risk factors are found in several families but they do not abuse their children while those with no identifiable risk factors abuse children (Glick, Lorand & Bilka 2016). The argument also supports Goldman et al. (2003) who identified that certain family behaviours could be considered as risk factors for child abuse and neglect however they are not always present. They concluded that child abuse occurs in all socioeconomic classes and cultural groups.

Making children feel as part of the whole to some participants creates a loving bond between the parent and the child.

> "Protecting the fundamental human rights of the child. Giving him a sense of belongingness and the provision of basic needs to the child" (Rad 071)

Arguably, fostering a sense of belonging in children will work against any behavioural problems normally associated with early childhood difficulties and enhance their learning capabilities (Kids Matter 2013). Children must feel their presence and significance within the family. When their own reality or existence is ignored they may be lonely and feel not needed (Department of Education, Employment and Workplace Relations 2009). Being isolated and uncared for as a child could expose the child to insecurity, a feeling which may persist throughout life. The WHO (2004) stated that: "In all human groups, babies depend on warm, responsive, linguistically rich and protective relationships in which to grow and develop. They cannot survive in environments that do not meet thresholds of these

161

characteristics" (WHO 2004 p.3). The majority of the participants defined child protection as ensuring that the child does not fall into any physical, sexual or emotional maltreatment. To guarantee this measures such as establishing laws that safeguard the rights of the child should be in place. For example a participant expressed that child protection is;

> "Protecting a child from physical, sexual or emotional mistreatment, or the neglect of a child (sic). This comes in the form of passing right of child law that will seek the protection of children" (Rad 10).

This also conforms to the UNICEF (2006) definition which partly suggests that measures must be put in place to ensure that the child is secured against these forms of abuses. Carroll et al. (2013) established that a child could experience protection from loving parents because, providing children in adversarial environments with a cherishing bond is fruitful for their overall wellbeing. This was iterated in this current study where some participants were of the view that child protection implies providing love and proper care to the child such that the child would be physically, emotionally, psychologically or mentally protected.

> "The proper care of a child that would prevent the child from being injured physically, emotionally, psychologically or mentally thereby enabling the child to operate at his/her maximum potential in the family or society as a whole" (Rad 077)

Other participants in this study used the phrase 'shielding the child' against any form of harm to signify child protection. Thus child protection under proper care (from the perspective a few participants) was making sure the child in any situation was protected by providing some form of shielding as a protective measure to safeguard the child. For example, Rad 059 and Rad 078 among some other participants understood child protection as;

> "...shielding of a child, from any harmful condition, or any unfriendly condition that can affect a child" (Rad 059)

> "The process whereby children are shielded from any kind of harm that may injure or endanger their lives" (Rad 078).

All these agreed with the definition of child protection posited by UNICEF (2006) because shielding children constitutes safety measures that protect children from any form of abuse.

However protection of children could be difficult when abuse was identified but not reported. In one participant's view child protection was about responding to abuse cases by reporting the abuse when noticed.

> "Responding to violence against children by reporting such incidences to appropriate authority…" (Rad 042).

This was in agreement with child protection discourse (Davies and Ward 2012; UNICEF 2010). Regarding the rights of children, participants (in defining child protection) indicated that Child protection should also embrace laws that seek the welfare of children in terms of their health, education and to include their protection as members of the community. Participants were of the view that a law that upholds child rights was a form of child protection. This they implied ensures that the child has good health, education and better social life. However, laws to protect children's rights would not have any impact if not imposed as a participant indicated, "Ensuring that the child's fundamental human rights are enforced" (Rad 076). Operational laws are thus necessary for child protection to work:

The perspectives provided by the participants in this study in relation to child protection totally does not provide a safety net for the child, however adherence to such principles could reduce harm to children (Hart et al 2003). participants in the current study inferred that the rights of the child when enforced, will provide the child with the right kind of protection for their sound development. Given the variable nature of the concept of child abuse, there will always be some form of protective measures that could form a definition of child protection. For participants in the current study, child protection was about the fundamental human rights that should be enjoyed by the child. By this, any act or omissions that trample on the child's freedom to live as a child disrupts the child's wellbeing. Though participants were from various cultures, few who were from the southern part of the country and do abhor child marriages and FGM mentioned these cultural practices as being examples of child abuse. These were the practice of few ethnic groups in the northern part of Ghana.

Child protection policy must be realistic such that it is culturally sensitive but should not ignore acts of manipulation that are generally labelled as abusive (Hart et al. 2003). If Child

protection is seen as more proactive, it is interesting that none of the participants mentioned early intervention and safeguarding work. This probably is because Ghana has always talked about child protection leaving safeguarding out in its policies. The Child and Family Welfare Policy which was described in that document the document as an aspect of child protection not safeguarding. People seem to be more aware of the term child protection even when what they are describing is safeguarding (which encompasses child welfare and child protection). In talking about child maltreatment generally, The Organisation for Economic Co-operation and Development (OECD) stated that "Child maltreatment has received less attention than child wellbeing in international comparisons. This is an important gap since the effect of maltreatment on individual children cannot be understated" (OECD 2011, p.245).

Ghana has always talked about child protection leaving out safeguarding. The Child and Family Welfare Policy were described as an aspect of child protection. The Ghanaian system seems to be more oriented towards the term child protection instead of safeguarding (which encompasses the overall child welfare and child protection). In talking about child maltreatment generally, The Organisation for Economic Co-operation and Development (OECD) stated that "Child maltreatment has received less attention than child wellbeing in international comparisons. This is an important gap since the effect of maltreatment (abuse and neglect) on individual children cannot be understated" (OECD 2011, p.245).

The laws could be there but it is the policies which would direct what to do. Policies will deal with the protocols and guidelines to operate with. Protocols for example may indicate not only the radiographic techniques, but also referral procedures that the radiographer must follow (see Davis & Reeves 2006). The OECD stated that "the moral imperative to protect children is considered so strong that it can override the privacy of the family and the rights of parents" (OECD 2011, p. 246). That is whatever parents accept as their cultural values should not override the welfare and protection of their children.

Munro & Manful (2012) examined child safeguarding data in England, Australia, Norway and United States, reported and found that countries that have aligned themselves with child protection, interpreted child protection as different from the broader variety of services for children with minimal needs, to stay intervention and apply more legalistic

method. A closer examination of the CFWP in Ghana shows that this policy aligns more to child protection as the policy classified the CFWP, as an aspect of child protection. According to Munro & Manful (2012), the family service methodology basically is needs based; while in their view child protection is centered on investigations which are classified as part of a range of services provided for children in need and their families. Moreover, they argued that child protection agencies respond to concerns regarding maltreatment (abuse and neglect) together with referrals for family support services for children who probably would not suffer any harm, but still have needs that require attention.

The safeguarding principle is established on ensuring the complete wellbeing and growth of the child by developing a common ground for child protection and family services (Gilbert, Parton & Skivenes 2011).

The terms child abuse and child protection as 'concepts' have many common and practical meanings which draws attention to the classical theory of concepts. Concept is a subject of analysis which should have a necessary condition to be what it is; and something must satisfy that condition in order to become what it is (Earl 2005). For example both rectangle and a square are both four sided figures however, a rectangle to be a square it should have the necessary conditions for it to be a square; thus the four sides should equal length and breath. Husserl (2001) talks about essences in his philosophy of phenomenology and according to Dahlberg (2006, p.11) 2 an essence could be understood as a structure of essential meanings that explicates a phenomenon of interest. The essence or structure is what makes the phenomenon to be that very phenomenon". In a study (Davis & Reeves 2006) referred to child abuse as a concept which in their view rely on the morals of a society at a given time. According to Cohen and Murphy (1984), to ask a question about how to exemplify concepts, let alone offer an answer, is a challenge to theoretical issues. The classical theory of concepts (Earl 2005) argues that for a complex concept 'C' to be acceptable as 'C', it should provide a set of discretely basic conditions for being a 'C' (or conditions that must be satisfied in order to be a C). Earl argued that all multidimensional concepts have a standard analysis, where the standard analysis is a preposition providing generally required and mutually sufficient situations for being an expansion across imaginable worlds for that concept. That is, a complex concept such as child abuse must provide additional and necessary details for it to be accepted widely to be what it is said to be. Radiographers in the current study, have, by their understanding and experiences,

165

provided information that appear to capture what they perceived to be child abuse (which was evidenced by previous studies) to extend across possible worlds.

Theoretically, the various definitions provided in this study by participants, constituted some form of child abuse they were somehow found to satisfy the necessary conditions that could arguably be acceptable by people internationally. For example one condition is whether a behaviour or actions meted on children infringes on their basic human rights. These have various elements in it such as whether the actions or omissions towards a child could harm or affect the child's wellbeing physically and emotionally. However, according to Earl (2005) there exist epistemological queries about concepts. In illustrating this point, Earl argued that concepts appear to be the categories of things that get grabbed, possessed, or implicit in coming to have beliefs (and eventually understanding) about the world.

In contributing to child protection discourse in radiography the emphasis was on broad issues regarding the role of diagnostic imaging and radiographer's performance and capacity to identify NAI and the legal aspect of it (Hogg et al., 1999; Brown and Henwood, 1997). Similarly in Rigney & Davis & (2004) study on radiographers and NAI, the attention was among other issues were on the radiographer's ability to produce images of good technical quality as a legal document. The current study differed by looking at what radiographers actually understood by child abuse and child protection in order to investigate further how they managed child physical abuse cases. The study has brought radiographers into the definition debate of child abuse and child protection by establishing, the understanding Ghanaian radiographers have of these concepts.

6.3 Summary
Overall most of the responses provided by participants, were broader and different perspectives of the definition or understanding of the concepts of abuse and protection were expressed. However, it was difficult for the current study to establish that child abuse definitions differ among cultures within the society. The responses showed that participants had fair idea about what could classified as child abuse and child protection. Child protection was not limited to using the law but providing proper care and needs of the child by parents. This included ensuring that children have positive attachments and a sense of belongingness within the family.

This is the first study in Ghana to document radiographers' cultural understanding of child abuse and child protection which was a necessary step to examine how their understanding shaped the way they approached child physical abuse cases in the work setting when they occurred in Ghana. This perspective raised both policy and practice implications which paved the way for Phase 2 to explore experiences of radiographers in the management of child physical abuse cases. It was to assess whether their understanding of the concepts of child abuse and child protection, would assist them to identify when a child was suffering from abuse and by their definitions of child protection they would apply these principles to protect the child.

The next section of this study examines the behaviour and perceptions of Ghanaian radiographers in the management of child physical abuse in Ghanaian hospitals.

*The Conclusion/Limitations of the study (Phase 1&2) are combined as one section in Chapter 9

CHAPTER 7

FINDINGS OF PHASE 2

7.0 Introduction

The purpose of this chapter is to present the results of the Phase two interpretive (hermeneutic) phenomenological study which explored the behaviour and perceptions of Ghanaian radiographers when children presented for imaging about whom there were suspicion of having suffered child abuse

Phase 2 was guided by the following research questions:

- How do radiographers in Ghana handle child physical maltreatment cases when they occur?

- What is the relationship between radiographers and other health professionals who handle child abuse and protection cases?

- Does Ghanaian culture, and the beliefs held by radiographers, appear to influence their actions with respect to child protection cases?

The research questions were necessary as a follow up to Phase 1 where the cultural understanding of the concept of child abuse and child protection by radiographers in Ghana was investigated. It became evident that an in-depth understanding of radiographers lived experiences of these phenomena needed to be explored further. Thematic analysis and hermeneutic phenomenological approach directed the analysis. It is worth noting that during the analysis, cultural influences as a major theme were found to transcend all the other themes. The specific cultural issues are presented in a summary context under sub-themes micro culture; organisational culture and national culture. Cross references are made where findings relate to each other. Specific cases are highlighted with vignettes in this chapter to allow for more thorough and contextualised findings to be distinct. The demographic profile of participants is first examined followed by the contextualisation of the themes developed.

7.1 Demographic profile of participants.

Twenty (20) radiographers from across the country's hospitals and polyclinics who voluntarily consented to participate were recruited (Table 5).

Table 5. Participants' Demographics.

Participant (by ID =Rad OX) (N=20)	Age	Gender	Ethnicity	Qualification	Professional rank	Years in Practice
Rad 01	52	M	Fante	Degree	Deputy Chief Radiographer	20
Rad 02	35	M	Ga	Diploma	Senior Radiographer	5
Rad 03	28	M	Ga	Degree	Senior Radiographer	7
Rad 04	57	F	Fante	Diploma	Principal Radiographer	29
Rad 05	54	M	Dagomba	Degree	Deputy Chief Radiographer	18
Rad 06	29	M	Eve	Degree	Senior Radiographer	6
Rad 07	42	M	Eve	Degree	Senior Radiographer	17
Rad 08	35	M	Akyim	Degree	Senior radiographer	7
Rad 09	35	M	Brong	Degree	Principal radiographer	12
Rad 10	30	M	Mamprusi	Diploma	Senior Radiologic Technician	5
Rad 11	32	M	Asante	Diploma	Senior Radiographer	8
Rad 12	30	F	Akyim	Degree	Senior radiographer	7
Rad 13	45	M	Dagate	Degree	Principal Radiographer	15
Rad 14	35	M	Asante	Diploma	Senior Radiographer	6
Rad 15	25	F	Ga	Degree	Basic radiographer	3
Rad 16	33	F	Ga	Degree	Principal radiographer	12
Rad 17	30	F	Nzema	Degree	Basic Radiographer	8
Rad 18	45	F	Guan	Diploma	Senior Radiographer	20
Rad 19	35	M	Eve	Masters	Principal Radiographer	12
Rad 20	34	M	Eve	Degree	Senior Radiographer	11

Participants were from settings of diverse cultural and ethnic background in the country. Out of the 20 participants recruited, 16 were males and 4 were females. They were all married with children except one female who was yet to marry and had no child. Participants' ages ranged from 25-57 years with majority in their thirties. Participants were drawn from 3 teaching hospitals, 1 municipal hospital, 2 polyclinics, and 4 regional hospitals within 8 out of the ten regions of Ghana.

Participants' working experience was mixed among the hospitals and most of them had practiced for 5-29 years with only one female who had worked for 3 years at the time of the interview. In the interview and presentation of the findings, participants were characterized with identity codes (ID) to ensure anonymity. The word "case" denotes physical abuse.

Five major themes were generated during the data analysis from the coding categories.

The five themes are stated below:

1. Case identification
2. Radiographers' decision trail (internal & external factors)
3. Influence of relationships
4. Reporting of suspected child physical child abuse
5. Attitudinal issues

Table 6. Themes and research questions answered.

Theme	Research question answered
Themes 1, 2 and 4	Research question 1
Theme 3	Research questions 2 and 3
Theme 5	Research question 3

7.2 Case identification

The clinical experiences of radiographers in identifying children suspected to be physically abused were explored. It enabled the researcher to understand how they recognised abuse cases for which they were prompted to either act or remain passive. Radiographers' suspicion of physical abuse was either through their pre or post-radiographic observations or combination of both. These observations provoked further investigations through questioning of the child, parent or both. Most of the radiographers were discontent with the referral history on the request form submitted for the imaging process. However, their initial suspicion through history taking was sometimes strengthened by the imaging findings. Figure 9 below shows the sub-themes derived from the theme "Case identification".
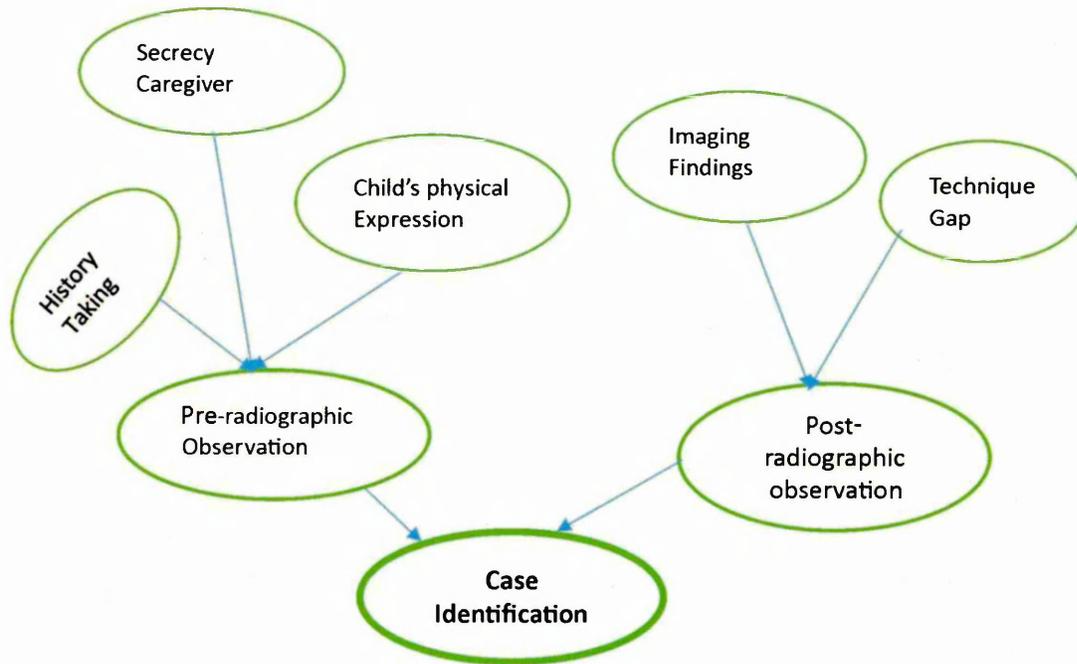
Figure 9. Theme structure for case identification

7.2.1 Pre-radiographic Observation

Observations by some participants before the X-ray examination (pre-radiographic observations) of the child were key in determining whether a case before them appeared to be physical abuse. Observations such as the behaviour of parents or caregivers and inadequate information (parent/caregiver secrecy) during history taking raised the radiographers' suspicion of incidence of child physical abuse. However with the history taking, language barrier was sometimes a problem and this hindered the radiographer's ability to probe the situation. The sub-themes history taking; child's physical expression and caregiver secrecy were derived.

7.2.1.1 History taking

Brief clinical histories on X-ray request forms were not totally relied on by some participants especially when the request did not provide information that could easily assist the radiographer to think that the case at hand had something to do with physical abuse. During such instances, further information was sought from the parent or the and sometimes both to ascertain the cause of the injury. These actions enabled some radiographers to ether suspect or conclude that physical abuse has occurred.

171

"For me if I see a case like that...sometimes I go further to ask the patient what actually happened. If it is non-accidental and if it is not indicated on the request form, I only talk to the patient or the mother of the child to find out what happened. It is then that I get to know if it is an abused child or not". (Rad 03)

"...upon interrogation and talking with the child, the child ended up giving us a clue that it was the mother who caused such a degree of injury to him and when I asked the child why the mother did that, he said it was because the father beat the mother". (Rad- 06)

Short clinical histories such as "trauma", were usually written on the X-ray request form. This created confusion among some participants because they were unable to decipher, from such short information, what form of trauma the child had experienced. However, by their personal enquiry a majority of them were then able to have a clear understanding of what was really went wrong.

"It is like they do not tell us on the request form the child has been abused but they tell you it is a trauma case. So maybe, through your own investigation before you come out to know that the child has been abused". (Rad 07)

One female radiographer felt that writing 'trauma' as the history could be anything. It was when the imaging findings showed something beyond normal accident that she suspected that something was not right.

"The doctor too has written trauma and trauma can be anything…but after you have done the case you probe further and you see that no this is not ordinary accident but there is something wrong". (Rad 04)

In one occasion, a radiographer observed that the clinical history did not match the injuries identified on the child.

"The history indicated a fall but if you look at it they even poured water on the child, and there were bruises as well so if you look at the injury and history, there is no relation" (RAD- 06)

When questioned about the short clinical history, Rad-12 shared his sentiments about it by indicating that clinical histories normally provided were problematic. Most often to be

172

certain of what case he was about to handle, further questioning was done to understand the child's situation better.

> "It is quite a problem that we are facing here but all the same, as a radiographer I try as much as possible to do my best and also know what is really happening. So normally I ask more questions on every case that I do to be sure" (Rad-12)

In contrast, Rad-16 probed parents only when imaging results appeared unusual and it was during that point that what actually happened were told.

> "Yes it is when we see the radiograph that is when we further ask the relatives who accompanied the victims what happened. We do not just give the films out but we try and investigate in a way to know what happened to the child. That is when they tell you the actual story when you see the outcome of the report" (Rad-16)

The history taking by some participants was occasionally affected by language barrier. This cultural problem hindered a participant's attempt to query further.

> "Ammm the only problem is when they don't speak your language or English it becomes difficult to probe or ask questions. In such situations am unable to tackle issues the way it should be" (Rad -14)

While the use of interpreter could help, RAD-14 observed that getting an interpreter as a result of the language difficulties during history taking was not only challenging but was time wasting which also affected other patients awaiting their turn.

> "It is not always easy getting an interpreter and even that will waste your time looking for one while other patients are waiting". (Rad-14)

Radiographers as shown by their reports acted professional by seeking further information when cases before them were curious. However one adverse approach to the patients was their failure to treat all manner of patients equally with the excuse of language barrier to communicate. This affected the needed help they could provide the victim.

7.2.1.2 Child's physical expression

Physical appearance was noticed from signs of physical injury and emotional expressions of the child. These unusual appearances alerted some radiographers to possible signs of physical abuse. For Rad-05 and Rad-10 the child's physical appearance provided a hint to suspect physical abuse.

> "…when they came and it was like the child has been crying and experiencing some discomfort" (Rad-02)

> "…the physical appearance of the person sometimes gives you a certain suspicion" (Rad-05)

> "…I had a baby and I was to do a pelvic x-ray for the child who had burns at the genital area and… it was too bad I wanted to know what happened " (Rad-10).

In recounting his experience, Rad 20 identified a child who was at risk of abuse from the multiple injuries the child presented before the imaging was done. The radiographer was convinced of physical abuse. Besides, he observed poor relationship between the parent and the child from the manner the parent communicated with the child.

> "… the child was as if you know has been run over by a train had several injuries all over and even physically and looked like somebody who was not being well taken care of and this one was so obvious because the way the parents even interacted with the child in my presence you could tell that this was a child who was undergoing abuse". (RAD–20)

For Rad-12, apart from using child's emotional and physical appearance as a clue to suspect physical abuse, they also observed parent's attempt to shield the culprit, an attitude, which signalled physical abuse of child and prompted further questioning to ascertain the truth.

> "From the look of the child and how he was crying, I felt that it was not just an ordinary injury because in the first place the mother lied to me that the child fell but looking at how there were swellings and lacerations on the head, I decided to ask more questions" (Rad-12).

Child's anxiety and unwillingness to talk and lack of warmth demonstrated by the parent (such as shouting and at times going to the extent of beating the child) created suspicion among Rad-07 and Rad-14 that the child was probably abused.

> "Most often when they come, it is like because they have been abused, the child is scared even to talk and then the parents are so agitated that they put some fear in the children so they cannot even open up...most often the parent will be shouting at the child at times they will even go to the extent of even beating them in front of you" (Rad-07).

> "Children suffering from child abuse ...are afraid of their parents and also sometimes because the child is not allowed to talk when they bring them here by the behaviour of the parents...but upon further investigation or queries you get to know the real situation or at times even from the images" (Rad-14).

Although several radiographers used questioning and combined this with imaging findings in some instances to know what actually happened to the child none indicated that they documented what they had observed or information received. Rad 20 particularly found abuse cases to be grey area which should not be meddled with and felt he had no reason to document his findings or observations but rather preferred to discuss the case with colleagues after performing the examination.

> "...for me it was a virgin area this was something we had only heard about in the course of our study and how to identify. But then there was no real procedure as what to do and what not to do in those cases so like I said I just did the examinations I suspected something, did some other views and then discussed it with one or two colleagues and that was it, I did not do a recording of it" (Rad-20).

From the above statement, knowledge gap in the area of child abuse generally was affecting the radiographer's confidence to approach the situation. Though the issue was discussed among the colleagues nothing prompted them to put on record what they suspected.

7.2.1.3 Parent inadequate information and secrecy

Parents were sometimes not ready to give any information or provide the truth about what actually happened. There were occasions the history did not match the child's age or ability of the child or the injury pattern. This was a problem especially where the child had not

reach the verbal age to be spoken to. Though this was from the radiographers' own feelings or suspicion, it in a way prompted them to seek further clarifications through questioning of the one who brought the child. It was also a problem when a child was accompanied by a nurse who had no clue of the situation. In such instances the brief clinical history was relied on.

> "If the child is not verbal I do probe the accompanying relative of the patient" (Rad 15)

Rad-15 complained that when a child was brought in by the nurse, the nurse could not provide enough information to rely. In that case, rad-15 relied only on the limited information on the X-ray request.

> "…it becomes difficult when the patient is brought in by a nurse you don't get much information. You are then just limited to the brief clinical history as provided on the request form so in such cases there's very little I can do especially also where the parent or whoever brought the child is not ready to talk to you" (Rad-15).

On one occasion, Rad-06 was doubtful of information provided by a parent as an explanation to the child's injury. To be certain of what actually happened, the radiographer took advantage of the child's cooperation to seek further information from the child who was capable of talking to confirm whether the child suffered abuse.

> "…this child was somehow cooperating so we got to find out that no, this was an abuse issue he (child's father) was trying to cover up the whole situation but from the child, we managed to gather some information in that situation". (Rad-06)

Similarly another radiographer recounted that when he identified that a parent of a child he was attending to was concealing vital information, he isolated the parent to question the child in privacy to be certain of what had actually happened. However one child out of fear could not provide any information to the radiographer who from the encounter suspected an abuse.

> …I asked the people to leave the room and when I further probed the child I realised that he was even more afraid to tell me what caused the fracture to the femur…So the boy could not give me the information I needed but I realised that it was a typical abuse case" (Rad-15).

In a similar situation, Rad-17 to conclude on his suspicion usually isolated the parent to gain more information from the child when the parent was seen as a threat to the child

> "…she told me the boy just fell…I told her I have to do another thing for the boy so she should wait outside because I had not given them the report yet. I called the boy back and asked him what he was doing and he fell. He then told me that it was the mother who rather pushed him so he fell down on the stair case and broke his arm". (Rad-17)

Rad-15 recounted that a child's immediate reaction to the parent's story and observation of the child's fear to talk about the cause of his injury prompted him to probe the parent as to what really was the cause of the child's injury.

> "… I asked the parents what caused the injury they said she fell but the child's prompt reaction proved that it was not a fall…I tried to ask the boy what caused the fall but he was hesitant to talk and he kept on looking at the elderly woman who accompanied him". (Rad-15).

Apart from the child's fear to talk, the radiographer was met with a negative reaction by another person in company with the child's mother.

> "When I tried to probe further a gentleman with the woman was trying to be cheeky by saying that "I should concentrate on the thing and let them go the doctors are waiting for the results to treat the boy". (Rad-15)

From one radiographer's experience, a parent's refusal to tell the truth was because they were fearful of legal implications if they revealed the truth and they were found culpable:

> "They feel like if it is exposed that this is what they did to the child the law might probably take them on so they try hiding it in order for them also to be safe".(Rad-02).

7.2.2 Post-radiographic observation

Beside their initial observations and history taking which helped the radiographer to be curious about the case, imaging findings also assisted some radiographers to confirm or disprove their suspicion with regard to physical abuse. Some of these radiographers did not initially probe for information until the imaging was completed and findings were found to be suspicious.

7.2.2.1 Imaging findings

Further questioning of parent was carried out by the radiographer was based on the injury identified from the imaging findings. However there were occasions that a radiographer met a parent who was unwilling to speak out to enable the radiographer know what exactly happened even though the imaging findings points to physical abuse.

> "Most of them you finish the procedure and the radiographs will tell you this person has a fracture... you probe further and you see that no this is not ordinary accident but there is something wrong… you asked the mother what exactly happened then maybe that is where they will come out with the truth". (Rad-04)

Identification of abuse was also from follow up imaging findings which were not evident on an initial imaging investigation.

> "…I did what the clinician actually requested for - a chest x-ray which we carried out but there seems not to be any major problem; only for them to come after some weeks and the same procedure is carried out and you could see some fracture healing, I mean callus formation around some of the ribs and you could suspect that something fishy is happening". (Rad-02)

Multiple healing fractures identified by a radiographer after the imaging made the radiographer look for other clues to confirm his suspicion of probable abuse.

> "There was one particular case…the patient came in with a request with the history of trauma...it was the right upper limb but as I began to do it I realized that there were several other fractures that were healing also. I became suspicious and so I began to get more inquisitive and tried to find out what really was the problem". (Rad-20)

178

In being inquisitive from the findings of the previous images, Rad-20 did not restrict himself to the area of interest for the X-ray examination as was initially requested for, and took X-rays of other areas of the body which although, the results gave a positive indication of physical abuse, it was done to satisfy his curiosity.

> …but on the same humerus there was another fracture you know that was healing and then I just per chance did a radiograph of the radius and ulna including the wrist and found two other fractures...I did the radius and ulna just to satisfy my own curiosity" (Rad–20)

The radiographer's behaviour was pointlessness because it served no purpose and has serious implication for the safety of the child.

The lack of knowledge and adequate training in identifying abuse using imaging findings was expressed by one participant imaging findings to conclude on physical abuse.

> "I do not think I have had enough training on that to use the image as an assessment of an accidental or non-accidental fracture". (Rad-03)

Some radiographers condoned the right of parents to discipline their children through corporal punishment. With this understanding commitment to report could be affected when a child got injured through parental discipline.

> "Oh! My cultural views, child discipline is very important you cannot take it out, because you spare the rod and spoil the child that saying still stands". (Rad-06)

When a child got injured in a situation like that they regarded it as normal which does not warrant reporting.

> "…we did not see that as child abuse then, but I think they are forms of discipline in our various homes and I have gone through that before". (Rad-03)

From the above, radiographers in this study adopted different approaches to confirm what they suspected to be child abuse however a knowledge gap in using imaging findings was also identified. However, they condoned child discipline through corporal punishment.

179

7.3 Radiographers' Decision Trail

The radiographers' decision trails to take action or not when suspicious of physical abuse, arose from internal and external factors. The major internal factors (hospital situation) were uncertainty of support (both administrative and legal support from the managers of the hospital); where to report physical abuse cases; their lack of knowledge (legislation, radiation protection and technique to apply), doctor's attitude when approached, cost and radiation (fear of over irradiating of the child). The external factors were police frustrations, fear of attack (both physical and spiritual) and cultural interdependency of a family. Almost all the radiographers were unfamiliar with the Children's Act of 1998 and Domestic Violence Act 2007 of Ghana (Child protection legislation). They had no awareness or understanding of the legal framework for child protection. These factors explained their presumed actions and inactions in child protection. Figures 10 & 11 respectively shows the internal and external factors impacting on decisions of the radiographer.
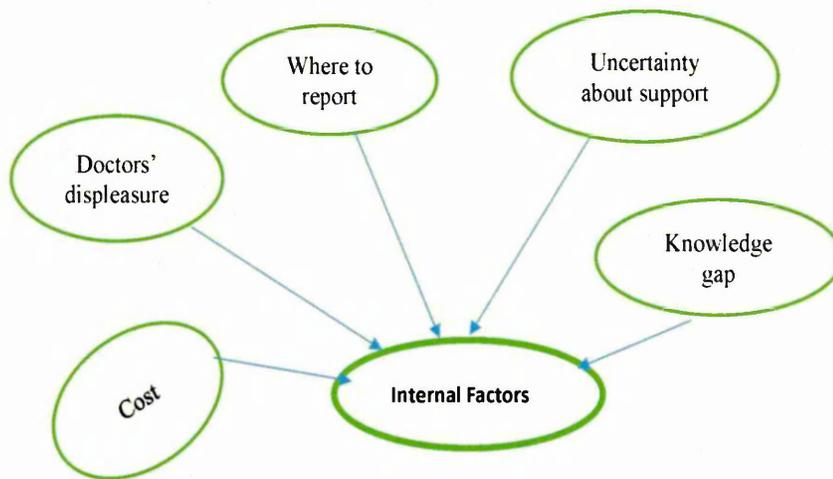
Figure 10. Internal factors in decision trail

7.3.1 Uncertainty about support

Participants' were uncertain of receiving any administrative and legal support from the hospital where they worked when they pursued such cases even though it was not the radiographers' responsibility to pursue the case to its conclusion.

180

"...you will not even know whether the hospital's legal team will be willing to support you should you go ahead to report such issue. So you are not sure whether support from the administration or your hospital will be forth coming to support you in such cases" (Rad-03).

The inflexible nature of the hospital system in dealing with cases was also an issue a radiographer perceived could make things complicated and challenging.

"Again the bureaucracy in our system makes it very difficult" (Rad-20).

From the radiographer's experience, the attention given to cases was undesirable which when any action was taken by them it was going to waste their time. Their reason was they ended up running around with no one coming in to help or take the case further. When faced with such hindrances the radiographer left the case with no action taken.

"It is supposed to be, I raise the alarm and then the systems comes in to help but if I have to be doing all that, you go up, you are sent here, you go there; and a whole lot of time wasting and a whole lot of running around you find that you just get frustrated and you would leave it" (Rad–20).

It was also an issue that a radiographer may be identified as a key witness for providing an information which would probably (as perceived by Rad 11) lead to being called and to be questioned on several occasions. The radiographer likened it to be as if he was the perpetrator of the incident by the police if the option of reporting to the police was chosen. This deterred Rad 11 to act on an identified or suspected case of child physical abuse.

"...I will be like the key suspect on this issue. Everything they will be asking me". (Rad-11)

Rad-11 also feared that the suspected abused child might provide contradictory information to the police which may have put the radiographer who reported the case in an undesirable situation. In consideration of these concerns, Rad -11 preferred to leave the case to the referring doctor to take the matter up.

"...the child can say another thing and I also will stand at another place or angle defending myself. I thought of all this and said no just let me leave it like that; the doctor will take it from that angle". (RAD- 11)

When participants were questioned about their knowledge of the child protection legislation (Children's Act 1998) of Ghana which probably could have guided them in providing assistance to a child victim of abuse, almost all the participants knew very little about it. Some of them reported thus:

"I am not very familiar with it in fact I barely know anything about Child Protection I know about the right of the child, that the child is entitled to the basic human rights, but I barely know anything about the Child Protection Act". (Rad-03).

"...we have little knowledge. We have not had any protocol or any training that gives us the knowledge about ...a legislature for child abuse". (Rad-07)

"I know very little about it". (Rad-13)

One radiographer just knew children had rights in the legislature but as with the detailed aspect of the child protection legislation, had no detailed knowledge of it.

"With the Child Protection Legislation in the country I know they have rights but I do not have detailed knowledge of the legislation, I do not have a detailed knowledge of it". (RAD- 06)

The perceived unsupportive nature of the hospital management both legally and administratively, negatively impacted on child protection. There were no indication from the radiographers that they could raise this issue to management for redress.

Radiographers were found to contemplate about whether the referring clinician would accept them cordially when they approached them with information they felt would help the doctor.

"Whenever you suspect something and you tell the clinician or doctor, is like most of them become peeved they think you want to do their work for them". (Rad-14)

This situation was critical in their decision making whether to approach them or not.

182

The participants were concerned about where to report such cases when they occur. Whether to go to the police, or a place within the hospital was a problem. This was because they were not aware of any unit to report to. Those who knew about the social welfare did not know their roles and much more to report an incident to them.

7.3.2 Cost

Some participants found the cost of providing services to a child suspected to be abused was a problem. The worry was that the economic hardship on some parents made it difficult for them to afford payments demanded by the healthcare system and the police as part of the diagnosis and investigation. Rad-07 explained that the various tests that the victim needed required payment for service and medication and because it was difficult for them to pay the fees, the radiographer was unable to take the issue further.

> "…they have to pay for the X-rays and maybe some other lab tests and then the medication so this even you know it becomes a barrier so with that you do not even have the urge to even pursue the case" (Rad-07).

Rad-11 also shared similar views about the police. The police request for a medical report to support their investigations from the person who reported the case. The challenge which was not supposed to be the radiographers' concern was about the medical report which attracted a fee.

> "... when you go to the police they will say they (victim and family) should bring a doctor's report and with this doctor's report they are supposed to pay some amount before the report is given to you" (Rad-11).

The study identified that because fees were paid for services which some parents could not afford, to enable them to seek justice. The charges to be paid were not limited to the medical report. Rad-07 reported that to obtain a subsequent report from the police also attracted charges which were difficult for some parents who were financially handicapped.

