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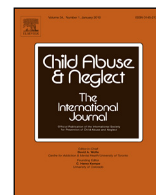

# The assessment of the readiness of five countries to implement child maltreatment prevention programs on a large scale☆

Christopher Mikton[a,*], Mick Power[b], Marija Raleva[c], Mokhantso Makoae[d], Majid Al Eissa[e], Irene Cheah[f], Nancy Cardia[g], Claire Choo[h], Maha Almuneef[i]

[a] *Department of Violence and Injury Prevention and Disability, World Health Organization, Switzerland*
[b] *University of Edinburgh, Edinburgh, UK*
[c] *University of St. Cyril and Methodius Clinical Center, Skopje, The Former Yugoslav Republic of Macedonia*
[d] *Human Sciences Research Council, Cape Town, South Africa*
[e] *King Saud bin Abdulaziz University for the Health Sciences, Riyadh, Saudi Arabia*
[f] *Kuala Lumpur Hospital, Kuala Lumpur, Malaysia*
[g] *University of Sao Paulo, Sao Paulo, Brazil*
[h] *University of Malaya, Kuala Lumpur, Malaysia*
[i] *National Guard Health Affairs, Riyadh, Saudi Arabia*

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ABSTRACT

This study aimed to systematically assess the readiness of five countries – Brazil, the Former Yugoslav Republic of Macedonia, Malaysia, Saudi Arabia, and South Africa – to implement evidence-based child maltreatment prevention programs on a large scale. To this end, it applied a recently developed method called *Readiness Assessment for the Prevention of Child Maltreatment* based on two parallel 100-item instruments. The first measures the knowledge, attitudes, and beliefs concerning child maltreatment prevention of key informants; the second, completed by child maltreatment prevention experts using all available data in the country, produces a more objective assessment readiness. The instruments cover all of the main aspects of readiness including, for instance, availability of scientific data on the problem, legislation and policies, will to address the problem, and material resources. Key informant scores ranged from 31.2 (Brazil) to 45.8/100 (the Former Yugoslav Republic of Macedonia) and expert scores, from 35.2 (Brazil) to 56/100 (Malaysia). Major gaps identified in almost all countries included a lack of professionals with the skills, knowledge, and expertise to implement evidence-based child maltreatment programs and of institutions to train them; inadequate funding, infrastructure, and equipment; extreme rarity of outcome evaluations of prevention programs; and lack of national prevalence surveys of child maltreatment. In sum, the five countries are in a low to moderate state of readiness to implement evidence-based child maltreatment prevention programs on a large scale. Such an assessment of readiness – the first of its kind – allows gaps to be identified and then addressed to increase the likelihood of program success.

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* Corresponding author at: Department of Violence and Injury Prevention and Disability, Noncommunicable Diseases and Mental Health, World Health Organization, 20 Avenue Appia, CH-1211 Geneva 27, Switzerland.

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In the last decade, a global shift has been occurring from responding to cases of child maltreatment after they have happened by providing services, support, and treatment – referred to as "child protection services" – to trying to prevent child maltreatment before it arises – referred to as "child maltreatment prevention".

The following five developments have contributed to this shift: (a) a better understanding of the far-reaching consequences of child maltreatment for mental and physical health and socio-occupational functioning (Garner et al., 2012; Mercy & Saul, 2009; Shonkoff, Boyce, & McEwen, 2009; Shonkoff & Garner, 2012); (b) findings that only a small proportion of victims of child maltreatment ever come to the attention of child protection services – e.g. 5–10% in the West, 0.3% in Hong Kong, and none in the many countries where such services do not exist (Finkelhor, Lannen, & Quayle, 2011; Gilbert et al., 2009); (c) epidemiological studies showing that child maltreatment is a global phenomenon that occurs in many low- and middle-income countries at rates that are higher than in high-income countries (Reza et al., 2009; Stoltenborgh, van Ijzendoorn, Euser, & Bakermans-Kranenburg, 2011; United Nations Children's Fund, Centers for Disease Control and Prevention, and Muhimbili University of Health and Allied Sciences, 2011; United Nations Children's Fund, Centers for Disease Control and Prevention, Together for Girls, and Kenya Vision 2030, 2012); (d) evidence suggesting that preventing maltreatment in the first place through either universal or selective prevention programs is cheaper and more effective than trying to remediate its effects later (Doyle, Harmon, Heckman, & Tremblay, 2009; Heckman, 2012; Kilburn & Karoly, 2008); and (e) reductions in rates of childhood mortality and diseases which have led to the prevention of childhood adversities – including child maltreatment – receiving more attention (Lozano et al., 2011). "Saving our children from these diseases only to let them fall victim to violence . . . would be a failure of public health" (Brundtland, 2002).

