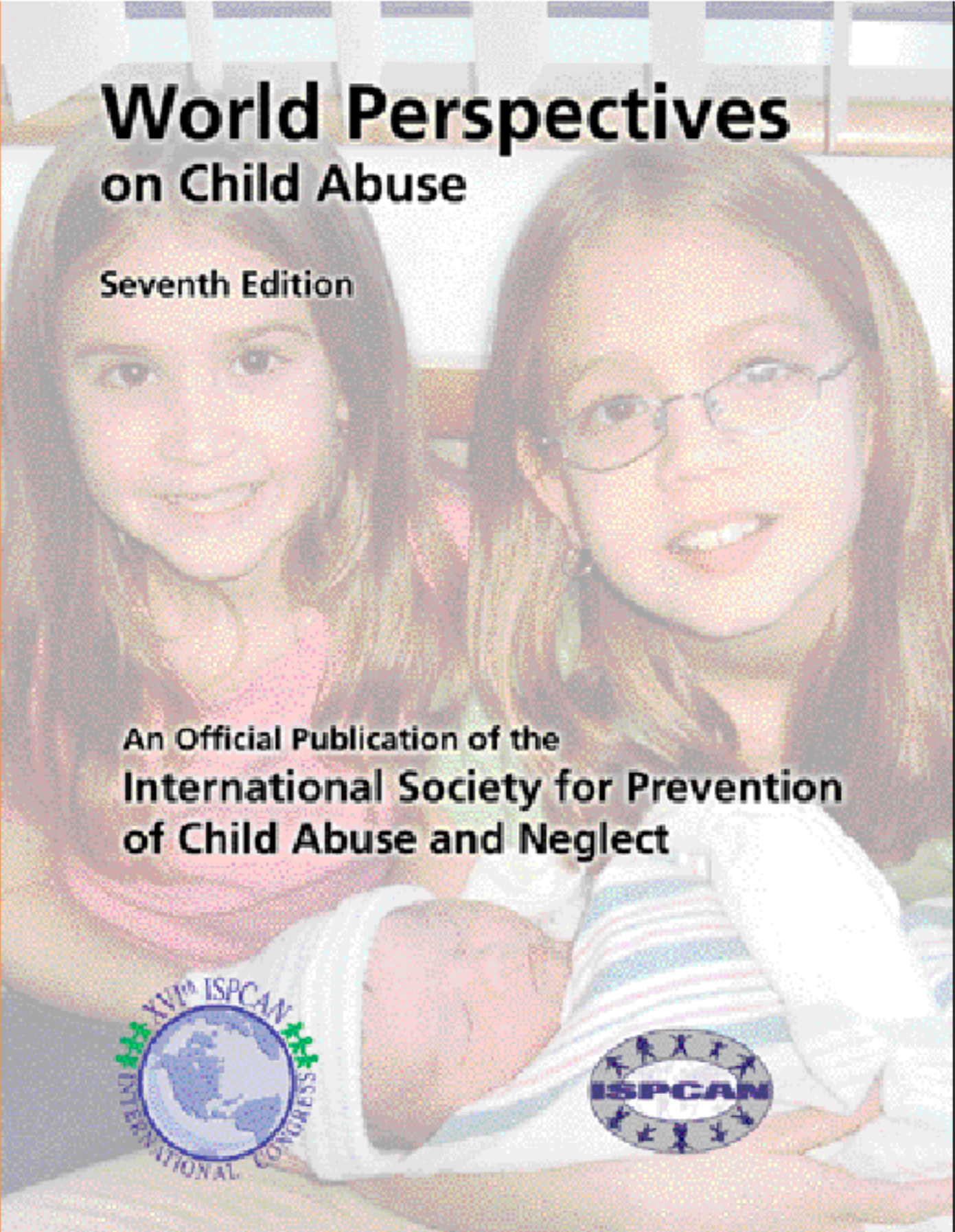
World Perspectives on Child Abuse

Seventh Edition



An Official Publication of the

International Society for Prevention of Child Abuse and Neglect

WORLD PERSPECTIVES ON CHILD ABUSE

Seventh Edition

An Official Publication of the
International Society for Prevention of Child Abuse and Neglect
(ISPCAN)

Edited by Deborah Daro, PhD

Sponsored by:

UNICEF
Health Surveillance and Epidemiology Division, Public Health Agency of Canada
Interchurch Organization for Development Co-operation (ICCO)

About ISPCAN

Mission: To support individuals and organizations working to protect children from abuse and neglect worldwide.

The International Society for Prevention of Child Abuse and Neglect, founded in 1977, is the only multi-disciplinary international organization that brings together a worldwide cross-section of committed professionals to work towards the prevention and treatment of child abuse, neglect and exploitation globally.

ISPCAN's mission is to prevent cruelty to children in every nation, in every form: physical abuse, sexual abuse, neglect, street children, child fatalities, child prostitution, children of war, emotional abuse and child labor. ISPCAN is committed to increasing public awareness of all forms of violence against children, developing activities to prevent such violence, and promoting the rights of children in all regions of the world.

ISPCAN Objectives:
To increase awareness of the extent, the causes and possible solutions for all forms of child abuse.
To disseminate academic and clinical research to those in positions to enhance practice and improve policy.
To improve the quality of current efforts to detect, treat and prevent child abuse.
To facilitate the exchange of best practice standards being developed by ISPCAN members throughout the world.
To design and deliver comprehensive training programs to professionals and concerned volunteers engaged in efforts to treat and prevent child abuse.

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Errors and Omissions:
The editors and authors have made every attempt to present factual information.
If a reader identifies an error or omission in the facts as presented, the reader is invited to submit a correction and explanation in writing to ISPCAN's Secretariat office for possible inclusion in future editions of this book.

Acknowledgements

This edition of *World Perspectives on Child Abuse* is the product of a successful partnership involving many individuals and organizations. First, we would like to thank our ISPCAN members, National Partners and professional colleagues for their willingness to complete their country-level surveys. These efforts have provided us rich descriptive information on the scope of child maltreatment in 72 countries and on the efforts underway in these countries to expand services, provide training and reform or establish effective public policy. Collectively, these individual contributions speak to the continued strides we are making as a field to recognize and more effectively address the problem of child maltreatment worldwide.

Second, we would like to thank the organizations that have provided generous financial support to cover the costs associated with completing the survey and the publication of this document. Their support enables us to provide copies to ISPCAN Congress delegates, and offer to other professionals at a subsidized rate. These fiscal partners include: UNICEF, Health Surveillance and Epidemiology Division of the Public Health Agency of Canada, and Interchurch Organization for Development Co-operation (ICCO). In addition, we are particularly grateful for the in-kind support we received from Dr. David Wolfe, ISPCAN Executive Council member and Professor of Psychology and Psychiatry at the University of Toronto, Canada and his research assistant, Jessica Pereira, in completing data entry. This direct financial assistance and in-kind professional support has been central in our ability to insure data quality and to implement an analytical plan that maximizes data utility and relevance.

It is important to acknowledge the UN Study on Violence Against Children, which is contributing to more accessible information for professionals as well as governments. In 2005-06, when we sent the World Perspectives questionnaires out to respondents, we included a link to the UN Study web page with their government reports – suggesting they might check the information provided. We also shared the information collected for this publication with the UN Study organizers.

Finally, we would like to recognize the long hours and consistent effort of the ISPCAN staff and consultants in securing the data from respondents, identifying emerging research and publications for inclusion in the Annotated Bibliography and managing the myriad details that are enviable in a project of this size. We want to particularly thank Kathy Shaw for her development of the Annotated Bibliography included in Section III; Kimberly Svevo, MA, ISPCAN Executive Director, for her tireless fund raising to support this project and her overall leadership; and Alexander Poleshchuk for his overall coordination of the World Perspectives project. We also wish to thank ISPCAN staff members and volunteers: Masah SamForay, Beeraj Patel and Cristina Sanchez for their project support through its development and publication. We also appreciate the important efforts by volunteer translators, Georges Abanda Ngon, Gina DeMarco, Carolina Gomez, Patricia Parten, and Alexey Poleshchuk, who made it possible to offer the survey and Executive Summary in Arabic, English, French, Spanish and Russian.

Since its initial publication in 1992, *World Perspectives* has been released in conjunction with most of the ISPCAN International Congresses. We believe timing the release of this publication to the Society's bi-annual meetings underscores our commitment to providing our members and those combating violence with the most recent and comprehensive assessment possible on the state of child abuse policy and practice worldwide. We believe that this *Seventh Edition* continues this tradition of contributing to the field's body of knowledge.

Deborah Daro
Editor

Cover: Valerie, Amanda and Natalie Marie Morales

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World Perspectives on Child Abuse:
An International Resource Book
Seventh Edition

Executive Summary

OVERVIEW

The International Society for the Prevention of Child Abuse and Neglect (ISPCAN) initiated its *World Perspectives on Child Abuse: An International Resource Book* in 1992 as part of the Ninth International Congress on Child Maltreatment, held in Chicago, Illinois. Since that time, six editions of this publication have been produced and released at subsequent bi-annual Congresses sponsored by ISPCAN. This document is the *Seventh Edition* in the series and is being released in conjunction with the 16th International Congress being held in York, England, September 2006. All of these efforts have sought to bring attention and understanding to the worldwide problem of child abuse and neglect and to highlight key differences and similarities across national policies.

A key component of this series has been a mail survey of key informants identified by the ISPCAN leadership as being knowledgeable about child maltreatment issues within their respective countries. In the first survey (1992), there were 80 respondents representing 30 countries. In the second edition (1996), responses were obtained from 53 respondents representing 37 countries. Beginning with the third edition (1998) emphasis was placed on obtaining one key respondent from as many countries as possible, resulting in 47 of the 94 countries invited to participate being included in the database. Since that year, the response rate has been consistent -- 58 of the 105 countries (55%) invited for the fourth edition (2000) responded; 67 of the 115 countries (58%) invited for the fifth edition (2002) responded; and 64 of the 98 countries (65%) contacted for the sixth edition (2004) responded. For the current edition, a total of 72 countries are represented out of a total pool of 161 countries (45%). The larger pool of potential respondents this year reflected, in part, the inclusion of 54 UNICEF regional officers in our sample. This extended outreach resulted in a record number of nine countries participating in this study for the first time. Although our sample of countries or respondents within countries is not consistent across all reporting periods, these bi-annual surveys offer a useful comparison of conditions over time within a diverse set of countries with respect to the scope of child abuse and the varying ways in which different cultures and political systems respond to the challenge of child protection. In order to facilitate participation in this survey effort, the questionnaire was translated and available to potential respondents in French, Spanish, and Russian.[1]

Section I of the report includes a detailed summary of the survey data as well as general child well-being indicators drawn from UNICEF's *State of the World's Children 2006*. In order to further augment our understanding of the diversity in the child maltreatment response and to provide professionals greater access to emerging research and best practice internationally, two additional components are once again included in this report. Section II includes 16 commentaries on specific research projects or practice reforms underway in one or more of the sample counties. Authored by ISPCAN members and researchers, these commentaries provide rich descriptions of the various ways in which child maltreatment is defined and addressed worldwide. Section III includes a detailed annotated bibliography summarizing the content of key journal articles and government reports issued over the past two years. These descriptions report on research or practice reforms underway in 23 countries.

KEY FINDINGS

The *Seventh Edition* represents a unique summary of the various ways in which child maltreatment is defined, measured and addressed in different regions of the world. Key findings emerging from the report are summarized below.

Scope of the problem

All but one of the countries surveyed consider sexual or physical abuse of a child by a caretaker to constitute child maltreatment. Other behaviors also frequently mentioned as abusive include children living on the street, child prostitution, abuse or neglect within foster care, and abandonment by parents or caretakers. In contrast to these areas of agreement, notable regional variation existed in the willingness to label other behaviors as abusive, such as failure to secure medical care based on religious beliefs, female circumcision and physical discipline.

[1] In order to facilitate access to the report's key findings, this Executive Summary is also available in Arabic, French, Spanish, and Russian on ISPCAN's web site (www.ispcan.org/wp).

Interestingly, the behavior least often mentioned by respondents as being considered child abuse in their country was physical discipline. Slightly less than half of the respondents reported this behavior constituted abuse in their country.

Surveillance Methods

Respondents from most countries reported using one or more surveillance methods to monitor child abuse and neglect (CAN) cases or to examine the public's general awareness of child abuse. Overall, 68% of the countries have conducted population surveys, 38% have conducted structured public opinion polls, 64% maintain an official count of CAN cases (i.e., a child abuse registry), and 39% maintain official records of child abuse fatalities. Of the 46 respondents who reported that their country maintained official counts of all suspected CAN cases, most (85%) included all four types of abuse in their records (e.g., physical, sexual, neglect, and psychological maltreatment). To determine whether the number of countries conducting official surveillance has increased over time, we examined data from the 1992, 1998, 2004 and current surveys. Although these data do suggest trends toward greater documentation and more established child maltreatment policies, caution is warranted, as these trends might simply be a function of different samples of countries responding to each survey.