> "... most often when they (victim and family) come (sic) because of the economic situation they cannot even afford to pay for the police report because they charge" (Rad-07).
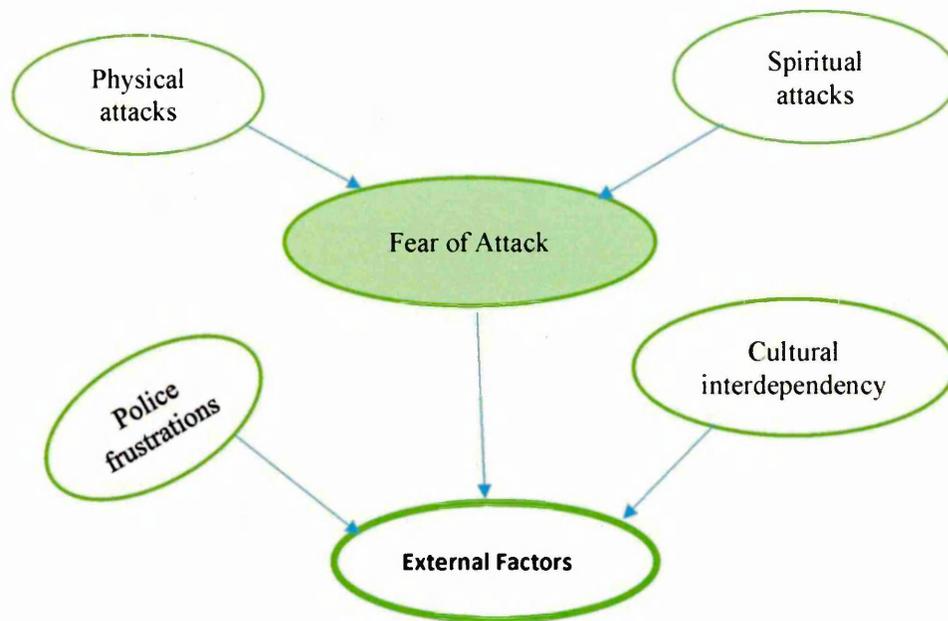
Figure 11. External factors in decision trail

7.3.3 Fear of attack

There was combined fear of both physical and spiritual attack; fear of being beaten up by those involved in the child's situation or being cursed by the perpetrator and family were some concerns that informed participants' decision making. Spiritually they feared reprisals from a "mallam" (a Muslim spiritualist capable of casting spell on people) and/or use of ju-ju (charms) in revenge for interfering. These cultural beliefs or superstition were deep-rooted in participants and prevented some of them from providing any help beyond the imaging task for the child victim.

7.3.3.1 Physical attack

Several of the radiographers were cautious of to intervene as a result of fear of aggression on them. A female radiographer saw the native community where she was working to be dangerous because of the existence of groups who could attack anyone they suspected had intruded in their affairs. The ensuing examples of expressions of intimidation from the findings suggest the reality of attacks from the community where they practiced;

"In this community, especially the people are indigenous and very rough who like fighting...If you don't take time, they will come with their groups; they are always in groups to attack you". (Rad-17)

She iterated that worst form of attack was eminent when one treads on a toe in trying to bring in a police on issues confronting these groups.

"If you meddle in their case where you want to put them in trouble or make a police case then prepare for the worst". (Rad-17)

The refusal to take action to seek justice for the child, was further explained by Rad-04 and Rad-17 who reported that when a member of the group was affected (culprit) and they identified who brought the case to the police, they gang up to attack you anywhere including the reporter's work place.

"...they hire some people to meet you on the way somewhere to beat you up" (Rad-4)

"...when one person commits a crime and you go to report they will go and call other people to come and attack you. So you will be in the hospital and before you realize they will come and attack you and some of us lives among them. Before any help comes the harm has been done". (Rad-17)

Rad-04 accepted these attacks as purely cultural. The reality was that just to prevent anyone from pursuing the case they schematise malicious things against the 'intruder'.

"...whatever evil thing that they will think of just to stop you from following the case they will do so that is our culture too" (Rad-04)

The culture of personal aggression against the 'intruder' willing to pursue the case was ingrained in the minds of the radiographers. This was found to be a barrier to act on cases of abuse.

7.3.3.2 Spiritual attack

Besides physical attack which was rife in some communities, superstitious beliefs were also identified as a significant issue for consideration for many radiographers in this study.

Participants' fear of attacks from ju-ju by the perpetrator or the family of the child causing the participant to suffer some consequences spiritually was shared by most radiographers (Rad-04, Rad-07, Rad-08, and Rad-12) in the study:

> "Most especially too with our culture and beliefs, and the person who did it can send you to a juju person, a mallam or whoever follows up to make you suffer because he is not going to sit down and watch you destroy him so all that he has to do is either they take you to ju-ju". (Rad-04)

According to Rad -07, he lived in a native community where cursing people was common and the belief held was that curses do have negative effect on the individual who intrudes in peoples' affairs.

> "...in our community, we are in the indigenous area and they like cursing so if you want to take somebody on, you know they will threaten you so because you are also afraid you cannot even pursue the case. So I think our socio-cultural environment does not permit us even to pursue such abuse cases". (Rad-07)

Rad-08 shared similar sentiments to support the belief in the effect of illogical forces which could be visited ion them by the party trying to hold back information about the cause of the child's predicament and for that reason, they were scared to go forward with their suspicion of abuse.

> "Yes, in our part of the world where we believe in spirituality to the highest degree any parent who tries to protect his image can go to the extent of using external powers of spiritual things to defend himself to cause you or whoever is trying to unveil whatever he or she is trying to hide. So he can use that to fight you to the extent that you can even be killed through your pursuit of a suspected child abuse case" (Rad-08).

To Rad-12, superstition was deeply rooted generally among Africans which was a living experience and as such would be careful in dealing with matters of child abuse.

> "That is Africa for you and Ghana I will say! That is what is here and most of us have lived with all this for a while. So if you are not careful and you step on somebody's toes, you might be killed mysteriously" (Rad-12).

186

As a result of fear of such attacks a female radiographer always checked first, the tribe or ethnic background of the family of the child before considering going to the police to report.

> "Oh you have to look at where the case is coming from which tribe or ethnic background else with such cases you can be attacked if you take it too far by some tribal families" (Rad -10).

Rad -10 further explained that her apparent lack of interest in an abuse case she handled was because of the fear of a tribal group attacking her for just showing interest by bringing in the law enforcement agency or the police.

> "That was one reason that case I handled, I did not take much interest because they were from a group that you dare not interfere much more bringing in the police or the DOVVSU"(Domestic Violence and Victims Support Unit) (Rad-10).

The belief in spiritual attacks was seen as a prevailing reality in Ghana from the findings and was accepted by most participants interviewed. Rad-11 made the following observations.

> "Ghana here they like juju so someone can just take you to a medicine man to put some sickness on you" (Rad-11).

Rad-11 in particular attributed sudden and unusual sickness to spiritual attacks as a result of interfering in someone's case and for the fact the one who reported could be traced easily was a deterrent to taking up matters of abuse.

> "They can even do it in such a way that when you come to your work place you would not feel fine, you will feel like someone who is sick but when you are outside of the room you will feel better so in that case they are preventing you from doing your work ...and then two, they can even attack you on your way home. They can get all information about you and plan and harm you" (Rad-11).

Rad-12, Rad-13 and Rad-17 reiterated these beliefs when interviewed on these spiritual attacks revealed by their colleagues. They spoke about how they were superstitious and the risk involved in intruding in abuse cases.

"Yeah, I will say that in our setting here we are mostly superstitious of everything. If you try and step on somebody's toes you might be harmed, you might be attacked spiritually if you do not take time your life might be ended by an aggrieved person using these traditional charms and all that". (Rad-12)

Helping the child was likened to stepping beyond one's boundaries which could be met with a curse or physical attack. Child protection became affected because (as expressed by Rad-13), they would not like to get involved because abuse of someone's child was "not much of their concern". This fear was noticed in most expressions of the participants interviewed which weighed over the needed professional intervention they had to provide the child.

"Our cultural setting is such that everybody minds his or her own business so if you step off beyond your boundaries, the mother can even invoke a curse on you or even organise a gang to attack you so that is why we normally don't want get involved in issues that do not concern us so much".(Rad-13).

Rad-017 was more concerned with her life and her children rather than getting involved in a case that may bring untold hardship or death to her. This was as a result of the strong belief in the powers of the unknown forces such as use of juju, curse and gods (deity) that could be invoked to act against her.

"Spiritual aspects too are there I know that in Ghana some people can consult bad spirits and use them against you or use juju or curses with river gods and lots of these things work. Anybody can take you to a juju man before you realize you are dead and leaving behind your children or get strange problems. So in order to live for your children, you leave those matters to them". (Rad-17)

Children were not protected by the majority of the radiographers who had strong beliefs in supernatural forces which could be used to attack them by any party involved in the child's situation and would not like to reveal the truth which might get that party of person into trouble.

7.3.4 Cultural interdependency
The cultural interdependency explains how a few of the radiographers felt that reporting a case of abuse involving a breadwinner could create a problem. They felt if the culprit

happens to be the person the whole family revolves, then reporting the incident will not in the interest of the family.

> "Sometimes it is a family thing we depend on each other and if you report a family member who has abused a child and happens to be the bread winner of the family and this person is arrested, then it's like you cut of the source of life for them. So it's like it becomes a problem as to whether to report or not". (Rad-03)

Another participant was of the view that by reporting, and the child is taken over by the state, the child might not receive any proper care and for that reason you leave the case without any action.

> "Another issue is that when you try to help the child and they send the child to this institution (referring to foster home) where they are being covered or protected you would not know what would be happening there maybe they would not go through any good condition there so we just keep it that way" (Rad-11)

These perceptions held by the radiographers could imply that various suspected cases of child physical abuse go unattended to due to these perceptions about the whole child protection endeavours.

7.3.5 Police frustrations

Rad-04 was aware that as a radiographer he had to support the victim however, he was deterred by the time needed to follow up abuse cases. Interestingly, Rad-04, further indicated that he felt he might be treated as if he was the culprit during the investigation when.

> "...as a radiographer, I have to help but...when I take it up it is going to waste my time" (Rad-04).
> "I am going to be handled as if I committed the crime" (Rad-04).

This concern appears to come from the notion that the case would not be treated on time and the informant may be needed anytime the case is visited till the prosecution ends. This was seen by Rad-04 as being treated as the culprit.

7.4 Influence of Relationship.

There were relationship challenges both within the hospital and with families of abused victims. Within the hospital, interdisciplinary cooperation seemed lacking. Two sub-

themes were generated under the influence of relationship Interdisciplinary relationship and previous relationship (that existed between families and the abuser or family with the radiographer as well as the radiographer and the suspect) Figure XX. Besides the ethnicity problem, when the language spoken by the radiographer was the same as any of the parties involved in the case, they tended to be biased to the one who spoke different language even if that one had a good case which required attention. Lack of trust was identified among the radiographers with the referring clinicians, the nurses and the social worker attached to their hospital. Their previous experiences with these categories of professionals affected successive actions of the radiographer in child physical abuse cases.
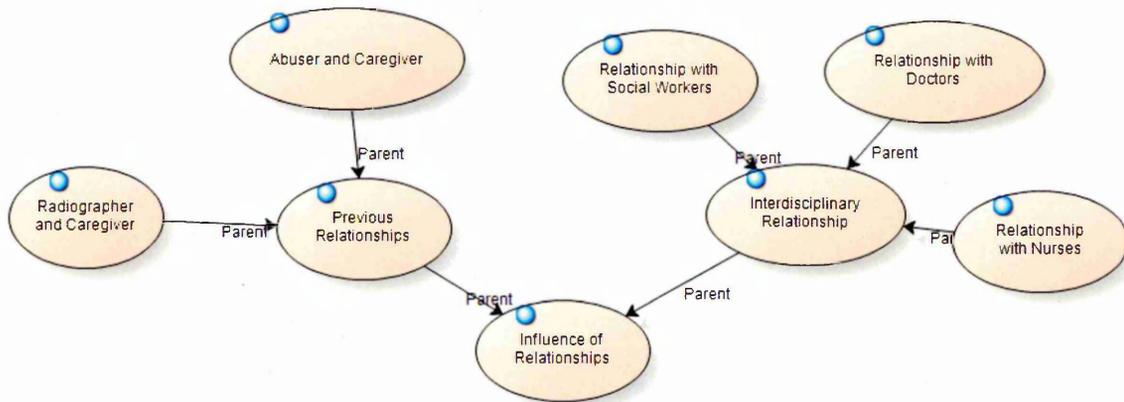
Figure 12 The Influence of Relationship.

7.4.1 Interdisciplinary relationship

The willingness of the radiographer to pursue physical abuse cases was persuaded by the strength of interdisciplinary relationship existing between them and other health professionals (particularly with doctors) in the hospital. This theme generated sub-themes of relationship with doctor, relationship with nurse and relationship with the social worker.

7.4.1.1 Relationship with doctors

Almost all radiographers in this study felt that doctors they worked with were not collaborative. They saw doctors to be authoritative because of their leadership role and as such were not ready to open up to them when they were approached with issues observed by the radiographer. This apathetic nature of doctors was provoking as reported by Rad-01:

190

"...the problem we have is that it is the uncooperative attitude of some of our colleagues within the chain I mean the doctors...some of them are not prepared to even listen to what you are saying they are only interested to do what they are saying because he feels he is the only leader in the team so what he says is final so when it is like that it becomes a little bit frustrating". (Rad-01)

The doctors' reaction through their comments when approached was also expressed by Rad-17 who indicated that the doctor would not listen and dismiss them from their presence.

"They will just shut you up and then tell you that they are in charge so leave everything to them". (Rad-17)

This insolence from the doctors (one radiographer explained) was as their held understanding that the radiographer's role was just to produce images. In harbouring this perception about the doctors, two of the participants (Rad-11 and Rad-19) were not willing to report a case of physical abuse to them to avoid any rebuff.

"The issue is in Ghana here the doctors do not take our opinions they think our duty is just to produce the images or the radiographs so I may not report such cases". (Rad-11)

"All I do is the doctor says I should do this, we do it and give it out, whatever happens at the next stage most often we do not seem to be much concerned about it". (Rad–19)

7.4.1.1.1 Professional Isolation with Doctors

The radiographers' feeling of professional isolation with doctors was identified as one of the key issues in the professional relationship with the doctors. This affected the required teamwork approach to provide the right care to the victims of physical abuse. The radiographers experienced feelings of isolation and lack of togetherness in this study.

In describing the teamwork spirit of the health care professionals, Rad-14 and Rad-19, indicated disconnected relationship; thus experiencing some form of professional segregation from the doctors.

191

"The relationship is like all of us work in isolation". (Rad-14)

Particularly Rad-19 threw more light on the loneliness nature of their work which run across all the professions working in the hospital.

> "We all work in isolation; I will say we more or less practice a silo sort of practice. The radiographer sees him or herself as a silo, the doctor sees him or herself as a silo, the lab man sees him or herself as a silo and in that case there is no collaboration between the various teams". (Rad–19)

Rad 20 described the situation using phrases such as 'lone ranger', 'lone crusader' and 'one man fight' in attempt to draw attention to critical situation such as child physical abuse in the hospital.

> "…at a certain point you become a lone ranger or a lone crusader and …there are no real support systems in place to help you, you back off". (Rad-20)

Rad-20 was further of the view that child protection against abuse was supposed to be a collective approach where the problem should not left with an individual to manage.

> "It is not supposed to be a one man fight so that when I notice it and then I am the one who fights". (Rad-20)

As a result of that the radiographer (as explained by Rad-14), was only interested in completing the examination requested by the referring doctor and went no further because when the attention of the doctor was drawn to an unusual situation such as an abuse, the doctor became provoked because of role conflicts.

> "The doctor sends a request to us we do it and that is it…Whenever you suspect something and you tell the clinician or doctor, is like most of them become peeved they think you want to do their work for them". (Rad-14)

> "I think the best word to use for it is, it is a very bad or poor relationship". (Rad-19)

The findings also showed that radiographers having this relational problems with doctors shared their observations with themselves without bringing in any doctor about their suspicion; teamwork spirit was thus lost. This was collaborated by Rad-03' Rad-14 and Rad-19.

"I prefer to discuss it with my fellow radiographers than with the radiologists or doctors". (Rad-03)

"But in the department we are together in a way and share ideas but mostly among radiographers". (Rad-14)

"We do not have that teamwork spirit whereby we all come together share ideas or put our knowledge together for the benefit of the patient". (Rad-19)

"I have a very cordial relationship with my fellow radiographers but with the radiologists or doctors at my department the relationship is not that cordial". (Rad-03)

The perceived intimidation from doctors and their control of the patient, the radiographer would not show any willingness to alert the doctor about their findings which they believed might have escaped the doctor. This was exemplified by Rad-14 who saw the doctor to be in control and would not do anything about the case.

"So sometimes with cases of child abuse when you alert them of your suspicion which might have eluded them and you see that he is not taking any step, you cannot go further because they are in charge".(Rad-14).

There were reported cases of egotism from the doctors which affected the collaboration and information sharing between them and the radiographers who felt the doctors would feel burdened.

"If you try to follow up too it might be like in a way you are putting pressure on him so you don't feel that togetherness in the care".(Rad-14)

Rad-17 shared a related experience when he informed a doctor and was snubbed:

"...I informed the doctor what I have observed or done and he just brushed me off". (Rad-17)

Rad-17 understood that for holistic care to be achieved, relied not only on what the doctor knows but the contribution also from the radiographer who was a player in the delivery of care.

> "…radiographer is part of the team taking care of the child we will have a holistic care of the abused victims and not only he (the doctor), depending on only what he knows, to care for the abused child". (Rad-17)

Radiographers in the study reported that when the doctor's attention was drawn to their suspicion the doctors felt the radiographer was directing them as to what to do. This was seen as a difficulty in their practice.

> "…because you have identified something and you are trying to make him or her feel that they do not know what they are doing. And so we have some of these situations which make it difficult for us to really come to terms with some of these issues. So it is a real challenge, it is a real challenge in this part of our world". (Rad-20)

One radiographer corroborated what other colleagues have reported about doctors' unruly attitude towards them when they were able to identify an error or wrong judgement on the part of the doctor and drew the doctor's attention. Rad -19 expressed the view that because the doctor was on top of the hierarchy they faced coercion which could affect their career progression. This according to the interviewee affected relationship.

> For instance in our part of the world even when you see something wrong and you approach a doctor that this is wrong, the doctor takes offence and if the doctor happens to be your superior, will start intimidating you even when it gets to your promotion time may decide not to promote you even when you are qualified for it. So because of some of these things we do not have cordial relationship with each other". (Rad–19)

Radiographers' apathy to taking action with cases of abuse was also inherently linked to unacceptable name calling by some doctors when approached with suspected cases of abuse.

> "You might even have a situation where a doctor you are trying to provide the information will tell you that you are being "too known" (which means you are interfering or crossing your boundaries of practice)" (Rad-20).

> "So it is a real challenge, it is a real challenge in this part of our world" (Rad-20).

Past negative experiences with a doctor deterred a female Radiographer (Rad-11) from approaching them with any case.

> "…because of that experience I did not want to even go to them on any case". (Rad-11)

The handling of child physical abuse was affected by the non-willingness of the radiographer to collaborate with the doctor as a result of the perception held that the doctors were full of immodesty and infuriating who only wanted the radiographer to be subservient to them. It was problematic for some radiographers to inform any doctor about an observed or suspected physical abuse:

> "...some of the doctors...are very irritating in the sense that they don't see why you should draw their attention to things like this. It puts you off to talk to them". (Rad-08)

> "The doctors here feel proud; they want you to be kowtowing (show deep respect) them every now and then, so it is difficult for you to even go to them and tell them about issues such as these". (Rad-03)

> "We do not go ahead to report to the radiologist or the doctor, the referring clinician or anything like that; we just leave it there". (Rad-03)

The problem with the radiographers was that because doctors enjoyed passion from the society, who worship and have the perception that doctors' are all-knowing characters for that reason the radiographers draw back with whatever they know which could probably assist the doctor to conclude about the child and leave such unfortunate children to their fate.

> "Here we make fetish out of doctors so the doctor is all". (Rad-09)

> "…there is this thinking that the medical officer in Ghana knows it all… the desire to draw their attention is most often not there". (Rad-18)

Rad-19 also attributed the relational problems with doctors to the supremacy they exert on the society making them sometimes distant.

> "I think it still boils down to the high power distance culture…whereby in the hierarchy those at the top are never to be approached by the junior ones". (Rad-19)

Rad-18 was of the view that because the key role of the radiographer is to produce images they were restricted in a way from sharing ideas; a situation which was not contributing positively to the care of victims of physical abuse.

> "...the radiographer is limited in its function in a way that you just produce the radiographs and that is it. Whatever you see you should keep it to yourself and that for me does not help matters". (Rad-18)

However the situation was not the same in all the hospitals studied. Four radiographers (Rad 02; Rad-06; Rad-07 and Rad-15) from different hospitals expressed that they had very good relationship with doctors. Doctors were free to approach them and vice versa on any matters of care delivery which included cases of suspected child physical abuse.

> "The relationship we have, I think it is good and I normally go to them if there is something I do not understand. Vice versa there are certain images they also find difficulty in the interpretation. For instance when they are not so sure of what is wrong they approach me on it. So concerning child abuse cases I think there is no difference between it and the other normal cases we do consulting each other and discussing the radiographs". (Rad-02).

> "Oh! We have quite a good working relationship. We work hand in hand, examination that their presence is needed, we do it together if there are certain things that we think have seen that you want to draw their attention we do that, then whatever we want, they take it on".(Rad-06).

Rad-15 recounts his good experience with a doctor he reported a suspected abuse case to demonstrate the good relationship that existed in their setting.

> " I relayed the information to the doctor and he was also interested in it and threatened to report to the police but once again I did not follow up to know if he carried out what he said he will do but we collaborate cordially".(Rad-15)

Rad-07, explained that clinical meetings involving all the professions enhanced professional relationship in their hospital; where clinical meetings were thus held which involved radiographers the relationship was better.

"Yes we have a cordial relationship because most often when they have these clinical meetings they do invite all of us. We share ideas about clinic at times too; we have what we call quality assurance meetings. Some of these meetings most of the staff and the heads of units are invited then we share ideas how to take care of clients and then ourselves, and how to be relating to each other. So with our place we have cordial relationships". (Rad-07)

The results as indicated by Rad-07 demonstrates that professional togetherness was enhanced where they were brought together to assess their performances.

7.4.1.2 Relationship with nursing staff

Relationships with nurses were limited to discussions at the time of imaging about children who had been abused.

"The nurses here, like we talk about it when they are around and we are doing the case we talk about it, but after talking about it, it ends there". (Rad-03)

From the findings, while one radiographer saw the nurse as professionally playing a clerk's role to the doctor and found no reason to talk to the nurse about suspected physical abuse, another felt the nurse was not in control to be reported to. They preferred to contact the doctor because the case is supposed to be decided by the doctor whom they felt the buck ends.

"The nurses…they act like secretaries to somebody (referring to the doctor) …I cannot discuss with the nurse it is the doctor that I have to because he is the final person." (Rad-04).

"I don't think they are in charge it is the referring doctors so my core person to contact is the one who has referred the case to me so that he will also take the necessary steps to help the victim". (Rad-14)

7.4.1.3 Relationship with Social Worker (SW)

When asked why they failed to bring in or report their observations to the Social Welfare in the hospital, several radiographers (Rad-01; Rad-02; Rad-04; Rad-20) gave mixed understanding of the roles and responsibilities of the which partly included the management of all manner of suspected child abuse cases. The radiographers as a result of their

197

ignorance only referred patients who had financial problems and could not settle the hospital bills to the Social Welfare leaving child abuse out.

"If the patient cannot pay the bills, you will direct the person to the social welfare". (Rad-01)

The majority of radiographers assumed that SWs only helped in cases of patients' who were unable to settle their hospital fees to get service and mistook this responsibility to be the core role of the SW. Faced with such ignorance, they did not bother the SWs with identified cases of physical abuse. Examples from Rad-01; Rad-02 and Rad-04 are used to reinforce these findings:

"... if a child comes and has been physically abused, I do not know how the social welfare will come in". (Rad-01)

"... we have the social welfare unit in the hospital but...the work of the social welfare as it stands now does not involve in children abuse like this".(Rad-01)

"Basically I understand their function to be assisting those who are in need and would not be able to afford the medical services because that is what I see them doing (Rad-02).

Rad -01 reiterated that there were neither rules nor directives that guided them to report incident of abuse to the SW.

"If a child has been abused, there are no guidelines or instructions that we should report to the social welfare ". (Rad-01)

It was also found that because radiographers had not spotted the presence of the SW in child abuse cases, they never send cases to them as was reported by Rad-04.

" That is what I see them doing but apart from that the abuse children and all those things I did not see them coming in and we did not take any problem to them".(Rad-04)

Despite the lack of knowledge about the responsibilities of the SW demonstrated by some of the respondents, two radiographers were aware of the role of the SW in matters of

identified or suspected child abuse generally and made reports to them. However, in the case of one the radiographers, the comments of the SW left him in a limbo. As reported by Rad-20, when he approached the SW, the official could not help because she had more demanding problems to tackle and would not have the time to pursue the abuse case brought in by the radiographer.

"I spoke to one welfare officer and to be honest she told me their arms were full either in quotes more pressing cases so it was going to be difficult to follow upon this… it was a difficult situation and that is the challenge". (Rad–20)

There was a trustful relationship with the SW in another hospital. Unlike the previous colleagues, Rad-05 reported that the right action to take was to involve the SW in identified cases because they sometimes gave good counsel on such matters. The SW was the first official Rad-05 reported such cases because they always had solutions to the problem.

"… fortunately for us at this hospital, we have a social welfare unit where we have professionals who can sometimes advise us on what to do".(Rad-05)

" the social welfare approach is better… it is better to go with the social welfare approach because…they are professionals the way they start asking the questions, the truth will start flowing ahaa " (Rad-05).

The mixed perceptions and experiences with the radiographers encounter with the SWs had implications for policy and practice. The ignorance about the role of the SW negatively affected child protection.

7.4.1.4 Previous Relationship

This study identified that the familiarity with either the family or culprit had influence on radiographers' reporting behaviour. They expressed doubts about the benefit to the child when the biological parent who was the culprit was reported. In a few cases the radiographers' behaviour was prejudiced by this perception and their relationship with the perpetrator. When the perpetrator was known to them, they were unwilling to help the child. Moreover when the radiographer was aware that the perpetrator was the one providing for the family, no action was taken to affect the family's source of survival. Their

partiality was also driven by the ethnicity or cultural type (such as whether the radiographer was the same ethnic background with the child's family or the perpetrator). This kind of relationship with either the family or the perpetrator had a greater influence on where the radiographer would skew his or her assistance to. Again when there was a relationship between the parent of the child and the perpetrator, the radiographer was unwilling to act to destroy the relationship as they perceived that it would have a negative outcome for the child. This was exemplified by the sub-themes: radiographer caregiver relationship, caregiver/perpetrator relationship

One participant was inclined to support whoever was involved in the abuse case when the radiographer spoke the same language as the perpetrator or the family of the suspected abused victim. Rad -01commented that he was apt to protect any of the parties (the perpetrator or the victim) when the same language was spoken.

> "… because of our cultural differences and barriers, you seem naturally to support where you understand in terms of language". (Rad 01)

It was observed in this study that if the perpetrator was related to the family in any way that radiographer was not ready pursue the case. The reason was similar interdependency problem that existed among families.

> "... it is her sister's husband (the culprit), it is a family thing she cannot report her sister's husband…we depend on each other for our source of living especially in the family setting. So I did not want to push so I stopped there".(Rad-03).

In buttressing his stand rad-01 and Rad-03 further recounted that if the perpetrator happened to be the bread winner taking action could affect the family a dilemma that confronted the radiographer:

> "...if you report now who is going to take care of the child?" (Rad-01).

> "… if you report a family member who has abused a child, who is also the bread winner of the family, and this person is arrested, then it's like you cut off the source of life for them. So it's like it becomes a problem as to whether to report or not". (Rad 03)

Child physical abuse was seen as a family matter. As a result a participant rather preferred to leave it to the family to handle.

> "Typically, it is a family matter". (Rad-09)

The cultural influence on the radiographer not to report abuse that had occurred within a family was a reality. The view was that the perpetrator might be the sole caretaker of the family and when such a person was reported, it would mean their source of care had been taken away.

> "…our culture does not give us that lead way to be reporting a father to the police or the authorities because when the father is not there, who will be taking care of the child". (Rad-09)

The abused child was seen to be better off with a parent who was the perpetrator than to report the parent and have the child put in a foster home. Rad-11 had maintained this thought and was sceptical about the conditions in foster homes where the affected could be sent for safety.

> "Another way too is when you try to help the child and they send the child to this institution where they are being covered or protected you do not know what is happening there maybe they would not go through any good condition there so we just keep it". (Rad-11).
>
> Reporting a family member such as the biological parents was culturally unacceptable by some radiographers. The perceived unreliable nature of child institutions where they could be catered for

7.5 Reporting of Suspected Child Physical Abuse.

During the interview, reporting of suspected physical abuse by radiographers in this study was further challenged by several factors. Whatever decision participants took in this study to either report abuse or not, was influenced by several background factors which included organisational failures and cultural issues. For example the absence structures in place at the institutions to deal with abuse cases and also their professional and personal/cultural

attitudes. As a result there were reduced reporting behaviours of most radiographers in this study.

7.5.1 Lack of structures.
Radiographers interviewed in this study had issues with the systems put in place for the reporting of child abuse. This was supported by the absence of guidelines, policy deficits and non-availability of established units to serve notification of physical abuse held them back to integrate their practice with actions to protect children suffering from physical abuse. Reporting to the police could have been an alternative place to report, the current study identified that participants perceived encountering frustrations with the police and were not ready to take that path.

7.5.1.1 Policy deficits.
The apathetic nature of the system as reported by some radiographers affected the warmth supposed to given to children suffering from suspected physical abuse and neither were they compelled to take action.

> "There seems not to be any clear policy in handling such cases and this have also affected the hospitality we give them as well because child abuse issues have not been given any proper attention at the hospitals". (Rad-17)

> "...am not too sure about the policies on child abuse so in order not to commit myself. I normally don't follow up on such cases". (Rad-13)

Rad-14 was critical of the MoH which was supposed to lead in policy formulation to bind the hospitals on the management of child abuse cases but this was not known to almost all the radiographers interviewed in this study. This gap extended to the hospitals where most of them worked;

> "With the Ministry they have the legal mandate to direct things give policies or something but in fact I don't see anything". (Rad-14).

> "I do not know of any laid down procedures by the hospital". (Rad-15)

The non-availability of a designated place to report suspicions of abuse was also a concern to Rad-15

> ..."the hospital itself has not got any established place like an office for child abuse so if there is a case like this you can come and report it". (Rad-15)

The findings recognised that the decision regarding whether to report was also centred on their personal security should they pursue cases of child abuse. For example, Rad-17 expressed that;

> "…we are not aware of what to we do not have any reporting procedure, protocols and how an informant can be protected". (Rad–17)

To intervene for a child, one radiographer explained it takes several days to complete the process if one was willing to pursue it.

> "…it is not something that when you take up one or two days it is over it will take time". (Rad-04)

Besides the long period it took in pursuing abuse cases, Rad-04 felt the police might not treat the case with the urgency it deserved. This was a deterrent to take a lead role in a case of abuse. As expressed by Rad-04, the tendency was to adopt the bystander attitude and allow the victim to go without any action.

> "…even if you report to the police you have to leave your work and go to the police and they will not take it as an emergency…just going up and down so all that I have to do is to sit somewhere to watch the person go his or her way". (Rad-04).

When asked whether (upon identification of abuse) observations were documented for investigation, Rad-20 reported:

> "… there was no real procedure as what to do and what not to do. I did not do a recording of it". (Rad–20).

As a result of absence of procedures and appropriate information to use, one participant's choice was to show sympathy to the victim.

> "…there is no information or procedure here that tells you do this or that when you see this or have a strong suspicion .So sometimes I just sympathize with the child (Rad-15).

7.5.1.2 Lack of reporting units

Participants interviewed spoke about ambiguous communication channels and guidelines. These concerns affected the reporting behaviour of radiographers interviewed. In deepening this concern, Rad-09 expressed that although they were willing to follow up a case, they did not know how to communicate it and also had nothing to guide them in the attempt to pursue the case;

> "...on the high side, we should have followed up or something but in our situation there is nothing much you can do because even the channel of communication around here is quite poor. We have been reading that elsewhere there are clear guidelines as to what to do about some of these things but unfortunately here even how to get your superior to report to is another problem".(Rad-09)

For a participant, apart from the feeling that they were not in control of affairs, inappropriate channels of reporting, the lack of education and the non-existence of a place or team to report their observation or suspicion, affected their ability to help.

> "...we are not in charge. If the reporting lines are clear so that we ourselves are educated on some of these issues and as soon as we see them we know where to go or who to call. Then we would have alerted the authorities that are trained to deal with these situations to deal with them. So it goes back to the previous issue of a multi-disciplinary team that will be dealing with some these situations and open reporting lines so that as soon as there is a suspicion you can call those people and give them the lead to start their investigation". (Rad-05)

The lack of appropriate channel to report abuse was also supported by Rad-09.

> "...there is nothing like a channel here". (Rad-09)

> "At least the channel should be there and it should be clearly stated as to where I should go". (Rad-09)

Participants felt the absence of structures in place to cater for child abuse cases also makes it a time wasting to report. A participant iterated that the responses from superiors were not encouraging and saw the exercise of reporting to them a waste of time. There was also no designated place or person to consult or report suspected abuse cases within the hospital as a result abuse cases were not reported by Rad-11.

"Is because we do not have any good measures in the hospital where to report this... for instance if something happens and you go to head of department to report to, the actions they will take will even cause you of your time...so I normally do not report it at all. They do not have good measures, where to report to and then who to consult". (Rad-11)

In corroborating with the Rad-11, another participant (Rad-15) reported that when physical abuse was identified the absence of laid down procedures led to no action being taken. The imaging report was given to the patient to go since there was no established system or unit to report such cases:

"Hmmm, the first is since I started working I have not known of any laid down procedures in this hospital which stipulates that when you see an abuse case maybe go here or there and tell this person or a unit. Apparently when it comes, we just do the case and we give the results back to the patient or the one who brought the child and he takes it to whoever requested for it". (Rad-15)

7.6 Attitudinal Issues

Attitudinal issues as a theme had two main strands. These were the commitment of the radiographer, and the desired pattern of reporting cases of physical abuse. These were driven by several factors within and outside of the organisation. Time needed to follow up cases, parental attitude, radiographers' perceptions about child discipline, frustrations they may encounter with the police all played on the radiographer's a role and commitment to act accordingly on suspected cases of physical abuse. Moreover, at the organisational level, the absence of clear reporting channels within the system confused the radiographer as to where they were supposed to go and report cases this led to discretional reporting patterns when they were willing to report.

Participants expressed concerns about indifference shown by some doctors which affected shared responsibilities. Despite this challenge some radiographers felt that doctors were in control and were the right people to report to about their suspicion of physical abuse. Others had a contrary view and would not report to any doctor about abuse because doctors' dismissiveness when approached. A few of the radiographers favoured reporting

to the police even though it was frustrating at times when they chose the police. The option of reporting to the SW was mixed as participants were not sure of the help the SW could provide. Only one radiographer, rather saw the SWs as the best professionals to report to. Others were ready to report to their heads of departments or the radiographer in charge of the department. However the findings also shows that their superiors were not showing any professional leadership in cases of child abuse reporting leaving them with no choice but to leave the case without any action taken. While others attached urgency to child injury cases resulting from physical abuse, others considered as any other trauma case they were handling. Examples of findings as reported by the participants follow:

7.6.1 Professional Commitment

The findings shows that participants were neither willing to leave their work and act on suspected cases of physical abuse nor showed any eagerness to approach the referring clinician or a unit for child abuse about their observation. They however, were interested in discussing their suspicion of child physical abuse with their colleagues. Rad -16 reported that they had no training in the area of child abuse and its management. This became a barrier to the actions they had to take when they identified that a child has been physically abused.