Also contributing to this shift has been the much greater prominence given to child maltreatment prevention by international and large national organizations active in the field. For instance, child maltreatment prevention has been identified as a priority violence prevention activity by the World Health Organization and the U.S. Centers for Disease Control and Prevention (CDC, 2012a; WHO, 2012). The UN Secretary General's *World report on violence against children* (UN, 2006) called for urgent action to prevent and respond to all forms of violence. The Special Representative of the UN Secretary General on Violence against Children is advocating for the prevention and elimination of all forms of violence against children (SRSGVAC, 2012). In addition, Article 19 of the Convention on the Rights of the Child[19] states that all measures should be taken to prevent child maltreatment (OHCHR, 2012a). Every country in the world – except for the USA, Somalia, and the new nation of South Sudan – have ratified, accepted, or acceded to the Convention on the Rights of the Child. The Committee on the Rights of the Child, the body of independent experts that monitors the implementation of the Convention on the Rights of the Child, recently published a General Comment 13 on the right of the child to freedom from all forms of violence which emphasizes the need for increased child maltreatment prevention (OHCHR, 2012b). An increasing number of national surveys of child maltreatment in low- and middle-income countries have been conducted in recent years with the explicit longer term aim of better preventing child maltreatment (CDC, 2012b; Together for Girls, 2012; UBS Optimus Study, 2012). Child maltreatment prevention is establishing itself as a global public health and human rights priority.

The shift from response to prevention has been accompanied by an emphasis on evidence-based child maltreatment prevention programs (CDC, 2012c; Krug, Dahlberg, Mercy, Zwi, & Lozano, 2002; WHO, 2006, 2009). However, evidence-based programs alone are not enough to prevent child maltreatment. Another critical condition must be met to ensure program success: sufficient readiness or capacity within countries to implement evidence-based programs on a large scale.

In the last decade, readiness or capacity and their assessment and development have become central concerns in the fields of health promotion, prevention science, and public health more generally (Bangkok Charter for Health Promotion in a Globalized World, 2007; Ebbesen, Heath, Naylor, & Anderson, 2004; Laverack & Wallerstein, 2001; Maclellan-Wright et al., 2007). Capacity is considered a "necessary condition for the development, implementation, and maintenance of effective community-based health promotion and disease prevention programs." (Goodman et al., 1998), while "[m]atching an intervention to a community's level of readiness" is viewed as "absolutely essential for success" (Plested, Edwards, & Jumper-Thurman, 2006).

We used the following four-faceted definition of readiness as a starting point for the development of the model on which the instruments were based: (a) the group's awareness of the problem and its perception of the problem's priority; (b) its willingness to take action to address the problem; (c) the nonmaterial resources, including human, social, and technical resources, it can apply to the problem; and (d) the material resources, including infrastructure, institutional, and financial resources, it can bring to bear on the problem.

An analysis of the concept of readiness and cognate constructs – including capacity, capacity building, community readiness, community empowerment, and sustainability – indicated that definitions of these concepts often overlap and that they are often defined in terms of each other. Nonetheless, an important distinction between readiness and cognate concepts is that the notions of willingness, drive, and motivation are prominent in the former, but missing from the latter – see Mikton et al. (2011) for a more detailed analysis of these concepts.

A review of the literature found no instrument specifically designed to assess child maltreatment prevention readiness (Mikton et al., 2011). Hence, this project aimed to develop and apply such an instrument. Assessing child maltreatment prevention readiness can serve to identify major gaps in readiness with a view to address them, establish a baseline measure against which progress in increasing readiness can be tracked, help allocate resources to increase readiness for child maltreatment prevention, assist in matching an intervention to the existing level of readiness, and act as a catalyst for taking action to prevent child maltreatment.

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