National child abuse policy characteristics

Overall, 82% of respondents (N = 62) reported that their country has an official policy regarding child maltreatment. About two-fifths indicated that their countries had longstanding policies (i.e., over 15 years), and another 30% noted that their countries established these policies between 1990 and 2000. Two-thirds of the respondents indicated that policies, once enacted, were revised on occasion but were not subject to an annual review. On balance, policies within developing countries were more recent and more likely to have undergone frequent revisions. Most of these policies include criminal penalties for abusing a child, and provisions for removing a child to protect them from further abuse. As noted in prior surveys, respondents reported that their policies often included the possibility of both mandatory *and* voluntary reporting of suspected cases. When we examined the frequency with which a variety of provisions were included in these policies, only one significant difference was observed between the pool of developed and developing countries. Despite the relatively low levels of services available within developing countries, child abuse policies in these countries were more likely to include a provision requiring treatment services for abuse victims than were policies within developed countries. It is possible that such language is included in these emerging policies in recognition of the growing data on the initial and long-term consequences of maltreatment for a victim's subsequent development. Although many developing countries are not in a position to offer the array of services victims need, advocates in these countries may consider it important to establish a framework that embraces this idea.

Common treatment strategies

Respondents reported on the availability and adequacy of an array of services falling into one of three broad categories: parent intervention services, child intervention services, and general services. Respondents first indicated whether a service was available, and then indicated whether it was adequate in less than one-third of the country, one-third to two-thirds of the country, or more than two-thirds of the country. Overall, a greater number of child or general service strategies were available in the sample countries than were service strategies targeting parents. Although only two of the seven parent service strategies were offered in at least three-quarters of the sample countries, four of the five children's service models and five of the eight general service models were identified by this proportion of countries. The types of parent intervention services most often mentioned by respondents were short-term hospitalization for mental illness (90%) and substance abuse related treatments (76%). Child intervention services most often mentioned were therapy programs for child victims of sexual (83%) and physical (83%) abuse. As for general services, case management services to help meet basic needs were mentioned most often by respondents (82%).

Significant differences by developmental status were observed on the majority of these variables, with developed countries demonstrating a much richer array of services than respondents from developing countries. Indeed, only five of the 20 service models we asked about were *not* significantly less likely to be offered in developing countries (e.g., short-term hospitalization for mental illness, therapy programs for those who had physically abused a child, group homes for abused children, access to free medical care for all residents, and free child care).

Even in those cases where a given service model is offered, very few of these services were judged by respondents to be adequate in at least two-thirds of their country. For example, 90% of the respondents in developing countries reported that short-term hospitalization for mental illness was available; however, only 31% of

respondents rated the capacity to provide this service to individuals in need as adequate in two-thirds or more of the country.

Common prevention strategies

Respondents reported whether various child abuse prevention strategies were used in their country or not, and if so, whether the strategy was effective or not. To better understand a country's overall response, each prevention strategy was categorized as either an individual-level strategy that targets specific behaviors (e.g., professional training, risk assessments, home-based services for at-risk parents, home visitation for new parents), or a community or systems-level strategy that targets a policy, system, or a population (e.g., prosecutorial methods, media campaigns, improving living conditions of families, increasing local services).

Results indicated that developed countries reported greater use of all strategies than developing countries, although not all differences were statistically significant. Developed countries were more likely to use the individual-level strategies of risk assessment, home-based services for at-risk parents, universal home visitation for new parents, and the community-level strategies of media campaigns and improving and increasing local services than were developing countries. Although we had observed a significant differences in the use of health care services and access to preventive medical care across the developed and developing country samples in prior surveys, this difference, while still favoring the developing country sample, was not significant in the current survey.

Regarding effectiveness, respondents from developed countries generally found these prevention strategies more promising than their counterparts working in developing countries. This pattern might reflect the fact that most prevention strategies may not be as fully developed or as systematically delivered in developing countries and, therefore, less effective in enhancing the service response. In contrast to this pattern, those working in developing countries were more optimistic than their colleagues in developed countries about the potential benefits of professional training as a child abuse prevention strategy.

Barriers to expanding prevention efforts

Respondents rated the significance of a number of possible barriers to CAN prevention for their country as (1) not a significant barrier (2) of moderate significance, or (3) of major significance. Barriers were examined individually, and we also classified each barrier into issues of a country's economic and social resources (e.g., limited government resources, poverty) or of a country's social norms (e.g., sense of family privacy, support for use of physical punishment). Overall, the most commonly cited barriers to CAN prevention were limited resources, general support for corporal punishment and use of physical discipline, and a lack of effective systems to investigate abuse reports.

Differences by a country's developmental status were found for eight of the 11 factors we examined, with developing countries reporting each barrier to be more significant than developed countries. We then computed a mean for the seven economic and social resource barriers and four the four social norm barriers. As expected, significant differences were observed on these mean score for both set of barriers, with resource barriers and social norms presenting a more significant challenge in developing countries. On average, normative barriers were viewed as more limiting to expanding child abuse prevention efforts in developed countries while resource barriers were the dominant issue facing developing countries.

Predictors of child well-being

There are many factors that can reduce the prevalence of maltreatment, and that can enhance child well-being. To facilitate this discussion we examined those factors that best explained variation in each country's Under-Five Mortality Rate (U5MR). Although not all early deaths of young children reflect abusive and neglectful situations, many do result from an unwillingness or inability of parents to adequately meet their children's basic needs. These deaths also reflect societal neglect and the failure of governments to place a sufficient priority on insuring adequate health care for children and support for their parents. As expected, mortality rates for young children are significantly higher within developing countries, particularly among those countries battling high rates of HIV infection. Significantly higher U5MR rates also are observed within those countries reporting a higher number of resource and social norms barriers underscoring the unavoidable relationship between high rates of poverty, limited social service infrastructure, and normative standards that place low priority on children's rights and safety. Such conditions and barriers were significantly more likely to be reported by respondents from developing countries and are likely to account for the dramatic differences in mortality rates for children living in these regions. Finally, countries which reported high levels of service availability have significantly lower child mortality rates. Significant

correlations were observed between U5MR rates and the number of parent services, child services and general services offered in a country.

In contrast to these patterns, specific child abuse policies were not always highly correlated with U5MR rates. The maintenance of a child abuse registry and having a policy that established specific time frames for responding to child abuse were the only two policy options that correlated significantly with lower child mortality rates, suggesting that most of these policies have minimal impact on mortality rates. The lack of policy impacts was further confirmed in our multivariate analysis where the only significant predictors of childhood mortality were the number of reported resource and social norm barriers and total number of services available with the country.

This pattern is not surprising. The ability of a public policy to influence the levels and severity of social conditions such as child maltreatment is largely determined by the extent to which it is effectively and consistently implemented. As noted earlier, almost half of the developing countries that reported the existence of a formal child abuse policy established these policies after 2000. And, although policies exist in many developing countries, services for families and children who have experienced or are at-risk of maltreatment remain scarce. The establishment of a formal child abuse policy appears to be a positive first step in addressing the child abuse problem. Making significant inroads in preventing this problem, however, is a long-term process and one which will most likely involve efforts to both support families and achieve contextual change.

SUMMARY

As we have observed in past surveys, there is global agreement emerging on the major behaviors that constitute child abuse and neglect (e.g., sexual abuse, physical abuse, children living on the street, child prostitution). Although some differences continue to exist between the definitions embraced in developing versus developed countries and local social conditions frame the relative emphasis professionals may place on various behaviors, those working in diverse contexts are working with cases involving many of the same characteristics. Children who have experienced physical mistreatment, sexual abuse and parental or societal neglect can be found in many countries around the world, regardless of a country's economic conditions.

Much of the world's response to child abuse and neglect, however, is inextricably linked to funding. Although the proportion of developing countries establishing formal child abuse policies and response systems is growing, wide discrepancies remain in terms of service availability. Although much has been, and is being, learned about how to establish effective surveillance and response systems, it is clear that a significant number of children remain at high risk for experiencing violence and other negative outcomes. Children living in countries facing extreme economic hardship and social disruption are at particular risk. Our data also suggests that well-defined and broadly available parenting assistance and other supportive services can provide children, even those living in difficult circumstances, a greater level of protection. It is our hope that ISPCAN, through its members and National Partners, will be able to improve service availability and quality through its ongoing education and training programs and dissemination of best practices.

World Perspectives on Child Abuse
Seventh Edition

INTRODUCTION

The International Society for the Prevention of Child Abuse and Neglect (ISPCAN) initiated its *World Perspectives on Child Abuse: An International Resource Book* in 1992, as part of the Ninth International Congress on Child Maltreatment held in Chicago, Illinois. Since that time, six editions of this publication have been produced and released at subsequent bi-annual Congresses sponsored by ISPCAN. This document is the *Seventh Edition* in the series and is being released in conjunction with the 16th International Congress being held in York, England. All of these efforts have sought to bring attention and understanding to the worldwide problem of child abuse and neglect and to highlight key differences and similarities across national policies in this area.

As part of this series, survey methods have been used to obtain descriptive information on the characteristics and response to child abuse worldwide. Each year the ISPCAN leadership identifies one or more key informants from as many countries as possible and asks these individuals to describe the current status of the child maltreatment response in his or her nation. Specifically, respondents have been asked to comment on key dimensions of the child abuse problem such as:

- the major behaviors commonly included in a country's perception of child maltreatment;
- the extent of the professional response to maltreatment (e.g., reporting systems, case investigation systems, legal procedures for prosecuting cases, etc);
- the scope and availability of interventions to address the needs of abused children and their families;
- the public's general awareness of the child abuse problem;
- the major barriers professionals face in improving the response to child abuse and neglect; and
- the particular strengths or strategies that have been found effective in preventing child abuse and neglect

A key component of this series has been a mail survey of key informants identified by the ISPCAN leadership as being knowledgeable about child maltreatment issues within their respective countries. In the first survey (1992), there were 80 respondents representing 30 countries. In the second edition (1996), responses were obtained from 53 respondents representing 37 countries. Beginning with the third edition (1998) emphasis was placed on obtaining one key respondent from as many countries as possible, resulting in 47 of the 94 countries invited to participate being included in the database. Since that year, the response rate has been consistent -- 58 of the 105 countries (55%) invited for the fourth edition (2000) responded; 67 of the 115 countries (58%) invited for the fifth edition (2002) responded; and 64 of the 98 countries (65%) contacted for the sixth edition (2004) responded. For the current edition, a total of 72 countries are represented out of a total pool of 161 countries (45%). The larger pool of potential respondents this year reflected, in part, the inclusion of 54 UNICEF regional officers in our sample. This extended outreach resulted in a record number of nine countries participating in this study for the first time. Although our sample of countries or respondents within countries is not consistent across all reporting periods, these bi-annual surveys offer a useful comparison of conditions over time within a diverse set of countries with respect to the scope of child abuse and the varying ways in which different cultures and political systems respond to the challenge of child protection.

As in the past, this edition includes a detailed summary of the survey data as well as general child well-being indicators drawn from UNICEF's *State of the World's Children 2006*. In order to further augment our understanding of the diversity in the child maltreatment response worldwide, we have again asked ISPCAN members and other professionals engaged in international and national research efforts to submit descriptions of their work. In some instances, respondents discussed incidence studies or other research methods that have been used to detect or define child abuse and other acts of violence toward children. In other instances, these briefs summarize the strategies used by professionals to raise awareness of the child abuse problem, to establish a more robust institutional response to the problem, or to develop specific strategies to include the voice of children in the research and policy process. We believe these types of descriptive studies offer useful guidelines for all professionals and particularly those working in the developing regions of the world where child abuse response systems are only just emerging.

As we did with the *Sixth Edition,* the current edition also includes a detailed annotated bibliography summarizing the content of key journal articles and government reports issued over the past two years that document the impact

of promising programs and policies. Most professionals in developed countries have relatively easy access to professional journals and printed information. This is not the case, however, for professionals working in Africa, South America, Asia and Eastern Europe.

STRUCTURE OF THE REPORT

The *Seventh Edition of World Perspectives* is divided into three sections. Section I describes the methodology and findings from our survey of key informants. Specifically, this section describes the survey respondents and the geographic representation reflected in our sample; the various ways in which maltreatment is defined across countries, the perceived scope of the problem and level of public awareness; and the public, institutional response to child abuse in each country as well as the degree to which various non-governmental agencies are involved in supporting or providing child abuse interventions. Finally, the section addresses the major barriers identified by respondents as limiting their ability to address child maltreatment.

Section II includes the commentaries and briefs we obtained from respondents and other professionals working in the area of child maltreatment research and practice. These 16 commentaries cover a range of topics and issues including examples of how others are measuring or collecting child abuse incidence data across or within countries; how professionals in developing countries have overcome extreme environmental challenges in crafting child abuse response systems, professional associations or individual interventions; and how professionals or others around the world have effectively engaged children in the research process.

Section III includes an annotated bibliography which summarizes over 60 articles and policy papers that have been published over the past two years on child abuse, organized in terms of the 23 countries in which the research has been conducted. Specific topics addressed in this array of articles include a variety of issues related to the identification and treatment of child sexual abuse; the identification and response to child physical abuse; child exploitation, street children and the effects of war on children; children in institutional care; familial and environmental factors that impact child safety and well-being; and professional issues and attitudes in responding to child maltreatment.

A listing of respondents, a copy of the survey instrument, country specific summaries of the data and a list of international and national resources are presented in Appendix A, B, C and D respectively.