> "…I cannot just leave my work and then go to the referral or where they handled these suspected issues. I don't know how to go about it. I have not had any formal training in that so I don't know where to go so we just discuss and leave it there".(Rad-16)

The police was a statutory agency who handles reported cases of abuse however a participant recounted how they could be frustrated by unreliable police emergency lines if the radiographer chose the option to call in the police.

> "The police people have put up telephone numbers but I am afraid to tell you that such numbers do not work. When you call, the numbers are always busy or you hear a strange tone meaning the line is not working". (Rad-09)

Compared to other patient cases child physical abuse was treated as a single case among the lot which should not warrant the radiographer's time to be following up to secure the child's wellbeing. Rad -09 was of the view that by following up, it would inconvenience the other patients in waiting for their examination and felt that there should be someone available to act on such cases.

> "I am working, so assuming I have other patients lined up waiting for me and I am leaving those patients there and following this child to the police station, I am going to inconvenience the other patients waiting for me and who is going to take care of them? ...Why will I follow one person and leave the rest behind I believe it is not very good so there should be someone who should be following up on all these things".(Rad-09)

Similar sentiments were expressed by another radiographer who felt that cases of abuse were lonely among patients waiting and suggested a unit to be available whom they could contact by telephone to handle the case when identified. In support of previous expressions from other colleagues interviewed, Rad-15 could also not his work to pursue a single case.

> "...there is a lot of work to be done you cannot leave the work and follow one case. If there is a unit, you can report by phone and they take it up from there but errr nothing". (Rad-15)

Participants' commitment to report child physical abuse cases was ruined by the attitude of the referring doctors who were found to be indifferent and sometimes rude to the radiographer for approaching them to report an issue of concern about suspected abuse cases:

> "I informed the doctor...But what the doctor was interested in was the diagnosis so he did not even bother to probe further or listen to my case from his looks".(Rad-13).

Some doctors were just apathetic about abuse cases and the anger they showed when radiographers approached some of them was a disincentive to the radiographer to get involved.

"Yes most of the time when you find out that a child has been abused not even with abuse cases alone, or you identify something and approached the doctor, … there are some of them who will not listen to you or just get angry at you because it is like you are telling them what to do and they don't care there are other people there". (Rad-17).

The radiographers felt that doctors were not committed to pursuing cases of physical abuse from their experiences with comments made by the doctors when approached with such cases. Radiographers held the view that the liability ends with the doctor so if they were not steadfast with abuse cases they had no other choice but to leave the situation in the hands of the doctor.

"With the abuse cases when you tell them the doctor will tell you that oh this one leave it to the parent it is not your field or problem yours is to take the X-rays it is not your problem so be at your end. They will just shut you up and then tell you that they are in charge so leave everything to them". (Rad-17)

Rad-19 indicated that their commitment as professionals to cases of child physical abuse was very poor and explained why they were reluctant to follow up cases of suspected abuse:

Yeah! I think we have a very poor commitment to that, very poor commitment. At times it is not that the health professional does not have the interest to help the child but even the reporting line, who do I report to and the person I report to how serious is the person to take up the matter further to the next level. These are all challenges for which most of us seem to be reluctant in pursuing some of these child abuse cases. (Rad–19)

Sometimes refusing to report a case of physical abuse resulted from the attitude of colleagues in the department. The perception among the colleagues was that after following up a case of abuse, it would not get anywhere. One radiographer observed:

"Hmm! Other challenges are like it is between my colleagues or among ourselves. Sometimes when you try, by discussing...they will tell you that leave it. This thing you will follow it but it will not get you anywhere. So with these challenges from our own colleagues and our bosses they will tell you that no you have done your part so leave it there". (Rad-16)

208

"It is not your business". (Rad-16)

It was identified that in some instances the social workers' indifference to reported cases of abuse affected the desire to report to them. One participant was affected by such attitude and lamented that:

> "If the hospital wants to channel it through the Social Welfare, or social worker then we should be made aware because you take some cases to them and they tell you look this one we do not deal with such cases let the relatives go to the Police Station and report and then they will take it on from there". (Rad-16)

The SW's commitment when approached with cases also impacted on a radiographer's desire to act on cases when they occurred.

> "… it has been a worry to me since I have been coming into contact with such cases. So this time I have decided not to get myself involved so much". (Rad-16).

Parental unwillingness to pursue the case or parent's preference to have the issue settled without the police because of the parental relationship with the perpetrator did not encourage the radiographer to help.

> "...some of the parents, like that woman whose lover hit her child, I suggested to the woman to report the matter to the police but she was reluctant and preferred the matter to be handled at home than to report it to the police". (Rad-15)

Rad 15 blamed their inaction on the cultural setting of the people who would not like to deal with the police on such matters.

> "…I realised that the cultural setting of the people here too is part". (Rad-15)

As a result of the cultural behaviour of some parents, the radiographer also felt it was not his duty to report the case if the parent was not willing to do so.

> "I feel it is not my job to report it". (Rad-15)

"The parents too are a problem if it relates a family member who it is known to have committed the crime they are reluctant to pursue it unless it is somebody else. Then some are willing but because of the money involved they at times just let it go you know most of them are from the poor background that is why at times they even delay in bringing the children for treatment". (Rad-17)

Child discipline by parents (also condoned culturally) which resulted in child's injury played a key role for the radiographer in their decision as to whether or not to report.

"Where cultural issues like disciplining your own child are condoned, errm there is little that you can do. Most of the parents do not see why they have to discipline their own child and at the end of the day it becomes a police issue that you as the radiographer whatever you see you have to report".(Rad-18).

If the parent whose child had suffered the abuse was unwilling to pursue the case because of time constraint, the radiographer also did not see the reason to report such a case.

"You know our culture because the best thing I could have done to help the parent is to report or help the parent to report but most of the parent themselves do not want to report because the follow up will waste their time". (Rad-04)

When parents were not committed the radiographer was also not committed either to provide help. Thus the willingness to help the child by the radiographer was tied to parents' own commitment to seek justice.

"…they would not take interest to see to their own children fate so if I will take up, personally I have my problems or I am very busy somewhere. In fact I will reluctantly take up the matter so what I do is to give advice to the parent but follow up is a hell of a problem so most at times we do not just follow up" (Rad-04).

Delays in the legal system in dealing with cases of abuse were not reassuring enough to one participant to be committed to reporting abuse cases that came up.

"Our legal system here takes very long time for justice to be delivered so even if it is a case of abuse I will not have that time to be going to court or visiting the police station regularly to be given information". (Rad-13)

210

The idea that child victims of physical abuse had to pay for services was discouraging to a few of the radiographers. A participant in this study expressed his discontent:

> "Ah why should a child victim of physical abuse or any abuse have to pay for doctor's report at that instant for legal action? The Ministry of Health too is not educating us on these things and allowing fees for such medical report is not right if we really take children at heart so who should stick the nose"?(Rad-14)

Scepticism about a culprit being set free and the possibility of the reporter encountering challenges from the culprit was a bother:

> "If you take the case up and at the end of the day nothing happens to the parents, what it means is that you are now a victim of circumstances".(Rad-01)

7.7 Preferred Model of Reporting.

The lack of structures for reporting identified physical abuse cases resulted in radiographers indicating who they would prefer to report abuse when it occurred for action to be taken. While some stated that they would report to the referring doctor, others preferred to report to their heads or radiologists in charge; alternatively some would go the police or to a nurse. It was found that some radiographers would notify or report to the parent of the child that abuse had occurred and would prefer that the parent take action. This was designed as model for easy understanding of the ready in the Figure 13 below.
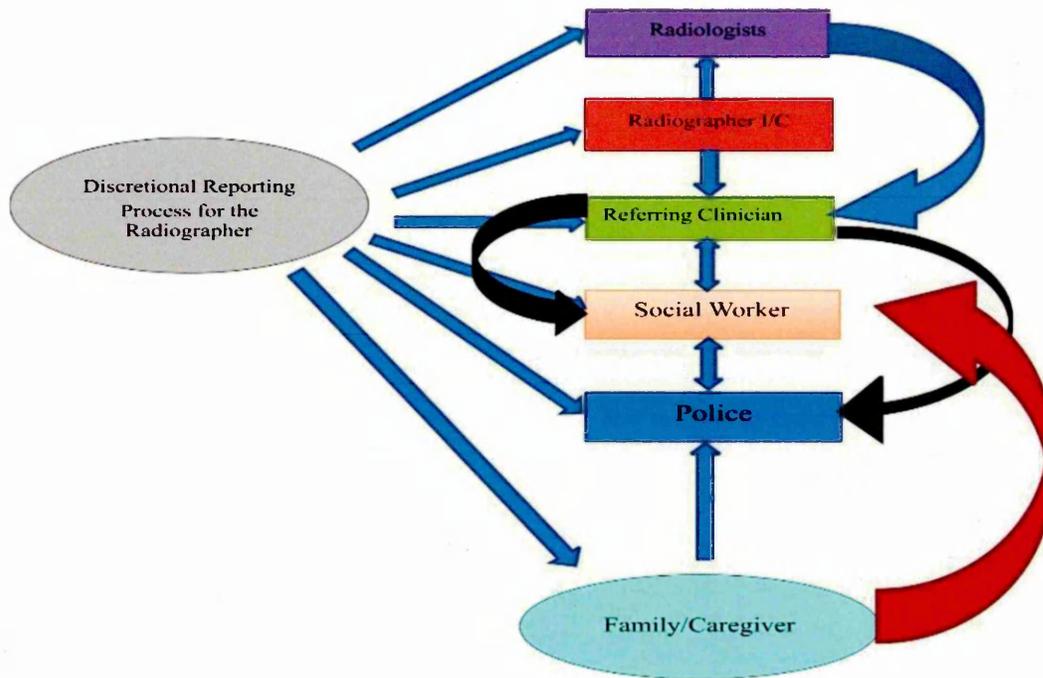
Figure 13. Radiographers' Preferred Model of Reporting

Rad-02 preferred to report identified or suspected physical to the doctor:

"…to my level of understanding or knowledge I am to complain to the doctor". (Rad-02).

Rad-12 chose to report to his chief radiographer (as his professional ethics demanded) when an abuse of a child has occurred.

"Well hmm! In our working settings, we have ethics so looking at what we have been told the next person in line is who you will report cases to. So to me as a radiographer, I have to report to my chief radiographer." (Rad-12)

Where the culprit was not a family member, the radiographer was only willing to report to the child's caregiver or the family member present as Figure 12 depicts.

212

7.8 Summary

This section constitutes a summary of the chapter's findings expressed differently by including participants' quotes to support this report. Cultural influence on the radiographer was identified to be a major issue at all levels of their social and practice environment which impacted on their behaviour and perceptions of child protection. These were seen at the micro, organisational and national levels. Most of these concerns have been raised in the previous themes developed in the study. These included relationships, practice culture and national attitudes towards child physical abuse and their negative impact on child protection by radiographers. At the micro level, most of the participants in this study were worried about the attitude of some parents when they or their intimate partners were involved in the child's predicament. Aside from that, the cultural setting of the locality where radiographers worked, superstitious beliefs and fear of attacks by an aggrieved culprit and their families were major issues at the micro level.

At the organisational level, participants were mostly not satisfied with the attitude of other professionals such as doctors, nurses and social workers attached to the hospitals when approached with cases they suspected to be abuse. There was a lack of clear structures such as policies, guidelines and procedural protocols in following up physical abuse cases. The challenge was where to report cases of suspected physical abuse when they occurred, and were identified by a radiographer within the hospitals where they work. They were in doubt about getting the needed administrative and legal support from the hospital even when they desired to follow up on matters of child physical abuse.

On the national front participants complained about the absence of clear policies by which they expected hospitals to have their own laid down processes of dealing with a child with physical abuse. This was compounded by total lack of understanding of the children's Act or the child protection legislation.

The findings of this study show that radiographers reporting a case which involved a couple or partners, was culturally wrong. This was because the breadwinner could be involved and beside this concern was the fear of becoming a principal witness to the case if reported.

"My cultural background might affect me in such instance because here, the relationship is between father and son, father and wife, it is ok for the father to be beating the child so it is no news". (Rad-09)

These cultural issues negated the professionalism of the radiographer in terms of providing a helping hand to protect the child.

"...true culturally we are not supposed to poke our nose into other people's matter as I should say is not our problem, so we turn to sit back in such instances". (Rad-09)

Superstitious beliefs held by the people that one could be harmed spiritually and also physically as indicated in the previous theme -Radiographers' decision trail was one of other cultural issues given consideration at the micro level before involving oneself in child abuse case as a radiographer. The impact of participants' cultural values was demonstrated in this study. Culture was above the law and as a parent Rad -01 was of the belief that child discipline was part of accepted culture.

" Our culture is such that you are not supposed to report your father when he disciplines you so when issues of this nature crops up, because I am also a father too and I am also part of the culture the cultural aspects at times supersedes the law because I can also do the same thing to a child so in doing that I am also standing in the shoes of that parent who did that because that is what the culture says so it becomes very difficult inherently to report a parent".(Rad- 01).

"I have that right but it is somehow limited what my duty is, is to help in the diagnosis of what the doctor has requested and after that you refer the person back to the doctor to go ahead with the treatment".(Rad-13)

In one situation where a child was abused by an intimate partner, the child's mother was not prepared to have the case reported by the radiographer because the issue could be settled at home:

"I called the lady's father and I said I wanted to report because he was of the idea that we should report but calling the lady and asking her she said no; she wanted an in-house settlement so I called her and cautioned her that the child is her only son so she should be careful. She should not allow the boyfriend to take over whatever she

214

has then I later called in the guy and warned him that the next time something of this sort happens again I will make a report to the police".(Rad-12)

Participants stated that there was a lack of units or designated person/s to report their suspicions. This concern was reported by most of the participants in the study as noted in the section dealing with reporting of abuse cases in the hospitals. Information about issues of child protection was either not available or not communicated within the hospital or to professionals. In supporting this concern, one participant stressed on the following:

"Yeah, I think currently the information linkage is not all that good, I do not know if in other hospitals they have this social welfare thing but fortunately for us at xxx ...it is there but even then; I still think that we could open more links. There should be some defined way of reporting some of these issues. Who should I tell this story? Where should they go if they get the story? There should be something like child protection units who are specifically in charge of those issues for now you know like I am even using the social welfare, their duties are so general that if they think that it is not within their core duties they could be more occupied doing other things ahaa. we should have teams within the hospitals that deals with it I mean multi-disciplinary professionals, so we could have the nurses, radiographers, doctors; a team that is broad enough to be able to take on some of these issues so that reporting lines should be clear from various areas and these are the people we should alert they should be well trained as well to be able to handle some of these things. I think at the hospital level if we are able to do some of these things it will help". (Rad-05)

Poor attention usually given to child physical abuse was a concern to a participant who observed that lack of a regulatory body within the hospital to take matters of abuse to a higher level was the reason for current apathetic attention given to it.

Personally, I think it is poorly managed because once a child is suspected to be abused in my personal opinion I think that the hospital management should have a regulatory body that must pursue issues that involves child abuse or suspected child abuse (Rad-08).

There were instances that the nurse who brought the child to the imaging department had no information as to the cause of the child's injury to help the radiographer. This was

evident of interest shown about child cases in some hospitals. One participant shared an experience with a nurse:

> "There was one case I suspected but the nurse apparently did not even know anything about the patient she just told me that she worked for afternoon shift and she was asked to bring the patient to the department. She was not there when the patient reported and this child was not verbal also but I suspected an abuse because of the appearance of the child but in this case the colleague who was a nurse could not be of any help" (Rad-15).

Lack of commitment was evident in one participant who felt following up abuse cases would not end anywhere and therefore was a waste of time.

> "As I said there was no time and I feel that it will not end anywhere so I will not waste my time but I know that there was a social welfare unit in the hospital but most at times they come to interact with us about the evidence about the payment that the person is not paying because he can really not pay". (Rad-04)

The attitude of some doctors when approached by radiographers with suspected cases of child physical abuse was a concern. Physical abuse cases which doctors could not identify with their initial contact with the victim were met with hostility when alerted by radiographers. This culture of power distance created apathy among some participants as indicated under influence of relationships affecting radiographers' commitment to assist the child.

Participants in this study were worried about the current policy situation in the health service needed to protect children against violence. There were objections regarding the disconnected policies of the two main health overseers in the country (the Ministry of Health and Ghana Health Service). They reported that the two bodies did not collaborate in terms of policy direction leading to conflicts. The Ministry of Health (which was the overall authority) had not provided any policies to guide the hospitals it supervised. Participants had not seen any training directives required by the professions regarding how to handle physical abuse cases. The situation led to discretional approaches to child physical abuse by radiographers. Rad-01 and Rad-13 in particular summed up the national situation that affected child protection in the hospitals.

216

"In Ghana, basically we have the Ministry of Health at the apex and within the middle we have the Ghana Health Service but now there has been some issue of confrontation between the Ministry of Health and the Ghana Health Service so they do not seem to be a clear with line of policies in oneness. The Ministry of Health and the Ghana health Service are not teaming up so when it comes to the hospital set up and with respect to child abuse issues, the Ministry does not have a clear cut policy regarding such issues. So I believe that it is because of these issues that things are as they are and has been transferred down to the various hospitals, clinics and other health facility because there is no clear cut policy from the top. So I believe that is why the system is the way it is because in the advanced countries, you have a clear cut policy from the top that trickles down so when issues of this nature happens, you know exactly where to report the case to and what to do. But in our set up, all what we have been doing in our various hospitals is by way of discretion". (Rad-01)

"Am not too sure of the health policy on children about what the health policy says about the abuse of children. We have not had any form of training as to how we should handle such cases even though we meet them. Maybe the doctors have had training but abuse cases affect all. So the healthcare system has not come out and let us know where we stand other than that when we them we will know what to do. The same problem of not knowing what to do may prevent us from having anything to do with the case. But when there are laid down procedures even discussion on it within our hospitals even in forums that will be fine because it's like everyone does his or her core job and that is it. I do not know whether I have answered you very well"? (Rad-13)

As a result of the absence adequate measures in place to be followed by hospitals, radiographers were not encouraged to act.

"I mean there are several cases not specifically of child abuse but several issues have arisen in the hospital and staff have pursued some of these things and they have just not ended well. You get so frustrated with the system because the system is not too result-oriented so you just find that you lose out in the end so some of these things do not encourage us to go the extra mile to do these things". (Rad-20)

Radiographers had the belief that the one who reports a case or a crime was initially treated as the principal witness by the law, was abhorred by them.

"…legally too our system is in such a way that following this thing up you might end up being the principal witness here if it should go to court or the police should pick it up. And when it happens like that it might affect my work". (Rad-09).

217

The study examined the Ghanaian radiographers' behaviour and perception about child protection in their work setting when children were physically abused and sent to hospitals for imaging intervention. Several factors affected the smooth management of these children by radiographers. Most of these factors were of cultural attitudes from micro to national level. Though most of the cases were not indicated on the X-ray referrals as abuse, radiographers were, through history taking and imaging results, able to identify physical abuse which may have eluded the referring doctor. Referral of cases of physical abuse was complicated by limited clinical histories which did not alert the radiographer to be aware of physical abuse. In Phase 1, radiographers understood child protection as measures in place to protect children. These measures were appropriate laws and policies to guide child protection. However these measures were found to be lacking within the hospitals leading to discretional approaches to handling child physical abuse. At the national level radiographers did not feel the impact of policies supposed to require the hospitals to put in appropriate protocols and procedures or guidelines that would help them to seek the safety of the child. Cultural beliefs were a concern as radiographers expressed their fear of physical and spiritual attacks should they become involved with cases which did not concern them. Parent/caregiver attitudes such as their refusal to provide appropriate information or concealment of information were a challenge to radiographers. The lack of support administratively and legally from the hospitals and police handling of abuse cases when radiographers were willing to pursue them led to bystander attitude towards child physical abuse when identified.

CHAPTER 8

DISCUSSION AND SUMMARY FOR PHASE 2

8.0 Introduction

This chapter discusses the main findings in Phase 2 which examine the behaviour and perceptions of the Ghanaian radiographer about child protection resulting from child physical abuse. In Phase 1, radiographers in the current study provided descriptions of their cultural understanding of child abuse and child protection. Phase 2 used interviews to explore how this was translated into practice by providing insight through verbal interaction with the radiographers.

This chapter concentrates on child physical abuse by looking at the key issues that informed the research questions posed in Chapter 1. The primary goal was to add to the child abuse intervention literature by examining the radiographers' behaviour and perceptions about child protection in Ghana.

8.1 Suspicions and Questioning

Many abused children go through several other forms of abuse as the existing literature suggests (Newton et al. 2010). This thus makes it imperative or appropriate for radiographers to recognise a child who has been abused. Managing child abuse cases generally depend on abuse identification, reporting and subsequent action. The actions taken by radiographers have implications for the welfare of the child who have been abused which was part of the significant issues addressed in the current study. According to some studies, the requirement to identify physical abuse falls on all those involved in the care of children including experts in the area of diagnostic imaging (Hattingh 2007). In the context of Ghana, the study found that cases of child physical abuse were either identified or suspected by Ghanaian radiographers through several evaluation processes. These processes are indicated in the model below (Figure 14):
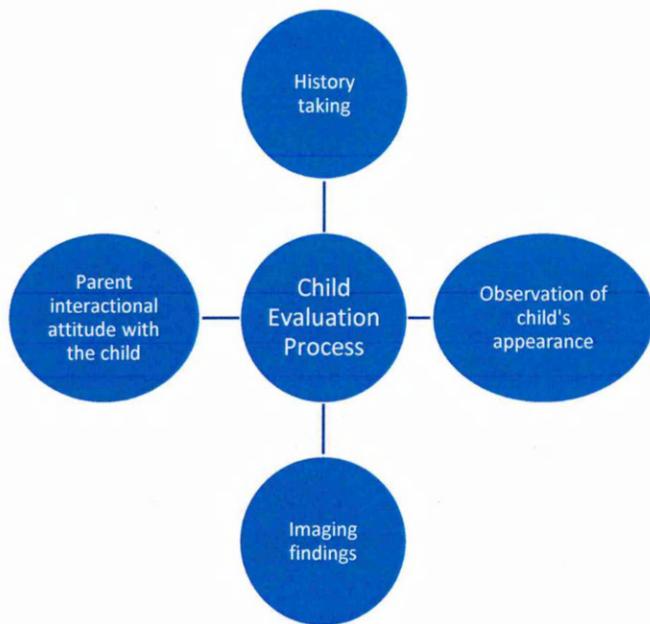
Figure 14. Child Evaluation Model.

Concerning a history taking, a few of the radiographers' suspicion depended upon the appearance of the child, especially the injuries observed before the imaging procedures were done and further information sought either from the child or parent. This was regarded as important step because as primary care professionals they have, by the nature of their work, the opportunity to examine children when positioning them for any radiographic examination (Hogg et al. 1999). Moreover, as a result of the growing number of the occurrence of several types of abuse, it is required that those providing the service to children who report with any of the sub types of mistreatment, undertake thorough evaluation of the child for identification any other form of abuse (Mangion & Buttigieg 2014).

The timely identification of child abuse is key to providing the necessary intervention for the child. However the mere observation of the physical appearance would be of no use to the child when there was strong conviction of abuse but no action was taken by the radiographer handling the case. Studies (Dubowitz 2007) have proven that timely recognition and diagnosis of abuse and neglect is very important because the condition is associated with morbidity and significant mortality rates. This is because with the high

incidence of child physical abuse in Ghana (Global Initiative 2015; Citifmonline 2013; UNICEF 2013) it was appropriate for radiographers to rely on such observations to raise the necessary alarm. Bromfield and Holzer (2008) had previously stated that aspects important in child protection include notification when abuse is identified which should prompt investigations to substantiate the allegation. Available evidence suggests that most children who have encountered abusive situations and have died, have gone through health care services prior to the abuse being properly diagnosed (King, Kiesel & Simon 2006; Jenny et al. 1999). It is also established that children continue to experience additional abuse when not identified or reported (Flaherty and Robert 2005) which makes it appropriate for professionals who handle children not to ignore steps such as the initial identification and reporting their suspicion.

As evidenced in this study, the imaging findings enabled some radiographers to seek further information from the parents to help them understand what actually caused the injury particularly when the imaging findings were curious. Consistent with previous studies (Davis & Reeves 2004; Hogg et al. 1999; Brown & Henwood 1997), through this process, radiographers were able to get useful information to distinguish accidental trauma from NAI. This information could be given to the radiologists to provide good reports; additional advantage radiographers have to indirectly, aid the child protection investigators. The case identification model (Figure 9 above) used by participants in the current study, was in large part consistent with the findings of previous work (Jacob et al. 2010; Legano, McHugh & Palusci 2009; McDonald 2007; Hogg et al. 1999).

8.1.1 Parental Warmth with the Child
Review of research findings indicate that children require parental warmth for their sound development and the lack of which should draw one's attention that the child might be at risk of abuse and would require help (Jacob et al. 2010).

It is from this argument that those around the child, apart from the parents, might be required to watch out for child-parent interactions and to raise alarm when this warmth is lacking and child is found to be in danger. This was emphasised as aspect of child protection during Phase 1 of this study. It was identified that radiographers interviewed relied on noticing such a parental bond with the child to suspect that a child to was under

abusive parenthood when no cordiality was seen between the child and parent. Findings from one of the respondents interviewed support this assertion. According to the interviewee,

> "...the way the parents even interacted with the child in my presence you could tell that this was a child who was undergoing abuse" (Rad 20).

A body of literature argued that injurious child nurturing incites major biological changes in children (biological embedding) which in turn alters their changing biological and the operating balance of the body's stress responding systems (Danese & McEwen 2012; Rogosch, Dackis & Cicctti 2011). The continual activation of the stress responding systems (also known as allostatic systems), lead to progressive wear and tear which has lasting consequences on natural aging and health (Danese & McEwen 2012; Rogosch, Dackis & Cicctti 2011). With this understanding, it is prudent for any radiographer detecting any undesirable parental aggressive attitude towards a child should take action. However, this was not the case with Rad 20 upon subsequent follow up question about the actions he took when the child faced this challenge.

> "...the child was as if you know has been run over by a train had several injuries all over and even physically and looked like somebody who was not being well taken care of and this one was so obvious because the way the parents even interacted with the child in my presence you could tell that this was a child who was undergoing abuse" (Rad 20)

Evidence also suggests that there has been unsupported reports of parents attempting to harm their children in the imaging department where the radiographer (as the only adult present) had to intrude and prevent further abuse (Davis & Reeves 2009). Similarity was established in the current study where radiographers observed parents beating and yelling at their children in the presence of the radiographer. However one radiographer who had experienced such negative parental behaviour did not act because to him it was a family affair.

8.2 Practice Limitations and Underperformances
There was a clinical issue that bothered radiographers in this study in their imaging services to children; especially with those children who had gone through any form of traumatic

experiences. The concern centred on the nature of the X-ray referral history driving the imaging investigation. There was a consensus among the majority of participants interviewed suggesting that the information usually provided by the doctors was often inadequate or imprecise to initially suspect an abuse. This assertion has been a general concern where limited clinical histories on X-ray referral requests in Ghana and elsewhere has been identified (Antwi 2012; Triantopoulou 2005; Jumah et al. 1995) and problematic to the imaging departments. In analysing the primary data of the current study, the majority of radiographers also reported about their dissatisfaction with such limited clinical history for imaging the child suspected to be physically abused. The history, as was reported by interviewees, was normally a simple statement '*trauma*'. This as was observed were inadequate as it did not specify, whether the condition was the result of NAI or accidental a situation not unique to Ghana. The identification of NAI by clinicians has generally been a problem especially where the radiographer has had no training or is inexperienced. This situation could be worsened in instances where parents concealed the truth from the doctors when reporting about the cause of their child's predicament (Jacob et al. 2010). The reality of the confusion surrounding the X-ray referral protocol was the fact that in any of the trauma cases received, normally came without stating the cause (such as from a fall) leading to the injury. Two radiographers from the current study required the doctor to provide information that could inform them of a possible abuse. Their concerns which has some relevance, was the fact that not all fractures (or trauma cases) seen in a child suggests abuse. Implying that trauma leading to child injuries could be far from abuse. A female radiographer iterated that,

> "The doctor too has written trauma and trauma can be anything...but after you have done the case you probe further and you see that no this is not ordinary accident but there is something wrong".(Rad 04)

8.2.1 Underperformances in History Taking

From the findings of this study, the participants' observations and additional information they gathered from further inquiries suggesting a possible physical abuse were not documented in contrast with recommendations from previous studies (Jacob et al. 2010; Hyden 1999; Hogg et al. 1999). They argued that record keeping is an important aspect of child protection. Why this was not a priority in the activities of Ghanaian radiographers studied is difficult to explain. However, it could be as a result of a prevailing culture where

incidents or accident reporting are not taken serious as has been proven in a previous study (Warren 2005). Keeping records of suspected or identified case of child abuse are generally relevant in imaging (Hogg et al. 1999). Hogg and colleagues were of the view that child physical abuse may result in legal action and the radiographer could be called upon to provide evidence and such instances, these records could be needed besides the imaging records.

In differentiating between fractures consequential of accidental trauma or child abuse, it is suggested that one should be guided by the complete medical record or information available to the health practitioner (van Rijn & Sieswerda-Hoogendoorn 2012). Again, (and consistent with Sprigg 2008; Flaherty & Robert 2005), when a child presented with a doubtful injury, a comprehensive clinical scrutiny and precise history are indispensable. They argued that such records or history enable radiographers to carry out their examination. A complete and a well recorded history undertaken early during child assessment are central in legal and medical roles (Kodner & Wetherton 2014; 2013). The findings of the current study were in contrast with radiological requirements in cases of child physical abuse. It is reported that such records assist the radiographer to validate their conclusions, and to guarantee that the necessary medico-legal requirements have been fulfilled and to minimise the chances of making a mistake (Lam, Egan & Baird 2004).

Moreover, to arrive at NAI with imaging findings, it should be supported with required clinical history (Kraft 2011). However in contrast to these arguments, one would also expect that once trauma was indicated and particularly in children, it would be prudent for the radiographer to have in mind that abuse could also be a possible cause for which reason the request for the examination has been asked for differential diagnosis. The referring clinician might have limited information to conclude that physical abuse has occurred (and for that reason would need imaging to support or disprove initial diagnosis of what might have actually happened to the child). Doctors may face numerous obstacles to identify child abuse (which could affect the history they provide the imaging department) such as criteria to arrive at abuse (Flaherty and Robert 2005). Moreover, the diagnosis of child physical abuse has been a challenge because of disbelieve by health professionals that caregivers could hurt children (Glick, Lorand & Bilka 2016). They argued that the identification of child physical abuse is additionally made difficult when faced with non-verbal children,

children in confusional state or clouded consciousness and are unable to speak out about their condition and show indicators that mimic general paediatric diagnosis. Others (Wadhera et al. 2013) however contend that clinicians are capable of identifying child abuse especially in circumstances where the child's maltreatment has been denied by either the offender or the victim of abuse. Taking these arguments into account, it would be expected that radiographers who had issues with the history of *trauma* would be circumspect in how they interpreted such histories and appreciate the doctor's position. The current study can however establish that radiographers studied were diligent through further probing which at times gave them fruitful information.

> It is like they (doctors) do not tell us on the request form the child has been abused but they tell you it is trauma case. So may be through your own investigation before you come out to know that the child has been abused". (Rad 07)

This step by Ghanaian radiographers is relevant to this debate because according to Flaherty and Robert (2005) some doctors may have emotional and hidden prejudices that affect their ability to distinguish abuse from non-abuse cases. This can impair appropriate assessment of the child which may result in their providing incorrect referral history to the imaging departments. Moreover, doctors may fail to seek adequate information from the caregiver or parent to enable them arrive at the possible cause of the child's injury (Flaherty & Sege 2005). It is essential that when children by their age are able to talk, they should be interviewed by the doctor for vital information (Hornor 2005). However, the referring doctor could face a verbal child who may not constantly tell the truth about how they suffered an injury, whether accidental or NAI (Sprigg 2008) which could also affect the history imaging departments receive. That is why a concurrent record helps in such situations (Sprigg 2008; Hornor 2005). The alternative the radiographer has, to be certain of what caused a child's injuries (apart from interacting with the child if able to talk or the parent for information) would be by contacting the referring clinician for first-hand account and information about the child (van Rijn & Sieswerda-Hoogendoorn 2012). The need to communicate with the referral source for further information is necessary or imperative to clarify the original information because of the possibility of having information which is inconsistent and unreliable as was identified in the current study consistent with (Hyden 1999); for example,

225

"...the history indicated a fall but...if you look at the injury and history, there is no relation". (RAD- 06)

Certainly, if the parent or the one in charge of the child up keeping cannot or fail to disclose a truthful history, constructing the right diagnosis becomes particularly challenging (Jenny et al. 1999). Despite this difficulty as posited by Jenny et al, seeking further clarification from the doctor in charge of the child could be an appropriate step (van Rijn & Sieswerda-Hoogendoorn 2012). However, this attempt was normally hampered in the Ghanaian context; - due in large part to several factors that might be unique to other developing countries. For example, communication was usually a challenge within and between hospitals because people mostly rely on their mobile phones to communicate rather than using fixed lines which are either non-existent or not working. In using mobile phones the caller would be compelled to use his or her own phone credit at a cost to make the calls. This could possibly be a disincentive for professionals in the health care delivery to communicate appropriately. Moreover when no telephone numbers are written on the X-ray referral forms, it would be difficult to communicate with phones even if the radiographer was willing to contact the doctor (when the professional was able to find out from patients from which hospital the request was made). Additionally, the X-ray referral forms in Ghanaian public hospitals to date, are the same bearing the heading 'Ministry of Health'. This makes it difficult for the radiographer to know where the request was ordered from especially when the referring doctor forgot to indicate the hospitals name. To make a call to that hospital in question for further elaboration and consultation becomes a challenge. Most often it was only the doctor's signature which was found on the X-ray request form which could not readily be used to trace them. Moreover, in terms of telephone communication in health care, Ghana lags behind because of infrastructural problems such as unsteady power supply and insufficient telecommunication services (Acheampong 2012).

8.3 The Absence of Structures in Place for Child Protection.
The Majority of participants in Phase 1 of the current study had stated that child protection was about putting measures in place that will ensure that the child is secured. However, report from the majority of the radiographers showed that measures in place such as

policies, guidelines and protocols were absent. This was identified to be a problem in all the hospitals studied which affected intervention with regard to acting on child abuse generally. Although the situation may not be peculiar to the Ghanaian situation as a previous finding in a British study (Mathers, Anderson & McDonald 2011) suggests, it is a worrying situation which requires attention. Mathers, Anderson & McDonald (2011) reported the absence of hospital policies concerning patient safety in the UK which included cases of child NAI. An operative child protection schemes necessitates a robust policy structure (UNICEF 2013) for appropriate child protection intervention. Similarly respondents in another study (Russel et al. 2004) demanded effective reporting measures with standard protocols which the current study collaborates. From the current findings, the absence of policies and standard protocols negatively impacted on the required actions the radiographer would have to undertake to ensure the safety of at risk children.

> "…this have (sic) affected the hospitality we give them as well because child abuse issues have not been given any proper attention at the hospitals".

Institutions which handle children should have a unit with set of protocols to respond to any abuse that is exposed to the unit to enable them act promptly and proficiently to the situation (Irene et al. 2006). Moreover, according to Doheny, Davis & Grehan (2014), local policies and procedures are needed by hospital workers (due to their exceptional capability to recognise abuse) to enable them to pass on their misgivings. The lack of child abuse framework to guide child protection in the hospitals led to the situation where some radiographers, for example, only discussed imaging findings which points to physical abuse among them and closed the case without providing any intervention beyond the images they produced.

The Ghanaian situation as identified in the current study was similarly an issue in a 2010 Mapping and Analysis Study in Ghana which reported that Ghana was deficient of a vibrant nation-wide policy structure for child and family welfare services (MGCSP 2014). The Mapping and Analysis Study according to MGCSP and UNICEF further established that the requirements in the Children's Act for reporting and reacting to children in need of protection are not appropriately designed to fit the Ghanaian culture and circumstance. Moreover, the Children's Act of Ghana failed to mirror family centred and consensus-based methodologies in making judgements (MGCSP 2014. All these failures might have

227

significantly contributed to the absence of needed policy frameworks for child protection in the hospitals in Ghana and affecting professional work. Policies structure that ensures the security of the one who reports a suspicion of abuse was important to one radiographer in the current study who stated that;

"…we are not aware of what to do and we do not have any reporting procedure, protocols and how an informant can be protected" (Rad -17)

This was a clear indication that the absence of such measures could lead to the radiographer assuming a passive posture and remain quite on identified cases of abuse. To avoid this situation from occurring many of the radiographers interviewed expressed the need for protocols and guidelines to operate effectively in support of similar findings in (Russell et al. 2004).

8.4 Culture and Linguistic Barriers to Child Protection
To get a grip on the situation of children in this different and dynamic world, it is imperative to examine how culture characterises the understanding of childhood difficulties and how to manage these problems (Raman & Hodes 2012). They suggested that it is important to take culture into consideration to be clear about definitions and appreciate some of the variables of cultural identity development and its impact on child wellbeing. In line with this, cultural issues took centre stage or became relevant in this study. There was the issue of language influence on radiographers' attitude towards child protection when seeking information from the victim or the parents became difficult due to language barrier. Whether the radiographer would succeed in getting vital information to provide good services, during the history taking (a record of client's health information), required some form of verbal communication with the patient or family.

Communication in radiography is important for the radiographer to realise the best quality diagnostic images (Adams & Smith 2003) which are important for radiology reports and subsequently for court investigations. However, the current study found that radiographers were sometimes limited in their abilities to communicate with some of their clients. This

challenged situation for example arose in the context where the radiographer encountered a parent who neither understood the English language (or lacked proficiency). Another communication difficulty identified was when the radiographer and those who needed the service did not understand each other's local language sufficiently enough to communicate effectively. In healthcare, cultural competence (as defined by Betancourt, Green & Carrilo 2002, p. v) is the "ability of systems to provide care to patients with diverse values, beliefs and behaviours, including tailoring delivery to meet patients' social, cultural, and linguistic needs". Cultural competence frequently signifies practice that is focused on knowledge of, and abilities in, working with cultural groups outside of one's own (Korbin 2002). A culturally competent healthcare system should be embraced for the acceptance of healthcare by culturally diverse populations (Anderson et al. 2003). Anderson et al argued that cultural competence is fundamental to healthcare quality, because healthcare delivery must promise appropriate services and lessen the regularity of medical errors originating from misjudgements caused by differences in language or culture.

This cultural challenge (though not unique to the Ghanaian or abuse situation), was a barrier to the full assessment of the patient in order to appropriately arrive at the cause of the injury. Language difficulties have been identified in healthcare (especially in culturally diverse countries) making linguistic competency an imperative in any multicultural settings (such as in Ghana) (The Royal Australian College of General Practitioners [RACGP] 2011). Under such language difficulties, the health professional involved should seek an interpreter (RACGP 2011). However, (contrary to RACGP assertion) radiographers, in this study, were not soliciting other staff members to help as interpreters because, to them, it was a waste of time. They were more concerned with waiting cases than reaching out for an interpreter. Professional values were identified to be in conflict with the radiographers' time. The radiographer preferred from the interview conducted, to perform what the imaging referral request indicated rather than worry about the subsequent outcome for the patient.

Relevant information is required by radiologists to provide good diagnostic reports and some of this information is provided by radiographers through their interaction with the patient (Ehrlich, McClosky & Daly 2004). Such action by the radiographer is appropriate

229

because it is known that referring doctors sometimes fail to seek adequate information from the parent or carer (Emalee & Robert 2005). Although linguistic obstacles are known to be a cause of workplace stress for clinicians (Bernard et al 2006), failing to seek further information because of language difficulties is unacceptable because the Ghanaian hospital set up is multicultural in terms of staffing and it would be easy to get a member of staff (or even a patient) to help in interpretation. It is also imperative to have effectual communication between the radiographer and the patient as radiographers are accountable for taking patient histories, giving instructions before and after procedural care to guarantee patient safety (Scott 2007). In whichever approach whether a patient is used as the interpreter or any member of staff who has not been trained, the patient privacy is shared in a way and besides important information may be lost or information provided by the patient interpreter may not be correct. Ccertified interpreters, who understand the medical language in a way, could help as the patient interpreters might not have this skill.

The use of interpreters by the radiographers studied was expected however, they did not take this option as has been suggested (Scott 2007). The reason some radiographers in the current study might not leave the imaging area to seek for an interpreter as an immediate consideration could be the fact that in several imaging departments in Ghana, the imaging facilities are managed by one radiographer and besides there are no interpreting services in the hospitals for the radiographer to access. This probably was an obstacle for such lone radiographers to leave other patients in waiting to look for an interpreter.

There are various choices in alleged physical abuse for the primary care clinicians (Mary 2011). One option is for the radiographers to learn and employ simple vocabulary in indigenous languages to have effective interaction with patients (Scott 2007). A critical aspect of child protection is identifying the obstacles to action (Mary 2011) and finding solutions to it. Consequently and to advance responsible reporting, it should be a necessary professional practice for the Ghanaian radiographer to comply with Scott (2007) to ensure that the chain of evidence (Davis & Reeves 2004) is not broken because of language. It is noteworthy however that, the code of professional ethics and conduct which should guide the Ghanaian radiographer in such matters had only recently been developed. In the past, radiographers in Ghana followed those codes pertaining to the British radiographer's

training which were provided during training but were not strictly enforced in practice. One of the key dimensions of professionalism is reliability (Carter et al. 2015).

8.4.1 Ethnic Solidarity and Child Discipline.

Moreover, in the current study, cultural or ethnic solidarity in some circumstances became the basis for abuse reporting or non-reporting as one interesting finding regarding language and ethnicity indicated;

> "…because of our cultural differences and barriers, you seem naturally to support where you understand in terms of language". (Rad 01)

Based on this observation, it is accurate to suggest that when radiographers spoke the same language as either the culprit or the victim, they tend to be biased towards the party who spoke or understood a different language making the radiographer an unreliable professional in such moments. In this situation where Rad 01 identified with the family or the culprit, as a result of ethnic bond between them no report would be made.

Studies on the influence of the reporter's ethnicity in Ghana on child abuse and victimisation reporting trends were not identified in literature. However, it has been reported elsewhere that the decisions to report child abuse also depends (in some cases) on the ethnicity of both the child and the reporter (Ibanez et al. 2006) in congruence with Brown and Keith's (2003). Brown and Keith argued that culture influences an individual's views about the world and forms the values people give to life experiences which could also be the case for the Ghanaian radiographer. What it means is that vital information would not be released for advancing investigation by a professional with the mind set of cultural solidarity. In this regard, once the radiographer identifies his or her own cultural affiliate, different interpretation would be given to the situation by the radiographer who tends to side with his own cultural or ethnic kind. The findings of the current study were inconsistent with (Tinberg, Bredlöv & Ygge 2008) who found that nurses', who had experience with encountering child abuse and their parents, abhorred the culprit who abused the child without any cultural considerations. There was a situation where a radiographer felt he was part of the culture and to him, their culture was more important than the law.

231

"..I am also part of the culture. The cultural aspects supersedes the law because I can also do the same thing to a child...so in doing that (meaning reporting a father) I am also standing in the shoes of that parent who did that because that is what the culture says. So it becomes very difficult inherently to report a parent". (Rad 01)

The belief was that when a father disciplines a child to the point of harm there is no need to intervene. The majority of radiographers felt that parents had the right to discipline their children and if anything happened it was considered as a *family matter* which should not warrant any external interference. As a result of these cultural solidarity and influences, it was a challenge for the radiographer to take any action because of their adherence to such cultural norms; "… it's like it becomes a problem as to whether to report or not" (Rad 03). The challenge is compounded when the perpetrator happened to be a family member and the family were not ready to follow the case. It is noted in Ghana that the dominance of corporal punishment results from the understanding that the child is owned by the parents. The approval of such beliefs has led to the situation where parents are hardly held accountable for the oppression of their children (Attakorah 2013). This misplaced practice is worrying because, the radiographer is placing culture above the professional code of ethics that was learnt during their training. Moreover such a person would not like to be reported when he treats his child in the same manner as Rad 01had earlier alluded to. Ferris's (2009) study on specialism identified professional recognition as an important aspect of the radiographer's job satisfaction. To attain professional recognition, is dependent upon the professional demeanour of the radiographer; how the radiographer behaves within the confines of the laws guiding the profession.

There was an interesting finding that had cultural values. A few of the radiographers indicated that they sometimes observed parents who physically and verbally assaulted their children at the imaging department. The radiographer took no action to protect the child; a mark of unacceptable professional behaviour. This conduct could relate to the fact that parent and child issues were treated as a family matter by the radiographers.

"…most often the parent will be shouting at the child. At times they even go to the extent of even beating them in front of you". (Rad 07)

Generally, the protection of the patient (irrespective of their age) should come first and particularly when it involves vulnerable children. Similar to Tinberg, Bredlöv & Ygge (2008) study on nurses, they indicated that one challenge facing nurses was responding professionally to the parent. Rad 07 in the current study could not uphold his skilled approach in front of the aggressive parent. Right based theories suggest that rights, irrespective of where it is derived from or character, cannot survive in seclusion (Rumbold 1993). What it means according to Rumbold, is that if individual actions are made to depend on their rights with no concern for others, confusion would result. The radiographer's actions, whether based on his moral or legal rights not to intervene, would have some repercussions with regards to the child's safety. The endorsement of child chastisement (which has cultural connotations) has been in some cases, inversely associated with the likelihood of reporting (Ashton 2001). The process of serving notification may be biased by reporters' characteristics, values, mind set and cultural factors (Goebbels et al. 2008; Ibanez et al. 2006; Alvarez et al. 2004; Yanowitz, Monte & Tribble 2003). One radiographer in the current study expressed that because there were no rules regarding child protection, child beating was taken for granted.

> "Once there is no laid down something to protect the child everybody thinks it is normal for children to be beaten or punished" (Rad 14).

Any form of aggression by parents should serve as a marker of a child experiencing abuse which required an immediate action from the radiographer (Hyden 1999) which should not be influenced by the radiographer's cultural beliefs and mind-set. Inconsistently in defining child abuse, radiographers in Phase 1 understood child abuse as aggressive parenting and also using harsh words on children. They also described child protection as proper care and loving relationship. With these attributes ascribed to child abuse and child protection by the radiographers, one would have expected that in practice, the Ghanaian radiographer would intervene by raising an alarm. According to Doheny, Davis & Grehan (2014), Children First in introduced in 2011 emphasises the importance of putting child protection at the core of institutions which have something to do with children. The Children First ideology in Ireland ensures child welfare and safety and has provided strategies which would enable individuals to recognise and report cases of suspected child abuse (Department of Children

& Youth Affairs 2011). However this kind of state interventions appears lacking in the Ghanaian situation. Ethically, the safety and wellbeing of children should take a centre stage in the practice of the radiographer. The obligation to intervene on behalf of a child clashed with radiographers' professional attitudes and personal beliefs as found in the current study. The attitude of Ghanaian non-observance of professional standards of practice is worrying which requires attention from the professional body.

Two radiographers from the current findings, felt that the child might not have any relation to take care of him or her should the bread winner who happens to be the culprit was reported and probably punished. They were more concerned about how and who, to take care of such children and provide them with their needs. This finding supports the MGCSP & UNICEF (2014) in Ghana which found that the police were reluctant to prosecute families which were involved in FGM because when they are prosecuted the child would rather suffer because there is no home to send the child to. However, these perceptions are inconsistent with previous studies that a child could be given to a distant relation to take care of without any challenges (Boakye-Boaten 2010; Kuyini et al. 2009). Moreover, traditionally, the extended family system practiced in the Ghana, suggest that some family members are always available who would cater for the child especially when the parent who was the bread winner was dead (Frimpong-Manso 2014). However the difficulty usually faced by the innocent victim of abuse, lies in the fact that the child might be been seen as having caused the parent or the bread winner to be in trouble. A few radiographers felt that the child could be denied the privileges she or he deserves from whoever would assume the care taker's role whether by one of the biological parents or not.

The misunderstanding of the true tenants of Christianity (the dominant religion as the data from the Ghana Statistical Service 2010 shows) in particular, has in some instances not helped in matters of child maltreatment in Ghana. The Christian faith in Ghana, is a key factor in understanding the prevalence of physical punishment. In Ghana, many parents often refer to biblical teachings, mainly from the Book of Proverbs and other sections of the Old Testament, to justify and explain the use of physical methods of punishment on their children (Imoh 2012). Moreover media reports in Ghana indicate that some children are deprived of conventional health care as a result of their parents' religious beliefs (The

Ghana NGO Coalition on the Rights of the Child 2005). As a health care provider, the radiographers' professional responsibility to secure the safety of the child was ignored and this was compounded by the fact that the child's parents were not interested to seek justice especially when they were the abusers. The issue of culture and interdependency (family members depending on each other) (Boakye- Boaten 2010; Kuyini et al. 2009) in the Ghanaian setting was deeply ingrained generally amongst radiographers in this study.

8.5 Bystander Apathy

The findings of this study and subsequent analysis demonstrate a *spectator* attitude of radiographers towards child protection. The study found areas of consistency with previous studies (Davis & Reeves 2009) while some other findings deviated from established causes of non-intervention in an emergency situation such as in child physical abuse. To further this discussion for more understanding of the Ghanaian radiographers' approach to child protection, there is the need to highlight some of the issues of radiographers' indifference in the context of the results. This is to enable the reader to appreciate some aspects of the analysis to enhance a holistic judgement of the behaviour of radiographers in the current study regarding child protection.

8.5.1 Seeking Help

The current study identified that radiographers interviewed were confronted by the lack of motivation from other colleagues when there was a strong evidence of physical abuse which needed to be reported. Two of the radiographers interviewed collaborated in this assertion for example,

> "…with these challenges from our own colleagues and our bosses they will tell you that no you have done your part so leave it there. It is not your business". (Rad 16)

This supported a typical situation of pluralistic ignorance as was explained in Davis and Reeves (2009) after Darley and Latane (1968). Davis and Reeves argued that 'informational influence or pluralistic ignorance' is a state where the radiographer would seek assistance and guidance about the situation from others. They further indicated that under such circumstances, each non-responding spectator instructs that no action should be

taken. The current study can suggest that the Ghanaian radiographers' professional indifference was influenced by the perception they held that when such cases were pursued nothing good would come out of it;

"This thing you will follow it but it will not get anywhere..." (Rad 16).

This stance which paints a picture of mistrust of the system could in no doubt significantly contribute to the insecurity of the affected children in dealing with cases of child physical abuse. Based on the report of Rad 16, it could be deduced that there was no professional leadership in dealing with suspected physical abuse cases by the radiographers. Again, neither were there professional role models nor any show of adherence to good ethics principles of practice among their rank and file. Professional role models demonstrate leadership as a mark of professionalism (Carter et al. 2015). The senior colleagues approached by the junior ranks might also be ignorant of the fact that, child protection is supposed to be a concern of all taking cue from the system's approach to child protection (UNICEF 2010). Moreover, among the constructs of professionalism in health care delivery, consideration of the needs of the patient and observance of ethical values of the practice (such as ensuring the safety of a patient) are critical issues to good professional conduct (Wilkinson et al. 2009). Most likely, these constructs may also not be known among the interviewees and as a result the information they gathered, were used for their personal desire for knowledge about the situation. For example, Rad 01 had reported in this study that;

"We can get information...whatever information we get is just for curiosity sake not for anything (Rad 01)

Arguably, one can also suggests that the Ghanaian radiographers' attitude also conformed to the behavioural beliefs that the presuppositions held by an individual concerning a situation are guided by the individual's judgement that certain actions could lead to unknown consequences (Natan et al. 2012). The individual attributes certain principles according to Natan et al. (2012) to the intended actions by assessing the cost and importance of whether the action should be executed or not. The stance of the Ghanaian radiographer is a critical issue for training and policy consideration to address them. The

236

findings of this study suggest that vital information that could serve as evidence to substantiate an allegation of abuse was kept back and it is the child who suffers the consequences such as the possibility of becoming a victim of continuous abuse. The findings reported above contradicts Bromfield & Holzer's (2008), study which indicated that to authenticate child abuse is only possible when investigators have enough evidence.

A profession is partly, the application of one's expert knowledge to the benefit of others (Ehrlich, McClosky & Daly 2004) which in large part was not the case in the current study. When the finding is considered in the light of the studies reviewed previously, the contention as expressed by Rad 01 leads to the same conclusion of Hogg et al. (1999) that the radiographers knowledge of child protection was previously inadequate to enable them use their expert knowledge to the benefit of the child.

Social factors and personal characteristics have been linked to bystander attitude. However, Lener, Benin & Ventrone (2001) were of the view that social psychological factors—the situation, the bystander's discernment of the situation and capability were key to bystander attitude. In follow up studies, Lener, Benin & Ventrone (2001) identified several situational factors that were perceived could lead to the bystander attitude one of which was the vagueness of the situation. They found that the graveness of the victim's suffering could trigger a bystander attitude; similarly the current study identified a situation where two radiographers separately found a child who was seriously injured; injuries which highly pointed to physical abuse but took no action. To advance this discussion two examples are used to illustrate the situation:

> "…the child was as if you know has been run over by a train had several injuries all over and even physically looked like somebody who was not being well taken care of" (Rad 20).

> "...I had a baby and I was to do a pelvis X-ray for the child who had burns at the genital area…and it was too bad I wanted to know what happened". (Rad 10).

Although radiographers are said to be capable of (Hogg et al. 1999) that radiographers are capable to identifying child abuse through the physical appearance of the child, however what is most significant is what is done by the radiographer upon recognition of these

doubtful injuries. There is the need to address the bystander effect in health care to protect at risk children.

The manner in which the request for help was sought, the degree of danger of the situation, and the physical appearance of the victim, were all considerations among other elements to trigger a bystander posture by people (Lener, Benin & Ventrone 2001). In the current study it was identified that the physical appearance coupled with the imaging findings of the child although raised radiographers' suspicion that child physical abuse is possible, however, the manner in which the referring doctors presented the history led radiographers not to act beyond their imaging roles. In all the scenarios discussed from the findings of this study, factors such as ethnicity, the issue of bread winner and seeing child abuse as a family affair were significant indicators of bystander apathy. Several elements have bearing on the clinical practice of the healthcare professional (Lenfant 2004). Moreover, Lenfant argued that the intention to undertake an action by a healthcare provider according to is influenced by several situational variables (both internal and external) and the characteristics of the healthcare professional. The current study as the subsequent discussion of findings will show, established that some cultural beliefs (such as fear of spiritual attacks) and social forces (such as fear of physical attacks), lack of support, teamwork difficulties, perceived cost and accountabilities , besides radiographers' cultural affiliation, language barriers affected intervention in child physical abuse. This significantly contributed to the bystander attitude of the Ghanaian radiographer.

8.5.2 Shared Responsibilities
Radiographers interviewed felt that they were not responsible to the take action when they recognise that child abuse has occurred ("…*we are not in charge*"- *Rad 05)* it was the doctor's responsibility to take up the matter because they were in control.

> "So sometimes with cases of child abuse when you alert them of your suspicion which might have eluded them and you see that he is not taking any step, you cannot go further because they are in charge".(Rad-14).

Diffusion of responsibilities as reported in Davis & Reeves (2009) was found to be true with radiographers interviewed in the current study. In a series of experiments on diffusion of responsibilities, Garcia et al. (2002) established that envisaging being part of a crowd,

creates onlooker attitude in the individual present in the situation. This diffusion arises from indecision where the individual would be contemplating whether he/she, is the proficient person to manage the situation. Davis & Reeves (2009), argued that radiographers may have good reasons to ensure they rather persist in a position where they feel habituated, at ease, in control and experiences little disquiet and stress. In the Victoria Climbe's case several professionals were involved but none took action; a typical example of bystander attitude of the professionals involved (Davis & Reeves 2009). In an earlier work, Davis (2004) cited in (Davis & Reeves 2009) in setting a text case of diffusion of responsibilities, pointed out that when the issue is about child protection, the radiographer, after completing the radiography of a child with suspicious injuries, may not pass on their misgivings (a thought of division of labour sets in); the radiographer may consider that the child will be back to the referring clinician, whom they anticipate will act based on their own judgements. The radiographers interviewed in the current study felt that the patient will go back to another professional involved in the management of the child whom they anticipated should take action.

8.5.3 Perceived Cost of Intervention

The cost in terms of monetary obligation and time of establishing and treating abuse cases became a professional concern in the current study. This was in congruent with Davis & Reeves's (2009) who in contributing to the Social Exchange theory using radiographers attitude in an emergency situation, explained that behaviour will be determined by comparative cost and benefit, the current study identified that radiographers would not intervene for the reason that it had no direct benefit to them. The real cost to them was not only time to be wasted in following up such cases but also fear of attacks (both spiritual and physical) on them by the culprit if they were identified to be seeking justice for the child.

As was identified by Davis & Reeves (2004), the actual costs were perceived to be the physical threats and having to appear in court which could affect them. They further ascertained that the cost of intervening could also affect their relations with other professionals (such as the SW) which was also established in the current study between the radiographer and the doctors. The study found that radiographers were reluctant to follow up child physical abuse cases to the police as a result of these cost involved. They were not distrustful of police demand for medical validation of the abuse however they had concerns

with the finances and time involved to obtain such reports from the hospital. In sharing his experience, one radiographer reported that when the parent was unable to settles such fees, they became only interested in the treatment of the child than help them seek justice:

> "... The police were asking for a medical report...the doctor handling the case demanded fifty Ghana cedis (equivalent of 10 pounds) before she (the parent) could be given the medical report to be submitted to the police. She (the parent) was not having the money so she showed no interest in pursuing the case again at the police". (Rad 17)

The implication is that when such situations persist, many children of abuse would be in further risk of continuous abuse. The difficulty is when the parent was the unidentified culprit. Though the payments of fees for various tests conducted to establish abuse was outside the remit of the radiographer, the case could not be pursued as no evidence could be shown the police. There is insincerity about payments made for the acquisition of a doctor's report demanded by the police on any incidence of inflicted injury in Ghana. Payments made to the doctor for a medical report has traditionally been accepted as private fees for the doctor but not to the health institution even though the medical forms used to provide the report is for the government or the health institution. This uncontrolled practice has been accepted because of the undue role of doctors and their supremacy in Ghana's health care set up. In providing such reports, doctors feel they might go to court to defend and they will use their private time when the case went to court. They would be called to provide evidence to the court and therefore treated the service as private. As a result of medical dominance and the authority they exercise, such behaviours are yet to be confronted by the MoH and GHS.

It was also difficult understanding why radiographers did not make use of the Social Welfare unit in their various hospitals to intervene when faced with the fee paying challenges. The majority of radiographers had expressed that patients who were unable to settle their hospital fees were normally referred to the DSW in the hospital. This was to seek the assistance of the DSW to intervene on behalf of the patient to enable the patient to receive the care they needed. One would have thought that with critical cases such as child physical abuse, this option would be been taken by the radiographers to help the child. When the radiographer refuses to provide this care, based on the victim's inability to pay,

the child is denied these services. Interestingly, basic medical care is catered for by the NHIS of Ghana but many people have not registered with it to obtain specific free services. Registration with the NHIS is relevant especially in a situation where the perpetrator cannot be found.

With the issue of reporting to the social welfare staff, who were available in some of the hospitals, none of the radiographers referred such child cases of payment problems to them; they chose to let the child go because the parent could not pay for the services required. However the majority of the radiographers had reported in this study that or understand the work of the SW as an official who assist patients who cannot pay their bills to have frees services. The system Ghana operated previously was what was termed 'cash and carry' where the patient must bear the cost of services fully even in emergency (Adinkrah 2014)

8.5.4 Time Factor

The time needed to do follow ups to the police station by the informant was demoralising to a few of the radiographers interviewed. They felt that one would have to leave work and respond to the legal issues which potentially could take long time to be completed. Thus radiographers' assessment of cost extended to time required to follow up cases of abuse.

> "…because of pressure there is a lot of work to be done you cannot leave the work and follow one case". (Rad 15)

Comparing radiographers' attitude in this study and the system in Ghana to the situation in Australia, the differences in the seriousness attached to child protection in both societies are clear. For example, apart from Western Australia, every state in Australia compels health professionals to report suspicion of abuse and failure to do so in some jurisdictions invites a fine or internment (Denham 2008); particularly in their northern province where, regardless of one's profession, refusal to report abuse of a child brings its own consequences of either a fine or a sentence (Australia's Northern Territory Department of Health and Community Services, Community Welfare Act 1983; Southern Australia Department for Families and Communities Children's Protection Act 1993). The apparent time constraints and difficulties in having an efficient health care system response, training gaps, as well as uncertainties with one's clinical capacity have all been reported to impact on acting on child abuse matters (Markenson et al. 2007; Socolar & Reives 2002; Wright et al. 1999). The

241

situation can be attributed to the lack of commitment of radiographers interviewed and also institutional failures in areas of child protection. When asked whether they would report to the police when they identified or suspected child physical abuse, a few participants were not ready to choose that option. One radiographer beside his concern about time was sceptical about how he was going to be treated when the case was reported to the police although he was aware of his professional obligation to support the patient.

> "…as a radiographer I have to help but as I said when I take it up it is going to waste my time and I am going to be handled as if I committed the crime". (Rad 04)

> "…legally too our system is in such a way that following this thing up you might end up being the principal witness here if it should go to court or the police should pick it up. And when it happens like that it might affect my work". (Rad-09).

This assertion resulted from anecdotal reports circulating in Ghana that any person who reports a crime to the police was treated as the first witness or culprit. It is also on record that the Ghana police have a poor record of investigating and dealing with severe crimes (US Department of State 2015). This might have informed the radiographer's decision not to follow up or report such incident to the police although the opposite could also be a possibility if attempts were made to notify the law enforcement agency.

Ignorance of the work of SW was demonstrated in this study when the radiographers interviewed gave varying understandings of the work of the SW. This was another symptom of their refusal to participate in child protection generally. Child abuse is both public health and social welfare concern (Gilbert 2009a) however in contrast one participant reported that child physical abuse was not an issue under the province of the SW. Although Ghana's Children's Act stated that cases of child abuse should be reported to the DSW, from the findings of this study it became apparent that there is the need for procedures or directives in the hospitals to report cases to the SW. Previously, there was little true data that linked how children's rights were perceived by professionals at the strategic and operational levels in Ghana and those who managed children in the foster homes, did not comprehend the legislation they worked with (Manful and Manful 2013).

8.5.5 Fear of Physical and Spiritual Attacks

The majority of radiographers validated an element of hostility in an attempt to provide intervention for the abused child. This arguably was in the form of physical attacks on any professional who fronted the investigation of a suspected abuse case. The real cost to the majority of radiographers interviewed were dangers that they presumed awaited them in terms of attacks (both physical and spiritual) from the culprit or the aggrieved family of the culprit. This was when they were identified to be seeking justice for the child. The possibility of physical aggression on the radiographer involved in child protection has been underscored in previous studies (Yielder & Davis 2009). This was noted as a challenging situation for two radiographers and as a result of the physical aggressiveness of some tribal groups. As a result, the cultural origin of the parties involved was checked before deciding to pursue a case involving child physical abuse.

> "Oh, you have to look at where the case is coming from which tribe or ethnic background else with such cases you can be attacked if you take it too far by some tribal families". (Rad -10).

Similar findings of aggression against the health professionals in the UK have been reported in the literature leading to their lethargic attitude towards the reporting of child abuse cases by professionals in the field. It was revealed in the UK examples that doctors who reported child protection concerns experienced several types of intimidation (Kmietowicz 2004). Kmietowicz identified that, official complaints to the General Medical Council UK, worsened astonishingly between 1995 and 2003. The seriousness of the issue (according to Kmietowicz) led to about a third of the vacancies being left unoccupied. This suggests that, there would be the need for protective measures against any form of aggression directed on any professional in an attempt to intervene on behalf of the child. This may be important in the prevention of subsequent child physical abuse.

The presumed influence of illogical forces on their persons were found to shape the radiographers approach to child protection issues especially in reporting such cases. The cognitive dissonance theory (Mcleod 2014), suggests that the individual possesses several cognitions about the world and themselves and when they clash, the outcome will induce inconsistencies which in turn lead to overbearing pressures known as cognitive dissonance. Radiographers aligned their work with their belief of being attacked by unknown forces

when they intervened to save a child at risk of abuse. Consistent with Davis & Reeves (2009), the radiographer's decision process, took into consideration the benefits and the risks involved before acting on suspicion of child abuse. Radiographers in the current study had their professional values coming second to their spiritual beliefs. They preferred to drop their ethical standards, in preference to their adherence to illogical culture of superstition in order to remove tensions and attain consonance with self. These beliefs and cultural mind set impacted on the majority of them who feared the repercussion of getting involved generally, in any incidence of child abuse. As was reported by the radiographers, one could experience sudden health challenges at the work place resulting from spiritual curses caused by the aggrieved culprit which could affect the working life of the individual;

> "They can even do it in such a way that when you come to your work place you would not feel fine, you will feel like someone who is sick but when you are outside of the room you will feel better so in that case they are preventing you from doing your work". (Rad 11)

The admonition of Rad 11 supported previous studies (Adinkra 2011, Tenkorang et al. 2011) in Ghana which indicated that the experience of any abnormal inexplicable ailment and its causes, premature deaths, or downfall of a businesses were ascribed to illogical forces as causative agents. Radiographers interviewed point out that these supposedly mysterious forces in their cultural environment are dangerous which cautions them to concentrate on their personal matters that confronted them. These beliefs certainly impacted negatively on their professional demeanour. Literature suggests that when a professional identifies any clear sign of child abuse, it is required that the professional takes a positive action rather than remaining uncommitted (Pearce 2012). The behaviour of the Ghanaian radiographers' was incongruent with Pearce's expectations because the radiographers generally exhibited a bystander attitude. The Radiographers' interest principally, rested in securing their personal safety in order to remain alive to care for their own children. A female radiographer interviewed strongly felt that she preferred to live and take care of her children than involving herself in an unknown child's case for which the cost to her spiritually might be high. A report by Rad 17 is used to advance this discussion;

> "Anybody can take you to a juju man before you realise, you are dead and leaving behind your children or get strange problems. So in order to live for your children, you leave those matters (Child abuse issues) to them". (Rad 17)

244

This irrational belief was strongly corroborated in this study by the majority of radiographers who entertained the fear that they would be seen as an intruder by the culprit for taking a front stage in a child's case. The perception they held to explain their assertions of attacks was that it was not uncommon for culprits or their families to invoke these illogical forces to cause harm or even death of the 'intruder' (the radiographer). The examples given by radiographers in Chapter 8 of this study regarding how they could be attacked spiritually included the use of charms, juju or seeking a 'mallam' (Muslim spiritualist capable of using charms and juju to cause problems on an individual) all of which might be ascribed to supernatural beliefs (Pearce 2012). Evidence suggest that many Africans have a long standing belief in superstition, witchcraft, juju, gods, black magic, sorcery and necromancy. Indeed all over Africa, particularly in the West African region (where Ghana is situated), many people harbour the belief that there exist witchcrafts that wander around the environment with their incredible bearing on farming, poverty, disease, accidents, business failures, famine, earthquakes and other happenings in life (Perry 2015).

The belief in spiritual forces and their power to adversely affect an individual by visiting beings occur across various faiths and are not peculiar to one nation or cultures (Pearce 2012) however not everyone is persuaded by these beliefs (Perry 2015). As was previously discussed, various studies had alluded to imminent attacks when a professional willingly provided support or intervene for abused children however, none indicated attacks from such illogical forces. Perry argued that these irrational beliefs and sacraments that have characterised most people have been a hindrance to performing several activities in Ghana and the West African sub-region. Ironically, Christianity has been the most dominant religion in Ghana with more than two-thirds of the population being believers (Ghana statistical Service 2010) in addition to the number of religious programs on television and the number of people who watch such programs being high (Pomicka, Addai & Takyi 2012). With such high number of believers one would have thought that superstition would not be held in the minds of radiographers interviewed. However as has been observed by the researcher the problem has been that most of these Christian religious faiths do emphasise the existence of these illogical forces to their followers on various radio and television stations.

Radiographers interviewed were strongly attached to these beliefs which made it appear that to demystify such long held dogmas, would require very strong education and training as they continue to live in that dread. The benefit of professionals collaborating in their work at all times has been a primary issue in health and social care (Wilby 2005). Several professionals would be involved in the child's journey of care, to which no single individual could be a target of any form of attack because the individual would be invisible to the aggrieved party. However this was not a consideration in this study by radiographers interviewed even though a few were aware that child protection was not exclusively an individual affair by which they could be invisible. It may be right to ask how Ghanaian health care will advance in the context of presumed belief in superstition and its unforeseen negative impact on the system.

Arguably, and as has already been stated in this Chapter, child protection first involves the recognition of abuse and serving notification for action to be taken (Bromfield and Holzer 2008). This means that it is not the radiographers' responsibility to take further action after notification because they need to carry on with their work. Donkor (2015) argued that the rights of the Ghanaian child, were still being overstepped because of deep-seated socio-cultural beliefs (social force field) and practices in Ghana that affected positive actions from the radiographer. While literature has linked child abuse to culture, faith and beliefs (Pearce 2012; Stobart 2006), this study also found that indifference towards child protection was adversely linked to the cultural mind set and belief in supernatural powers of a people. Professionalism was thus affected because the ethics of professional conduct to safeguard child victims of abuse generally were often discarded by the radiographers as a result of needless fears.

In the ideal situation, the radiographer should not be fully responsible for intervening on child physical abuse when identified from their side. A unit designated for child protection or a designated professional is required to handle that after the radiographer has raised a red flag (a challenge which is a subject of discussion in the later sections of this chapter). According to Natan et al. (2012) and Davis & Reeves (2009), if undertaking a particular role would lead to certain consequences, to which the individual attributed to certain repercussions, the required action may not be performed. With the smaller towns in Ghana,

246

people know each other, and health professionals are easily identifiable by the community making them vulnerable to several forms of physical attacks by the aggrieved individual or family members. This could happen when a case of abuse is known to have been reported by a particular health professional as validated by Rad 10 and Rad 11 in the findings. Davis & Reeves (2009) had identified that in lager cities the propensity to report cases of NAI by radiographers were high because of the neutrality of the society.

Though Ghana's child protection orientation is based on its legislation which has a lot of gaps (Manful & Manful 2013), a UNICEF (2009a) report argued that nations need arrangements that encourage clear discourse of matters relating to child protection because legal measures wholly would not meet child protection concerns unless (through public discourse), awareness is raised and attitudes reformed. However it appears that this has not been fully addressed in Ghana which probably, had led to people being aggressive on members of the society who attempt to champion the course of child protection. It is probable that the Ghanaian radiographer entertaining this fear of attacks may not be ready to go forward to authenticate any clear case of physical abuse from any other findings beyond the imaging report. Although several studies (Cross and Casnueva 2009; King, Trocmé & Thatte 2003) have argued that child protection professionals' authentication of abuse based on their judgements, are influenced by impartial concepts commonly echoed in national laws, expert decisions correspondingly seem to be prejudiced by a number of other factors not directed by national regulations.