SECTION I: SURVEY OF KEY INFORMANTS

METHODOLOGY

Study Procedure

The *Seventh Edition*, as with previous editions, utilizes a convenience sample to gather the impressions of informed individuals regarding their perceptions of child abuse and neglect (CAN) in their country. Active ISPCAN members with access to national perspectives and data are invited to respond to the *World Perspectives* survey on behalf of their countries. With membership in 178 countries worldwide, ISPCAN has the capacity to identify a broad respondent pool that includes representation from all regions. More recently, the pool of survey respondents has been augmented by a number of National CAN Professional Societies participating in ISPCAN's National Partner program. In the current survey, representatives from partner societies in Australia, Benin, Britain, Cameroon, Colombia, Congo, Denmark, Ethiopia, Germany, Hong Kong, Italy, Japan, Malaysia, Nordic Association (e.g., Denmark, Greenland, Iceland, Finland, Norway and Sweden), Singapore, and South Africa contributed information to the data base. In addition to these sources, the current pool of potential respondents included representatives from 54 UNICEF regional offices.

The 2006 initial respondent sample included informants from 161 countries, a 65% increase over the number of countries contacted in 2004. All respondents were sent a questionnaire by electronic mail to obtain their assessments on a range of issues as described below. Seventy-two respondents (45%) returned the questionnaire in time for inclusion in our analysis.[2] Table 1 summarizes our response rate by the world's five major regions – Africa, Americas, Asia, Europe and Oceania. As indicated in Table 1, our response rate was at least 25% in all five regions, with the highest response rates being in Europe, Asia and Oceania. Although our overall and regional response rates are lower than in the prior years, in part due to our larger pool of potential respondents, the absolute number of countries represented in the survey is 12% higher this year than in 2004 (i.e., 72 versus 64).

It is important to bear in mind that these data may not be representative of all ISPCAN members or all countries in a given region, and although these data reflect the impressions of highly informed individuals, they were not systematically corroborated. The names and affiliations of all respondents who agreed to have their identity cited in the report are included in Appendix A.

Table 1: Regional Participation and Response Rate

	# of Countries in Region	# of Countries Invited to Respond	# of Countries that Responded	% of Respondents by # of Invited Countries
Africa	57	44	11	25%
Americas	51	26	10	38%
Asia	50	46	24	52%
Europe	51	40	25	63%
Oceania	25	5	2	40%
Total	**234**	**161**	**72**	**45%**

[2] We received one additional survey after the deadline (e.g., Ethiopia). Although the information from this country is not included in our summary discussions, a country specific profile capturing the Ethiopian responses is included in Appendix C.

Measures

Questionnaire. The questionnaire was composed of closed and open-ended questions. Topics covered in the questionnaire included:

- the major behaviors commonly included in a country's perception of child maltreatment;
- the extent of the professional response to maltreatment (e.g., reporting systems, case investigation systems, legal procedures for prosecuting cases, etc);
- the scope and availability of interventions to address the needs of abused children and their families;
- the public's general awareness of the child abuse problem;
- the major barriers professionals face in improving the response to child abuse and neglect; and
- the particular strengths or strategies that have been found effective in preventing child abuse and neglect.

Respondents also were asked questions about their discipline and whether they had participated in prior editions of *World Perspectives.* Finally, respondents were asked to describe any milestones or events that have shaped their efforts to address child abuse and neglect. To improve our response rate, the questionnaire was made available in English, French, Spanish, and Russian. A copy of the English version of the questionnaire is included in Appendix B (French, Russian and Spanish translations are available on the ISPCAN website at www.ispcan.org/wp).

UNICEF Indicators. In addition to respondent data, several indicators were included in this report from UNICEF's *State of the World's Children 2006*. These indicators are meant to reflect a country's level of national and child well-being by considering several pieces of information (e.g., rates of infant mortality, proportion of infants with low birth weight, proportion of children under five with moderate wasting, etc.). In addition, other information such as maternal mortality, percent of female primary school enrollment, proportion of the population with access to safe water, and HIV/AIDS rates can be used to reflect the safety and well-being of adult caregivers, which is related to children's safety and well-being. Together, this set of indicators is suggestive of a country's capacity and success in providing for a child's basic health care, educational, economic, and safety needs, and offers an overall picture of the climate in which respondents in the current sample work to reduce the prevalence and impacts of child abuse and neglect.

Analyses presented later in this report examined specific predictors of child well-being. One indicator, the under-five mortality rate (U5MR) was chosen to reflect a country's general level of child well-being. Although a combination of various indices would have been preferable, the amount of missing data for the countries in the current sample prohibited us from creating such an index. As a single indicator, the U5MR is preferable to other single indicators because it measures an outcome rather than an input (e.g., school enrollment), and has been demonstrated to reflect a number of others conditions such as maternal health knowledge, immunization levels, income and food availability, access to clean water and safe sanitation, and the overall safety of the child's environment.

Data Collection Procedures

Human Subjects Approval. The study's data collection methods and questionnaire were reviewed by the ISPCAN Institutional Review Board. In order to protect the rights of human subjects, all respondents were informed of the voluntary nature of the survey, and their right to withhold any information or to respond to the questionnaire anonymously. All those completing a survey provided a signed authorization to ISPCAN indicating that they understood their right to withhold information or to withhold disclosure of their identity without penalty, in terms of their ISPCAN benefits.

Data Analyses

Data in the body of this report are generally presented by region and a country's developmental status rather than by individual country. Specific country-level summaries are provided in Appendix C. In combining country level data into specific regions, we relied on the criteria used by the United Nations Statistics Division for grouping countries (http://unstats.un.org/unsd/methods/m49/m49regin.htm#ftnb).

Countries were classified as developed or developing countries based upon the designations used by the World Bank (http://www.worldbank.org/data/countryclass/countryclass.html). The World Bank's main criterion for classifying economies is Gross National Income (GNI) per capita. In previous *World Perspectives* reports, this term

was referred to as Gross National Product (GNP). GNI, a broad measure, was considered to be the best single indicator of economic capacity and progress; at the same time it was recognized that GNI does not, by itself, constitute or measure welfare or success in development. GNI per capita is therefore the Bank's main criterion for classifying countries. Based on its GNI per capita, every economy is classified as low income, middle income (subdivided into lower middle and upper middle), or high income. For the purposes of this report, countries with low and lower-middle incomes were classified as developing; countries with upper middle and high income were classified as developed.

Analyses consisted of computation of frequencies or means, followed by chi-squares or t-tests/ANOVAs where appropriate to examine differences by region and developmental status. Unfortunately, regional differences could not always be tested because there were small samples in some of the regions (e.g., Oceania, $N = 2$). In cases where regional variation appears large and noteworthy, we highlight trends and discuss them as potential rather than statistically significant differences. A final multiple regression analysis examines the unique contributions of CAN predictors on U5MR.

SAMPLE DESCRIPTION

Figure 1 summarizes the participation rate for the 118 countries that have ever responded to any of the *World Perspectives* surveys. Those countries participating in the current survey are shaded in black while respondents from any previous year are shaded in gray. Specific countries, along with their participation in current and previous questionnaires, are shown in Table 2. As this table indicates, the 2006 sample includes 12 countries that have been represented in all seven editions and nine countries participating for the first time. Over 60% of these respondents have participated in three or more of the previous surveys. Collectively, these countries represent all regions of the world, with 37 classified as developed countries and 35 classified as developing countries. Although not an exhaustive sample, the responding countries cover almost 78%% of the world's total population and 73% of the world's children. This represents a notable increase in the coverage of this report from our earlier survey efforts. For example, the 2000 survey covered only 40% of the child population and the 2002 survey covered only 60% of the child population (Bross, Miyoshi, Miyoshi, & Krugman, 2000; Bross, Miyoshi, Miyoshi, & Krugman, 2002). This increase in coverage in recent years is due largely to the inclusion of India beginning in 2004. From a regional perspective, almost half of all the Asian and European countries are represented in the current sample. In contrast, approximately one-fifth of the countries in Africa and the Americas, and only 8% of the countries in Oceania are included in this sample. This pattern generally reflects the distribution of ISPCAN's membership (and therefore access to survey respondents) as well as the concentration of identified efforts to address child abuse and neglect.

As noted above, we augmented our descriptive data on the sample countries by examining broad indicators of child health and well-being compiled by UNICEF. These data are summarized in Table 3. As expected, significant differences exist across regions and developmental status. For example, the average infant mortality rate for children under five was 6.5 times higher in developing countries compared to developed countries (73 per 1,000 and 11 per 1,000, respectively). Regional differences showed the African region to have the highest under-five mortality rate (142/1,000) compared to Asia (45/1,000), the Americas (21/1,000), Europe (10/1,000), and Oceania (6/1,000). Several additional indicators show similar patterns by region and developmental status, with the African region, and developing countries in general, reporting higher rates of HIV/AIDS, maternal mortality, and lower rates of female primary school enrollment. For example, the maternal mortality ratio (per 100,000 live births) for countries included in this sample is 540 for African countries compared to 121 for those in Asia, 68 for those in the Americas, and 18 for those in Europe. Maternal mortality is 13 times higher in developing countries compared to developed countries. All of these indicators highlight the dramatic differences in health conditions and financial resources across and within regions as well as across developmental status.

Figure 1. Countries Responding to Current and Prior Questionnaires

Table 2. Countries Responding to 1992-2006 Questionnaires by Region*

Country	1992	1996	1998	2000	2002	2004	2006
Africa							
Benin			a	✓	✓		✓
Cameroon			✓	✓		✓	✓
Congo, Dem. Rep of					✓	✓	✓
Côte d'Ivoire					✓	✓	✓
Egypt					✓	✓	✓
Ethiopia							a
Ghana			a	✓	✓	✓	
Kenya	✓	✓	✓		✓	✓	
Liberia						✓	
Mauritius						✓	✓
Namibia					✓		
Nigeria	✓				✓	✓	
Rwanda				✓	✓	✓	✓
Senegal			✓	✓			
Somalia							✓
South Africa	✓	✓	✓	✓	✓	✓	✓
Tanzania			a	✓			
Togo				✓	✓		✓
Tunisia	✓	✓	✓	✓			
Uganda					✓		
Zambia				✓	✓		✓
Zimbabwe					✓		
Americas							
Argentina		✓	✓	✓	✓	✓	✓
Aruba				✓	✓		
Barbados				✓			
Belize	✓	✓		✓	✓		
Bolivia					✓		
Brazil	✓	✓	✓	✓	✓	✓	✓
Canada	✓	✓	✓	✓	✓	✓	✓
Cayman Islands			✓				
Chile	✓				✓		✓
Colombia			✓		✓	✓	✓
Costa Rica	✓			✓			
Dominica				✓			
Dominican Rep.	✓	✓	✓		✓		
Ecuador		✓					
El Salvador						✓	
Honduras							✓
Mexico			✓	✓	✓	✓	✓
Panama			✓	✓			
Peru	✓				✓	✓	✓
St. Lucia							✓
Trinidad & Tobago				✓			
United States of America	✓	✓	✓	✓	✓	✓	✓
Uruguay	✓						
Asia							
Eastern Asia							
China			✓		✓	✓	✓
Hong Kong Sp Adm. Reg. China		✓	✓	✓	✓	✓	✓
Japan		✓	✓	✓	✓		✓
Korea, Rep of				✓	✓	✓	✓

Table 2. Countries Responding to 1992-2006 Questionnaires by Region*

Country	1992	1996	1998	2000	2002	2004	2006
Mongolia						✓	✓
Taiwan, Rep. of China			✓	✓	✓		✓
South-Central Asia							
Bangladesh		✓	✓				✓
India	✓					✓	✓
Iran					✓		
Kyrgyzstan				✓		✓	
Maldives					✓		
Nepal						✓	✓
Pakistan	✓	✓	✓		✓	✓	✓
Sri Lanka			✓	✓	✓	✓	✓
Tajikistian							✓
Turkmenistan							✓
Uzbekistan					✓		
South-Eastern Asia							
Indonesia				✓	✓	✓	
Malaysia	✓	✓	✓	✓	✓	✓	✓
Philippines		✓		✓	✓	✓	✓
Singapore		✓	✓	✓		✓	✓
Thailand			✓		✓	✓	✓
Western Asia							
*Armenia						✓	✓
Bahrain					✓	✓	✓
Cambodia					✓		
Georgia						✓	✓
Israel	✓	✓	✓	✓	✓	✓	✓
Jordan						✓	
Lebanon						✓	✓
Palestinian Territory						✓	
Saudi Arabia						✓	
Syria						✓	✓
Yemen							✓
Europe							
Albania			✓				✓
Austria	✓	✓					
Belarus							✓
Belgium	✓	✓	✓	✓	✓		
Bosnia & Herzegovina							✓
Bulgaria					✓	✓	✓
Croatia				✓			
Czech Rep.		✓	✓		✓		
Denmark		✓	✓	✓	✓	✓	✓
England	✓	✓	✓	✓	✓	✓	✓
Estonia		✓		✓	✓	✓	✓
Finland	✓	✓		✓			✓
France	✓	✓	✓	✓	✓	✓	✓
Germany	✓	✓	✓	✓	✓	✓	✓
Greece	✓	✓	✓	✓	✓		✓
Hungary				✓	✓	✓	✓
Iceland					✓		✓
Ireland	a	✓	✓				
Italy	✓	✓	✓	✓	✓	✓	✓
Latvia				✓		✓	

Table 2. Countries Responding to 1992-2006 Questionnaires by Region*

Country	1992	1996	1998	2000	2002	2004	2006
Luxembourg				✓			
Macedonia			✓				
Montenegro							✓
Netherlands	✓	✓	✓	✓	✓	✓	✓
Northern Ireland			✓	✓			
Norway	✓	✓	✓		✓		
Poland			a		✓	✓	✓
Portugal			✓		✓	✓	✓
Romania				✓		✓	✓
Russian Federation			✓	✓	a	✓	✓
Scotland		✓	✓	✓	✓	✓	✓
Serbia				✓	✓	✓	✓
Slovak Republic			✓	✓	✓	✓	
Spain	✓	✓	✓	✓	✓	✓	✓
Sweden	✓	✓			✓	✓	✓
Switzerland			✓	✓	✓	✓	
Turkey					a		✓
Ukraine						✓	
Wales			a	✓			
Oceania							
Australia	✓	✓	✓	✓	✓	✓	✓
New Zealand		✓	✓	✓	✓	✓	✓

a. Survey was received after the deadline for submissions. As such, these data are not included in the summary report developed for a given year.