8.6 Clinical Capacity to Identifying NAI.
To be able to contribute and make child protection work operative, necessitates a variety of clinical skills such as in history taking, clinical analysis, documentation, communication abilities, and capacity to make the right judgement (Bannon and Carter 2003). There exist several anathemas regarding child abuse and neglect identification and reporting. Studies (Tinberg, Bredlov and Ygge 2008) have shown that it is less difficult for clinicians to conclude on accidental trauma than child abuse even where there is a clear indication of abuse (Flodmark 2002; Lewis 2002). The current study identified that imaging findings were very important evidence of physical abuse or NAI for the majority of radiographers interviewed however in most instances they need concrete clinical history from the referring clinician to be sure. According to Sudbery et al. (1997) radiographers have

exceptional capability to identify the clinical appearances of NAI. However this is debatable as the current study identified that, a few of the radiographers interviewed lacked this professional self-efficacy in the evaluation of fractures to determine NAI from images produced and also to perform the correct imaging projections to establish NAI. The relative inability of some radiographers to recognise NAI has also been established in literature (Davis & Reeves 2006; 2004; Brown & Henwood 1997) in contrast to the assertion of Sudbery et al (1997). Child physical abuse which has resulted in physical injuries most often result in referral to the imaging departments; as such one would expect that the training of the Ghanaian radiographers in the imaging of children would largely cater for these aspects. However, evidence from the current study, indicate that the processes of child protection as a result of physical abuse was absent in the education of the Ghanaian radiographer. Practically, the issue of child abuse and child protection has not been a well-known subject among the radiographers;

> "…for me it was a virgin area this was something we had only heard about in the course of our study". (Rad 20)

> "I do not think I have had enough training on that to use the images as an assessment of accidental or non-accidental fractures". (Rad 03)

Under such training shortfalls, radiographers could become helpless which would allow them to remain in their comfort zone and have nothing to do with matters of child physical abuse (Yielder and Davis 2009). Further studies on radiographers in Ghana and in other African countries would be required to conclusively establish this assertion of Sudbery et al. (1997) taking cue from the current findings. Davis and Reeves (2009) argued that radiographers, by the nature of their work, meet patients who require several imaging interventions resulting from accidents and other fracture cases, this places them in good position to provide service to children with earlier unpredicted NAIs. This is a possibility because radiographers are noted to be on the front line to detect early signs of NAI (Davis and Reeves 2009; Synergy News 2009). Although radiographic findings provide important evidence to ascertain whether a child's injury is as a result of NAI or not (Davis and Reeves 2004; Hogg et al 1999) the radiographer would require training. They posit that when training is combined with the radiographers' clinical experience with several trauma cases, it would enable them to conclude on NAI. Training for identification and reporting of child

physical abuse was however found to a shortfall in the training of the interviewees in the current study. Radiographers in identifying their limitation in associating child injuries to physical abuse generally advocated for training consistent with Russell et al (2004). Training is crucial for all workers to be self-assured and capable of using the appropriate avenues to report child protection concerns (SoR 2016).

It has been reported that it is at times difficult to determine that some types of injuries was as a result of maltreatment (Christian 2015, Flaherty and Robert 2005). In the light of this it could be assumed that the radiographers' capacity to report will depend upon their competency to also identify that physical abuse has really occurred. Although it may be hurting reporting of abuse, SoR (2016) is of the view that ensuring the child safety and wellbeing is most significant and it is the responsibility of the radiographer to inform and record concerns. Brown and Henwood (1997) had a different view about radiographers who were having challenges identifying NAI. They argued that some radiographers faced such difficulties because they have no insight about the benchmarks necessary for NAI. The reason for this situation is as a result of the occasional appearance of such cases at the imaging department according to Brown and Henwood. Another school of thought suggest that some radiographers inability to determine NAI is because fractures due to abuse present only a small number of childhood fractures (Kraft 2011) which probably was affecting some radiographers' capacity to identify NAI. Despite this shortfalls, radiographers in the current study were found to be suspicious about some injuries presented by children however, the majority of them took no action because they did not know where to go and present their observations.

The current body of literature has noted the importance of training of professionals for them to be able to recognise abuse and how to report it (Kodner and Wetherton 2013, Bannon and Carter 2003). Lone working by radiographers (especially in rural Ghana) with no radiology back-up is a common situation which implies that the radiographer in such situation would not be able to 'construct ways to negotiate communication and disclosure or their radiographic opinion with their practice world' (Squibb et al 2016, p.2). Image interpretation has been at the basic level in the training of the Ghanaian radiographer compared to the situation in the UK where advanced courses are run for radiographers to be knowledgeable in that area. This is important in NAI identification because a more recent

249

study (Squibb et al 2016) reported that there is a possibility for a doctor to miss an import sign indicating an injury which radiographers have identified.

As a result, they argued that to prevent the doctor making any wrong judgements in the interpretation of images, radiographers sometimes require direct communication with doctors to avoid any oversights. The confidence to do this would require that the radiographer is skilful in that area.

Good patient care is facilitated by individual professional learning; inter-professional group learning and system based organisational learning (Ratnapalan and Uleryk 2014). This according to Ratnapalan and Uleryk, embraces improved structure which is explicit in scholarship by several groups and group members in a health organisation. Within the premise of role theory, the Society and College of Radiographers (2005) in the United Kingdom found the need to develop professional skills in the imaging of alleged abused children. They further recommended that radiographers should be properly trained in all imaging departments where children are imaged. Providing expert opinion is vital in healthcare however studies (Elcock, Sidebotham and Welbury 2009; Bannon and Carter 2003), have shown that without relevant education in child abuse, the radiographer may be disabled to provide the required professional judgement to assist the referring clinician. This is important because difficulties exist in trying to reach a consensus on whether an injury was accidental or not (Nicholas et al 2012). They further concurred that it is equally challenging to rely solely on the appearance of fracture to make a case of abuse. This makes training very important to improve the radiographers' chances of identifying whether injuries are accidental or non-accidental, to report cases of child abuse and to advance child protection (Elcock, Sidebotham and Welbury 2009; Emalee and Robert 2005; Flaherty et al 2000).

In Ghana, the MoH (2007) as overseer of health care delivery in Ghana, had laid out a requirement for training of health professionals in matters of child abuse in a policy document. However this came without any clear guidelines of such training and how it should be monitored. The only training institution in the country for radiographers had also not been aware of this policy. This was either the training institution failed to avail itself with the MoH health training policies or its enactment did not involve the training institution for the institution to be aware thus creating this knowledge gap. As such this

250

was absent from the curriculum even though it was expected that training on paediatric imaging would cater for this whether policies were known or not. It also shows a general poor attitude towards child physical abuse and the protection of such victims in healthcare. Fortunately there was a curriculum review in the Ghanaian training programme this year, which enabled the researcher to include this aspect in the curriculum for approval from the University.

Child protection may be assumed to be a new role beside their core job of producing images. It is also noteworthy that while patient wellbeing is central to the radiographer's practice, involvement in patient activism is difficult (Squibb et al 2016). Finding themselves in a role set, additional kills will imply role development for the radiographer. Squibb et al further argued that radiographers clearly consider patients' interest above their engagements and choices. However, from the findings of the current study, patient interest was not adequately pursued by radiographers for child victims of physical abuse.

8.7 Legal Concerns

Child physical abuse could have legal implications whereby anyone involved in the identification or have information of the case could be summoned to clarify issues. To be on the safer side, professionals who encounter children suffering from physical abuse should be knowledgeable in such matters (through their training and education) when confronted with the situation. As a result, in child protection cases, professionals dealing with child cases are required to be conversant with the relevant laws in child handling (Hogg et al. 1999). However, when asked about their knowledge of Ghana's Child Protection Act 1998 in the current study, none of the radiographers interviewed had any detailed knowledge about it; *"I know little about it"* (Rad 13). This requires urgent attention because several authorities (Davis & Reeves 2006; Davis & Reeves 2004; Hogg et al. 1999; Hancock et al. 1997) have insisted that it is important for radiographers to appreciate the legal aspects of their practice obligating them in respect of managing children. For compulsory reporting of abuse to be operative under guise of the law, one must be guided by procedures to take in handling such cases. Imperatively, what permits reporting of an incident of child abuse, is the professionals' knowledge of regulations and procedures including professionals' knowledge of these agencies who receive the reports

251

and their contacts (Glaser & Chen 2006; Mudd & Findlay 2004). According to Inter-Parliamentary Union (IPU) and UNICEF (2006, p. 2),

> 'for legislation to have teeth, many elements are required. Legislation needs to be known and understood so it can be enforced. Awareness-raising campaigns and training of enforcement agents (such as police and judges) are necessary to ensure that legislation makes a difference' (IPU & UNICEF 2006, p. 2).

Radiographers handle children and are expected to be acquainted with the legal issues on child protection and also have good training in that area. They could be blamed for their deficiency in training and worsen their legal battles when they fail to intervene for the excuse that they lacked the requisite knowledge of the law. Similarity of this problem was identified elsewhere in a similar study (Russell et al. 2004). Although several research reports argued that child protection experts' judgements in the authentication of abuse are influenced by impartial concepts commonly echoed in national laws expert conclusions correspondingly seem to be prejudiced by a number of other factors not directed by national regulations (Cross & Casnueva 2009, King, Trocmé & Thatte 2003). The radiographer and the referring clinician could find themselves in the hands of police investigators or a court of jurisdiction to provide evidence for investigations (RCR, RCPCH 2008) which in itself act as a deterrent for the radiographers. According to Sullivan (2011) when child abuse is reported, the case is given to a state body that has legal backing to take up the issue and implement decisions (such as take custody of the child, imprisonment and the need for medical intervention and others).

In a document about the radiographer's role in child protection in the UK, emphasis was made on training members in this area (SOR 2005). Although in the Ghanaian context, there has been a training policy in MoH (2007) document, it was until lately the Society in Ghana had put forward for consideration a legislative instrument to guide the practice of radiography, to be considered by parliament which factored in the welfare of the child and the radiographer in matters of child abuse. This was made possible by the researcher as a result of the findings of this study which showed some gaps in radiographers handling of children affected by violence. Ghana has wide-ranging national laws which extends to both children in need of protection and juvenile justice (UNICEF 2013). However, according to the UNICEF, these laws are issue-specific and overlying; and in large part are replicas of

UK models. UNICEF further identified that there are extensive divides between laws - that disregard the methods adopted by the public in tackling child protection - and what actually occurs in practice.

Although it is generally and legally mandatory to report suspected child abuse cases, clinicians worldwide do not follow the requirements in the reporting legislation (Hendricks 2014). Hendricks, recognised that impediments leading to this noncompliance, is the misconceptions surrounding child abuse reporting.

Davis & Reeves (2004) had postulated that, for fear of the radiographer appearing in court, the professional may not take any action and would also remain quiet in clear case of physical abuse. They again sought to suggest that the radiographer may appreciate child protection concerns but would take no action for fear of wrong judgement and its investigative implications. The radiographer might consider that the safety of the patient is a shared responsibility and may standby (Davis & Rigney 2004). The concern is that experts who have ethical and legal responsibility to secure the wellbeing of children are not held answerable for their refusal to report (Hendricks 2014). The findings of the current study characterised the attention deficit given to issues of child protection in the practice of radiography in Ghana. The overarching concern in these scenarios borders on lack of support and structures; both legally and administratively.

Although radiographers interviewed expressed the importance of using the legal system in child protection in Phase 1, ironically the same people were found to be shying away from getting involved with the legal system. They felt that the country's justice system delayed in delivering justice and that if they get themselves involved, may affect their work by constantly going to court. Sullivan (2011) reported that when the courts are involved, the delay in even solving a reasonable case of non-abuse is of concern. Radiographers imagined threat of losing one's job in handling such cases as a result of the long delays took precedence over protecting a child from the current findings. This draws attention to the Social Exchange Theory (SET) which explained that behaviour is contingent on comparative costs and benefits of that behaviour (Brooks et al. 2007). Indeed, the logic of SET and the views Yielder & Davis (2009), suggest that the actual cost in NAI is seen as

the physical danger and court action that may befall radiographers, especially those who may involve themselves without required training; for that reason the radiographer would prefer to have nothing to do with such cases (Yielder & Davis 2009; Rigney & Davis 2004).

Apart from participants having expressed their lack of knowledge of the law in the current study, they also had misgivings about the legal support they might receive when they acted on cases of physical abuse. Radiographers studied perceived that legal backing would not be forthcoming within the healthcare system in Ghana when they embarked on such child protection activities. Despite this fear, it would have been a good practice that radiographers could arguably, have tested the law to see whether their fears were truly a reality rather than merely a perception. The current study suggest that the behaviour of the radiographers have practice and policy implications. This is because their decision to act on child physical abuse in Ghana was a freedom of choice issue as opposed to a professional responsibility from their assertions during the interview. The intention to engage oneself in child physical abuse (as reported by the interviewees) was predicted collectively by various factors such as culture, support, trust and mutuality leading to their poor commitment to child abuse cases.

> "…you are not sure whether support from the hospital administration or your hospital   will be forth coming to support you in such cases". (Rad 03)

In examining the Ghanaian legal provisions in the Children's Act 1998, it was observed that the Act was not specific about the responsibilities of the health professional. Moreover the Act did not indicate any immunity to the health professional as support to direct them in their field of practice as to what to do in child protection when abuse had occurred. Working under such limited legal frame work, issues mentioned above (including non-reportage) would be expected from any Ghanaian health care professional. With health professionals' responsibilities in child protection the Irish and UK laws are specific and provide immunity for the professional who reports abuse (SOR 2005; Protection for the Persons Reporting Abuse Act. No 49 of 1998).

The Children's Act (1998) of Ghana stated that when abuse was identified it should be reported to the Department without any mention of mandatory reporting by health care

professionals. Though reporting in the Ghanaian context was generalized without mentioning any specific group or persons as mandatory reporters, one would have thought that as professionals, they would report such cases. However, because radiographers demonstrated knowledge gap in both the law and the absence of channels for reporting in this study, this could be expected. Unlike UK's child protection laws, the specifics and emphasis of the child protection legislation in the Ghanaian Children's Act 1998, in most part elaborated on the regulations guiding the creation of nurseries, process of child adoption and issues regarding children in a foster care. The current study can also conclude that the current child protection situation in Ghana could also be part of the reasons why Ghanaian radiographers were not enthusiastic about their involvement in child protection in the context of their professional work.

The current findings indicated that radiographers were in demand for a clear legal system in Ghana that will check child issues when abuse is identified and a governing system to handle child protection in the hospitals was an issue in this study. To one radiographer, the absence of such a regulatory system specifically to guide health care professionals' involvement was the cause of inappropriate handling of child physical abuse cases in the hospitals. Indeed the professional body of radiographers in Ghana would require clear legislative guidance to enable the society to factor this into their training programmes so that it would not appear that radiographers had broken any confidentiality of the patient especially when it is an issue of child abuse. In Australia, it was or still is not an offence if one breaks confidentiality laws or professional politeness, ethics or values of professional behaviour to serve notification of suspected abuse (Denham 2008). A common aspect of child protection regulation is the designation of classification of persons and groups mandated to report suspected abuse (Nayda 2013). In the Ghanaian laws clear expectations are not specified on health professionals which could empower professionals to handle cases of child abuse appropriately.

8.8 In-group and Out-group Tensions
Reports provided by the majority of radiographers (In-group) in the current study suggested a culture of separation due to the difficulty getting help to pursue any case of practice concern to the benefit of the patient. Radiographers' dissatisfaction was largely with the

way they were treated by some doctors (Outgroup). Davis & Reeves (2009) iterated relational problems between radiographers and doctors which truncated information sharing. They argued that radiographers may take into consideration their professional bearing on other colleagues and remain indifferent about the patient's situation. Radiographers have the chance to identify cases of child physical abuse with collaborative approach with other health care professionals to protect and prevent further abuse of at risk children. In general, the harmonisation of work by professionals, has been an all-embracing issue in the delivery of health and social care (Wilby 2005). The manner in which professionals conceptualise their practice could affect efforts to have effectual collaboration (Easen, Atkins & Dyson 2000)

8.8.1 Radiographer and Doctor Relationship

While teamwork should advance child protection, given the common objective of the security of the child, the truth is that several factors impede efficient collaboration among health professionals globally (Nayda 2002a, Easen, Atkins & Dyson 2000). The majority of the radiographers (in-group) in their general practice experienced frustration when they were able to identify a child suffering from physical abuse and wanted some assured support in the form of teamwork to advance the protection of the child. This frustration was particularly heightened when they approached the referring doctors (outgroup) to provide information on their observation in their encounter with the child

> "We all work in isolation; I will say we more or less practice a silo sort of practice" (Rad 19)

> "…you don't feel the togetherness in the care". (Rad 14)

They understood that child protection was supposed to be a collective issue for professionals however this was not experienced when physical abuse was identified. Their fear of illogical forces and aggression towards them (as was discussed previously in this Chapter) was one form of professional isolation as the radiographers obviously felt they had no-one to turn to. Professional segregation has been an issue in several areas of health care delivery. This situation as reported above confirms the medical dominance of health care delivery. Child protective services (CPS) depend on frontline health professionals to conclude whether a child's injury was caused by abuse (Mudd & Finlay 2004). Accepting

this fact implies that each healthcare provider has some information to aid the child protective services, to carry on with their mandate of securing the wellbeing of a child at risk and in need of protection. However the current study identified that the opposite was the case in the Ghanaian healthcare child protection services. When there was a clear evidence of child physical abuse identified by them, the fight to seek the welfare of the child became an individual affair creating a 'silo' system of work as was identified in the study. For example,

> "It is not supposed to be a one man fight so that when I notice it and then I am the one who fight" (Rad 20).

> "you become a lonely ranger in the case' or a lone crusader" (Rad 20).

A participatory work system in child protection would imply that the advancement of the patient journey through health care provision relies on several individuals and professionals working in harmony (Komet 2001). Each individual in the team is viewed as having a body of knowledge and expertise that when brought together, will enhance patient outcome. While a few of the radiographers in the current study were ready to follow up on cases of NAI, the needed support was not forth coming and found themselves neglected in the fight to secure the wellbeing of the child. The care teams have to coordinate and communicate among their team members and with other teams to function in a cohesive manner to execute the highly coordinated and high risk activity that is called patient care (Ratnapalan & Uleryk 2014). Situating this argument in child protection, it requires the commitment of individuals and groups to ensure successful but better outcome for the victim.

Radiographers are in position to provide relevant information to the CPS as continuity of evidence to advance the intervention in child physical abuse cases. Diverse roles are played by various professionals in matters related to child abuse. Indeed each profession has different knowledge and competence, and hence defines and responds differently to child abuse and a decision to report accordingly (Feng et al. 2010). Radiographers, like other professional colleagues, gain from a work practice that encourages information sharing and scholarship from each other's experiences (Scoot 2007). However what was reported in the current study in health care services in Ghana appeared to be further from the truth. In illustrating this point, radiographers experienced exclusion in their practice in terms of sharing their opinion with doctors. The crossing point of many disciplines in the child

protection activities has some established benefits, including enhanced parent and child fulfilment and improved prosecutions (Faller & Palusci 2007; Jones et al. 2007; Miller & Rubin 2009) when professionals collaborate (Laming 2010). However with current isolation of some professionals this noble goal of team work cannot be achieved. Glaser & Chen (2006), argued that key to controlling and eradicating maltreatment of children is the aptitude of health professionals to diagnose, and notify appropriate authorities in the chain of abuse resolution. Like the relay race (Feng et al. 2010) the baton (evidence) to complete the race (child protection) is dropped and the child suffers. Moreover the geographical location of some radiographers (lone radiographers) especially those in the rural areas could also contribute to their isolation and no relay to run in child protection.

In child protection, quite a lot of specialised groups are of the view that, child abuse is a serious concern whose resolution is only possible when there is group collaboration (Glissen & Hemmelgarn 1998). As a result, interdisciplinary collaboration has been advocated for in primary health care due to its benefits for the progression of the patient in the care delivery (Nolte 2005). In contributing to the discourses of collaboration, Mattessich, Murray-Close & Monsey (2001, p. 24) defined collaboration as "a mutually beneficial relationship that is well-defined and entered into by more than one organization or individual to achieve mutual goals". This idea was found to be a problem from the shared experiences of radiographers studied with the doctors. They felt their motivation was hampered by the medics as a result of pejorative comments some doctors made when approached. This situation affected the reporting of suspect cases of physical abuse by the radiographer which might have eluded the referring clinician.

The concept of collaboration, has been described as "a process by which members of various disciplines (or agencies) share their expertise. Accomplishing this requires these individuals understand and appreciate what it is that they contribute to the whole" (Henneman et al. 2005, p. 363). The majority of radiographers in the current study felt that in most part of their practice, doctors were not ready to accept their views when something curious was identified from either the imaging findings or when extra information was gained from their interaction with the patient or the family. This might have been the

perception to date among the medical profession in Ghana in the way the radiographer was seen;

> "The issue is, in Ghana here the doctors do not take our opinions. They think our duty is just to produce the images or the radiographs so I may not report such cases". (Rad 11)

The perception held by the Ghanaian doctors as reported by (Rad 11) place limitation to the professional space of the expanded role of the radiographer in the care delivery. The comments above, add to the existing evidence (Reeves 2002) that radiographers met restrictions in their practice as they were chiefly known to produce just images. Health care delivery is supposed to be team work however medical dominance seem to be affecting this noble idea. According to Reeves, the accepted notion that, radiographers were not medically trained and the fact that their work was under the supervision of radiologists, put them in a subservient position. This has been an observable situation to date, in several countries (including Australia, and Ghana), where radiologists are in authority in the imaging departments and is deemed by them to be subservient (Lewis et al. 2008).

In contributing to image interpretation dynamics in rural practice, Squibb et al. (2016) argued that each time an issue defining matters of interprofessional limits arises, past hierarchical relationships may impact and determine the way the collaborations take place. Radiography has advanced through technology changes and as a result, new and advanced roles in the imaging have developed in certain countries. Moreover, these new roles have brought new academic scholarship into the profession; making radiographers push hard to obtain a higher status and recognition as a result of what they can do beyond the production of images (Squibb et al. 2016). However this was not demonstrated by radiographers in the current study as they were found to coil into their shells when faced with the collaborative challenges with other disciplines. They failed to take pride in their profession; one of the constructs of professionalism (Papadakis et al. 2008). It could be that radiographers were unable to demonstrate competence and capacity to take additional roles.

The worries confronting the medical governance of health systems, (among others) include the shifting roles of healthcare occupations other than the medical profession, who are

found performing roles, which were formerly the province of medicine. Nolte (2005) argued positive outcomes are assured when organisational values regarding cooperation among disciplines are supported. She was of the view that these institutional values must be governed by legislative instrument and with a system devoid of ideological differences and territorial conflicts. While acknowledging the doctor as one in charge, radiographers in this study found doctors arrogant when approached. In support of Lyndon et al. (2012) and Watcher (2012) who separately, found that many nurses reported having been ridiculed by doctors when they raised an alarm on an issue of care importance. As a result they found that many nurses were unwilling to show any concern when they felt there were strong indications of patient safety compromises. A similar stance was identified in the current study where the radiographers felt reluctant to draw the doctors' attention to an important observation that could benefit the patient. Radiographers were found to back down when faced with abusive doctors to whom they had attempted to report their suspicion.

> "I informed the doctor what I have observed or done and he just brushed me off…he is in charge". (Rad 17)

> "…some doctors… are very irritating in the sense that they don't see why you should draw their attention to things like this. It puts you off to talk to them?" (Rad 08).

Lyndon et al. (2012) noted that regarding the possibility of speaking up with doctors about potential harm of a new intervention to a patient, nurses reported recurrent subjection to contempt and coercion by doctors. Despite these professional clashes, previous studies have reported some benefits of professions working in synergy while accepting that problems of affinity with each other existed (Lalayants & Epstein 2005). Where evidence was required to pursue or investigate the case of abuse further, this was lost due to professional inaccessibility:

> "We do not go ahead to report to the radiologist or the doctor, the referring clinician or anything like that; we just leave it there" (Rad 03).

> "…whatever you see you should keep it to yourself and that for me does not help matters". (Rad 18)

These experiences have bearing on the child protection work especially where legal proceedings are required and prosecutors trust that information derived from frontline health professionals will assist them to determine whether a child's injury resulted from abuse (Mudd & Finlay 2004). Similar to the current study, inter-professional relationships, the issue of trust and medical dominance, created problems in child protection. Attention was drawn by Yielder & Davis (2009) to the risks of giving exclusive right or power to some professions in protection issues. Freeth & Reeves (2004) also recognised that collaboration among professionals is required to progress health care outcomes. Where effective child protection systems are working properly, the radiographer would have an option to present his or her case.

The progress of an occupation, demands serious enquiry of limited control, by one group to allow the preservation of 'best practice' (Yielder & Davis 2009). Similarly, the results of several health problems in large part, rest on the effectiveness of working in partnership rather than the cleverness of the overseeing doctor (Wachter 2012). As true as this is, professional space to ensure the togetherness of disciplines in the delivery of service has become tight with each fighting to get hold of good space leading to difficulties in multidisciplinary approach to care (Bleakley 2013; Wilson 2012; Holyoake 2011; McGregor 2010; Yielder & Davis 2009; Wicks 2005).

In contributing to the discourse of division of labour, Freidson (1994, p.58), indicated that "...in the everyday world of work from which we abstract conceptions of the division of labour, it seems accurate to see the division of labour as a process of social interaction in the course of which the participants are continuously engaged in attempting to define, establish, maintain, and renew the tasks they perform and the relationships with others which their tasks presupposes". Radiographers in the current study might have conceived this concept to approach the doctors to advance care treatments. However, these professional endeavours were thwarted. The situation radiographers found themselves conceptually is explained in Freidson (1994).

Freidson clarified that it is erroneous for one to think that such professional exchanges is totally without restrictions. In using Adam Smith's division of labour market as an example of where such exchanges were seen to take place, Freidson argued that Adam Smith's

division of labour (which is also the case with healthcare organisations), was completely characterised by idiosyncratic rivalry. It is thus not surprising to identify similar rivalry situation in the healthcare industry as the current study had also established. Moreover, Blumer (1969, pp.87-88) cited in Freidson (1994), stated that " Social organisations is a framework inside of which acting units develop their actions…It sets conditions for their action but does not determine their actions…It shapes situations in which people act, and …it supplies fixed sets of symbols which people use in interpreting their situations." This was the portrayal of radiographers' actions in the current study which was characterised by apathy as a result of relational difficulties. This be expected in any human institution and for that reason the radiographers should have been assertive enough to push their stand for the safety of the child. Interdisciplinarity has indisputably contributed positively to child protection however, it has not been without interactional difficulties (Doheny, Davis & Grehan 2014). They posit that misperception is possible among dissimilar occupations in their professional accountabilities which tend to affect their reporting alliances which are vital to prevent repetitive abuses on children.

The current findings of radiographers' preferences in reporting cases of abuse in large part corroborates Rigney & Davis (2004) where in their study, radiographers indicated who they preferred to report to, however, their study did not indicate whether Irish radiographers had experienced problems with doctors when they approached them on issues of abuse. Despite the complaints reported in this study, a majority of radiographers preferred reporting abuse they suspected to the doctor who they expected to refer the case because they saw the doctor as being on top of the care delivery; *"…he is in charge"* (Rad 17). The reporting preference that compares and contrasts the findings of (Rigney & Davis 2004) is illustrated in Figure 12 (p.198). Radiographers advance from a model of practice that inspires information sharing and learning from each other's experience (Scoot 2007) and when this is broken the entire care system fails in its desire to provide quality service. Moreover, the curtailment of information by the radiographers as result of rivalry and tensions disrupts the relay race, breaks the chain of evidence because the information (relay baton) is dropped by a disillusioned radiographer.

The systems approach to child protection (UNICEF 2008, 2010) was emphatic about multiple agencies and disciplines coming together with their knowledge and expertise to protect vulnerable children from abuse. The prevailing working environment surrounding the management of child physical abuse in the hospital by radiographers and doctors in Ghana as identified in this study is in disagreement with the concept of child protection as propounded by UNICEF.

It has been acknowledged that in child abuse, the capacity of the clinician to be able to identify, diagnose and notify the important stakeholders about a possible abuse is central to its resolution (Glaser & Chen 2006). One way to achieve successful diagnosis especially in child physical abuse where injuries to the child are suspicious is through diagnostic imaging. Professionals in healthcare have been cited as having contributed in the death of Baby P in a UK child abuse incident because professionals failed to collaborate (Haringey Local Safeguarding Children's Board 2009). Contrasting the UK incident with the relational problems in the Ghanaian context identified in the current study, the events of Baby P might have occurred in Ghanaian healthcare system and gone unnoticed as a result of professionals keeping to themselves and refusing to collaborate. The above discussion supports Davis & Reeves (2006) assertion that radiographers' capacity in child protection has not effectively received the required publicity. The lack of recognition of radiographers' fitness to contribute to positive patient outcomes as a profession, (beside their imaging roles) is one reason for discontentment experienced by radiographers (Ferris 2009). The experiences of respondents in the current study alludes to these claims and is a case of professionals who have become disillusioned about their cognitive maps of the current state of professional collaboration in their practice; a situation which could affect important decisions that need to be taken to safeguard a child at risk of abuse or suffering from physical abuse. One radiographer was aware of the benefits of working together and willing to operate within it:

> "… if he (doctor) also understands that the radiographer is part of the team taking care of the child we will have a holistic care of the abused victims and not only what he knows to care for the abused child". (Rad 17)

The RCR, RCP and Child Health 2008) have argued about each individual's contributions in matters of child abuse. When professionals are dissatisfied with a system the system

itself suffers because consumers are not provided with the service needed. Allegorically when two elephants fight it is the grass (abused child) who suffers in the context of child protection.

In contrast to the relationship challenges faced by a majority of radiographers interviewed in the current study, the situation was different with three radiographers who enjoyed collegial relationship with other professionals including doctors especially in their various hospitals. What brought them together was chiefly, clinical and quality assurance meetings which were always held involving all disciplines. At such meetings, clinical issues and professional welfare were discussed freely because they had a common vision and objectives. This was in support of the argument that where professionals meet together with shared objectives, positive team work is possible leading to good patient outcomes (Ratnapalan & Uleryk 2014; West & Pouton 1997). This is because social collaboration work against distrust, give meaning and fulfilment in the organisation (Zwarenstein 2002, Molyneux 2001, McNeese-Smith 1999).

In several English speaking countries (including Ghana), doctors have established authority, self-governance and power across a number of areas in health care services (Kenny & Adamson 1992). This has resulted in the allied health professions becoming disenchanted about their important contributions to healthcare as the current study has observed and also consistent with (Holyoake 2011; Yielder & Davis 2009; Lewis et al. 2008; Reeves 2002; Brannon 1990; Hazelton 1990) who reported that these problems stems mostly from the culture of high power gradient recognised in healthcare services by medical dominance. While generally officials have recognised the importance of multidisciplinary collaboration and communication as indispensable if health care quality and safety of patient care was to be advanced (Institute of Medicine 2008, Larson et al. 2004, Department of Health 2001, Institute of Medicine 2001), problems continue to exist among professions in trying to work as a team in health care.

8.8.2 Relationship with the Nurse
Much as radiographers in this study were not trustful of doctors, their perceptions about nurses were not really different although some radiographers in this study preferred to

report abuse to nurses. The reason the radiographer might report to the nurse was not established in this study. However, it is true also to note that in Ghana, some hospitals are managed by nurses which might prompt the radiographer to relate to the nurse by reporting cases of abuse to them. The findings alternately showed that two radiographers were dismissive of the role of the nurse. One perceived the nurse as a clerk to the doctor who was referred to as 'somebody' and for that reason did not see why they should be approached with cases of child physical abuse.

> Yeah! ...they act like secretaries to somebody so what happens is they will bring the child if it has been requested I cannot discuss with the nurse". (Rad 04)

A few of the radiographers felt nurses provided second hand information which might also not be the truth or was limited and could not be trusted. While some radiographers did appreciate the nurses' role in child protection and normally did discuss abuse with them, after such discussions, often the case was not followed up. Such an observation supports Lyndon et al. (2012) and Watcher (2012) findings discussed previously. Why radiographers were dismissive of the nurse is a worrying situation given that they complained about the treatment received from doctors when approached. One would have thought that their perception and relationship with the nurse would be more trustful.

8.8.3 Relationship with the Social Worker (SW)

There were mixed perceptions and trust regarding their relationship with the SW. The majority of radiographers from their experience with the SWs had concluded that these professionals were not helpful when they approached them with such cases. One might argue that this is the radiographers imposing self-isolation. It appeared that they had no trust for any of the professionals they worked with and decided to isolate themselves from them a situation which required attention. From the majority of participants, they found the SW to be occupied with cases of patients who were unable to settle their hospital bills. This financial role of the SW is similar to that of the hospital almoner in the UK in the past. Despite this the situation was not the same with one particular hospital in the current study where a radiographer was interviewed. This radiographer had a contrary view of the SW and believed that the SW was the right professional to contact in matters of child abuse.

This was a deputy chief radiographer whose hospital had a social welfare unit which was active and took cases of abuse seriously. The coordination was fine in the hospital and they appreciated the role of the social welfare.

> "…fortunately for us we have a social welfare unit where we have professionals who can sometimes advise us on what to do" (Rad 05).

Radiographers wanted guidelines that they could follow in order to report to the SW. The laws did not cater for this aspect which probably could be part of hospital policy. However these policies and guidelines of reporting by the health professional were also absent interestingly, a majority of the radiographers demonstrated ignorance about the role of the Social Welfare worker in child abuse particularly in cases of child physical abuse.

> "…but if a child comes and has been physically abused, I do not know how the social welfare will come in" (Rad 01).

> "…the social welfare as it stands now does not involve in children abused like this" (Rad 01).

With the current mind-set of radiographers, it would be difficult for the SW to gather any information to assist them in their work to save children from their predicament. It is believed that when abuse has occurred, the SW should request assessments from other experts (Hollows 2001) which in the case of hospitals, include but not limited to radiographers, doctors and nurses. With this attitude of mistrust and feelings of isolationism by radiographers studied, and constraints faced by the SW, the affected children are bound to suffer. However the overarching fact is that Ghanaian professionals do not understand each other's roles and capacity in managing child abuse.

Evidence suggests that SWs have suffered contempt resulting from doctor's egotism and control while doctors and nurses together perceive social workers' mistrust and unwillingness to contribute to information sharing and feedback (Goad 2008; Lalayants & Epstein 2005). This seems to contradict Hollows' (2001) position that in child and family welfare, under the UK Assessment Framework for children in need and their families, social workers would be ordering assessments from other experts (such as clinicians) while

266

appreciating the comprehensive information they receive from such experts . Holloway however in recognising these possibilities, attested to these contentions about the self-centredness of other professions such as medicine, experienced by social workers. She concluded that social workers, in most part are not well-regarded despite their capacity and expertise. Healthcare occupations have reached a period where there is a growing demand from politicians, health policy experts and intellectuals for better-quality healthcare established on inter-professional cooperation (Salhani & Coulter 2009). It has been agreed that child protection anticipation requires professional teamwork and joint action to arrive at the recognised and stated goals of assisting children (Davies & Ward 2012; Munro 2011; UNICEF 2010; Davis & Reeves 2006; Lalayants & Irwin 2005)

The current situation in Ghana also affirms the lack of infrastructure and support needed by the Ghanaian SW (Laird 2008; Laird 2002) to enable them carry out their duties efficiently without discrimination. Although the laws of Ghana (Children's Act 1998) are emphatic that when abuse is identified, it should be reported to the DSW, however, owing to radiographers' self-established ignorance of the law (as was discussed earlier in this chapter), their reporting or actions taken regarding child protection were viewed as being discretional. The DSW, as a major child protection service agency in Ghana, have their professionals in some hospitals in Ghana responding to various welfare issues of patients including children. However, the DSW is challenged in many ways, including resource constraints and training in their field which affects all areas of their practice including child protection (Manful & Manful 2013; Laird 2008). Laird (2008) in a study of Ghana's Social Welfare system identified staff who were not motivated and were poorly trained. The perception of the Ghanaian radiographers about the SWs also stem from the constraints which some SWs were experiencing (as was identified in this study) which partly contributed to these perceptions.

> "…I spoke to one welfare officer and to be honest she told me their arms were full either in quotes more pressing cases so it was going to be difficult to follow upon this especially when the parents have not come to say they cannot afford to take care of the child."(Rad 20)

This supports the assertion that Social Welfare staff in Ghana lacked the necessary capacity to respond to important social issues that affected society including services to children in

need of support and protection (Laird 2008). There are evidence to suggest that the SWs in Ghana had complained about lack of appropriate resources and funding which weakened even the most basic activities (Laird 2008). Laird's study also concluded that the Ghanaian Social Welfare was unable to impose compliance with legal necessities.

Hollows' (2001) argument that SWs teamwork with other professionals was necessary, in a way supported Feng et al (2010) relay race analogy regarding multidisciplinary collaboration in child abuse reporting. According to Feng et al. (2010), participants from different professional groupings saw interdisciplinary togetherness in child protection as a form of a relay race. The individual occupations were acknowledged as members of the relay team while compulsory reporting was seen as the baton that is handed to the next team member within a particular time and space. Each profession, according Feng et al, runs its own race within the team with different style, speed and timing. This in their view is with the sole aim of saving the child from subsequent abuse. Their study revealed that doctors felt their fundamental obligation in the race was to manage any physical injuries of the child and refer the case to social workers whose primary concern was to get information about suspicion of child abuse. In Taiwan, social workers are regularly the initial designation for other professionals to get in touch with when a case of child abuse is suspected (Feng et al. 2010) which is actually the same as the Ghanaian setting.