*Web-page referenced for regional breakdowns: http://unstats.un.org/unsd/methods/m49/m49regin.htm#ftnb.

SCOPE OF CHILD ABUSE WORLDWIDE

What is Considered Child Abuse or Neglect?

Participants were asked to indicate whether a series of parental or caretaker behaviors and social or institutional conditions were considered child abuse and neglect in their country. Table 4 shows the percentages (overall, by region, and by developmental status) of respondents who indicated that a specific behavior is considered child abuse and neglect in their country. The most common behaviors considered child abuse and neglect across all or most subgroups were sexual and physical abuse by parents or caretakers; these were considered child abuse and neglect in all countries. Other behaviors also mentioned by at least 90% of the respondents as abusive include failure to provide adequate food, clothing or shelter; child prostitution; children living on the street; and abuse or neglect occurring within foster care settings. At least 80% of the respondents also considered abandonment by parents or caretakers, physical beatings of a child by any adult (regardless of relationship), forcing a child to beg, child infanticide, and abuse within a school or detention facility as constituting an act of child maltreatment.

There was considerable regional variation in what is viewed as CAN behaviors for several specific items including: failure to secure medical care based on religious beliefs, female circumcision, and physical discipline. This variability may reflect the very different cultural and religious contexts across regions. Other items that showed wide regional variation were parental mental illness and non-organic failure to thrive (FTT), which may be out of the control of parents or caregivers and, in the case of FTT, may be linked to extreme poverty in some regions.

Many behaviors that are considered child abuse and neglect also varied according to a country's developmental status. On balance, respondents from developed countries were significantly more likely than respondents from developing countries to list the following behaviors as maltreatment: failure to provide adequate food, clothing, or shelter; failure to secure medical care for a child based on religious beliefs; psychological neglect; parental substance abuse; non-organic failure to thrive; female or child infanticide; female circumcision; and abuse or neglect within a variety of settings including foster care, schools, daycare centers, or psychiatric institutions.

In some instances, these patterns may reflect a normative standard within more developed and economically secure countries that children should be provided with a minimal level of basic necessities and some form of emotional support regardless of the family's personal resources or inclinations. Although many children in developed countries may not enjoy these benefits, such failures are commonly viewed as constituting child maltreatment. In contrast, countries facing extreme economic hardship or those dealing with armed conflict within their territorial boundaries may find it difficult to distinguish between the standard of care generally available to children living in countries with minimal resources and those behaviors which constitute special or unique abusive situations.

Interestingly, one of the behaviors least often mentioned by respondents as being considered child abuse in their country was the use of physical discipline. Only 48.6% of all respondents reported that this practice is considered abusive within their country. Although an equal proportion of respondents from developed and developing countries included this practice within their definitions of child maltreatment, the proportion of respondents across regions noting this pattern ranged from a high of 60% in the Americas and Europe to roughly one-third in Asia, and no country within the Oceania region (i.e., Australia and New Zealand). This pattern suggests that physical discipline, although often cited in the research as being potentially harmful to a child's emotional and physical well-being, remains normative practice within many countries and is not considered, in and of itself, synonymous with child abuse.

That said, efforts have been underway for a number of years to enact legislative reform aimed at reducing or eliminating the use of corporal punishment, particularly in institutional settings. Most notable have been the efforts of the Global Initiative to End All Corporal Punishment of Children (www.endcorporalpunishment.org), an organization supported by UNICEF, UNESCO, the UN High Commissioner for Human Rights, ISPCAN, and many other international and national agencies and human rights institutions. According to this organization, 15 countries have passed laws to protect children from all forms of corporal punishment. These countries include Austria, Croatia, Cyprus, Denmark, Romania, Finland, Germany, Israel, Iceland, Bulgaria, Latvia, Norway, Sweden, Ukraine, and Hungary. In addition, Belgium added a clause to its Constitution in 2000 confirming children's right to moral, physical, psychological and sexual integrity, and is currently considering an explicit ban on all corporal punishment. Although not yet confirmed through legislation, court rulings in Italy and Portugal have declared corporal punishment to be unlawful.

Surveillance Methods

Respondents answered a set of questions aimed at determining whether various methods of CAN surveillance exist in their countries. Specifically, we asked if population-based surveys had been conducted in the past ten years; if public opinion polls to assess awareness had been completed; if the country had an official counting system for CAN cases and, if so, the types of behaviors documented by this system; and if the country had a method for recording CAN fatalities.

Respondents from most countries reported using one or more surveillance methods to monitor CAN cases or to examine the public's general awareness of child abuse and neglect. Overall, 67% of the countries have conducted population-based surveys, 38% have conducted structured public opinion polls, 64% maintain an official count of CAN cases, and 39% maintain official child abuse death records. Table 5 presents more detailed information about these methods by country. Of the 46 respondents who reported that their country maintained official counts of formal child abuse reports, most (85%) included all four types of behaviors commonly used to define child maltreatment within public records (e.g., physical, sexual, neglect, and psychological maltreatment). Those countries not embracing this typology generally omitted psychological maltreatment or physical neglect reports. In addition to documenting formal reports of child maltreatment, approximately one-third of these countries also maintain formal child abuse fatality registries. Both of these strategies were found across regions and across countries at different levels of development, suggesting that the process of formally documenting the frequency of at least some aspects of maltreatment is wide-spread. Indeed, as reported in Figure 2, the proportion of respondents indicating that their countries have formal child maltreatment policies and maintain these types of registries has increased since 1992. Although the proportion of countries reporting the use of child abuse death registries is slightly down from the 2004, the absolute number of countries using this strategy was higher in the 2006 sample than in previous samples (i.e., 27 countries reported death registries in 2004 while 28 countries reported such registries in the current sample).

Based on these types of administrative data, respondents were asked to comment on the extent to which they believe maltreatment levels have increased, decreased, or remained the same over the past ten years. Forty-three of the respondents (59%) were able to provide these assessments. Of this group, 77% reported that child abuse rates have increased in their countries, 7% reported a decline in incidence, and 16% believe the number of cases

have remained relatively stable over the past ten years. When asked to assess what might have accounted for these changes, respondents were more likely to suggest that an increase in identified cases reflected a change in public awareness and a willingness to report suspected cases than to reflect an actual increase in the incidence rate. Overall, these types of general assessments are difficult to interpret. The accuracy of this information may be confounded with the type of reporting system that exists in each country. For example, mandatory reporting systems may yield higher rates of child abuse and neglect than voluntary reporting systems. Also, reports may vary depending on the types of data sources considered, with data from population studies yielding different results than data from official reporting systems.

The fact that many respondents reported increases is troubling, but may indeed be due to increased surveillance or awareness. Newly implemented recording systems often document increases because more professionals are trained to assess and attend to child abuse and neglect, and therefore, uncover more cases (Zellman & Fair, 2002). Likewise, there are many factors that could cause an increase in CAN rates within countries that have longstanding surveillance systems. To fully understand changes in incidence and prevalence, it would be necessary to conduct more rigorous evaluations, where rates are plotted each year and confounds (e.g., types of CAN policies in place, when they were implemented, funding levels for CAN programs, historical effects, etc.) are statistically controlled. Because of the costs associated with such efforts, very few national incidence studies or careful analyses of child abuse reporting data have been conducted on an ongoing basis. (For exceptions in this area, please see Trocmé, MacLaurin, Fallon, et al., 2001 and Sedlek & Broadhurst, 1996).

Raising Awareness. One effect of instituting a surveillance system is that it will likely lead to an increase in awareness about the extent of a problem. Increased awareness is important because countries with greater awareness and recognition of child abuse and neglect are more likely to support prevention and intervention programs (Lewis, Sargent, Chaffin et al. 2004). Respondents who had completed structured public opinion polls or who had other evidence on which to assess changes in public awareness answered several questions regarding which aspects of the problem were best known to the general public as well as which strategies they considered most likely to have influenced awareness levels. Overall, 28 respondents (39% of the full sample) had completed a formal public opinion poll and a total of 34 respondents (47% of the full sample) felt they had sufficient information to respond to the questions. Results, about awareness of specific issues and factors influencing awareness reported by this subgroup of respondents, are displayed by region and developmental status in Table 6. In general, the respondents were more confident that the public understood how they might act to prevent child abuse and multiple causes of maltreatment than they were that the public fully understood the scope of the problem and how they could collectively, as a society, better protect children. No significant differences in these assessments were noted between developing and developed countries, although African countries tended to assess the level of public awareness in all areas more favorably than did respondents in the other regions.

With respect to the relative impacts of various public awareness strategies, no significant differences were observed between respondents from developing versus developed countries, although respondents from the developing countries were generally more confident in these strategies than respondents from developed countries. The one exception to this pattern was in the area of professional education. As noted in Table 6, over 57% of the respondents from developed countries viewed this method as an effective way to raise awareness in contrast to only 43% of the respondents from developing countries. One possible hypothesis regarding this shift might be the length of time extensive professional education efforts have been available in these regions. Professional training efforts, such as those provided through ISPCAN's multi-site ITPI training program, are relatively new in developing countries, often offering the first systematic introduction of the concept and its impacts on children to various key informant groups. Health care professionals, educators and social workers are often in a pivotal position to pass on new information or understanding to their clients, thereby influencing public awareness and action. In contrast, professionals in Western Europe, North America, Australia and New Zealand have had access to such training for decades and have already had substantial impact on how child abuse is defined within their countries and on levels of public awareness. As such, the additional gains that might be achieved in public awareness as a result of continued professional education may be quite modest.

The potential emphasis on public awareness campaigns, particularly in the USA, may reflect a belief that individuals have a unique responsibility for their own well-being and those of their immediate family. Rather than expecting formal, institutional solutions for a variety of social problems, U.S. public policy in the area of child abuse is often built around the assumption that if parents better understand their own limitations and the needs of their children, they will be able to find help within their informal networks or among local services operated by community-based agencies. The emphasis on public awareness efforts in Asia and to a lesser extent in Africa, however, may reflect that professionals in these areas are at the very early stages of responding to this problem and are using public awareness efforts simply to educate the public on the existence of child abuse and neglect.

Table 3. UNICEF Indicator Data

Region/Country	Total Pop[a] (thousands)	Pop under 18[e] (thousands)	Under 1 Infant mortality rate (per 1000)[a]	Under 5 infant mortality rate (per 1000)[a]	% infants with low BW[b]	% of under-5 children with moderate wasting[b]	Maternal mortality ratio[f] (per 100,000 live births)	% of pop with access to safe water[c]	Total life expect[e]	% primary school enroll: Male[d]	% primary school enroll: Female[d]	% of adults (15-49) w/ HIV/ AIDS[g]	GNI per capita (USA $) 2004
Africa													
Benin	8177	4192	90	152	16	8	500	68	54	69	47	1.9	530
Cameroon	16038	7801	87	149	11	5	430	63	46	-	-	6.9	800
Congo, Dem	55853	30127	129	205	12	13	1300	46	44			4.2	120
Côte d'Ivoire	17872	8829	117	194	17	7	600	84	46	67	54	7	770
Egypt	72642	29491	26	36	12	4	84	98	70	93	90	<0.1	1310
Mauritius	1233	364	14	15	14	14x	22	100	72	96	98	-	4640
Rwanda	8882	4640	118	203	9	6	1100	73	44	85	88	5.1	220
Somalia	7964	4016	133	225	-	17	-	29	47	-	-	-	130x
South Africa	47208	18417	54	67	15	3	150	87	47	89	89	21.5	3630
Togo	5988	3030	78	140	18	12	480	51	55	99	83	4.1	380
Zambia	11479	6127	102	182	12	5	730	55	38	69	68	16.5	450
Americas													
Argentina	38372	12277	16	18	8	3	44	-	75	-	-	0.7	3720
Brazil	183913	62194	32	34	10x	2	64	89	71	98	91	0.7	3090
Canada	31958	7007	5	6	6	-	-	100	80	100	100	0.3	28390
Chile	16124	4989	8	8	5	0	17	95	78	85	84	0.3	4910
Colombia	44915	16685	18	21	9	1	78	92	73	88	87	0.7	2000
Honduras	7048	3284	31	41	14	2x	110	90	68	87	88	1.8	1030
Mexico	105699	39787	23	28	8	2	65	91	75	99	100	0.3	6770
Peru	27562	10701	24	29	11x	1	190	81	70	100	100	0.5	2360
St. Lucia	159	57	13	14	8	6x	35	98	73	99	100	-	4310
USA	295410	74694	7	8	8	1X	8	100	78	92	93	0.6	41400
Asia													
Armenia	3026	852	29	32	7	2	9	92	72	95	93	0.1	1120
Bahrain	716	231	9	11	8	5x	46	-	75	89	91	0.2	10840x
Bangladesh	139215	58970	56	77	36	13	380	75	63	82	86	-	440
China	1307989	358887	26	31	4	-	51	77	72	99	99	0.1	1290
Georgia	4518	1115	41	45	7	2	52	76	71	89	88	0.1	1040
Hong Kong*	-	-	-	-	-	-	-	-	-	-	-	-	
India	1087124	419442	62	85	30	16	540	86	64	90	85	-	620
Israel	6601	2169	5	6	8	-	5	100	80	99	99	0.1	17380
Japan	127923	21949	3	4	8	-	8	100	82	100	100	<0.1	37180
Korea, Rep. of	47645	11031	5	6	4	-	20	92	77	100	100	<0.1	13980