8.9 Structural Deficiencies
The need for policies, guidelines and protocols in dealing with child physical abuse were issues of concern among radiographers interviewed in this study. A child protection policy establishes guidelines for organisations and their staff to ensure safe settings for children. It is a means by which children and staff are both protected. This is to be expected as these guidelines clearly describe what action is required to keep children safe (Child Matters 2016). Child Matters agree that policies guarantee a uniformity of behaviour so that all staff goes by those standards. Further, they are of the view that a child protection policy proves an organisation's commitment to children and ensures public confidence in its safe practices.

Almost all the radiographers in the current study expressed deficiencies in the management of child abuse which the attributed to the lack of systems in place to provide a road map for

the handling of child abuse cases in general. There were no institutional reporting channels or unit and who to report to. This from the study affected their perception of the obligation to provide help to the child. Irene et al. (2006) emphasised that organisations which work with children should have set of protocols to respond to any abuse to enable them act promptly and competently to the situation. They also acknowledged the importance for institutions to understand that the child's wellbeing must be held supreme against any apparent risks to the status of the establishment or the persons involved. It is suggested in the current study can suggest that, in the Ghanaian context as reported by radiographers interviewed, the situation was different, leading to their poor commitment to issues of reporting child physical abuse.

The intention of the radiographer to engage in child physical abuse issues was predicated by factors such as support, trust and mutuality. Although the majority of radiographers interviewed shared similar views, one radiographer explained the issue further to clarify this discussion.

> "Yeah! I think we have a very poor commitment to that, very poor commitment. At times it is not that the health professional does not have the interest to help the child but even the reporting line, who do I report to and the person I report to how serious is the person to take up the matter further to the next level? These are all challenges for which most of us seem to be reluctant in pursuing some of these child abuse cases". (Rad 19)

Radiographers' commitment to child physical abuse and the protection of the affected child was affected by their attitudes, beliefs and perceptions about the behaviour of doctors in particular. From the above discourse, radiographers in the current study argued that there was an absence of colleagues to whom they felt they could take the matter of abuse. As a result of the absence of structures, attitudes centred on mistrust and fear of approaching those who significantly were supposed to advance the protection of the child but were unwilling to listen to the radiographers. This was all the more reason why they felt the need for policies and guidelines to direct the way abuse cases should be managed or reported. Advanced restructuring of Ghana's policies and strategies was ongoing at the time of writing. In certain circumstances in Ghana, either standards have not been defined or there is no firm execution of the policies which also differ from place to place (Saleh 2012). In Ghana, the main policy intervention (from 1990 to 2015) on child health is aimed

at reducing under-five mortality rate by two-thirds through the execution of the Child Health Policy and Strategy (UNDP 2015).

In Phase1, radiographers felt child protection could be achieved where there is a regulatory system in place. Although this existed radiographers were not acquainted with it. However it could be accepted also that regulatory frameworks were absent within the organisations. Similarly, in Phase 2 the radiographers lamented the lack of such protocols and guidelines to operate and blamed the health care Ministry. Participants acknowledged that this has led to improper management of cases of child abuse generally. It was clear from the findings of this study that radiographers had no knowledge of policies on child abuse for them to follow. The absence of suitable working policies in health care and in radiography has been a challenge in several areas of practice in Ghana (Antwi & Griffiths 2012). Radiographers unanimously, needed education and information about the whole issue of child abuse.

> "Am not too sure of the health policy on children about what the health policy says about the abuse of children... the healthcare system has not come out and let us know where we stand other than that when we them we will know what to do. The same problem of not knowing what to do may prevent us from having anything to do with the case. But when there are laid down procedures even discussion on it within our hospitals even in forums that will be fine because it's like everyone does his or her core job and that is it. I do not know whether I have answered you very well"? (Rad-13)

This led to discretional preferences as to the ways or to whom child abuse would be reported when willing to do so (see Figure 13 Chapter 7). Although in some hospitals social welfare services were available it was not the choice for some interviewees to report cases. Radiographers though were sceptical about the nurse in relation to managing child abuse, others would prefer to report cases to them. Some interviewees felt they would rather report to the doctor whom they thought should report to the police. The researcher identified that the premier and the largest teaching hospital had a child protection unit at the Child Health Department where cases could be reported. However, none of the radiographers interviewed from this hospital was aware of this unit. From the investigations made by the researcher about this unit, its establishment had not been communicated to the entire hospital staff or its professionals who handle children. It was expected that the unit

would educate the hospital members about its presence and core responsibilities but as at the time of writing this report nothing this has not been observed.

8.10 Professional Treatments

The majority of radiographers after the interview expressed their gratitude and happiness about being part of the study. They were optimistic about the study's impact on policies of the health Ministry and nationally to enable children receives the needed protection. They expressed that the study has changed their attitude and perception about child abuse and reporting of such cases. According to them it has raised their awareness and understanding of what was expected of them as health care professionals.

> "I think that this is a good course of action. This project is a good one and my prayer is that it will go to influence policy not only in our health sector but in the country at large so that such children will receive some kind of protection from parents who abuse them …so I am very happy to be part of this project". (Rad-20)

This could lead to professional scholarship in matters of child protection in Ghana when respondents work in synergy to safeguard children. This study supports the statement of Bell (2011, p. 103) that: "individual beliefs and attitudes towards abuse do not exist in isolation, but are a part of a shared system of beliefs". This may explain the mutual belief system by radiographers in the current study about child abuse and protection.

8.11 Summary

This chapter discussed Ghanaian radiographers' behaviour and perceptions about child protection in their work setting when children were physically abused and sent to hospitals for imaging intervention.
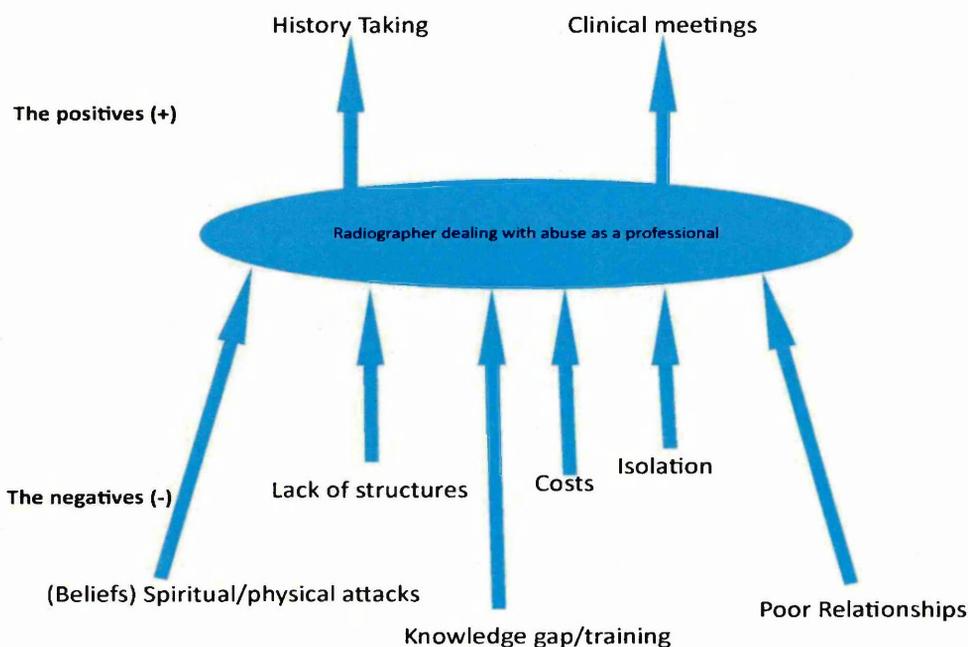
Figure 15: The positive and negative aspects of radiographers' approach to child protection.

Several factors indicated in Figure 15 above worked against the radiographers' commitment to child protection. Some of these factors were spiritual fear, cultural expectations and behaviours, fear against potential physical attacks, and the absence of an established legal and regulatory framework.

Arguably as the Figure above suggests, one good thing that the radiographers were doing involved their commitment about the history taking to find more about the cause of the child's injury. Through the history taking and imaging results, they were able to identify physical abuse which may have eluded the referring doctor.

Professional relationships were among the issues that partly worked against the proper handling of abuse cases by the radiographers studied. However, one positive aspect that brought professionals to work as a team was where clinical meetings were held to discuss patient care issues involving all the professionals. The time needed to follow up cases and absence of structures such as policies, protocols and procedures (including guidelines to follow in handling cases of abuse) led most radiographers to adopt the bystander attitude

272

towards child physical abuse cases they handled. The absence of structure meant that support was not forth coming. The radiographer then felt isolated and a lone ranger in the pursuit of justice for the child. Moreover, professional commitment by the radiographer was hugely influenced by their own attitudes and perceptions about other professionals such as the doctors, nurses and the social worker. There were several areas where professionalism and the ethics of practice were not exhibited by the radiographers studied. For example, they failed to champion the course of child protection where there were clear evidence of child physical abuse.

Training and knowledge gap created fear because having no knowledge about how abuse could be identified and pursued, led the respondents to perceive that one could get problems on the way when the case was pursued. Radiographers lost their professional commitment and patient advocacy as part of their professional responsibility when parents showed no interest in their child's case and as a result, some radiographers did not see the need to help the child. Though radiographers had several difficulties in handling abuse cases which affected their commitment, they could not be fully blamed because in almost all the hospitals there were no established unit or persons designated to consult apart from the social welfare staff who were also not available in all the hospitals. The misunderstanding of the role of the SW was partly due to lack of proper education and training and coordination within the health care intuitions about the management of child abuse in general. The most important aspect in this situation was weakened awareness of child protection matters consequential of insufficient training (Bannon and Carter 2003).

If child protection was to be operative, any radiographer who experiences a child in need of protection must act on time and make suitable recommendations to statutory agencies (Bannon and Carter 2003). However when asked about their reporting preferences when abuse was identified, respondents gave varied opinions as to whom they would prefer to report. Despite clashes with doctors, the majority of the radiographers interviewed preferred to report to the doctor because they were seen to be in charge of the case. The crux of the matter is that reporting abuse cases were viewed as being discretional as a result of structures which are yet to be put in place for the professionals to act appropriately. The

professionals were partly to be blamed for their ignorance of the Children's Act 1993 of Ghana.

The systems thinking draws attention to the fact that the interactions between the various elements of a system and the outcome of these interactions is more significant with the result that the parts of the system are reasonably linked towards a collective enterprise. This was expected in the child protection activities in the health system in Ghana. However the findings of this study suggest that the various parts of the system were not relating appropriately to achieve a mutual goal. The health care system operates with system thinking; towards a common goal of helping the patient through the interaction of all its parts (i.e. the professionals and non-professionals alike). When this interaction is disconnected the whole cannot achieve its gaol because the system becomes faulty and the outcome is the suffering of the patient and break down of the organisation. Organisational culture determines its image or nature; it tells how things are performed in the corporate system which impacts on how workers go about their duties, the relationship that exist between them and also with their clients (Huczynski and Buchanan 2013). The current study is clear case of organisational culture within the hospitals in Ghana and how its professionals relate to each other which has bearing on the patients generally.

CHAPTER 9

CONCLUSION AND RECOMMENDATIONS

9. 0 Introduction

Child abuse and maltreatment cases have consistently made the news on Ghana's various news outlets, including the internet, newspapers, radio and television. Given the health and human rights issues such abuses entail, the way authorities handle abuse cases is becoming a topic of great importance for advocates of child human rights. In the adjudication of child abuse cases, particularly child physical abuse, the role of radiographers becomes indispensable as they play a critical role in providing imaging evidence as to whether an abuse has occurred or not, and if so, the extent of the abuse or injury. Clinicians are the initial point of contact for identifying evidence of NAI, and their joint effort with other professionals is crucial in the identification of children at risk of abuse. The significance of any precise medical evidence to aid such investigation however may be hampered if the will and empowerment of those in a position to provide some of this evidence-such as the case of radiographers-is lacking. Radiological evaluation is, for example, to assess the presence or absence of NAI in children. Yet, there seemed to be significant ignorance and knowledge gap among clinicians and other health professionals in Ghana as to the role and involvement of radiographers in child protection.

It is in this context that this dissertation focused on questions dealing with the lived experiences of radiographers in their dealings about child abuse and maltreatment cases in Ghana. The study generally, was designed to offer some insight into the role of Ghanaian radiographers with regards to child protection. In Phase 1, the understanding amongst Ghanaian radiographers of the concepts of child abuse and child protection was explored. The study further investigated how radiographers in Ghana perceive and participate in child protection within the health system in the country (Phase 2). For example, it asked: How do radiographers in Ghana deal with child physical maltreatment cases when they encounter them? What is the relationship between radiographers and other health providers who handle child abuse and protection cases?

This study is unique and contributes to the knowledge base and scholarship on child abuse management in sub-Saharan Africa. It is also unique as research on the handling of child

abuse cases routinely focus on the legal system and social workers. Rarely do such studies focus on the actions or inactions of clinical radiographers, who play a key role in enforcing abuse laws in Ghana. Evidence (Phelan and Davis 2015) suggests that there are reports of system failures in several countries regarding their legal approaches to protect children. The focus of the study, (the first to be conducted in Ghana on diagnostic radiographers) about their management of child victims of physical abuse and brought to the hospital for either treatment and/or substantiation of the abuse is thus timely to reveal the Ghanaian situation as posited by Phelan & Davis (2015).

To improve on child protection in Ghana, it is critical for major stakeholders whose responsibilities include child protection (e.g. healthcare, education, the justice system, the police and social welfare) know their roles, and what to do when they encounter abuse cases. Several autonomous inquiries about failures in child protection, have blamed system inefficiencies, the actions of health professionals and social workers as contributing factors to these failures (Bannon & Carter 2003). Such an effort requires that doctors and other allied healthcare professionals are capable of determining a suspected victim of child abuse and collaborate in their efforts to protect the child for resolution by the appropriate authorities.

9. 1. The Study and Its Major Findings: A Summary

Child abuse has become a global problem. Child and infant maltreatment occur in various forms and providing the necessary protection for this vulnerable section of the world population, has become a critical global issue because of its negative socio-economic and health implications.

The abuse perpetrated against children takes a variety of forms and proliferates among different cultures and subcultures. They include, among others, physical abuse. Evidence also suggests that, despite its prevalence worldwide, literature on child abuse was mostly from western countries (Raman & Hodes 2012). Equally important, most of the protective measures adopted by most developing and even some advanced countries have not been holistic enough to deal with the situation. The absence of a holistic policy to deal with cases of child abuse around the world was partly the reason why the United Nations International Children Emergency Fund (UNICEF) has produced treaties and conventions

for the Rights of the Child as a universal law and guidance to be accepted by all countries. Ghana is a signatory to these treaties. Available literature suggests that child protection requires a multi-disciplinary approach as established in the five main areas of UNICEF's child protective strategy document (UNICEF 2008). The protection of children from maltreatment is a collective duty yet in the context of Ghana, there appeared to be some gaps in its approach to child protection which provided the impetus for this project.

9.1.1 Phase 1

Phase 1 did examine Ghanaian radiographers understanding of the concepts of child abuse and child protection. Literature search on child abuse and child protection in health care in Ghana regarding radiographers elsewhere did not provide any results linking radiographers understanding of the concept of child abuse and child protection. This is a gap this study has filled. Radiographers have been brought into the debate or controversies surrounding the universal definition of these concepts. This is particularly relevant to child protection discourse as it helps to clarify whether, with this understanding, radiographers would apply this knowledge in their child protection activities. However, the current study could not establish a common definition of child abuse supporting the inconclusiveness of the concept (Fallon et al. 2010; Munro 2008) and similarly with the concept of child protection.

Ghana is a unicameral and multicultural country having the same laws in all regions. This makes it difficult to have various definitions of child abuse which took into consideration these different cultures and what they accepted. Despite these challenges their definitions was in conformity with the theory concepts.The study established that child protection is limited by only using the law to protect children. The study established that child protection should ensure that children have positive attachments and a sense of belongingness not only within the family but in the community and that they have the right to live in safety to develop in a protective environment. Radiographers studied saw the family as the primary point of protection for children.

This is the first study in Ghana to document radiographers' cultural understanding of child abuse and child protection. This perspective has raised both policy and practice

implications which paved the way for Phase 2 to explore experiences of radiographers in the management of child physical abuse cases.

9.2 Phase 2

The present study upholds the tenet that to improve on child protection, it is imperative to involve the larger community of health professionals. In this case, the focus was on the participation of Ghanaian radiographers, as professional health service providers (in child protection in particular child physical abuse), especially where injury of the child was suspicious and required radiographic intervention for precise diagnosis. The ability of the Radiographer in Ghana to recognise and report an incident of physical abuse, vis-à-vis accepted cultural norms, is not only crucial but could also have policy implications.

9.2.1 Examples in Phase 2

1) Several things were found to impede the radiographers work on child abuse cases. These factors that impacted on the radiographer's professional commitment in managing child physical abuse cases in Ghana ranged from factors such as spiritual fear, cultural expectations and behaviours, fear against personal attack, to the absence of an established legal and regulatory framework for handling abuse cases all of which affected the smooth management of these children when they were abused and brought for imaging purposes.

   Though the radiographers faced some challenges in their work in Ghana some were purely self-created. For example there were instances that radiographers failed to exhibit their professionalism by going against the ethics principles of the practice to protect children at risk of abuse. One example was when radiographers failed to intervene for a child whose parents beat them infront of the radiographer.

   One good thing that they were however, doing involved their commitment regarding history taking to find more about the cause of the child's injury. When most of the X-ray referrals did not indicate any suspicion of physical abuse, through history taking and imaging results, radiographers are able to identify physical abuse which may have eluded the referring doctor. However the study established that, this positive action by

the radiographers, was also negated by the fact that when the information gained gave clear indication of physical abuse, what happened was that:

(i) the information was discussed among themselves but their observations were neither documented nor reported.

(ii) they claimed they had no place to go and report the cases within the hospital even where there were established social welfare units as a result of ignorance and lack of trust.

2) where teamwork was challenged by poor interdisciplinary relationships and understanding of roles, passive attitude was adopted by the radiographer to intervene for the child. However, one positive aspect that brought professionals to work as a team was where clinical meetings were held to discuss patient care issues involving all the professionals.

Ethnic solidarity was found to be one of the basis for abuse reporting or non-reporting. When radiographers spoke the same language as either the culprit or the victim, they tend to be biased towards the party who spoke or understood a different language making the radiographer an unreliable professional in such moments. This is the first study in Ghana reporting the influence radiographers' ethnicity on child abuse and victimisation reporting trends. In this regard, once the radiographer identifies his or her own cultural affiliate, different interpretation would be given to the situation by the radiographer who tends to side with his own cultural or ethnic kind. The findings of the current study were inconsistent with (Tinberg, Bredlöv & Ygge 2008) who found that nurses' who had experience with encountering child abuse and their parents, abhorred the culprit who abused the child without any cultural considerations.

3) Similarly when seeking information from the victim or the parents became difficult due to language barrier the radiographer was bound to perform only the imaging role.

4) The study identified that culture was more important than the law to the radiographer in Ghana. As a result child discipline was seen as a family matter which did not warrant any action even when injury occurred during child correction.

279

5) The primacy of these beliefs in the context of their work and behaviour is something that needs to be addressed if policy makers want to make inroads in their attempt at reducing child abuse in the country. This is the case as their behaviour run counter to good health policy and their scientific training.

6) The cultural origin of the parties involved in child abuse conflict was checked before deciding to pursue a case due to the aggressiveness of some indigenous communities. The study has established that the Ghanaian radiographers' attitude supported the theory that individual behavioural beliefs and presuppositions concerning a situation are guided by the individual's judgement that certain actions could lead to unknown consequences (Natan et al. 2012).

7) The absence of a framework to guide child protection activities (such as policies, protocols and procedures including guidelines were among other barriers that led most radiographers to adopt the bystander attitude towards suspected child physical abuse cases they handled. The absence of these structures meant that support was not forth coming to help the radiographers in their work. These social force fields in turn made the radiographer felt isolated and a lone ranger in their willingness to pursuit justice for the child.

8) Moreover, professional commitment by the radiographer was hugely influenced by their own attitudes and perceptions about other professionals such as the doctors, nurses and the SWs.

9) The absence of training and knowledge gap created fear among the radiographers because not having competencies or knowledge about how abuse could be identified and pursued, created the perception that one could get problems on the way when the case was pursued.

10) The radiographers in the current study appear to have lost their professional commitment and patient advocacy as part of their professional responsibility when parents showed no interest in their child's case. As a result, some radiographers did not see the need to help the child.

11) The study established misunderstanding of the role of the SW which might have been taken for granted. This was partly due to lack of proper coordination within the health

care intuitions about the management of child abuse in general. The most important aspect in this situation was weakened awareness of child protection matters consequential of insufficient training (Bannon & Carter 2003). The radiographers were either ignorant about the role of the SW or held a negative perception of them restricting the radiographer from soliciting the intervention of the SW. The SWs were sometimes found to be of no help (according to a few respondents)

12) The study confirmed that case overloads the SWs and resource constrains to handle child abuse cases resulted in uncomplimentary responses from the SWs when approached by a few knowledgeable radiographers. In such circumstances, the radiographers refrained from approaching the SWs when similar cases confronted them.

13) The current study can argue that time factor plays a key role in radiographers attempt to protect children. Radiographers preferred to perform what the imaging referral request indicated rather than worry about the subsequent outcome for the child. This was as a result of time needed to follow up cases of suspected child physical abuse. Time factor reduced the radiographers' motivation to act because they felt the radiographer in question would have to leave work and respond to the legal issues which potentially could take long time to be completed.

If child protection is to be effective healthcare professionals who experience a child in need of protection must act on time and make suitable commendations to statutory agencies (Bannon & Carter 2003). However when asked about their reporting preferences when abuse was identified, they gave varied opinions with regard to whom they would prefer to report. Despite clashes with doctors, the majority of the radiographers interviewed preferred to report to the doctor because they were seen to be in charge of the case. The crux of the matter is that reporting abuse cases was seen as discretional as a result of a lack of clear reporting structure. The professionals were partly to be blamed for their ignorance of the Children's Act 1993 of Ghana.

9.3 Policy Implications and Recommendations.

The findings of this study raise several policy and training issues with respect to how child physical abuse cases are managed in Ghana. The main focus of the dissertation was to examine- how radiographers in Ghana handled child physical abuse cases, and whether their actions and behaviours were influenced by their cultural beliefs, experiences and upbringing. This was based on the expectation that the social environment in which people are raised or socialised invariably can affect their behaviour in child abuse cases. For example, if they believe that children should be punished for their wrong doings (as this study found), then perhaps how they treat child physical abuse cases may be different from those who frown on such behaviour. Though culture may have something to do with how Ghanaian radiographers handle child abuse cases, no study to date had inquired about the link between the two processes.

There are good reasons to suggest that the findings reported here have policy implications for our understanding of children, child wellbeing and protection in Ghana. Among the policy issues this study brings to fore are the following; first, it has profound implications for general issues dealing with child wellbeing and child protection in Ghana. As the stories and information provided by the radiographers have shown many radiographers perceived the child protection process in the country particularly in the hospitals to be in need of serious attention. Policies and legislation currently in place both nationally and at the institutional levels are lacking in direction affecting their practice and willingness to help the child who is either in need of protection or is at risk. Policy and practice structures currently in place seem to have no impact on the professional handling of child physical abuse cases. Arguably there is the need for urgent policy and practice framework overhauling which would appropriately direct professionals who handle child cases in healthcare to operate efficiently to the benefit of the child and the society.

Second, while the existing laws about child protection are noteworthy and some child advocates may be knowledgeable about these laws; this was not the case with respect to the radiographers surveyed. Indeed, none of the radiographers interviewed were fully aware of the content of the child protection legislation of the country and how it bound on them in their practice. They additionally, not cognisant of the country's health policies guiding violence against children and how health professionals should respond to the situation. It is

imperative for the tertiary institution involved in training radiographers and other allied health professionals who have a role to play in the adjudication of child abuse cases to offer courses on child protection laws, and also ethics in the country.

The Ghanaian legislation does not specifically mandate health professionals including radiographers in any way to report what they observed and the current situation where there are no laid down protocols or structures in place to check how abuse cases are handled has some critical policy considerations and concerns.

Participants' reports suggest training deficits with regard to identifying and reporting physical abuse cases. However, the child health policy of Ghana (MoH 2007) recommends inclusion in the curriculum of healthcare training institutions, aspects that deals with child abuse and protection issues. The situation indicates lack of monitoring of training programmes to evaluate whether the training is in conformity with the health training policies of the country. As a result there have been discretional approaches to managing cases of abuse not limited to physical child abuse alone. Many of the radiographers were aware of or could identify physical abuse cases when they arose, however, where to go and report was a challenge. Most felt the doctor was in charge and that they should report to them about their suspicion. However, some failed to do that due to demeaning responses they received from some of the referring doctors. It was clear that several cultural influences were at play behind whether the radiographers decided to act on cases of suspected physical abuse. This was strengthened by superstitious beliefs of unknown forces which they believed would attack them should they report cases of abuse. The worrying situation is that one may not know how many children who are in dire need of protection are left to go back to their dangerous environment to suffer.

Third, attitudinal issues were among the factors cited by the respondents' for impeding their work on child protection. While some radiographers attended to victims of suspected abuse with urgency, others treated abuse cases as any normal case that to them did not warrant any quick attention. The reason(s) given for such behaviours, stemmed from the nature of the referral history indicated on the imaging request form and the radiographer's lack of knowledge in identifying physical abuse. Despite many references in the literature about the advantages of multidisciplinary approach to child protection, teamwork was lacking in many Ghanaian hospitals. It should be noted that the teamwork should be differentiated

283

from division of labour where each professional performs their core duties as part of their multidisciplinary care process. It is necessary for managers of the various health facilities to imbibe in their workers the need for such collaboration to advance healthcare delivery as a whole in the country, and in particular cases involving child abuse.

Fourth, child protection requires regular follow-ups in most cases and collaboration among the team members handling such cases. In contrast the comments made by the participants from their lived experiences showed that this had not been the case in the imaging departments and hospitals where they work. This was attributed to the absence of structures in place of (i.e. policies, guidelines/protocols and an instituted legal unit to report abuse) for proper management of issues pertaining to suspected child physical abuse.

Multidisciplinary training which would educate professionals of the specific roles of each profession in managing child physical abuse appears to be lacking in the Ghanaian context. Therefore some clinicians felt it was not in their domain to pursue such cases. Some radiographers appeared to feel they knew better and would not accept any other opinion from other professionals dealing with child enforcement and protection. Finally, the lack of serious educational campaign at the organisational level on the issue of child protection seems to have some implications for child abuse and prevention in the country. Another factor noted in this study which seemed to discourage radiographers was about the reporting to the police. They had the perception that the police would frustrate them when they report to them. Some felt that apart from the time wasted in getting a report from the police and the medical doctors, they actually feared being treated by the police as the culprit. The fact that the victim of abuse (most of whom are from poor background) has to pay for all the medical expenses including the medical report needed by the investigators or the court, also discouraged a few of the participants to intervene even though it was not their responsibility to bear the cost they feared they might end up paying for the victim.

Clearly the findings from the study suggest the need for strong policy guidelines that health professionals should be required to follow to guide them in dealing with child protection matters. Arguably, there exist some sense of cooperation among the various stakeholders in charge of child protection in Ghana but the reality of the situation is that the collaboration between these groups have not always been cordial and possible—for a variety of reasons (some bureaucratic or administrative in nature others attitudinal and cultural). This calls for

a comprehensive framework that will involve all stakeholders interested in child protection and the welfare of the child and family.

1. Equally important, there is the urgent need to train radiographers in Ghana, in the management of child physical abuse cases and the other forms of abuse individually as a profession and also collectively to enhance multidisciplinary approaches in the child protection efforts using all available teaching methods.

2. The Social Welfare agencies should also be resourced and trained in a way that they would support the role of radiographers in child physical abuse cases rather than their normal attention to patients having difficulty paying their hospital bills.

3. It is expected also that radiographers' fear of spiritual attacks will be tackled as a matter of urgency through education and counselling. Moreover a bystander legislation which would indicate mandatory reporting would in part solve the bystander attitude of radiographers to advance child protection.

4. Radiographers should take the responsibility through their continuous professional development to approach their duty in a professional manner devoid of cultural, tribal or ethnic sentiments and take pride in their profession by demonstrating their role in child protection.

5. This implies that curriculum of radiographers' training should include cultural and linguistic competencies which were found to have a profound influence in their handling of child physical abuse cases.

6. Disconnected relationship was a reality in this study where radiographers experienced alienation by doctors. There is the urgent need for multidisciplinary training and education programmes for health care professionals to enable them to understand each other's role in managing children suspected or identified to be abused. Such a combined training will lead to connected relationship among the health care professionals which will encourage free flow of information and no one would feel the need to hold back vital information.

7. The establishment of appropriate communication channels and systems within the hospitals to deal with issues of child abuse within the hospitals could enhance child protection activities.

8. Finally, perhaps the time has come for child protection units to be established in all the hospitals. If possible, hospitals should create their own child protection committees or units where radiographers can report and seek advice on issues of child abuse they encounter in their practice without fear of retribution. This could also alleviate any fear of probable attacks when they report any cases of abuse.

9. The government should include in the new Child and Family Welfare Policy (CFWP) aspects that provide protocols and guidelines for healthcare professionals to ensure the welfare and protection of children who seek their services; the type of the training that they should have in the areas of child abuse and child protection and how reporting of cases should be done.

9.4 Limitations of the Study

In the absence of any existing study that deals with radiographers and their handling of child abuse cases, this study used data on radiographers to offer some insights about the management of child abuse cases in Ghana. Though the study provides some useful insights and advances our knowledge about how radiographers manage child physical abuse cases in the health care system in Ghana, there are several limitations with the study that needs to be pointed out. First, this study cannot overclaim the results to encompass how other professionals handle child physical abuse cases in Ghana specifically because only radiographers were studied.

Second, the sample chosen in Phase 1 was large which made the analysis fairly cumbersome for the reason that most of the responses were very similar or the just the repetition of the various forms of child abuse identified in literature. However it also provided the opportunity to get a wider view of participants understanding of the concepts investigated. Moreover, because interviews were not conducted, the study could not probe the radiographers further for clarification of their understanding of these concepts. Such a step could have revealed how the meanings they assigned to these concepts could shape child protection. However, the large sample helped to gain a level of consensus of the

understanding of the concepts. Further studies may consider using interviews to allow for more detailed findings to enrich literature on the subject.

In the course of the study (Phase 2), it was identified that one teaching hospital had a child protection unit where cases of abuse could be reported however participants interviewed in this study reported they were not aware of any such unit in the hospital. The study also failed to associate participants reports with their gender to gain insight into whether males had different perceptions and behaviour from their female counterparts. However because this was the first study of its kind the researcher was of the view that gaining initial insight into the situation was more paramount in order to establish base line information for future research which would cover other areas which would add to the existing knowledge.

Though the study targeted radiographers, their relational challenges should have prompted further interaction with the necessary stakeholders to understand their situation and how it corroborated with radiographers' reports. However the findings of this study would be disseminated to the Ghanaian community in scientific conferences that suits the study and more widely to the outside world through publications.

Despite this limitation the study has brought out more issues that require further research and directional change policy and professional practice.

9.5 Further Research

Though child maltreatment cases frequently appear in the mass media and the limited data that exist suggest that child abuse cases may be common in Ghana, as the case is in other African countries. Yet, there have been no studies that have been conducted in Ghana that deal with radiographers and their actions and inactions when it comes to child maltreatment cases. Probably this is also the case with other African countries as well. This makes the current study unique and timely. Besides, and based on the findings, the current study raised several issues that have policy implications when it comes to the adjudication of child abuse cases. These range from culture, superstition, isolation, to training and professional commitment.

➤ Based on the prominence that the radiographers studied have or expressed about the fear of the unknown (such as dread of supernatural powers) when they act on child

physical abuse, future research should examine the implications of such fears on the work of radiographers. The question is how wide spread is this fear of illogical forces among other health professionals to holistically address the situation. This is important because, 'individual beliefs and attitudes towards abuse do not exist in isolation, but are a part of a shared system of beliefs' (Bell 2011, p 103).

➤ Second, the radiographers in the study demonstrated non adherence to ethics principles of their professional practice in their encounter with cases of child physical abuse. Arguably, and in the contest of health care practice, such a behaviour is inconsistent with professional standards of care delivery. There is the need for further studies on professionalism directed at radiographers to gain knowledge and address any shortfalls in their understanding of what constitutes professionalism (using existing assessment tools).

➤ In the context of Ghana (and perhaps other African countries), the ethnic dimension of people's behaviours cannot be ignored completely as this study and several others dealing with ethnicity and social processes have observed (Mann & Takyi 2009; Takyi & Gyimah 2007; Takyi & Dodoo 2005; Nugent 2001a, 2001b). Others have alluded to the growing influence of ethnicity in the voting patterns in Ghana (Addai 2000), and in marital stability (Takyi 2007). It appears that in the context of child abuse cases, the ethnic influence is also evident. Ethnic and cultural solidarity among radiographers were seen to influence their approach to child protection. Whether the situation is prevalent among healthcare professionals in the country requires further studies. In the face of extensive literature about how ethnicity influences a host of social processes and behaviour in Ghana, it is imperative that a concerted effort is made to either eliminate or reduce such biases in the work of radiographers.

➤ The study identified a gap in professional commitment to child physical abuse by radiographers. This appeared to be affected by several factors (relationship, training, reporting procedures and culture). Whether the situation as reported by the radiographers is the same with other health care professionals, who work with children, requires further studies.

> Whether bystander attitude is a prevailing situation among other stakeholders in healthcare delivery is an issue that would need research attention.

9.6 Contributions of the Study

This study has raised many more issues than it initially anticipated. The researcher was of an initial view that it would be able to discover a definition of child abuse and child protection from the Ghanaian perspective that would be unique in culture to serve all purposes. The study has, made a unique contribution to phenomenological studies as it combined two philosophical approaches to phenomenology in studying Ghanaian radiographers' experiences and approach to child protection. Moreover, its uniqueness also lies in the fact that it has contributed to the greater understanding of child physical abuse and child protection and how they are managed in health care in Ghana by diagnostic radiographers. The study established what others have initially found (such as the need for training, and factors leading to bystander attitude) in child protection. It also adds to knowledge on which person radiographers would prefer to report their suspicion of physical abuse. The study also supported the knowledge that disconnected relationships among health care professionals if allowed to prevail would have negative impact on the optimum care of the patient.

While tactical interprofessional cooperation are becoming increasingly imperative to protect children (Horwath & Morrison 2011), this study established poor interprofessional relationship among the radiographers and other clinicians which adversely affected any attempt to intervene and safeguard children. The relational problems were shown to be not only between the radiographer and the doctors but also with the nurses and SWs. One important finding was that, where mutual discussion of clinical issues was encouraged in organised meetings, there was no acrimony among the health professionals in their delivery of care. This was particularly important where child protection required a multidisciplinary approach and information sharing. Role ignorance among the radiographers about the significant contribution of the SW in child physical abuse was established. This has a critical practice implication.

Cultural solidarity and supernatural beliefs contributed to bystander attitude adopted by radiographers towards children in need of protection. Radiographers' commitment to child

289

protection was in part affected by their own professional attitude of putting their cultural values first before their adherence to the ethical values of the practice to protect all manner of patients under their care. In summing up,

❖ This study has added to the body of knowledge in child physical abuse and child protection. Radiographers reporting attitudes towards physical abuse in Ghana were influenced by contextual factors such as behavioural beliefs about culture and superstition and the perceived threat of physical aggression. The Social Exchange Theory (SET) explains that behaviour depends on relative costs and benefits of that behaviour (Shahsavarani 2016) such as radiographers assisting in child protection.

❖ Tribal affiliation and language of the family or culprit of abuse influenced action taken by the radiographers when physical abuse was suspected.

❖ Perceived personal costs of intervening on behalf of the child created a bystander attitude among the radiographers as they did not see any direct benefit in pursuing cases of physical abuse.

❖ Lack of awareness and understanding of the laws, regulations and procedures to follow were among factors preventing the radiographer from reporting.

❖ Prevailing professional relationship with other clinicians determined the extent to which a radiographer was willing to pursue child protection cases aside of their core professional responsibilities.