Table 3. UNICEF Indicator Data

Region/Country	Total Pop[a] (thousands)	Pop under 18[e] (thousands)	Under 1 Infant mortality rate (per 1000)[a]	Under 5 infant mortality rate (per 1000)[a]	% infants with low BW[b]	% of under-5 children with moderate wasting[b]	Maternal mortality ratio[f] (per 100,000 live births)	% of pop with access to safe water[c]	Total life expect[e]	% primary school enroll: Male[d]	% primary school enroll: Female[d]	% of adults (15-49) w/ HIV/ AIDS[g]	GNI per capita (USA $) 2004
Lebanon	3540	1230	27	31	6	3	100x	100	72	91	90	0.1	4980
Malaysia	24894	9529	10	12	9	-	30	95	73	93	93	0.4	4650
Mongolia	2614	1009	41	52	7	6	99	62	65	78	80	<0.1	590
Nepal	26591	12260	59	76	21	10	7	84	62	75	66	0.5	260
Pakistan	154794	71297	80	101	19x	13	530	90	63	68	50	0.1	600
Philippines	81617	34448	26	34	20	6	170	85	71	93	95	<0.1	1170
Singapore	4273	1033	3	3	8	4x	6	-	79	-	-	0.2	24220
Sri Lanka	20570	6108	12	14	22	14	92	78	74	-	-	<0.1	1010
Syria	18582	8309	15	16	6	4	65	79	74	100	96	<0.1	1190
Taiwan *	-		-	-	-	-	-	-		-	-	-	-
Tajikistan	6430	3062	91	118	15	5	45	58	64	97	91x	<0.1	280
Thailand	63694	18617	18	21	9	6x	24	85	70	87	84	1.5	2540
Turkmenistan	4766	1896	80	103	6	6	14	71	63	-	-	<0.1	1340
Yemen	20329	10986	82	111	32x	12	370	69	61	84	59	0.1	570
Europe													
Albania	3112	1048	17	19	3	11	23	97	74	96	94	-	2080
Belarus	9811	2048	9	11	5	-	18	100	68	95	94	-	2120
Bosnia & Herzegovina	3909	827	13	15	4	6	10	98	74	-	-	<0.1	2040
Bulgaria	7780	1406	12	15	10	-	15	100	72	91	90	<0.1	2740
Denmark	5414	1203	4	5	5	-	10	100	77	100	100	0.2	40650
Estonia	1335	273	6	8	4	-	46	-	72	95	94	1.1	7010
Finland	5235	1108	3	4	4	-	6	100	79	100	100	0.1	32790
France	60257	13290	4	5	7	-	10	-	80	99	99	0.4	30090
Germany	82645	14933	4	5	7	-	8	100	79	82	84	0.1	30120
Greece	11098	1968	4	5	8	-	1	-	78	99	99	0.2	16610
Hungary	10124	1993	7	8	9	2x	5	99	73	91	90	0.1	8270
Iceland	292	78	2	3	4	-	-	100	81	100	99	0.2	38620
Italy	58033	9861	4	5	6	-	7	-	80	100	99	0.5	26120
Netherlands	16226	3556	5	6	-	-	7	100	79	100	99	0.2	31700
Poland	38559	8243	7	8	6	-	4	-	75	98	98	0.1	6090
Portugal	10441	2010	4	5	8	-	8	-	78	100	99	0.4	14350
Romania	21790	4490	17	20	9	3x	31	57	72	89	88	<0.1	2920
Russian Fed.	143899	29809	17	21	6	4x	32	96	65	89	90	1.1	3410

Table 3. UNICEF Indicator Data

Region/Country	Total Pop[a] (thousands)	Pop under 18[e] (thousands)	Under 1 Infant mortality rate (per 1000)[a]	Under 5 infant mortality rate (per 1000)[a]	% infants with low BW[b]	% of under-5 children with moderate wasting[b]	Maternal mortality ratio[f] (per 100,000 live births)	% of pop with access to safe water[c]	Total life expect[e]	% primary school enroll: Male[d]	% primary school enroll: Female[d]	% of adults (15-49) w/ HIV/ AIDS[g]	GNI per capita (USA $) 2004
Serbia & Montenegro	10510	2416	13	15	4	4	7	93	74	96	96	0.2	2620
Spain	42646	7407	3	5	6x	-	6	-	80	100	99	0.7	21210
Sweden	9008	1949	3	4	4	-	5	100	80	100	99	0.1	35770
Turkey	72220	25283	28	32	16	1	130x	93	69	89	84	-	3750
United Kingdom	59479	13208	5	6	8	15x	7	-	79	100	100	0.1	33940
Oceania													
Australia	19942	4816	5	6	7	-	-	100	81	96	97	0.1	26900
New Zealand	3989	1050	5	6	6	-	15	-	79	100	99	0.1	20310

[a] Selected Indicators – The State of the World's Children 2006 – Table 1 Basic Indicators.
[b] Selected Indicators – The State of the World's Children 2006 – Table 2 Nutrition.
[c] Selected Indicators – The State of the World's Children 2006 – Table 3 Health.
[d] Selected Indicators – The State of the World's Children 2006 – Table 5 Education.
[e] Selected Indicators – The State of the World's Children 2006 – Table 6 Demographic Indicators.
[f] Selected Indicators – The State of the World's Children 2006– Table 8 Women. Data are adjusted to account for the well-documented problems of underreporting and misclassification of maternal deaths.
[g] Selected Indicators – The State of the World's Children 2006 – Table 4 HIV/AIDS
* Independent statistics for Hong Kong and Taiwan are not included in the UNICEF report.
x = data refer to years or periods other than those specified in the column heading, differ from the standard definition or refer to only part of a country.
-- data missing

Table 4. Behaviors Generally Viewed as Child Abuse or Neglect by Region and Developmental Status

	Total (N=72)	Region					Developmental Status	
		Africa (n=11)	Americas (n=10)	Asia (n=24)	Europe (n=25)	Oceania (n=2)	Developed (n=37)	Developing (n=35)
Relationship between child and parents/caretakers								
Sexual abuse (e.g., incest, sexual touching, pornography)	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Physical abuse (e.g., beating, burning)	98.6	90.9	100.0	100.0	100.0	100.0	100.0	97.1
Failure to provide adequate food, clothing or shelter (neglect)	90.3	72.7	100.0	91.7	92.0	100.0	100.0	80.0**
Abandonment by parent or caretaker	88.9	81.8	100.0	83.3	92.0	100.0	94.6	82.9
Emotional abuse (e.g., repeated belittling or insulting a child)	77.8	63.6	100.0	62.5	88.0	100.0	89.2	65.7
Failure to secure medical care for child based on religious beliefs	73.2	72.7	80.0	60.9	84.0	50.0	80.6	65.7**
Psychological neglect (e.g., failure to provide emotional support/attention) [a]	69.0	63.6	80.0	54.2	79.2	100.0	80.6	57.1
Parental substance abuse	68.1	63.6	70.0	45.8	88.0	100.0	78.4	57.1*
Domestic violence	59.7	63.6	60.0	41.7	76.0	50.0	67.6	51.4
Parental mental illness	48.6	36.4	40.0	37.5	64.0	100.0	54.1	42.9
Physical discipline (e.g., spanking) [b]	48.6	45.5	60.0	37.5	60.0	0.0	48.6	48.6
Non-organic failure to thrive (FTT)	47.2	36.4	50.0	37.5	56.0	100.0	64.9	28.6**
Social conditions affecting child safety								
Child prostitution	98.6	100.0	100.0	100.0	96.0	100.0	100.0	97.1
Children living on the street	90.3	100.0	100.0	83.3	92.0	50.0	91.9	88.6
Physical beating of a child by any adult	86.1	72.7	90.0	83.3	96.0	50.0	83.8	88.6
Forcing a child to beg	83.3	63.6	90.0	87.5	84.0	100.0	89.2	77.1
Female/child infanticide [c]	81.7	72.7	70.0	82.6	88.0	100.0	91.9	70.6*
Child labor	69.4	63.6	80.0	70.8	68.0	50.0	75.7	62.9
Abuse by another child	68.1	63.6	80.0	62.5	76.0	0.0	67.6	68.6
Children serving as soldiers [d]	57.6	60.0	66.7	59.1	50.0	100.0	64.7	50.0

Table 4. Behaviors Generally Viewed as Child Abuse or Neglect by Region and Developmental Status

	Total (N=72)	Region					Developmental Status	
		Africa (n=11)	Americas (n=10)	Asia (n=24)	Europe (n=25)	Oceania (n=2)	Developed (n=37)	Developing (n=35)
Female circumcision[e]	56.9	60.0	60.0	45.0	60.9	100.0	71.4	40.0**
Abuse/neglect of child within specific settings								
Foster care, group home or orphanage	93.1	81.8	100.0	91.7	96.0	100.0	100.0	85.7**
School or educational training center	84.7	72.7	100.0	75.0	92.0	100.0	91.9	77.1*
Detention facility	83.3	72.7	100.0	75.0	92.0	50.0	83.8	82.9
Day care center	79.2	72.7	90.0	79.2	76.0	100.0	91.9	65.7**
Psychiatric institution	66.7	54.5	80.0	62.5	68.0	100.0	78.4	54.3*

[a] Total N = 71 (Europe, n = 24)
[b] Total N = 71 (Asia, n = 23)
[c] Total N = 71 (Asia, n = 23)
[d] Total N = 66 (Africa, n = 10; Americas, n = 9; Asia, n = 22; Europe, n = 24; Oceania, n = 1)
[e] Total N = 65 (Africa, n=10; Asia, n = 20; Europe, n = 23)

* = $p < .05$, ** = $p < .01$, *** = $p < .001$.

Table 5. Surveillance, and Types of Abuse Included in Official Counts

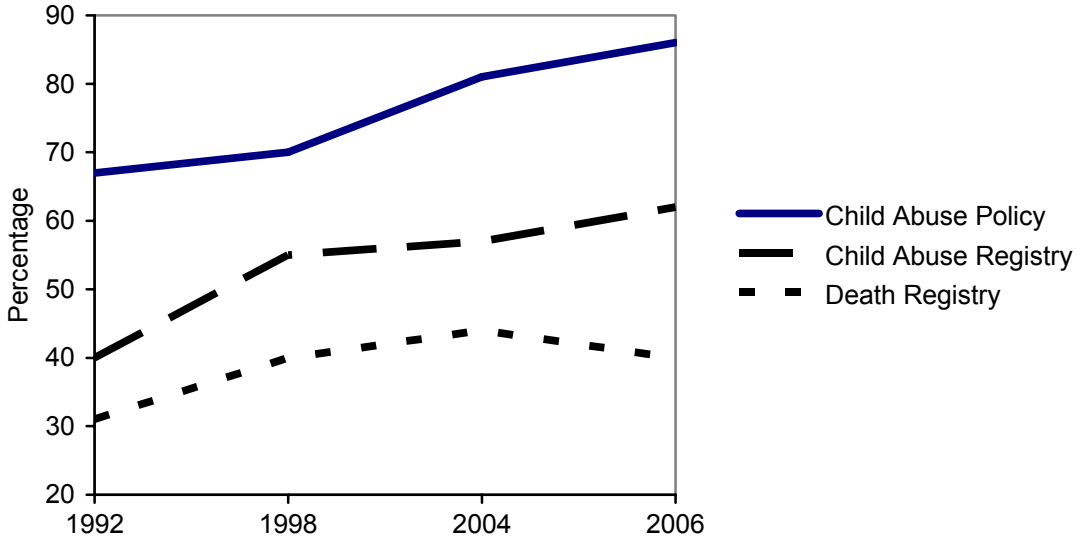
	Surveillance method				Abuse type included from official count of child abuse			
	Public opinion poll done? [a]	Pop. based surveys done in past 10 yrs? [a]	Tenure of CAN fatality reporting system [b]	Tenure of CAN reporting system [b]	Phys [c]	Sexual [c]	Neglect [c]	Psych [c]
Africa								
Benin	✓		5 - 10	5 - 10	✓	✓	✓	✓
Cameroon		✓						
Côte d'Ivoire	✓	✓						
Congo, Rep of	✓	✓		< 5	✓	✓	✓	✓
Egypt	✓	✓	5 - 10	5 - 10				
Mauritius	✓	✓	10 +	10 +	✓	✓	✓	✓
Rwanda		✓	< 5	< 5	✓	✓	✓	✓
Somalia		✓						
South Africa		✓		10 +	✓	✓	✓	
Togo								
Zambia								
Americas								
Argentina								
Brazil			5 - 10	5 - 10	✓	✓	✓	✓
Canada		✓		5 - 10	✓	✓	✓	✓
Chile		✓		< 5	✓	✓	✓	✓
Colombia	✓	✓	5 - 10	5 - 10	✓	✓	✓	✓
Honduras		✓		10 +	✓	✓	✓	
Mexico	✓	✓	10 +	10 +	✓	✓	✓	✓
Peru	✓	✓		< 5	✓	✓	✓	✓
St. Lucia				10 +	✓	✓	✓	✓
United States of America	✓	✓	10 +	10 +	✓	✓	✓	✓
Asia								
Eastern Asia								
China	✓	✓	5 - 10	5 - 10	✓	✓		
Hong Kong Special Adm. Reg. of China	✓	✓		10 +	✓	✓	✓	✓
Japan		✓	< 5	10 +	✓	✓	✓	✓
Korea, Republic of			< 5	< 5	✓	✓	✓	✓
Mongolia		✓		< 5	✓	✓	✓	✓
Taiwan		✓		10 +	✓	✓	✓	✓
Central Asia								
Bangladesh	✓		< 5	10 +	✓	✓	✓	✓
India	✓							
Nepal	✓	✓						
Pakistan		✓						
Sri Lanka	✓	✓		< 5	✓	✓	✓	✓
Tajikistan	✓	✓	DK	DK	✓	✓		
Turkmenistan								
South-Eastern Asia								
Malaysia				10 +	✓	✓	✓	✓
Philippines			10 +	10 +	✓	✓	✓	✓
Singapore	✓	✓	10 +	10 +	✓	✓	✓	✓
Thailand	✓		< 5					