❖ Indifference within the organisation about child abuse was a key determinant for Ghanaian radiographers' refusal to proceed on any abuse identified or suspected.

❖ While radiographers had appreciated that child protection was about proper care (Phase 1), they in most part failed in their professional obligation to provide such care to these at risk children when they were in need of help.

❖ The attitude of radiographers and perception about the SW added to existing knowledge that clinicians sometimes are either ignorant or have wrong perception about the SW and their roles in child protection.

290

This study has also revealed areas of practice that affected proper care of victims of child physical abuse which hitherto were not identified or were taken for granted in previous studies. This study is distinctive in the sense that it provides a snapshot of the radiography profession in Ghana and how they approach critical care situations such as in child physical abuse. The knowledge gained in this study adds to the existing body of literature regarding the management of child physical abuse in the area of radiographic practice. This research suggests that for improvement in child protection in Ghana to take place, it should be characterised by, effective teamwork, communication and harmonisation among all professions and agencies and individuals who handle children. Ghanaian radiographers need to tailor their practice towards patient centred care rather than projecting their cultural values and fear of unknown forces. Moreover, the Ghana Society of Radiographers should shape their future deliberations on paediatric imaging to embrace child at risk of abuse and how the profession should help these children.

CHAPTER 10

REFLEXIVITY

10.0 Introduction

Growing concern has been raised by many child advocates and policy makers about the child abuse in many African countries including Ghana. In response to these concerns, and also develop a broad understanding of the role of radiographers in reaction to the phenomenon, this study examined the experiences of radiographers, one of the health professionals involved in helping adjudicate child abuse cases. Because the study used qualitative methods in understanding the experiences of these radiographers, this chapter reflects on the study.

Overall, reflexivity is an essential aspect of qualitative inquiry as many scholars (Holloway & Biley 2011; Bryman 2008) have pointed out. Reflexivity provides an opportunity for the researcher using qualitative approaches to examine self and reflects on any thoughts back to the self (Woolgar 1988). Langdridge (2007, p.58-59), sums up the whole process as one through which researchers are conscious of, and reflective about, the ways in which their questions, methods and very own subject position might impact on the psychological knowledge produced in their study. Langdridge (2007) suggested that these considerations are important before, during and after the investigation which apart from proving reflexive activity, also allows for changes to be made.

Following Woolgar's (1988) approach, the chapter narrates the reflexive considerations and decisions made before the study. Such reflections include, for example, issues dealing with myself and childhood experiences, as well as those which examine the researcher as a professional radiographer and academic. It then examines the reflexive approach during and after the study. Woolgar (1988) separated reflexivity from reflection, by suggesting that reflection is a more general set of thoughts concerned largely with procedure and authentication, ensuring that actions are taken to represent participants in their true light. During reflectivity, the researcher maintains a strong posture to the study done while in reflexivity the researcher's personal reactions to the study are suggested (Holloway & Biley 2011).

10.1 Reflexive Considerations before My Study

Although there is no single approved method of reflexivity used by phenomenological scholars, Mauthner & Doucet (2003) have argued that if researchers are encouraged to be reflexive about the manner in which they analysed other people's accounts of their lives, it is equally relevant for researchers to reflect on their personal interpretations about social reality. Such an expectation is particularly relevant in the context of qualitative data analysis whereby the researcher's social identity and background that could influence the study's process are distinguished (Lathlean 2010).

As a radiographer, and a member of the same professional group as the study participants, I was conscious about how this position might impact all aspects of the research process, especially the interpretation of the research findings. Consequently it was essential that I disclosed and identified any biases I may have brought into the study. This would in turn allow the analysis to be viewed in the right perspective by outsiders (Lathlean 2010). Being human as my study participants, and also having life and social experiences, it was imperative that I reflected and brought to the fore, my human self and presence and how it affected the data generation and analysis as (Shaw 2010) has pointed out.

I chose an approach in my study that enabled me to acquire knowledge regarding how radiographers have acted, interacted and been perceived in child protection activities in the health care delivery in Ghana. Not only that, such an approach also enabled me to gain insight into how radiographers in this study ascribed meaning to these experiences. Coming from the interpretative school of thought, the objective reality (quantitative) was thus rejected because it separates the researcher from the researched and does not take into consideration the everyday taken for granted occurrences. A qualitative paradigm informed my understanding of the world and how it is lived. This is because it does not incline to the objective world separated from its inhabitants, but rather has its main attention on inter-subjectivity. As Woolgar (1988, 20) stated, "representation and object are not distinct, they are intimately interconnected". I am not a pragmatist and I do not submit to an objective world which is fixed, out there to be realised and also isolated from those who occupy it.

To appreciate the Ghanaian radiographers' shared commitment and participation between the self-governing individuals, which unswervingly shape their respective experiences of

the world their relationship and beliefs, and how my exemplifications were affected by time and place, the phenomenological methodology was selected.

10.2 Who Am I?

I am a married man with children who are very young. Having gone through childhood, I experienced a parental upbringing where discipline was the norm in the house. I was nurtured by my biological parents who were from the Presbyterian religious background with strong convictions regarding the biblical idiom *spare the rod and spoil the child* (Proverbs 13:24). As a result, the discipline in the house was the tough colonial Presbyterian style where the cane was never dropped with the slightest deviation from the acceptable norm: both in the house and in the school. For example, as a child, swimming in a river, refusing to go to the farm or to do school assignments were all punishable offences.

In the Western European culture, children are encouraged to know how to swim but my context was different. This was a time when even if you were not beaten in the house you could be sent to your school for your teachers to punish or humiliate you in the presence of your classmates. Where was the protection then? I did not know and neither did I ever think these punishable acts were abusive. Culturally as a child we were not brought up to report our parents no matter the pain and the psychological trauma one went through. Ghana was the first country to sign the UNCRC in 1998. Even though the UNCRC was signed when I had long completed the mainstream education to the tertiary level, Ghana is yet to ban completely corporal punishment as was explained in Chapter 1 of this study. During my childhood, no matter how severe the beatings or punishment were, I could not differentiate between punishment and abuse and took the experiences as normal. It was a period where non biological parents could also discipline any child for wrong doing in the absence of one's parents without problems. This was so because child upbringing was seen as the responsibility of the whole community and as such, a child could be punished by any senior citizen of the community.

The idea of abuse was not preached neither was there any education about child discipline and what constituted physical abuse. When I grew up learning and listening to international issues about children I came to have a different view point about child discipline. Although I went through all these as a child, I found it difficult to take my children through the same

294

'strict discipline' as I experienced in my childhood; or permit anyone to physically discipline my children. I do also appreciate that these experiences have shaped my life and made me resilient. However when I look back (and also look at my children now) I realise there are other positive parental measures that could be used to correct a child. I therefore abhor the use of physical punishment on children as a whole. This backdrop situates my study and position about child physical abuse. I also came to realise that, child protection instead of child discipline, rather, was everyone's responsibility. This influenced my choice of the topic, to ascertain how my colleague radiographers appreciated child abuse and child protection from their cultural and professional perspective.

10.2.1 My Professional Self

I qualified originally as a diagnostic radiographer with a diploma and later gained a bachelor's degree in the discipline. I was also fortunate to later complete my Master's degree in radiography and move from there into a doctoral programme at my current university. With my professional background in radiography, my experience in handling children suspected to have been physically abused had to be brought on board in this study. Though no longer in the clinical area for the past 14 years, having joined academia, I still remember what I experienced as a clinical radiographer during my pre academia period. For example, during my practice days, I encountered a number of cases of abuse. However I did not report the cases or assist the child in any way because I felt my duty was to perform the imaging role by carrying out the X-ray examination.

I never had any formal training at either the diploma or degree level on how child physical abuse cases should be handled beyond performing a skeletal survey when physical abuse was suspected. In most of the hospitals I worked (until coming to the largest teaching hospital) I was working alone in a department. There were no discussions between the radiographers and the referring clinicians and neither were there any clinical meetings held to address broader issues of concern including child abuse. The situation was no different in the teaching hospital where radiography staff numbered over 20 but with only 2 radiologists. The curriculum for the training of radiographers in Ghana though has seen changes to include current advances in imaging, however, there is no content in the area of child physical abuse and non-accidental injury which made this study timely and important to effect some changes in the training of radiographers.

10.2.3 My Motivations in Conducting This Study

Before commencing the research, as a lecturer in the Department of Radiography, University of Ghana, it was expected that each faculty should conduct an interfaculty lecture. The topic that was selected was the role of radiography in the investigation of non-accidental injury (Antwi 2011). One surprising incident that happened was that during question time, it came to light that most health professionals in academia and clinical practice did not know much about radiography and how we were involved in child protection. A second incident happened during a doctoral training programme in the University which was organized in collaboration with Copenhagen University, Denmark where the facilitator asked each delegate to present their research topic and questions. During my turn I stated my topic and research questions which were driven by my experience during the inter-faculty lecture. There too, it was evident that the facilitators and participants did not know much about the role of the radiographer in child protection. Fortunately I gave a strong defence backed by literature (Davis & Reeves 2009; 2006; 2004) about radiographers and child protection. This enlightened all of them and ironically after the day's proceedings both the SWs and the medical personnel who were co-participants invited me to speak in one of their conferences or workshops to educate them. This fortified my conviction that I have chosen the right topic for my PhD.

The researcher's (my) concern was the fact that child abuse is a major problem in the Ghanaian society yet, because it involves children, who are vulnerable and the culture of the people, not much is known about their predicaments. As a result of the importance of UNICEF (2010) system's approach to child protection, there was the need to examine the Ghanaian situation in the hospitals. Following from this and the general phrase that charity begins at home, I decided on a research topic in my professional area of radiography and child protection resulting from child physical abuse.

10.3 Radiographer-Researcher Role in the Study

My role in the current study is/was a researcher looking for information from peers who were also radiographers. This seemed to be a concern as I thought there would be a situation where participants might say things which they thought I would want to hear because I was a radiographer. I contemplated this issue at the beginning of the study because I felt that participants might provide responses that would satisfy me but were not

reflective of their truth. Britten (1999) observed the importance of giving thought to what could happen in interviewing peers or analogous professionals. Britten argued that participants could feel obligated to provide answers which fall within the 'social desirability' context (thus they may provide information they consider appropriate for the researcher).

My other related difficulty was whether my peers (by virtue of my position as an academic) might create a power distance which could curtail vital information from them. My contemplation was whether the study would bring out some weakness regarding their professional ethics and principles in the management of child abuse. The question I kept asking myself was whether they would be able to provide an accurate account of their lived experiences to me as a researcher but not as a radiographer. As part of reflexive debate, consideration is frequently given to the significance of identifying the social position of the investigator including the manner by which the investigators' emotional reactions to participants can shape our interpretations of participants' analyses (Mauthner & Doucet 2003). They however argued that few approaches deal with the tangible ways of undertaking this. Moreover, Mauthner & Doucet posited that positioning the self socially and emotionally with regards to the participants is an essential component of reflexivity.

The participant information sheet which was provided to them indicated that I was a research student of Sheffield Hallam University without identifying myself as a Ghanaian radiographer or academic. However I did not fail to explain to them my interest in the study which some researchers might not do for fear of introducing bias. It has been established that researchers are more interested in and stimulated by the phenomenon they are researching rather than only the theoretical significance and originality of the study to the profession (Lowes & Prose 2001). Despite this stance, I worked towards avoiding any leading questions to satisfy my research aims and objectives. Kvale (1996) contended that it is imperative for the researcher not to use 'leading and loaded' questions as this would inhibit insight into the true experiences of the interviewees. Though a novice in the qualitative paradigm, I made sure (as stated elsewhere in this chapter) I practiced interview skills to enable me undertake rigorous interviews.

10.4 Reflexive Considerations during My Study

According to Reed (1995), a challenge usually faced by researchers is the way in which their knowledge and personality influences their data collection; particularly when the researcher was also an expert. One realistic way of solving this problem is by applying a reflexive process (Lambert, Jomeen & McSherry 2010). One important step which I undertook was to indicate my professional status and my current identity to the interviewees (previously as a radiographer and now as academic seeking information) which was specified in Chapter 5 of this study in line with suggestions by Reed (1995).

In my research diary, I outlined my background which I have reported in the section titled 'Who am I' of this Chapter and how I had experienced the phenomenon I was studying. I also indicated how I understood child discipline and child abuse. In Chapter 2, I explained the cultural setting of Ghana within which I was born and how I had come to accept some social norms and beliefs. Chapter 4, discussed the rationale of the methodology adopted for the thesis. Taking the concepts of child abuse and child protection, I was convinced that radiographers (as participants in this study and from diverse cultural backgrounds) would have different understanding of these concepts. I valued that bracketing my own presuppositions and ideas about these concepts allowed me to achieve a rich and pure understanding of the others due to our different cultural backgrounds and experiences. My cultural background and experiences during my clinical practice were not brought to the fore to cloud the interviewees own experiences which enabled me to collect unbiased data from participants. This was achieved by making sure I did not infuse my thoughts into theirs although my professional experiences helped me to ask appropriate questions that fitted the study's aims and objectives. Being a novice in qualitative enquiry I decided to test my interview skills. This was done before my local supervisors who noted my limitations for corrections.

One important aspect of consideration was whether to apply member checking after the interviews. A lot of arguments have been raised about its usefulness in qualitative research and in phenomenology in particular. To some contributors, member-checking does not demonstrate rigour (McConnell-Henry et al. 2011; King & Horrocks 2010; Barbour 2001). Barbour argued that it serves as a checklist to the researcher rather than proving rigour in the study. Similarly, McConnell-Henry, Chapman & Francis (2011) indicated that member

checking does not prove rigour in Heidegger's phenomenology despite its high status in qualitative studies. They have argued that it possesses several challenges one of which (from Barbour's perspective) puts pressure on the participant's time in reading the manuscript. Member checking challenges many of the underpinning philosophies and also engaging 'authorities' to approve of the findings clashes with the principles of interpretivism.

Indeed, while 'hermeneutics draw attention to the interpretive character of understanding' (Walsh 2003 p.53), Lincoln and Guba (1985) stimulated member checking which they considered to establish the trustworthiness of the investigation. However, Bradbury-Jones et al (2010) argued that member checking supported the hermeneutic cycle. These arguments were considered and member checking was chosen by presenting the results in a poster form to those who provided the information in a national scientific workshop organised for radiographers in Ghana in April 2015 (Antwi 2015). The decision was taken because during the workshop presentation, the researcher was of the view that participants would have the opportunity to ask questions and challenge the findings without going through the process of reading the entire manuscript. However, the manuscripts were kept because the majority of the participants had taken part in the study could not be represented with all their responses in the poster presentation. If all present had requested their responses to the questionnaire and the interview transcripts, it could have been difficult trying to respond to each of them at that limited conference time. Moreover the participants were anonymised on the transcripts. However participants were satisfied with the depth of answers given to their questions during and after the two poster presentations.

10.5 My Concerns and the Participants' Interest
Serious thought was given to the wellbeing of participants in this study. According to Caroline (2009), the awareness of researcher liability for the "protection" of participants has been a strong issue in hypothetical debates about qualitative interviewing. In view of this there was the need for me to ensure that I provided an environment where participants' safety was assured. To that end, all the participants were given a briefing about the study and were assured that any information they provided would not be tagged to their names, but rather they would be given identity codes to protect them from harm and also ensure their anonymity and confidentiality.

None of the study participants were coerced to participate in the study and all were given informed consent forms to complete. Participant information sheet were also given to them explaining decisions they could take in before, during and after the study. Due to the sensitivity of my study, I kept asking participants in the course of the interview during Phase 2 whether they were ready to continue with the interaction. Taking cue from Caroline (2009), in my attempt to protect participants, I declined to use a longitudinal approach by going back to re-interview the participants within my research design, although it could have ensured credibility and augmented the study (Caroline 2009). Thus, rather than doing follow up interviews on each participant in Phase 2, was interviewed once. More data could have been gathered to either strengthen or contradict their earlier submissions if a second interview had been conducted. However I was convinced that much data was not lost and subsequent studies could cater for any gap that longitudinal studies could have uncovered.

10.6 Considerations in Using Husserl's Phenomenology in Phase 1.

Husserl (1962) talked about 'constitution' as being what makes up words and how it is used to describe a phenomenon. I had the interest to seek from participants in this study what to them constituted child abuse and child protection and accordingly chose Husserl's phenomenology for Phase 1. Husserl was emphatic about bracketing in phenomenology; a stance that has generated a lot of debate about its practicability. I do acknowledge this challenge, however by studying and reading about this aspect of phenomenology I started the journey of bracketing. By aligning myself to Walsh (2003) who argued that when a study is situated on experiential accounts and methodological principles of bracketing, it is inevitably a reflexive research approach.

The development of the study from Husserl in Phase 1 to Heidegger in Phase 2 was given deep thought because of the dichotomy that existed in their respective philosophical stance. The former for instance advocate for bracketing while the later abhor the use of bracketing in phenomenology. I was in support of the school of thought which advocated for the consideration of various philosophical thoughts in phenomenology research (van Manen 1962). Moreover, my stance was also influenced by what I wanted to know from the perspective of the research aims and how this could be known and why.

10.6.1. How I Achieved Bracketing

As with mathematics, brackets are used to separate one part of an equation from another, allowing one to focus on that part in isolation from the others (Hamill & Sinclair 2010). In phenomenological ideology as well, it has been suggested that illusory brackets can be used to highlight and put on hold our everyday understandings (Wall et al. 2004). The researcher (myself) recognised that, in exploring the cultural understanding of radiographers of the concepts of child abuse and child protection, a descriptive phenomenological approach was appropriate. This also implied staying in abeyance of every preconceived ideas, knowledge and bias about the topic area before, during and after the study to inspire a pure description of radiographers' understanding of these concepts. The initial step was to keep a reflexive diary throughout the study from its conceptions to data gathering and analysis. It also helped me to remain immersed in the data generated rather than having thoughts about what was to be expected. I kept my reflective diary active which is required to acknowledge and set aside biases (Wall et al. 2004). The steps taken by Wall et al was adopted to ensure good bracketing. By being reflexive and use of bracketing, rigor and trustworthiness was assured.

A semi-structured questionnaire was administered to participants for them to respond in their own words without the researcher's interference which could happen in interviews and probably force participants' response towards what was initially presumed by the researcher (me). I maintained an open mind about what participants might write. I became quiet after sharing the questionnaire to them, giving them time to provide what they understood about the concepts. My mind was prepared to accept without prejudice any information that would be provided. Since I did not conduct interviews, it enabled me to remain in a reflective mood while waiting for the participants to complete their questionnaire. However, before the study began, I practiced neutral nonverbal behaviour, and perfected active listening skills to facilitate bracketing in preparation for the research. This was necessary during the familiarisation period with the text report given by participants. The text was seen as the participants talking to the researcher. I immersed deep into the participants' own descriptions, while remaining reflective rather than expecting anything that was in line with my own ideas about the concept of child abuse and child protection.

What made the bracketing difficult, vague and confusing was the fact that some writers suggested that in attempting bracketing literature review should be put aside until data was collected and analysed (Hamill & Sinclair 2010). This could not be possible in a study of this nature because in any academic research approval need to be sought from the appropriate Ethics approval Boards and Committees and to gain such approval requires submission of a proposal which normally have some elements of literature reviewed. However, the literature was also put aside until the completion of the analysis of Phase 1 data. My attention was focused on the meaning the participants ascribed to the two concepts (child abuse and child protection) rather than my own assumptions.

10.7 Considerations in using Heidegger's Phenomenology in Phase 2

I progressed to Phase 2 where I had a different thought. I am a radiographer by profession as described in section 11.1.2 (My professional self) and have gone through a series of experiences with imaging children some of whom had suffered physical abuse. My social world as a health care professional brought me in contact with the police in cases of defilement where age of the culprit or the victim was being contested in court. I felt that my experiences should provide valuable insight to my study by becoming a co-participant. As a co-participant I was able to interpret their lived experiences of child physical abuse and how they handled it.

10.8 Developments from the Study

The report writing itself coincided with the University's five year curriculum review of the undergraduate programme which was in progress. During the review, I made my contributions and provided some insights in the area of paediatric imaging. From the experience obtained from the analysis of accounts of radiographers interviewed in this study, I ensured the inclusion of principles of radiographers' handling of child physical abuse, and identification of NAI as aspects of paediatric imaging. I also recommended that the curriculum should include the radiographer, the child and the law which would allow radiographers to be acquainted with the laws of Ghana regarding handling of abused children. The legislative instrument (LI) guiding the radiographic practice in Ghana has been drafted for approval by Parliament Select Committee on Health. When I was asked to review LI, I made a recommendation that the radiographers' approach to child protection against all forms of child abuse particularly NAI should be included in the LI.

10.9 My Reflexive Thoughts after the study

After the study, I did contemplate how I could appropriately share the findings to indicate honesty and provide a vivid account of the research. My thoughts were also about how my study could impact on training of radiographers in the area of child protection. This is because I came to realise the gap in the curriculum for the training of radiographers in Ghana. Moreover, my thoughts were also about how I could use my study to improve child protection activities within the hospitals and the country generally. I felt I had read a lot about what constitutes child protection and have realised the inherent problems in the Ghanaian context particularly with health care management of child physical abuse.

10.9.1 Connected knowing

Connected knowing is defined as a change of knowledge and experience into understanding (Sigad et al. 2016). 'Connected knowing' in child abuse, according to Sigad et al. (2016, p483) suggests that "knowledge of child abuse transforms into understanding". In Phase 1 of this study, I sought to gain knowledge about the concept of child abuse from the 'natural attitude' of radiographers for which reason I had to put in abeyance my assumptions about the concepts (child abuse and child protection). I was optimistic that they were going to provide answers which were the accurate reflection of what they had experienced in their practice and cultural setting. Although I was previously part of the system, I needed to understand their experiences (natural attitude) without prejudice.

Citing Gilgun (2008), Sigad et al. (2016) indicated that Gilgun advanced the hypothetical debate of how familiarity with something becomes understanding by explicitly defining the lived experience of the change that enabled her to appreciate violence as a researcher of interpersonal violence (IPV). In juxtaposing Gilgun's experience with my own clinical experience as a radiographer who had worked with children suffering from physical abuse, I likewise, came to understand violence within my own self which is known as connected knowing (Gilgun 2008). My knowing came from my experience (connection) with imaging of children who were physically abused. Moreover, having practiced as a radiographer I felt that I would understand radiographers' situation better nevertheless, from their context (natural attitude) that which has been taken for granted.

By distancing the self from the information or data they provided I was able to gain or acquire fresh understanding of their world as against the everyday assumptions about what constituted child abuse and child protection in Phase 1. In relating to the radiographers through their shared experiences, my knowledge was going to be changed from what I already knew into new understanding (connected knowing) (Sigad et al. 2016).

In qualitative study investigators' intentions are to position themselves in the participant's world and to appreciate the subjective (personal) experiences of their research participants (Lambert, Jomeen and McSherry 2010). In doing so I was able to turn my personal experiences into representations that allowed interpretation and revealed insights that applied more generally beyond those individuals studied (Lambert, Jomeen & McSherry 2010).

To further my 'connected knowing', using Phase 2 of this study as an example, I had previously assumed in the beginning of the study that radiographers would exhibit professionalism in the handling of children physically abused. However, I came to realise during my interaction with the radiographers that the ethical principles of the practice came second to their personal belief systems and were not issues for consideration when faced with child victims of abuse.

Professional role models were lacking as I learnt that radiographers were not encouraged by their superiors to report incidents of suspected or identified cases of physical abuse. Moreover, I gained knowledge that radiographers were not guided by any known policies or guidelines or protocols in reporting child physical abuse cases that were identified or suspected in their departments. Neither did I ever think that belief in supernatural powers would be influencing the way child protection was handled. Further to this I gained the understanding and transformation of knowledge which was that radiographers in this study were held back by professional isolation among other contextual variables, from taking a centre stage in child protection. Thus I came to understand participants' *natural attitude* differed from my assumptions leading to a transformation of my knowledge. My familiarisation with them during the interviews, enabled me to acquire new knowledge that transformed my understanding as a researcher and a radiographer. Sigad et al. (2016) argued that reflexivity, is a constituent of connected knowing, and has the supposition that

investigators are part of the research as the participants, and reflexivity is one way by which this transformational process arises (Sigad et al. 2016).

Having stated previously in this Chapter that my religious upbringing was a Presbyterian background, and being part of the Ghanaian culture, I was made to belief from my cultural setting that there were supernatural forces (such as forces from river deities, juju and other gods) which when one is summoned to such fetishes, could influence one's life negatively. However, these powers have not been proven in court and had no scientific basis so I could not give credence to its influence on my life and so did not believe them. However, little did I anticipate that superstition characterised the practice of the Ghanaian radiographer in the discharge of their services to children suffering from physical abuse. There were stories of witches having been caught and disciplined by some of these gods for wrong doing (such as killing influential people in their family or being the cause of people's predicament. These same beliefs I felt radiographers interviewed held to dread these forces. The strength and forcefulness with which radiographers interviewed held and narrated their beliefs made me to realise that it would not be easy to change their mind set. My contemplation was about how as a professional member I could disabuse their minds from such beliefs when the opportunity arose.

10.10. Reflections on my Research Journey
Before coming to SHU I had presented a topic on NAI and the role of the radiographer in child protection at an inter-faculty lecture in my home university. This presentation however did not cover many things on child protection from the point of view of health care providers. There was the need however, to re-examine the area of child protection in Ghana and how radiographers were involved. That was how I started this journey into child protection and choosing phenomenology as the method to achieve my objectives. Throughout my research I had no experience of qualitative enquiry so the new topic informed this research design. Although it has been a difficult journey, I enjoyed what came up in the various phases. It was challenging defending my stance on why I adopted the two schools of thought in phenomenology which have separate approaches to it. Upon deep considerations, finally I got the clarity required to defend my choices. There were times I felt I could have used only one for the entire study however the focus of my study demanded otherwise. I had a lot of insight about phenomenology though in a hard way.

However although I realised that either of the philosophies could have been used for the entire study, the use of Husserl's in Phase 1 was more appropriate as the understanding of concepts of child abuse and child protection vary from a cultural viewpoint and I therefore had to put in abeyance my preconceptions of the these concepts through bracketing of what I previously understood about them.

Phase 2 (in which I adopted Heidegger's phenomenology) was to bring my experience in parallel with those of the interviewees. I did listen to them carefully without interfering apart from probing further to get better understanding of issues being discussed. If I were to repeat the study I would use Heidegger's. This is because bracketing was not easy and for the fact that there is no direct or acceptable method of bracketing (Wall et al. 2010) making it an ambiguous approach for the novice in phenomenology. Moreover, because in Phase 1 participants were asked to write what they understood by the concept of child abuse and child protection I could not probe further to gain more insight into why they provided those responses.

10.10.1 How I See Myself Now

After this journey, I have learned that determination and perseverance helps to achieve goals. I have learnt to become an independent researcher and thinker. I have also learnt how good it is to listen to advice from those who have crossed this hurdle before.
I see myself as a more diligent person than before and that if I want to achieve my goals I need to work on problems with perseverance. Diligence, determination and perseverance are what I have developed for myself in this journey.

10.11 Summary
In this Chapter I provided the reflexive path that I took in conducting the study, before during and after the study. I first drew attention to my childhood experiences and linked them to how I acknowledged child abuse and child protection which assisted me in bracketing in Phase 1, my preconceptions about these concepts. I also established in this Chapter, my position and how it impacted on the research. I took into consideration the fact that I was a radiographer studying peers but from a position of an academic/researcher looking for radiographers' lived experiences in relation to child abuse and child protection.

This was important to bring out any hidden bias that I might have inadvertently introduced in the study. I explained how bracketing was achieved in Phase 1 and the thoughtful consideration of the two major phenomenological philosophies of Husserl and Heidegger. My position in this study was clarified. I was of the view that in providing this account, the reader would also understand where I was coming from and why this study was preferred. My role in this study as a researcher and the self as a radiographer could both have introduced bias into the study during the collection and analysis of data (Lambert, Jomeen & McSherry 2010) for which reason this reflexive process was undertaken

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308

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310

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328

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APPENDICES

Appendix A: SHU Provisional Ethics Approval for Phase 1

Sheffield Hallam University | Centre for Health and Social Care Research

31.10.2012

William ANTWI
c/o
Pauline Reeves
Diagnostic Radiography and Research
SHU

Dear William ANTWI

This letter relates to your research proposal: Radiographers' Perceived Level of Participation in Child Protection in Ghana.

I understand that an opportunity has arisen to collect data for the project above which will eventually form part of your doctoral work. You are not yet in a position to submit the RF1 but you would like to collect data from the Annual Congress of Radiographers in Ghana 22-25 November. You have submitted a form for approval. I have reviewed this form and the letters of approval from Authorities in Ghana. I am happy to provide interim approval for this work so that you can get it done. You will then be in a position to use this data for your doctoral work once you have the RF1 approved. In the unlikely event that the RF1 is not approved you can still use the data collected; this letter will constitute proof of review and approval for that.

The documents we reviewed were:
- William Faculty Ethics stage 1 final SUBMISSIONFORM 2 (2)
- William ETHICS CLEARANCE- back
- Ghanaian Society

Good luck with your project

Peter Allmark
Chair Faculty Research Ethics Committee
Faculty of Health and Well-being
Sheffield Hallam University
32 Collegiate Crescent
S10 2BP

0114 225 5727
p.allmark@shu.ac.uk

Sheffield Hallam University

Sheffield Hallam University

Faculty of Health & Wellbeing

34 Collegiate Crescent

Sheffield

September 25, 2012

Dear GSR President,

I am a Ghanaian PhD student at Sheffield Hallam University in the UK. I am conducting a study on:

'*Child Protection in Ghana: Exploring the Perceptions and Behaviour of Radiographers*'.

I would be grateful to grant me permission to recruit Ghanaian radiographers for the study. The study is in two Phases and would like to take opportunity to conduct Phase 1 during the upcoming National Congress of GSR in November 2012. Phase 1 which I would like members to voluntarily participate seeks to explore their cultural understanding of the concepts of child abuse and child protection. Details of the study would be communicated to the participants upon my arrival at the Congress from the UK when granted the opportunity.

I very much appreciate your continue support and also do acknowledge your contribution to radiography and child protection to make this study successful.

Thank you
Yours sincerely

William K. Antwi
(PhD Student Sheffield Hallam University)
Email: b2026089@my.shu.ac.uk /
     wkantwi@chs.edu.gh /
     williamantwi@yahoo.com
Mobile #: 027 632 0092 or 020 480 3880

APPENDIX C: GSR Ethics Approval (Phase 1)

GHANA SOCEITY OF RADIOGRAPHERS (GSR)

Bankers: GCB, Korle Bu. Accra	National Secretariat
Tel:	P.O. Box KB 602
Website:	Korle Bu. Accra,
Email: gsradiographers@yahoo.com	Ghana

Our Ref No...GSR/EEC/V1/003   September 29, 2012
Your Ref No.....................................

MR. WILLIAM ANTWI
DOCTORAL RESEARCH STUDENT
SHEFFIELD HALLAM UNVERSITY
FACULTY OF HEALTH & WELLBEING
34 COLLEGIATE CRESCENT
SHEFFIELD

Dear Mr. Antwi,

PERMISSION TO USE RADIOGRAPHERS FOR RESEASRCH PROJECT

Your letter dated September 25, 2012 on the above subject refers.

I am pleased to inform you that the Ethical and Education Committee of the Ghana Society of Radiographers at its Meeting of Saturday September 29, 2012, has provisionally granted your request. You are therefore permitted to attend the 26th Annual General Congress of the Society between 22-25th November, 2012 to avail yourself the opportunity to interact with the Radiographers and also collect your data.

Research Title: *'Child Protection in Ghana: Exploring the Perceptions and Behaviour of Radiographers'.*

The temporary approval requires that you submit your detailed research proposal for perusal and further action by the Committee

When final the approval is given, you would be required to submit Quarterly and Final reports of the Protocol.

The Society observes or caused to be observed procedures and records of the study during and after implementation. Please note that any major modification of the project must be submitted to the Society for review and approval before its implementation.

The Society will further require that all ethical aspects of any manuscript that may be produced from this study meet the appropriate standards. You will therefore be required to furnish the Society with a copy of a manuscript meant for publication.

NATIONAL PRESIDENT

DR. Samuel .Y. OPOKU, PhD
    syopoku@chs.edu.gh

cc
CONVENER,
ETHICAL AND EDUCATION COMMITTEE
GHANA SOCIETY OF RADIOGRAPHERS

SCHOOL OF ALLIED HEALTH SCIENCES
COLLEGE OF HEALTH SCIENCES
UNIVERSITY OF GHANA
ACADEMIC AFFAIRS

Phone: +233-0302-687974/5
Fax: +233-0302-688291

My Ref. No. SAHS/PSM/R/03
Your Ref. No.

P. O .Box KB 143
Korle Bu
Accra
Ghana

24th October, 2012

Mr. William K. Antwi,
Dept. of Radiography
SAHS.
Korle Bu.

Dear Mr. Antwi,

ETHICS CLEARANCE

Ethics Identification Number: SAHS – ET./SAHS/PSM/R/03/AA/26A/2012-2013.

Following a meeting of the Ethics and Protocol Review Committee of the School of Allied Health Sciences held on Tuesday 23rd October, 2012, I write on behalf of the Committee to approve your research proposal as follows:

TITLE OF RESEARCH PROPOSAL: **"Radiographers'   Perceived   Level   of Participation in Child Protection in Ghana".**

This approval requires that you submit six-monthly review reports of the protocol to the Committee and a final full review to the Committee on completion of the research. The Committee may observe the procedures and records of the research during and after implementation.

Please note that any significant modification of the research must be submitted to the Committee for review and approval before its implementation.

You are required to report all serious adverse events related to this research to the Committee within seven (7) days verbally and fourteen (14) days in writing.

As part of the review process, it is the Committee's duty to review the ethical aspects of any manuscript that may be produced from this research. You will therefore, be required to furnish the Committee with any manuscript for publication.

Please always quote the ethical identification number in all future correspondence in relation to this protocol.

Thank you.

Yours sincerely,

Dr. (Maj. Rtd.) George Asare
(Chairman, Ethics and Protocol Review Committee)

    cc   Ag. Dean
            Senior Assistant Registrar

Sheffield Hallam University

Secretary and Registrar's Directorate
City Campus Howard Street
Sheffield S1 1WB

GT/RDSC
20 March 2013

Tel no: 0114 225 4047
E-mail: g.taylor@shu.ac.uk

Mr WK Antwi
Box An 15241
Accra-North
Accra

Dear Mr Antwi

Application for Approval of Research Programme

At its meeting on 20 March 2013 the Research Degrees Sub-Committee noted receipt of the information previously requested and I am pleased to inform you that it was satisfactory. Your application is now fully approved.

Please find enclosed an information sheet: 'Principal Stages in the progress of a Research Degree Student' outlining the timescales involved for completion of your research degree. The next stage for you will be the approval of your thesis title and examining team. These details should be proposed on an RF3 by your Director of Studies, and submitted to Student Systems and Records (Research Degrees) at least 4 months in advance of submission of your thesis. In your case we would expect to receive an RF3 by no later than 12 April 2014.

If you have any queries, please contact Student Systems and Records (Research Degrees) based at City Campus, using the contact details above.

Yours sincerely

Secretary
Research Degrees Sub-Committee

cc   Director of Studies
        Head of Programme Area (Research Degrees)
        Research Administrator

Enc

APPENDIX F: Participants Information Sheet

Sheffield Hallam University

PARTICIPANT INFORMATION SHEET

> CHILD PROTECTION IN GHANA: EXPLORING THE PERCEPTIONS AND BEHAVIOUR
> OF RADIOGRAPHERS

You are being invited to participate in a research study which is about **child protection and the radiographer in Ghana as entitled above.** Before you decide, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully. Talk to others about the study if you wish.

Ask the investigator if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

"Why have I been asked to take part in this study?"

I am inviting you as a radiographer to assist me to gather information for my PhD study about the situation in your practice regarding imaging of children suspected to have been abused.

What if I do not wish to take part?"

It is up to you to decide whether or not to take part. If you do, you will be given this information sheet to keep and be asked to sign a consent form. You are still free to withdraw at any time and without giving a reason.

What will happen to me if I take part?

There could be an emotional distress in particular if you have had any difficult childhood experiences that may surface in the course of the interview. However, in such a case you have the options of having the interview re-scheduled, or stopped and also withdraw. Also a counsellor will be available to you without any cost to you.