Table 5. Surveillance, and Types of Abuse Included in Official Counts

	Surveillance method				Abuse type included from official count of child abuse			
	Public opinion poll done? [a]	Pop. based surveys done in past 10 yrs? [a]	Tenure of CAN fatality reporting system [b]	Tenure of CAN reporting system [b]	Phys [c]	Sexual [c]	Neglect [c]	Psych [c]
Western Asia								
Armenia	✓	✓		< 5	✓	✓	✓	✓
Bahrain		✓	10 +	10 +	✓	✓	✓	✓
Georgia								
Israel		✓	< 5	5 - 10	✓	✓	✓	✓
Lebanon	✓	✓		< 5	✓	✓	✓	✓
Syrian Arab Republic		✓						
Yemen		✓						
Europe								
Albania								
Belarus								
Bosnia & Herzegovina	✓	✓						
Bulgaria				5 - 10	✓	✓	✓	✓
Denmark		✓						
Estonia		✓						
Finland								
France		✓	10 +	5 - 10	✓	✓	✓	✓
Germany		✓	10 +	10 +	✓	✓		
Greece								
Hungary	✓			5 - 10	✓	✓	✓	✓
Iceland		✓	5 - 10	10 +	✓	✓	✓	✓
Italy		✓	10 +					
Netherlands				10 +	✓	✓	✓	✓
Poland		✓						
Portugal								
Romania		✓	10 +	DK	✓	✓	✓	✓
Russian Federation	✓	✓	10 +	< 5	✓	✓	✓	✓
Scotland		✓		10 +	✓	✓	✓	✓
Serbia & Montenegro	✓			10 +	✓	✓	✓	✓
Scotland			10 +					
Spain	✓	✓		< 5	✓	✓	✓	✓
Sweden		✓						
Turkey		✓		5 - 10	✓	✓	✓	
United Kingdom	✓	✓	10 +	10 +	✓	✓	✓	✓
Oceania								
Australia	✓	✓	5 - 10	10 +	✓	✓	✓	✓
New Zealand	✓	✓	10 +	10 +	✓	✓	✓	✓

[a] check = yes, blank = no.
[b] Numbers are in years where < 5 = less than five years, 5-10 = between 5 and 10 years, 10+ = > than 10 years.
[c] Phys = physical abuse, Sexual = sexual abuse, Neglect = child neglect, Psych = psychological abuse.

Figure 2. Changes in Number of Countries with Surveillance and Official Child Abuse & Neglect Policies



THE CURRENT RESPONSE TO MALTREATMENT WORLDWIDE

There are different ways to respond to a social problem, one of which is to create a national policy that clearly delineates how institutions and individuals should respond to cases. To examine countries' responses to child abuse and neglect, we asked a series of questions about CAN policy including the presence of an official policy, when it was established, the number of revisions, and the specific elements included in the policy. Overall, 86% of respondents (*N* = 62) reported that their country has such a policy. Regarding the tenure of these policies, 41.2% indicated that their countries had longstanding policies (i.e., over 15 years), and another 30% noted their countries established child abuse policies between 1990 and 2000. Two-thirds of the respondents indicated that these policies, once enacted, were revised from time to time but not subject to an annual review. On balance, the child abuse policies within developing countries were more recent (χ^2 = 12.48, p < .006) and more likely to have undergone a greater number of revisions (χ^2 = 14.56 p < .002).

We examined three broad categories of policy elements: nature of their reporting system (e.g., mandatory, voluntary or both); elements of their "criminal justice" legal response; and elements of their "social service" or clinical response. Table 7 shows policy elements of the 62 countries that indicated the presence of a national policy. Most policies included criminal penalties for abusing a child and provisions for removing a child to protect him/her from further abuse. As we have observed in prior surveys, respondents reported that their policies included language allowing for mandatory *and* voluntary reporting. Although some states or regions may have policies with language requiring that reports only be accepted if filed by those identified as mandated reporters (e.g., doctors, law enforcement), many jurisdictions accept reports from any individual who voluntarily comes forward to report a case.

It is noteworthy that only one-third of respondents reported policies in their countries containing a requirement that all abusers receive some form of service or intervention, whereas two-thirds of countries' policies included provisions for the development and support for prevention services. One explanation for the absence of a specific emphasis on providing therapeutic services to offenders is the increasing trend toward viewing child abuse as a crime rather than as a mental health problem. If child abuse were a crime, then emphasis would naturally be on prosecution and punishment rather than on treatment. Another possible explanation for the tendency to favor prevention over treatment is that policy makers perceive prevention as the less costly policy to pursue – it is generally less expensive to provide short-term parenting education or family support services than it is to provide intensive, ongoing therapy to abusers or their victims.

Table 6. Awareness of Child Abuse and Neglect by Region and Developmental Status

Level of Awareness	Total (N=72)	Region					Developmental Status	
		Africa (n = 10)	Americas (n = 10)	Asia (n = 24)	Europe (n = 25)	Oceania (n = 2)	Developed (n=37)	Developing (n=34)
% Conducted Public Opinion Poll	39.4	50.0	40.0	45.8	24.0	100.0	32.4	47.1
Based on poll and other information, % reporting moderate or more awareness of:								
	(n=34)	(n=6)	(n=5)	(n=12)	(n=9)	(n=2)	(n=15)	(n=19)
# of abused children	61.7	100.0	80.0	50.0	67.6	50.0	60.0	63.2
Multiple causes of child abuse and neglect	70.6	83.3	80.0	66.7	55.5	100.0	80.0	63.2
How a society can prevent child abuse and neglect	58.8	83.4	60.0	50.0	55.6	50.0	53.4	63.2
How individuals can act on their own to protect children	76.4	83.4	80.0	75.0	77.8	50.0	80.0	73.7
% viewing strategy as major impact								
Use of public awareness campaigns	66.7	66.7	80.0	80.0	50.0	0.0	68.8	65.0
Professional education	51.4	50.0	0.0	71.4	62.5	0.0	43.8	57.9
Government policies	38.2	16.7	20.0	61.5	37.5	0.0	31.3	44.4
Advocacy efforts to change public policies and behaviors	34.3	16.7	0.0	53.3	42.9	0.0	33.3	35.0

Also, such early intervention programs can address a wide range of social concerns, not simply child abuse. As such, a number of primary prevention policies might be more likely to be built into various legislative efforts than would be mandatory treatment for identified victims or offenders. Clearly, as articulated in previous *World Perspectives* editions, these findings highlight the need to examine more fully the roles that punitive vs. therapeutic vs. preventive interventions play in reducing the prevalence of child abuse and neglect (Bross, Miyoshi, Miyoshi, & Krugman, 2002). We will return to this point later in the report after consideration of respondents' reports of prevention and intervention strategies and perceived effectiveness.

One significant difference in these policies was observed between the pool of developing and developed countries. As noted in Table 7, the policies reported by respondents from developing countries were significantly more likely to include an explicit provision around the availability of treatment services for victims ($\chi^2 = 7.63$, $p < .006$). Given the limited availability of such services within these countries noted elsewhere in the survey, it is not clear how to interpret this policy provision. It is possible that such language is included in the child abuse policies currently being crafted in developing regions of the world in recognition of the growing data on the initial and long-term consequences of maltreatment for a child's emotional, social and physical development. Although these countries are not currently in a position to offer the full array of services needed by maltreatment victims, they may consider it important to establish a framework that embraces an ideal rather than be limited by current fiscal or service realities. In contrast, the more established child welfare systems operating in the developed world may be hesitant to identify any type of response for which resources are not clearly available to fully implement.

Service Availability

In addition to a policy response to child abuse and neglect, it is critical to examine the availability of services to prevent new cases or to reduce rates of recidivism. We asked respondents to report on the availability and adequacy of an array of service strategies falling into one of three broad categories: parent intervention services, child intervention services, and general services. Respondents first indicated whether a specific service was offered, and then indicated whether it was adequate in less than one-third of the country, one-third to two-thirds of the country, or more than two-thirds of the country. Table 8 displays the availability of each service by region and developmental status, and whether that service was rated adequate in two-thirds or more of the country.

Overall, a greater number of child or general service strategies were available in the sample countries than were service models targeted specifically to parents. Although only two of the seven parent-focused service strategies were available in the sample countries, four of the five children's services, and five of the eight general service models were reported as being offered in these countries. The parent intervention strategies most often mentioned by respondents were short-term hospitalization for mental illness (90%) and substance abuse related treatments (76%). The child intervention services most often mentioned as being offered were therapy programs for child victims of sexual (83%) and physical (83%) abuse. As for general services, case management services to help meet basic needs were mentioned most often by respondents (82%).

Regional differences in the availability of services surfaced for all types, with the African countries generally reporting a less diverse pool of parent, child and general services. There also were differences by developmental status on the majority of these variables, all of which showed that respondents from developed countries reported a much richer array of services than respondents from developing countries. Indeed, only five of the 20 service models we asked about were *not* significantly less likely to be offered in developing countries - short-term hospitalization for mental illness, therapy programs for those who had physically abused a child, group homes for abused children, access to free medical care for all residents, and free child care.

Even in those cases where a given service model might be offered within a country, very few of these services were judged by respondents to be adequate in at least two-thirds of their country. For example, 90% of the respondents in developing countries reported that short-term hospitalization for mental illness was available; however, only 31% of respondents rated the capacity to provide this service to individuals in need as adequate in two-thirds or more of the country.

Table 7. Elements of National Government Policy on Child Abuse and Neglect by Region and Developmental Status

	Total (N = 62)	Region					Developmental Status	
		Africa (n = 10)	Americas (n = 10)	Asia (n = 18)	Europe (n = 22)	Oceania (n = 2)	Developed (n = 33)	Developing (n = 29)
Nature of Reporting System								
Voluntary reporting by professionals or individuals	82.0	80.0	90.0	72.2	85.7	100.0	87.9	75.0
Mandated reporting by professionals or individuals	80.3	77.8	90.0	72.2	86.4	50.0	81.8	78.6
Initial Criminal Justice Response								
Provisions for removing child from parents/caretakers	96.6	100.0	100.0	87.5	100.0	100.0	100.0	92.0
Specific criminal penalties for abusing a child	93.4	100.0	100.0	94.1	90.9	50.0	87.9	100.0
Requires that a separate attorney or advocate be assigned to represent child's interests	70.0	77.8	90.0	64.7	59.1	100.0	60.6	81.5
Requires that reports be investigated within a specific time period	63.2	50.0	77.8	58.8	61.9	100.0	66.7	58.3
Service Provisions								
Requires that all victims receive services/intervention	82.3	80.0	90.0	88.9	77.3	50.0	69.7	96.6**
Development and support for prevention services	69.2	54.5	50.0	75.0	81.3	100.0	60.6	71.4
Requires that all abusers receive services/intervention	36.2	33.3	30.0	62.5	23.8	0.0	36.4	36.0

Notes: Respondents from 62 of the 72 (86.1%) countries indicated that they have a national child abuse and neglect policy. Countries without an official policy include: Albania, Bahrain, Georgia, Greece, Hong Kong, Poland, Somalia, Tajikistan, and Yemen. Due to missing data, the number of respondents for each category outlined above range from 57-62.

Table. 8. Available Services and Capacity Level by Region and Developmental Status

Service		Total (N=72)	Region					Developmental Status	
			Africa (n = 11)	Americas (n = 10)	Asia (n = 24)	Europe (n = 24)	Oceania (n = 2)	Developed (n = 37)	Developing (n = 35)
Parent Intervention Services									
Short-term hospitalization for mental illness	*Availability* *Adequate for >66.6%*	90.3 31.7	63.6 0.0	90.0 62.5	91.7 25.0	100.0 34.8	100.0 50.0	94.6 73.3	85.7 41.4*
Substance abuse related treatments for parents	*Availability* *Adequate for >66.6%*	76.1 25.5	45.5 0.0	70.0 16.7	79.2 5.6	87.5 50.0	100.0 50.0	91.1 40.6	58.8*** 0.0***
Therapy programs for those who physically abused a child	*Availability* *Adequate for >66.6%*	52.1 20.0	27.3 33.3	70.0 16.7	62.5 7.1	41.7 30.0	100.0 50.0	51.4 27.3	31.4 7.7
Home-based services to assist parents in changing their behaviors	*Availability* *Adequate for >66.6%*	50.7 27.0	18.2 0.0	30.0 50.0	47.8 0.0	72.0 38.9	100.0 50.0	73.0 38.5	26.5*** 0.0**
Therapy programs for those who sexually abuse a child	*Availability* *Adequate for >66.6%*	43.7 12.9	18.2 0.0	60.0 16.7	45.8 9.1	41.7 10.0	100.0 50.0	63.9 20.0	40.0* 0.0
Family resource centers for parents to share experiences/concerns	*Availability* *Adequate for >66.6%*	41.7 21.4	18.2 0.0	50.0 50.0	33.3 0.0	52.0 23.1	100.0 50.0	59.5 33.0	22.9** 0.0*
Targeted home visits for new parents at-risk	*Availability* *Adequate for >66.6%*	41.7 27.6	9.1 0.0	40.0 20.0	29.2 16.7	64.0 33.3	100.0 50.0	58.3 38.1	28.6** 0.0*
Child Intervention Services									
Therapy programs for child victims of sexual abuse	*Availability* *Adequate for >66.6%*	83.3 10.3	54.4 0.0	90.0 12.5	87.5 5.0	88.0 13.6	100.0 50.0	97.9 17.1	68.6*** 0.0*
Therapy programs for child victims of physical abuse	*Availability* *Adequate for >66.6%*	82.5 29.4	54.5 16.7	90.0 12.5	83.3 5.6	84.0 14.3	100.0 50.0	97.3 17.6	62.9*** 4.8
Substance abuse related treatments for children	*Availability* *Adequate for >66.6%*	77.5 19.6	36.4 0.0	90.0 14.3	79.2 11.1	87.5 30.0	100.0 50.0	89.2 33.0	60.0** 0.0*
Institutional care for abused children	*Availability* *Adequate for >66.6%*	75.0 34.7	54.5 20.0	90.0 28.6	79.2 27.8	80.0 47.4	0.0 --	89.2 43.3	64.7** 21.1

Table. 8. Available Services and Capacity Level by Region and Developmental Status

Service		Total (N=72)	Region					Developmental Status	
			Africa (n = 11)	Americas (n = 10)	Asia (n = 24)	Europe (n = 24)	Oceania (n = 2)	Developed (n = 37)	Developing (n = 35)
Group homes for abused children	*Availability*	54.3	45.5	50.0	59.1	52.0	100.0	64.9	42.4
	Adequate for >66.6%	21.6	0.0	50.0	7.7	28.6	50.0	34.8	0.0**
General Services									
Case management services/meeting basic needs	*Availability*	81.7	9.1	70.0	70.8	84.0	100.0	83.8	48.6**
	Adequate for >66.6%	51.0	100.0	50.0	11.8	33.3	50.0	43.3	5.9**
Universal health screening for children	*Availability*	79.2	54.5	80.0	75.0	92.0	100.0	91.1	65.7**
	Adequate for >66.6%	64.8	50.0	50.0	52.9	81.0	100.0	78.1	45.5**
Foster care with official foster parents	*Availability*	73.2	40.0	90.0	58.3	92.0	100.0	97.6	47.1***
	Adequate for >66.6%	33.3	25.0	42.9	6.7	47.8	50.0	44.1	11.8*
Universal access to free medical care for children	*Availability*	69.4	45.5	60.0	62.5	88.0	100.0	83.8	54.3**
	Adequate for >66.6%	66.7	60.0	66.7	38.5	81.8	100.0	76.7	50.0*
Financial and other material support	*Availability*	65.2	45.5	70.0	63.6	70.8	100.0	83.8	43.8***
	Adequate for >66.6%	30.2	0.0	33.3	7.1	52.9	50.0	51.5	7.4***
Universal access to free medical care for all citizens	*Availability*	54.2	36.4	50.0	50.0	68.0	50.0	62.2	45.7
	Adequate for >66.6%	68.4	75.0	60.0	45.5	82.4	100.0	73.9	60.0
Free child care	*Availability*	47.8	11.1	50.0	50.0	59.1	50.0	58.8	36.4
	Adequate for >66.6%	37.9	100.0	40.0	9.1	63.6	0.0	38.9	36.4
Universal home visits for all new parents	*Availability*	39.4	0.0	40.0	16.7	75.0	100.0	61.1	17.1***
	Adequate for >66.6%	48.3	--	20.0	20.0	61.1	50.0	50.0	50.0

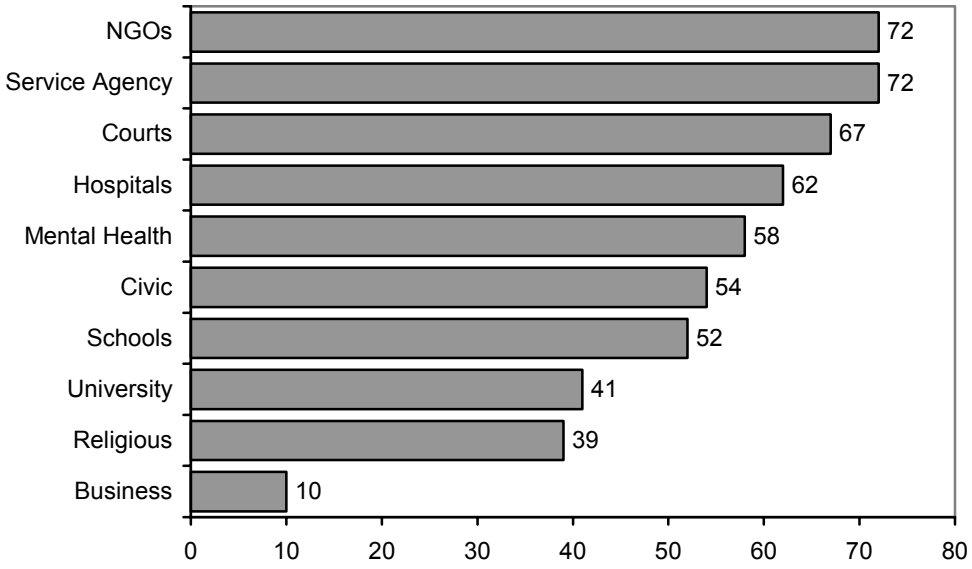
Notes: *Availability* indicates the percent of countries stating a service was available. "*Adequate for >66.6%"* indicates that, of countries that had a service available (between 55 and 35 countries depending on the specific service), the percent that stated the service was adequate in more than two-thirds of the country.

* p < .05; ** p < .01; *** p < .001 for t-test of developed vs. developing countries.

Involvement by Community Sectors

Respondents were asked to indicate the involvement of 10 different community sectors in providing support for child abuse treatment and prevention services (Table 9). On average, respondents reported that all six sectors were at least minimally involved in CAN treatment and prevention. However, the sectors that most often were reported as being moderate to fully involved in local efforts to address child abuse included community-based non-governmental organizations (NGOs), public social service agencies, courts and law enforcement, and hospitals and medical centers (see Figure 3). Sectors with the least amount of involvement included religious institutions, universities, businesses and factories. In fact, 90% of the sample rated businesses as somewhat to totally *inactive*. As summarized in Table 9, differences by developmental status were significant for five sectors, with the strongest differences being the lower levels of involvement on the part of public social service agencies and primary and secondary schools within developing countries. This pattern is understandable given the dearth of social service infrastructure in many developing countries. In the absence of a coherent and reliable array of governmental support in this area, those addressing the problem of child abuse in developing countries come to rely upon grants and staff provided by international relief organizations such as UNICEF, World Vision and other charitable entities.

Figure 3: Involvement by Community Sector
(% moderate to very active)



Funding for Child Abuse and Neglect

Much of what drives agency involvement, and service availability and adequacy, is funding. Respondents reported whether agencies in their country receive funding (ranging from no funding, moderate, to major funding) from a variety of sources, including international organizations, government, and private sources. Overall, the most common funding sources were national, state and local government, and international NGOs (Table 10). Differences in developmental status were observed with respect to the role played by international organizations, and all levels of government and private foundations, though these effects varied by type of funding. Developing countries received funding more often from international NGOs ($t = 5.60$, $p < .000$) and international relief organizations ($t = 2.34$, $p < .02$) than developed countries, whereas developed countries received funding more often from national government ($t = -3.27$, $p < .002$), state government ($t = -3.80$, $p < .000$), local governments ($t = -4.18$, $p < .000$), and private foundations ($t = -3.11$, $p < .003$). As noted above, the governmental budgets for social services in developing countries are extremely limited, and often inadequate for meeting even the basic needs of local residents for food, housing and minimal health care.

Table 9. Community Agency/Institution Involvement by Region and Developmental Status

Community Sectors	Total (N = 72)	Region					Developmental Status	
		Africa (n = 11)	Americas (n = 10)	Asia (n = 24)	Europe (n = 25)	Oceania (n = 2)	Developed (n = 37)	Developing (n = 35)
Public Social Service Agencies	3.10	2.82	3.00	2.75	3.54	4.00	3.56	2.62***
Community-Based NGOs	3.03	3.36	2.50	3.13	2.91	4.00	3.11	2.94
Courts/Law Enforcement	2.91	2.82	3.15	2.86	2.79	4.00	3.14	2.65*
Hospitals/Medical Centers	2.90	2.91	2.90	2.83	2.88	4.00	3.17	2.63*
Mental Health Agencies	2.73	2.55	2.80	2.46	3.00	3.00	3.00	2.42**
Voluntary Civic Organizations	2.56	3.09	2.33	2.50	2.42	3.00	2.58	2.53
Primary/Secondary Schools	2.54	2.40	2.44	2.30	2.83	3.00	2.89	2.18***
Religious Institutions	2.30	3.18	2.20	2.04	2.05	3.50	2.36	2.24
Universities	2.17	2.20	2.44	2.00	2.18	2.50	2.31	2.00
Businesses/Factories	1.45	1.22	2.44	1.48	1.17	1.00	1.56	1.34

Notes: Responses are the average across countries on a 1-4 rating scale where 1 = no involvement, 2 = minimal involvement, 3 = moderate involvement, and 4 = full involvement. The number of respondents commenting on the role each sector played in their country's response to child maltreatment ranged from 67 to 72.

* $p < .05$; ** $p < .01$; *** $p < .001$ for t-test of developed vs. developing countries.

Strategies Used and Effective in Child Abuse and Neglect Prevention

Respondents reported whether various CAN prevention strategies were used in their country or not, and if so, whether the strategy was effective or not. Table 11 shows results by region and developmental status of the country ordered by the frequency of each strategy. The most commonly used strategies were advocacy, prosecution, media campaigns, professional training, and improved and expanded local services. However, it is often the case that a strategy can be widely available, but reported as generally not effective at preventing child abuse and neglect. For example, respondents reported the use of some strategies (93% prosecuted child abuse offenders) but when asked to rate the effectiveness of this strategy, only 43% of respondents rated prosecution as effective.

Returning to the earlier discussion of what types of interventions may be most useful in preventing child abuse and neglect or reducing recidivism, it may be helpful for local professional associations and advocacy groups to ascertain why there are discrepancies in the availability and effectiveness of some types of strategies. It could be that some strategies were not effective because of the lack of resources needed to implement them as broadly as necessary or with the level of quality required to enhance their effectiveness, as discussed in greater detail below. The manner of implementation could also lead to an ineffective strategy (e.g., an abuser was sentenced too harshly or too leniently). It may also be important to probe the nuances of how different strategies are, or should be, linked. One last point for consideration is that most interventions are successful with only a portion of the at-risk population (e.g., young parents, those with certain information needs or concerns) or more appropriate for only a certain type of maltreatment (e.g., physical abuse versus child neglect). As such, the most effective prevention system for a given country may be one which includes a careful assessment of a family's specific set of needs and offers an array of interventions to address them (Daro, 2002).

To better understand a country's overall response, each CAN prevention strategy was categorized as either an individual-level strategy that targets specific behaviors (e.g., professional training, risk assessments, home-based services for at-risk parents, home visitation for new parents), or a community or systems-level strategy that targets a policy, system, or population (e.g., prosecutorial methods, media campaigns, improving living conditions of families, increasing local services). Some strategies could not easily be categorized as they could be applied at either level (e.g., advocacy to help individuals obtain services or advocacy lobbying for CAN policies). Even with this limitation, however, we can begin to examine whether there are differences in the broad classes of strategies used by countries.