You will be engaged in one to one interview for a period of about 60-90 minutes. You may be invited again for further interview if there is a need for any clarification.

The interview will take place at a convenient time and venue safe for both of us (this will be discussed when you agree to participate). The interview will be recorded as data for the study.

There will be a debriefing section after the interview to discuss and address any questions or concerns you may have.

A consent form will be provided for you to sign as a proof that you have agreed to voluntary participate in this study.

If the above is understood and accepted by you, I would be grateful if you could, in good faith, agree to voluntarily participate in this study to advance the radiography profession and child protection efforts in Ghana.

How long will the study last?

The information gathering will take about 6 months and you will be engaged on one occasion and for about an hour.

What if I change my mind during the study?
You are free to withdraw from the study at any time without needing to explain your decision for doing so.

Are there possible disadvantages and risks of taking part?
I am aware that, in studies such as these involving adults who have had a difficult childhood experiences, emotional distress could occur. If you think participation will affect you negatively, I suggest that you reconsider your decision to consent to participation in this study.

The study is also, not about recounting of participant's childhood experiences of abuse which may raise psychological and emotional problems. It is about practice behaviour and perceptions of radiographers regarding child protection in the practice setting

"What will happen to the information from the study?"

All information will be kept entirely confidential. All recordings, field notes and transcripts will be destroyed five years after the study has ended. Unidentifiable quotes will be used in the report. You will be informed of the results of the study if you wish.

"What if I have further questions?"

If you have any questions feel free to contact the researcher (William K. Antwi) on any of the following email addresses or telephone numbers if you are not connected to the internet or have no email address.

b2026089@my.shu.ac.uk
wkantwi@chs.edu.gh
williamantwi@yahoo.com

Mobile # 0276320092 or 0204803880

APPENDIX G: Participants' Informed Consent Form

Sheffield Hallam University
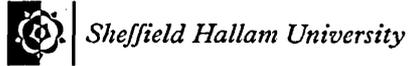
CONSENT FORM

CHILD PROTECTION IN GHANA: EXPLORING THE PERCEPTIONS AND
BEHAVIOUR OF RADIOGRAPHERS

Please give your consent to participating in the study by answering the following questions

Have you read the information sheet about this study?	Yes ☐	No ☐
Have you been able to ask questions about this study?	Yes ☐	No ☐
Have you received answers to all your questions?	Yes ☐	No ☐
Have you received enough information about this study?	Yes ☐	No ☐

Which investigator have you spoken to about this study?   ....

Are you involved in any other studies?   Yes ☐   No ☐

- If you are, how many?

Do you understand that you are free to withdraw from this study:
- At any time?   Yes ☐   No ☐
- Without giving a reason for withdrawing?   Yes ☐   No ☐

Do you agree to take part in this study?   Yes ☐   No ☐

Your signature will certify that you have had adequate opportunity to discuss the study with the investigator and have voluntarily decided to take part in this study. Please keep your copy of this form and the information sheet together.

Signature of participant: ....   Date: ....

Name *(Block Letters):*   ....

Signature of investigator: *(signature)*

William K. Antwi

December 4, 2013.   Version 2

364

Sheffield Hallam University | Centre for Health and Social Care Research

27 November 2013

PA/SH

William Antwi
Sheffield Hallam University
Collegiate Crescent
Sheffield
S10 2BO

Dear William

This letter relates to your research proposal: **Child protection in Ghana: Exploring the perceptions and behaviour of radiographers**

This proposal was submitted to the Faculty Research Ethics Committee for ethics and scientific review. It has been reviewed by two independent reviewers and has been passed as satisfactory. The comments of the reviewers are enclosed. You will need to ensure you have all other necessary permission in place before proceeding, for example, from the Research Governance office of any sites outside the University where your research will take place. This letter can be used as evidence that the proposal has been reviewed ethically and scientifically within Sheffield Hallam University.

The documents reviewed were:

ANTWI Binder 1
ANTWI Review 1
ANTWI Review 2
William Antwi Ethics app. ANNOTATED #
William Antwi Ethics app. Nov. 2013
William Antwi Research Ethics Review
William Antwi Review #2

Good luck with your project.

Yours sincerely

Peter Allmark

Peter Allmark
Chair Faculty Research Ethics Committee
Faculty of Health and Wellbeing
Sheffield Hallam University
32 Collegiate Crescent
Sheffield
S10 2BP

0114 224 5727
p.allmark@shu.ac.uk

GHANA SOCEITY OF RADIOGRAPHERS (GSR)

Bankers: GCB, Korle Bu. Accra　　　　　　　National Secretariat
Tel: 0303685487　　　　　　　　　　　　　P.O. Box KB 602
Website:　　　　　　　　　　　　　　　　Korle Bu. Accra,
Email: gsradiographers@yahoo.com　　　　　Ghana

Our Ref No...GSR/EEC/V2/17　　　　　　　December 9, 2013
Your Ref No................................

MR. WILLIAM ANTWI
DOCTORAL RESEARCH STUDENT
SHEFFIELD HALLAM UNIVERSITY
FACULTY OF HEALTH & WELLBEING
34 COLLEGIATE CRESCENT
SHEFFIELD

Dear Mr. Antwi,

<u>**ETHICAL APPROVAL FOR RESEASRCH PROJECT**</u>

. **Research Title:** *'Child Protection in Ghana: Exploring the Perceptions and Behaviour of Radiographers'.*

I am pleased to inform you that the Ethical and Education Committee of the Ghana Society of Radiographers at its Meeting on Monday November 25, 2013, upon thorough review of your RF1 from Sheffield Hallam University and summary of Phase 1 of your study, was satisfied and has accordingly given approval for the Phase 2 of the study.

The approval requires that you submit three (3) monthly review reports of the protocol to the Society and a final review at the completion of the study.

Please note that any major modification of this project must be submitted to the Society for review and approval before its implementation.

The Society observes or caused to be observed procedures and records of the study during and after implementation.

You will also are required to report any serious adverse event related to the study within seven (7) days verbally and fourteen (14) days in writing.

The Society will further require that all ethical aspects of any manuscript that may be produced from this study meet the appropriate standards. You will therefore be required to furnish the Society with a copy of a manuscript meant for publication.

NATIONAL PRESIDENT

DR. Samuel .Y. OPOKU, PhD
syopoku@chs.edu.gh

cc
CONVENER,
ETHICAL AND EDUCATION COMMITTEE
GHANA SOCIETY OF RADIOGRAPHERS

APPENDIX J: SAHS Ethical Approval (Phase 2)

SCHOOL OF ALLIED HEALTH SCIENCES
COLLEGE OF HEALTH SCIENCES
UNIVERSITY OF GHANA
ACADEMIC AFFAIRS

Phone: +233-0302-687974/5
Fax: +233-0302-688291

My Ref. No. SAHS/PSM/R/03
Your Ref. No.

P. O .Box KB 143
Korle Bu
Accra
Ghana

22nd April, 2013.

Mr. William K. Antwi,
Dept. of Radiography,
SAHS,
Korle Bu.

Dear Mr. Antwi,

ETHICS CLEARANCE

Ethics Identification Number: SAHS – ET. /SAHS/PSM/R/03/AA/1A/2012-2013.

Following a meeting of the Ethics and Protocol Review Committee of the School of Allied Health Sciences held on Wednesday 10th April, 2013, I write on behalf of the Committee to approve your research proposal as follows:

TITLE OF RESEARCH PROPOSAL: "**Child Protection in Ghana: Exploring the Perceptions and Behaviour of Radiographers**"

This approval requires that you submit six-monthly review reports of the protocol to the Committee and a final full review to the Committee on completion of the research. The Committee may observe the procedures and records of the research during and after implementation.

Please note that any significant modification of the research must be submitted to the Committee for review and approval before its implementation.

You are required to report all serious adverse events related to this research to the Committee within seven (7) days verbally and fourteen (14) days in writing.

As part of the review process, it is the Committee's duty to review the ethical aspects of any manuscript that may be produced from this research. You will therefore, be required to furnish the Committee with any manuscript for publication.

Please always quote the ethical identification number in all future correspondence in relation to this protocol.

Thank you.

Yours sincerely,

Dr. (Maj. Rtd.) George Asare
(Chairman, Ethics and Protocol Review Committee)

cc   Dean
        Co-ordinator, Dept. of Radiography
        Senior Assistant Registrar

APPENDIX K: Ethics Approval from GHS (Phase 2)

GHANA HEALTH SERVICE ETHICAL REVIEW COMMITTEE

In case of reply the
number and date of this
Letter should be quoted.

My Ref. :GHS-ERC: 3
Your Ref. No.

Research & Development Division
Ghana Health Service
P. O. Box MB 190
Accra
Tel: +233-302-681109
Fax + 233-302-685424
Email: Hannah.frimpong@ghsmail.org

10th June, 2014

Antwi William Kwadwo
School of Allied Health Sciences
University of Ghana
Legon – Accra

ETHICAL APPROVAL - ID NO: GHS-ERC: 14/01/14

The Ghana Health Service Ethics Review Committee has reviewed and given approval for the implementation of your Study Protocol titled:

"Child protection in Ghana: Exploring the perception and behaviour of Radiographers"

This approval requires that you inform the Ethical Review Committee (ERC) when the study begins and provide Mid-term reports of the study to the Ethical Review Committee (ERC) for continuous review. The ERC may observe or cause to be observed procedures and records of the study during and after implementation.

Please note that any modification without ERC approval is rendered invalid.

You are also required to report all serious adverse events related to this study to the ERC within seven days verbally and fourteen days in writing.

You are requested to submit a final report on the study to assure the ERC that the project was implemented as per approved protocol. You are also to inform the ERC and your sponsor before any publication of the research findings.

Please always quote the protocol identification number in all future correspondence in relation to this approved protocol
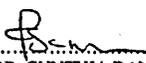
SIGNED..
DR. CYNTHIA BANNERMAN
(GHS-ERC VICE-CHAIRPERSON)

Cc: The Director, Research & Development Division, Ghana Health Service, Accra

APPENDIX L: Debriefing Letter (Phase 2)

Sheffield Hallam University

Debriefing Letter

Dear Participant,

Thank you for your participation in this study as a research participant and for your valuable contribution. If you have any questions about the study after the interview we just had please feel free to ask me. If any question I asked in other to gain better understanding of issues to inform the study was sensitive and caused you any emotional or psychological trauma I do apologise as it was not my intention to cause you the distress.

Moreover if upon second thought you have any concerns that needs to be addressed I will be glad to respond to your concerns about any aspect of the study and any information you gave. You can therefore contact me any time on my contact details provided below.

Thank you.

Yours sincerely

William K. Antwi

(PhD Student Sheffield Hallam University)

Email: b2026089@my.shu.ac.uk / wkantwi@chs.edu.gh /

Mobile # 027 632 0092 or 020 480 3880

APPENDIX M: Sample Questions (Phase 1)

QUESTIONNAIRE

1. Rank... Senior Radiographer

2. Years of professional experience... Six (6)

3. What is child abuse? Has to do with the physical, mental and emotional trauma mutted unto children by adults, parents and the society at large. This causes several degrees of damage to the well being of the child.

4. What is meant by child protection? Has to do with the structure built around the child to ensure his/her safety. Involves physical, emotional, ~~social~~ mental care for the upbringing of the child.

5. Would you be available to voluntarily participate in the main study? (Please tick the appropriate box).

Yes [ ]   No [✓]

If you agree to participate please provide your contact details below

Telephone: ....E-mail: ....

Rank of Radiographer (Rad)	Years of practice	Question - What is child abuse?
Rad 01	2	The physical and mental disorientation of a child's stability by an individual. It includes sexual harassment, child trafficking, hawking.
Senior Rad 02	10	A phenomenon where one deliberately does things at the detriment of a child without his or her consent.
Senior Rad 03	10	The physical, sexual or emotional mistreatment or neglect of a child.
Rad 04	3	A procedure in which a child is maltreated in a way which visual marks can be seen on the child and radiological investigation can demonstrate injury on an image.
Assistant Chief Rad 05	25	Actions perpetuated against a child that affect a child negatively knowingly or unknowingly
Principal Rad 06	10	Introducing a child to work that is meant for adults, such as Fishing, Mining, not sending a child to school, hospital or allowing a child to go hungry.
Rad 07	1	An unfair and inhumane treatment a child goes through which results in infringement on the child's basic right such as dignity, care, support.
Assistant Chief Rad R08	18	Basically, infringing on the child's rights.
Rad 09	1	The social situation where a child lives in conditions or receives treatment that inhibits his growth physically or socially. The abuse can be either verbal or physical.
Rad 010	10	It occurs when there is a child labour or defilement
Rad 011	2	The infringement of a child's right either physically, mentally, emotionally, or otherwise to put a child's life or health in danger.
Rad 012	8	The treatment given to a child that may cause non-accidental injury or the child may feel insecure, anxious or scared.
Rad 013	10	When a minor is physically being hurt which could affect him/her mentally and psychosocially.
Assistant Chief Rad 014	20	To deprive a child of basic life needs e.g. Food, shelter, education, health. Use of child for labour meant for adults. Subject child to dangers; beating
Senior Rad 015	15	Infringing on the rights of a child.
Senior Rad 016	9	Infringement of the fundamental human rights of the child as a person. This could be in varied forms, some of which are physical, verbal or psychological. It could be beating of the child, not giving the child food, forced

		labour and many other things like sexual abuse.
Rad 017	2	Any actions done to undermine the fundamental human right of a child.
Senior Rad 018	16	Anything one does to a child without seeking his/her consent or that of their guardians.
Senior Rad 019	10	Takes many forms such as; if the child is not allowed to go to school or have education. If the child is beaten without any reason, if he/she is restricted from doing what he wants.
Rad 020	1	Act of meting out or introducing the child to an act which is injurious to his/her physical, emotional, psychological wellbeing.
Senior Rad 021	9	Any action, either verbal or physical taken against a child which causes either emotional or physical harm
Senior Rad 022	10	A situation where a child under the age of 18 years is physically and emotionally molested to the extent that there are physical marks or manifestations on the skin, skull and other part of the abused child's body e.g. When a child is beaten with a rod, belt and sometimes a hot iron(pressing) are used to burn part of the body
Rad 023	1	When a child between the ages of 0-11 years undergo physical and emotional and psychological attack from an individual who is an adult.
Rad 024	1	It is a phenomenon of causing a child to go through undesirable experiences that could be detrimental to his/her physical or psychological wellbeing.
Rad 025	1	Taking away or violating the freedom of a child which subsequently affects either the physical or psychological aspect of the child.
Principal Rad 026	16	Any action taken against a child that might cause the child physical and/or psychological pain or discomfort
Rad 027	2	The infringement of a child's rights as described in the constitution, such as right of education, freedom and healthcare. It also describes any physical harm that is unduly meted out to a child and emotional torture of a child.
Senior Rad 028	10	Treating a child so badly that the fundamental right is being denied, such as, education and shelter.
Senior Rad 029	15	Acts or actions that subject the child to danger, trauma, neglects and feelings of insecurity, etc.
Rad 030	10	Any action or inaction that is taken by the parents, family, friends or a health professional that can affect the child's physical, emotional, social and the psychological wellbeing. It is not taking actions to secure privacy.
Rad 031	3	A threat of a person below the age of 18 years by an adult e.g. Sexual, corporal punishment
Senior Rad	15	A situation where a child's rights and freedom are

032		trampled upon by the parents, family members, close friends and relations as well the general public as a whole.
Principal Rad 033	34	Actions and activities of any person or persons whether parents, guardians, adults and older persons or the community/society or institutions that endangers a child's life whether physically, psychologically or emotionally.
Senior Rad 034	20	Practices that infringe on child's rights to protection from harm, human dignity, freedom to explore one's environment.
Rad 035	2	The maltreatment of young children either mentally, physically, sexually or emotionally.
Rad 036	3	The abuse or violation of the right of the child physically, emotionally, mentally.
Rad 037	1	Denying a child of his/her right and freedom.
Rad 038	9	When the right of a child is not respected.
Principal Rad 039	23	Any type of cruelty against a child who is less than 18 years.
Rad 040	2	A situation where a child (under 16 years) is treated or handled in a way by an older person such that the child is physically or psychologically traumatised.
Rad 041	2	Ill-treatment of a child against the child's will. It involves assigning arduous tasks, infringement on the child's rights as well as maltreatment of the child.
Rad 042	3	a violent way of mishandling a child which in effect causes injury to the child physically, emotionally and psychologically.
Rad 043	6	A process of maltreating a child.
Rad 044	4	Any act which inflict harm to child either physically, emotionally and/or mentally
Senior Rad 045	7	Any action that will physically inflict wound on a child or put him/her in emotional trauma.
Principal Rad 046	20	Cruel treatment of a child. It can be physical, verbal, sexual and neglect etc.
Rad 047	2	An act or actions that cause adverse negative effect on a person below 18years, physically, emotionally and psychologically.
Rad 048	3	It is when a child is subjected to responsibilities below his capabilities for the selfish gains of the perpetuator, which could even be his parents. It could also be the physical maltreatment of a child.
Senior Rad 049	3	It is harming a child both physically, psychologically or infringement on the rights of the child. If a child is denied his or her rights, it is said to be child abuse
Rad 050	3	Is when someone infringes on the rights of the chil.
Principal Rad 051	12	It refers to denying a child his/her rights and forcing him/her to do something against his/her wish. Child abuse can be in the form of sexual harassment, involving

		the child in heavy duty works such as quarrying, selling etc. against his/her wish.
Rad 052	2	Child abuse is any form of action which is subjected to a child below a certain conventional age and therefore depriving the child his/her right to comfortable life
Principal Rad 053	15	It is the physical, sexual or emotional mistreatment or neglect of a child. It is any act or series of actions of commission or omission by a parent or caregiver that results in harm, potential for harm or threat of harm to a child.
Senior Rad 054	7	Physical assault or emotional harm to children, against the child's rights and freedom.
Senior Rad 055	4	It is an ill-treatment of children that may affect the physical, emotional and psychological state of the child in a negative way.
Senior Rad 056	4	Maltreating a child physically, mentally and emotionally. It is a situation that occurs when the rights of the child are not recognised by the abuser
Rad 057	2	Indiscriminate and unlawful treatment of one's child or another's child through beating and the use of insults
Senior Rad 058	5	It is severe mistreatment of a child by the parents or guardian.
Principal Rad 059	3	The maltreatment of a person underage who normally does not know his/her rights and freedom. It is treating a child in harsh and wicked way.
Principal Rad 060	20	Physical treatment to a child and preventing them to enjoy their various right and freedoms.
Senior Rad 061	5	Maltreating a child and taking undue advantage of the child as well due to financial, social issues etc
Principal Rad 062	19	Denying the child of his/her basic human right or maltreating children.
Rad 063	2	Any act that has a potential risk of endangering the child with regards to his/her survival or livelihood
Rad 064	2	Refers to the physical or psychological maltreatment of persons below 18 years of age.
Senior Rad 065	2	Subjecting any child below the age of 18 to any treatment that violates the rights of the child as stated in the constitution of a nation.
Rad 066	2	When a child is physically or sexually maltreated or harmed. It can also be reigning harsh insults on a child for committing a small mistake.
Rad 067	2	This is a way a child is maltreated both physically and sexually. When a child is asked to go to farm, sell in the street or carry loads at market places when he/she is supposed to be in school. Also when a child has not reached the age of marriage and she is forced into it. in short, asking a child to do something against his/her will.
Rad 068	3	It is the infringement on the rights of a child. It involves

		neglecting one's responsibilities in regards to ensuring that the child's rights are respected.
Rad 069	3	The maltreatment of a child, either sexually, physically or psychologically.
Rad 070	3	Using children in the wrong way/ excessive use of children. That means, before proper/actual maturity, children should be more considered as liabilities than assets. Sadly, once a child can walk, talk and handle certain personal things on his own, some adults take advantage and make the children more of assets.
Rad 071	2	Infringing upon a child's rights by denying him the right to education, allowing him to work to fend for himself and inflicting upon him an undue punishment.
Rad 072	3	Subjecting or exposing a minor to adverse situations both domestically and socially.
Rad 073	3	The unlawful assaulting of the child whether physically, emotionally and mentally.
Rad 074	3	The physical, psychological, emotional and sexual maltreatment of a child. Or any form of neglect from a parent/guardian or a care giver to fulfil responsibility.
Rad 075	4	Any activity that causes emotional, physical, psychological pain to a person below the age of 18.
Rad 076	1	The infringement of the fundamental human rights of a child which causes pain and injury to the child.
Principal Rad 077	8	The treatment or handling of a child in a way that would cause physical, emotional, psychological and mental injury to that child, therefore preventing the child from behaving or performing as maximally as he ought to in the family or society as a whole.
Rad 078	2	The unlawful handling, mistreatment of children by causing harm/endangering their lives against their human rights as enshrined in the constitution.
Rad 079	3	Causing physical and mental harm to a person below the age of 18 years.
Senior Rad 080	8	Refers to mental and physical maltreating of a child. Generally subjecting a child to severe beatings and unwillingness to cater properly for the child's physical and mental needs.
Rad 081	2	Any action on the part of the parent, caregiver, guardian or any other person or persons that seeks to harm the physical or mental well-being of the child by subjecting him/her to any treatment or condition that subtracts from his/her dignity and/or welfare as a child
Rad 082	2	Any act that harms an individual under the age of 18 years whether it is intentional or not. The harm caused may be physical, psychological, social and/or emotional.
Principal Rad 083	11	when a child (below 18 years of age) is being given a duty or assignment which is above him/her or that is

		supposed to be done by an adult (above 18 years of age), then the child is being abused intentionally or unintentionally.
Senior Rad 084	7	Maltreating a child who can't protect himself/herself by subjecting such a child through beatings and other wicked acts.
Senior Rad 085	6	Has to do with the physical, mental and emotional trauma meted unto children by adults, parents and the society at large. This causes several degrees of damage to the wellbeing of the child.
Rad 086	9	The use of a child for activities that are legally prohibited and also the involvement of a child in any activity which children are not to be part of.

Rank of Radiographer (Rad)	Years of practice	Question - What is meant by child Protection?
Rad 01	2	The prevention of a child abuse may be by law
Senior Rad 02	10	Attributes that tends to protect the child from harm or any adverse effect on his/her health state.
Senior Rad 03	10	Protecting a child from physical, sexual or emotional mistreatment or the neglect of a child. This comes in the form of passing right of child law that will seek the protection of children.
Rad 04	3	This is when there is a legal protection of the child. radiographer is seen as his/her duty to protect the child who has been maltreated.
Assistant Chief Rad 05	25	Process being put in place to protect the child from abuse.
Principal Rad 06	10	child have to be educated, clothed, fed and sheltered
Rad 07	1	The radiation Protection that can be provided to a child at the radiology department.
Assistant Chief Rad R08	18	Assisting and making sure the child is safe in all endeavours. Also, being there always and/or delegating someone to take care of the child's needs.
Rad 09	1	Child protection is measures put in place for child safety against abuse.
Rad 010	10	A law which take care of a child, in areas such as health, education and socially.
Rad 011	2	Child protection is good parental care backed by the law.
Rad 012	8	The treatment given to a child to feel comfortable and safe.
Rad 013	10	The legislature that protects the activities of the child/minor from other people(adults).
Assistant Chief Rad 014	20	Provision of all the actions that promote the wellbeing, growth and development of the child physically and mentally.
Senior Rad 015	15	Ensuring the rights of a child.
Senior Rad 016	9	Ensuring the rights of the child are protected and in cases where the child's rights are abused, there should be legal remedies.
Rad 017	2	All measures put in place to protect a child from any form of harm.
Senior Rad 018	16	Anything one does to seek the best interest of the child (i.e. mentally, physically and socially).
Senior Rad 019	10	(No response)

Rad 020	1	Ways and activities if implemented can help secure the child from any harmful attack.
Senior Rad 021	9	Various mechanisms put in place to ensure that the safety, emotions and wellbeing are secured. These are mainly in the form of policies and laws set aside for the above purpose
Senior Rad 022	10	Measures put in place by government and parents to ensure that children are protected from abuse of any form by relations and others. These are in the forms of laws and whoever frowns on these laws are punished according to the law.
Rad 023	1	When a child is secured from harmful activity and this should be provided by child's parents, teachers and the law.
Rad 024	1	The adoption of recognized approaches aimed at ensuring a child's welfare is taken care of.
Rad 025	1	Taking care of a child in order to prevent it from harming him/herself or by any other external agencies.
Principal Rad 026	16	Any action taken to prevent the child from experiencing physical and/or psychological pain and/or discomfort.
Rad 027	2	The protection of a child's rights. Ensuring that a child's safety and wellbeing is assured
Senior Rad 028	10	Making sure the child feels secure, and then has confidence in the parent or the carer.
Senior Rad 029	15	Keeping the child safe from emotional and psychological stress and respecting his/her rights to live, life, needs and ensuring his security is guaranteed by the constitution of the land
Rad 030	10	Any action that is taken to protect a child from physical, psychological, radiation abuse. It also ensures the privacy and confidentiality of the child
Rad 031	3	Special care given a child or person below the age of 18 that will protect children from any sort of activity that will or could endanger their lives.
Senior Rad 032	15	Anything that is done to ensure the child's freedom and dignity.
Principal Rad 033	34	Actions, activities or laws and rules that ensure that a child is safe in any environment that he/she finds him/herself.
Senior Rad 034	20	Parents have duty to protect child from the dangers of the environment. Child protection also ensures that children are entitled to a danger free environment.
Rad 035	2	Protective measures put in place to enable child safety and for adequate well being
Rad 036	3	It is the measure or instruments put in place to ensure that the physical, emotional and mental right of the child are not infringed on or abused

Rad 037	1	Shielding a child from any form of harm.
Rad 038	9	When the child's right is respected
Principal Rad 039	23	Any legislative laws a country makes to protect a child being abused.
Rad 040	2	Involves measures put in place to protect a child or prevent the child from being abused, especially by an older person. This involves protection from physical, psychological and emotional abuse.
Rad 041	2	Provisions made to ensure the rights and privileges of a child are respected. It is a measure put in place to protect the child against activities that are contrary to the child's wellbeing.
Rad 042	3	Responding to violence against children by reporting such incidences to appropriate authority or organizing child safety programmes.
Rad 043	6	It is a process by which a child is protected from all hazards or prevented from injuries.
Rad 044	4	Any act which prevent the infliction of harm on the child.
Senior Rad 045	7	Any action or law put in place to protect the child from physical or emotional abuse.
Principal Rad 046	20	Giving a child the needed protection against cruel treatments.
Rad 047	2	Any action taken by an individual, a group of individuals or an organization to ensure that the rights of a minor (below 18 years) are not violated by any one.
Rad 048	3	It is when a child is provided with the necessary guidance and needs to ensure his safety and provision.
Senior Rad 049	3	It is keeping the child from being harmed. Ensuring the safety of the child.
Rad 050	3	This is when the rights of the child is prevented from being violated.
Principal Rad 051	12	It refers to the care and quality guidance given to a child to prevent him/her from all forms of social, emotional dangers.
Rad 052	2	Child protection is a means of ensuring that the rights and privileges of the child is not infringed upon.
Principal Rad 053	15	A set of usually government run services to protect young children who are underage from danger and also to foster care and unity for the children.
Senior Rad 054	7	Preventing violence and abuse against children. Shielding children from abuse.
Senior Rad 055	4	These are set of laws or regulations set aside to protect children of all ages from abuse.
Senior Rad 056	4	The provisions of a sense of safety to a child. This is done by ensuring that the child is physically, mentally and emotionally safe.

Rad 057	2	This involves the confinement and the guidance of an individual child under the laws of the state and ensuring that the child's rights are equally protected and ensured.
Senior Rad 058	5	The process of putting adequate measures in place to ensure that children are safe from abuse
Principal Rad 059	3	The shielding of a child from any harmful condition or any unfriendly condition that can affect a child.
Principal Rad 060	20	Guiding the child or avoiding the child to undergo any physical assault and the child enjoying his/her right and freedoms.
Senior Rad 061	5	Supporting the child in decision making and providing good counselling to the child till the person is of age to make good decisions.
Principal Rad 062	19	Protecting the rights of children according to law or a set of law set aside to safe guard the rights of children
Rad 063	2	Any conscious effort made to protect the child and isolate him/her from things with a potential risk of endangering the child's life or adversely affecting their livelihood.
Rad 064	2	Refers to the various ways in which children below 18 years are shielded from physical and psychological abuse.
Senior Rad 065	2	Putting necessary structures and strategies in place to prevent the rights of children from being violated
Rad 066	2	The physical, emotional and psychological guidance given to a child. It can also be the parental support given to a child.
Rad 067	2	Defending the child from trouble, harm or any form of attack. Child protection can be best done by the parents of that child or any close relative.
Rad 068	3	It is the act of ensuring that a child's rights are respected. It involves provision of basic needs for the child and making sure that the child meets his/her basic needs for existence.
Rad 069	3	Preventing a child from something that is dangerous to the child's health or psychology.
Rad 070	3	Providing a child with the optimum if not maximum cover that is necessary for the child's healthy growth in any environment.
Rad 071	2	Protecting fundamental human rights of the child, giving him a sense of belongingness and the provision of basic needs to the child.
Rad 072	3	Shielding the child against abusive conditions and allowing the child to enjoy certain basic rights.
Rad 073	3	The act of providing guidance to the child in the form of finance, food and shelter, clothing and education.
Rad 074	3	Providing a guide or building a hedge around a child to

		prevent any harm from befalling the child. Shielding the child from any form of danger.
Rad 075	4	Providing the needs thus any kind of need to a person below 18 years, be it education, moral upbringing and the like that will secure that person's life.
Rad 076	1	Ensuring that the child's fundamental human rights are enforced and bringing to justice all those who infringe on them and cause harm and injury to the child.
Principal Rad 077	8	The proper care of a child that would prevent the child from being injured physically, emotionally, psychologically or mentally. Thereby enabling the child to operate at his/her maximum potential in the family or society as a whole.
Rad 078	2	The process whereby children are shielded from any kind of harm that may injure or endanger their lives
Rad 079	3	Protecting a person below the age of 18 years from abuses which include physical and mental abuses.
Senior Rad 080	8	Giving physical, mental and psychological care of a child to enhance his/her development and growth. Caring for a child such that he/she is well prevented from certain hazards and other activities that would hinder his/her mental, physical, psychological development.
Rad 081	2	Treatment conditions or welfare system that seeks to enhance the physical or mental well-being of the child by provision of necessities.
Rad 082	2	Any act or plan that intends to keep an individual under the age of 18 years from harm.
Principal Rad 083	11	When a child (below 18 years) is given a duty or assignment which is within his/her capabilities.
Senior Rad 084	7	A way of providing adequate protection for a child who cannot protect him/herself.
Senior Rad 085	6	Has to do with the structures built around the child to ensure his/her safety. Involves physical, emotional, mental care for the upbringing of the child.
Rad 086	9	The act of preventing children from children from social hazards or any activity/condition that could endanger the life of the child.

APPENDIX O: Approval to Amend Sample Size (Phase 2)

Sheffield Hallam University | Centre for Health and Social Care Research

30 September 2014

William Antwi
Box AN15241
Accra-North
Ghana

Dear William

This letter relates to your research proposal

Child protection in Ghana: exploring the perception and behaviour of radiographers

and the amendment received on **30 September 2014**

This amendment to your proposal was submitted to the Faculty Research Ethics Committee for review. It has been reviewed by an independent reviewer on behalf of the Committee and is now passed as satisfactory. You may need to get further permission for the amendment from other governance bodies, such as R&D departments or NHS ethics committees.

The documents we reviewed were:

Request for major amendment Form

Good luck with your project.

Yours sincerely

Peter Allmark
Chair Faculty Research Ethics Committee
Faculty of Health and Wellbeing
Sheffield Hallam University
32 Collegiate Crescent
S10 2BP

Direct Line: 0114 225 5727
p.allmark@shu.ac.uk

APPENDIX P: Cover Letter Inviting Radiographers to Participate in Phase 2.

Sheffield Hallam University
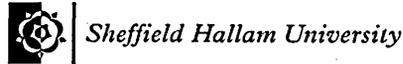
<div align="right">December 4, 2013</div>

Dear Radiographer,

In November 2012 at the National Congress of Ghana Society of Radiographers held in Koforidua you did indicate your willingness to continue to be part of my on-going PhD research which is about

'Child Protection in Ghana: Exploring the Perceptions and Behaviour of Radiographers'.

I am now writing to inform you that the next stage of the above study is about to commence and I would very much like to arrange further interviews with you to advance the study. The interview would take place within an agreed setting and time to suit you and it will last approximately 30-90 minutes. Before you decide to confirm your readiness to continue with the study, I would like you to understand why the research is being undertaken and what it will involve for you.

The study seeks to gain some insight into the role of Ghanaian radiographers with regards to child protection by exploring, and also articulating, the understanding that radiographers in Ghana have of their role and potential contribution to child protection efforts in the country. The study also takes into account the cultural views and beliefs held by radiographers in Ghana with regard to child abuse and child protection and will contrast these with international perspectives.

You may feel uncomfortable in if you have had any childhood difficulties and you have the right to withdraw from the study without needing to inform the researcher. Although you probably would not benefit directly from participating in this study, it is hoped that the children and other members of the society in general will benefit by your rich contribution to this study.

Participation is confidential. Study information will be kept in a secure location at Sheffield Hallam University. The results of the study may be published or presented at professional meetings but your identity will not be revealed. Thus participation is anonymous so please you will not be required to write your name or any identifying information on any of the research materials.

For your information I have included an information sheet spelling out the details of this study. I also have some questions for you to answer on a consent form before the study can commence. This is when you have agreed to voluntarily participate. I will be ready to answer any further question you may have. I very much appreciate your continue support and also acknowledge your contribution to make this study successful.

Thank you
Yours sincerely

William K. Antwi
(PhD Student Sheffield Hallam University)

Sheffield Hallam University

INTERVIEW PROTOCOL –PHASE 2

A. Introduction questions

a. Can you tell me about yourself?

b. What motivated you to participate in this study?

c. Are you willing to share with me your work experience with cases of child abuse?

B. Experience and knowledge of abused children (general)

Key question

1. What are your experiences in radiography of children suffering from abuse?

- **Supplementary questions**

a. Can you tell me of any occasion that you were suspicious of an abuse of a child?

b. What key challenges do you face under such circumstances?

C. Professional behaviour.

Key question

1. Would you report your suspicion if the referral history does not indicate a suspected abuse but your images points to that direction?

- Scenarios

a. If yes, to whom?

b. If not, why not reporting? Probe

- **Supplementary Questions**

a. Could you describe the urgency you attach to such referrals compared to non-child abuse cases?

b. How familiar are you with the child protection legislation?

D. Relationship with other health professionals

Key questions

1. Please tell me how you work with other health professionals regarding issues of child abuse.

- With Doctors?
- With Nurses?

Probe – relationship with Social workers?

APPENDIX R: Themes/Sub Themes Developed (Phase 2)

Themes	Sub-themes

Case identification	• **Pre-radiographic observation**
	   ○ History taking
	   ○ caregiver secrecy
	• **Post radiographic observation**
	   ○ imaging findings
	   ○ technique gap

Radiographers' decision trail	• **Uncertainties of support**
	   ○ police
	   ○ administrative
	   ○ legal
	• **cost**
	   ○ financial
	   ○ time
	• **Fear of attack** (cultural)
	   ○ spiritual
	   ○ physical

Influence of Relationships	• **Interdisciplinary relationships**
	   ○ Relationship with doctor
	   ○ Relationship with nurse
	   ○ Relationship with social worker
	• **Previous relationships**
	   ○ radiographer & caregiver
	   ○ abuser & caregiver

Reporting of suspected child abuse	• **Lack of structures**
	   ○ Policy deficits
	   ○ Lack of reporting units
	• **Attitudinal issues**
	   ○ Radiographer's commitment
	   ○ Perception on child discipline

Cultural influence	• **Micro-culture**
	   ○ Caregiver secrecy
	   ○ History taking (language barrier)
	   ○ Child discipline
	   ○ Fear of attack
	   ○ Previous relationship
	• **Organisational culture:**
	Interdisciplinary relationships
	
	   ○ Relationship with doctor
	   ○ Relationship with nurse
	   ○ Relationship with social worker
	
	• **National Culture:**
	   ○ Lack of structures