Results indicated that developed countries reported greater use of all strategies than developing countries, although not all differences were statistically significant. Developed countries were more likely to use the individual-level strategies of risk assessment, home-based services for at-risk parents, universal home visitation for new parents, and community-level strategies of media campaigns, and improving and increasing local services than were developing countries. Although we had observed significant differences in the use of health care services and access to preventive medical care across the developed and developing country samples in prior surveys, this difference, while still favoring the developing country sample, was not significant in the current survey.

Regarding effectiveness, respondents from developed countries generally found these prevention strategies more promising than their counterparts working in developing countries. This pattern might reflect the fact that most prevention strategies may not be as fully developed or as systematically delivered in developing countries and, therefore, less effective in enhancing the service response. In contrast to this pattern, those working in developing countries were more optimistic than their colleagues in developed countries about the potential benefits of professional training as a child abuse prevention strategy. As noted earlier, systematic professional training programs are relatively new in developing countries, and in the future may play an important role in both raising awareness, and building a core group of individuals in a position to advocate for practice and policy reforms and influence normative standards. Although respondents from developed and developing countries differed in which prevention strategies they found useful, the only significant differences between the answers of the two groups involved ratings of risk assessment methods and improving general living conditions.

Table 10. Level of Activity for Agencies that Fund Child Abuse Treatment or Prevention Services by Region and Developmental Status

Funding Sources	Total (N = 72)	Region					Developmental Status	
		Africa (n = 11)	Americas (n = 10)	Asia (n = 24)	Europe (n = 25)	Oceania (n = 2)	Developed (n = 37)	Developing (n = 35)
International Organizations								
International NGOs/Agencies (e.g., UNICEF, World Bank)	1.94	2.50	1.80	1.96	1.82	1.00	1.53	2.35***
International Relief Organizations (e.g., World Vision, Red Cross)	1.61	2.20	1.22	1.64	1.52	1.00	1.44	1.80*
Government								
National Government	2.19	1.80	2.20	2.14	2.36	2.50	2.42	1.94**
State or Provincial Government	2.12	1.82	2.00	2.00	2.38	3.00	2.43	1.80***
Local Government	1.95	1.64	2.00	1.83	2.22	1.50	2.29	1.59***
Private								
Private Foundations	1.75	1.70	1.75	1.76	1.74	2.00	1.97	1.48**
Individuals	1.49	1.45	1.75	1.58	1.33	1.50	1.59	1.38
Corporations/local businesses	1.37	1.50	1.67	1.45	1.13	2.00	1.44	1.29

Notes: Responses are the average across countries on a 1-3 rating scale where 1 = no funding, 2 = moderate funding, and 3 = major funding. The number of respondents commenting on the role of each sector in supporting child abuse efforts in their country ranged from 61 to 69.

* $p < .05$; ** $p < .01$; *** $p < .001$ for t-test of developed vs. developing countries

Table 11. Strategies Used and Effective in Preventing Child Abuse by Region and Developmental Status

Strategies		Total (N = 72)	Region					Developmental Status	
			Africa (n = 11)	Americas (n = 10)	Asia (n = 24)	Europe (n = 25)	Oceania (n = 2)	Developed (n = 37)	Developing (n = 35)
Advocacy (I, C)	Used	94.2	100.0	100.0	95.7	87.0	100.0	94.1	94.3
	Effective	70.8	54.5	80.0	77.2	70.0	50.0	75.0	66.7
Professional training (I)	Used	88.1	72.7	100.0	85.7	91.3	100.0	97.1	88.6
	Effective	78.0	62.5	70.0	88.8	80.9	50.0	32.4	54.8
Media campaigns (C)	Used	90.0	89.9	100.0	83.8	91.3	100.0	97.2	82.4*
	Effective	66.6	30.0	90.0	80.0	61.9	50.0	68.6	64.3
Prosecution of child abuse offenders (C)	Used	92.9	81.8	100.0	87.5	100.0	100.0	94.1	81.8
	Effective	43.0	44.4	50.0	47.6	39.1	0.0	87.5	66.7*
Improving/increasing local services (C)	Used	82.1	63.6	87.5	79.2	90.9	100.0	93.8	71.4*
	Effective	67.3	28.5	85.7	63.2	80.0	50.0	68.0	63.6
A system of universal health care and access to preventive medical care (C)	Used	77.1	72.7	50.0	75.0	91.3	100.0	85.7	68.6
	Effective	59.3	37.5	80.0	44.4	76.1	50.0	66.7	50.0
Improving living conditions of families (e.g., housing, clean water) (C)	Used	72.3	72.7	80.0	72.7	65.0	100.0	80.6	64.7
	Effective	66.0	62.5	75.0	68.7	69.2	0.0	73.7	43.5*
Increasing individual responsibility for child protection (I, C)	Used	59.4	72.7	60.0	62.5	50.0	50.0	65.7	52.9
	Effective	53.6	12.5	83.3	40.0	90.9	0.0	65.2	38.9
Home-based services and supports for parents at-risk (I)	Used	54.1	0.0	30.0	37.5	75.0	100.0	63.9	25.7***
	Effective	75.0	--	66.6	77.7	72.2	100.0	82.6	55.6
Risk assessment methods (I)	Used	44.8	30.0	50.0	29.2	63.6	50.0	64.7	24.2***
	Effective	53.3	0.0	60.0	42.8	60.0	100.0	72.7	12.5**
Universal home visitation for new parents (I)	Used	36.2	0.0	30.0	13.0	73.9	100.0	55.6	15.2***
	Effective	64.0	--	66.6	0.0	76.4	50.0	65.0	60.0

Notes: The total number of respondents commenting on the use and effectiveness of each strategy in their country ranged from 65-72. *Used* indicates the percent of respondents stating a strategy was used in their country. *Effective* indicates that, of countries that had used a strategy, the percent of respondents who indicated that the strategy was generally considered effective in preventing child abuse. Letters in parentheses denote (I) individual-level strategies, and (C) community-level strategies.

* $p < .05$; ** $p < .01$; *** $p < .001$ for chi-square test of developed vs. developing countries.

Barriers to Child Abuse and Neglect Prevention

Respondents rated the significance of a number of possible barriers to CAN prevention for their country as (1) not a significant barrier (2) of moderate significance, or (3) of major significance. Barriers were examined individually, and we classified each barrier based upon a country's economic and social resources (e.g., limited government resources, poverty) or a country's social norms (e.g., sense of family privacy, support for use of physical punishment). Results are presented in Table 12. Overall, the most commonly cited barriers to CAN prevention were limited resources, general support for corporal punishment and use of physical discipline, and a lack of effective systems to investigate abuse reports.

There was substantial variation within regions on the economic and social resource items. European and Oceania respondents rated extreme poverty, inadequate systems of basic health care or social services, and dependency on foreign investment low in terms of significance in limiting prevention efforts, whereas African respondents rated all of these issues as somewhat to very significant barriers. Regarding the number of children living on their own, all regions rated this as less significant compared to the African region. This finding makes sense given the enormous impact that HIV/AIDS has had on Africa, resulting in large numbers of orphaned children. As for social norms, regions were similar with one exception: respondents from Europe appeared less likely to report that the use of corporal punishment played a significant role in limiting prevention efforts compared to other regions.

Differences between a country's developmental status were found for eight of the 11 factors we examined, with developing countries reporting each barrier to be more significant than developed countries. We then computed a mean for the seven economic and social resource barriers, and for the four social norm barriers, and hypothesized that given the nature of developing countries' economic status, resource barriers would be greater than social norm barriers. This hypothesis was tested using ANOVA. The model was significant ($F = 21.67$ $p < .000$), and the means confirm that resource barriers are more substantial for developing countries (developing = 2.37, developed = 1.69; difference = .68) than the social norms barriers (developing = 2.22, developed = 1.93; difference = .29) (see Figure 4).

PREDICTORS OF CHILD WELL-BEING

There are many factors that can reduce the prevalence of child abuse and neglect, and enhance child well-being. To facilitate this discussion, we have selected the Under-Five Mortality Rate (U5MR) from the *UNICEF 2006 State of the World's Children* report to represent a country's level of child well-being and to serve as a link to the prevalence of child abuse and neglect. It is important to note that while not all early deaths of young children reflect abusive and neglectful situations, many do result from an unwillingness or inability of parents to adequately meet their children's basic needs. These deaths also reflect societal neglect and the failure of governments to place a sufficient priority on insuring adequate health care for children and support for their parents. As such, an increased emphasis on child maltreatment and its prevention might be expected to result in a reduction in early childhood mortality and morbidity. In addition to developmental status, we identified a number of contextual and policy variables that might be related to U5MR. With respect to contextual issues, we examined the correlations between U5MR rates and the number of resource and normative barriers cited by respondents, and the number of available service models. With respect to policy characteristics, we examined the correlation between U5MR rates and various characteristics of a country's child maltreatment policy that were equally common within developed and developing countries (e.g., the maintenance of a child abuse reporting registry, mandatory reporting provisions, voluntary reporting provisions, requirement that reports be investigated within a specific time frame, provisions for specific criminal penalties for abuse, provisions for child victims to have independent counsel, and the development or support of prevention services). Table 13 presents these correlations.

As reported earlier, mortality rates for young children are significantly higher within developing countries, particularly among those countries battling high rates of HIV infection. Significantly higher U5MR rates also are observed within those countries reporting a higher number of resource and social norms barriers underscoring the unavoidable relationship between high rates of poverty, limited social service infrastructure, and normative standards that place low priority on children's rights and safety. Such conditions and barriers were significantly more likely to be reported by respondents from developing countries, and most likely contribute to the higher mortality rates observed among children living in these countries. Finally, countries which reported high levels of service availability have significantly lower child mortality rates. As reported in Table 13, significant correlations were observed between U5MR rates and the number of parent services, child services and general services.

In contrast to these patterns, specific child abuse policies were not always highly correlated with U5MR rates. As noted in Table 13, the maintenance of a child abuse registry and a policy that established specific time frames for

responding to child abuse were the only two policy options that correlated significantly with lower child mortality rates. Although the correlation coefficients were in the anticipated direction for several other policy elements we examined, this pattern was not universal across all policy components. As noted in Table 13, countries with policies that identified specific criminal penalties for abusing a child and those that require that a separate attorney or advocate be assigned to represent a child's interest correlated with *higher* U5MR rates. It is unclear how to interpret this relationship. Certainly, the relationship is not causal. The pattern may in part be driven by the fact that a higher proportion of developing countries have adopted these more legalistic strategies, although this relationship was not significant. Countries, including these strategies as part of their child abuse response, may be placing greater emphasis on developing their legal response to child maltreatment than on improving their health and social service systems.

On balance, it is important to remember that only two of the seven policy characteristics we examined were significantly correlated with child mortality, suggesting that most of these policies have minimal impact on mortality rates. This pattern is not surprising. The ability of a public policy to influence the levels and severity of social conditions such as child maltreatment is largely determined by the extent to which it is effectively and consistently implemented. As noted earlier, almost half of the developing countries, reporting the existence of a formal child abuse policy, established these policies after 2000. Indeed, one possible indicator of the limits of such existing policies in developing countries is the consistently lower levels of services available for families and children who have experienced or are at-risk of maltreatment. The establishment of a formal child abuse policy appears to be a positive first step in addressing the child abuse problem. Making significant inroads in preventing maltreatment, however, is a long-term process, and one which will most likely involve efforts to both support families and achieve contextual change.

In order to test these relationships further, we examined the factors that were significant from the bivariate analysis simultaneously so that the effect of one factor could be considered in light of other factors. We thus examined the predictive power of context and policy in the current dataset on the U5MR using hierarchical linear regression. Because developmental status was highly correlated with resource barriers (r = .57) we included the resource barrier variable as a rough proxy of developmental status. To further reduce the number of independent variables, we developed a new variable ("total services available") by adding the number of family, child and general service models identified by the each respondent as available in their respective country. This multivariate model accounted for 41% of the variance in the U5MR (Table 14). The model indicates that after controlling for the variance explained by social context (i.e., resource barriers, social norms barrier, and service availability), neither of the policy characteristics accounted for additional variation in U5MR.

The model presented in Table 13 describes one set of variables that may affect U5MR; however, the nuances of these variables must be investigated further before definitive recommendations can be made. In order to effectively assess the impacts of policy on child mortality or child maltreatment one would need more extensive information as to the quality and consistency of the implementation of these polices.

Table 12. Factors that Limit Child Abuse Prevention by Region and Developmental Status

		Region					Developmental Status	
Factors	Total (N = 72)	Africa (n = 11)	Americas (n = 10)	Asia (n = 24)	Europe (n = 25)	Oceania (n = 2)	Developed (n = 37)	Developing (n = 35)
Social Conditions								
Limiting resources for improving the government's response to child abuse	2.63	2.90	2.80	2.67	2.48	2.00	2.49	2.79**
Lack of effective system to investigate abuse reports	2.27	2.64	1.90	2.48	2.16	1.00	2.03	2.51**
Decline in family life and informal support systems available for parents	2.19	2.27	2.20	2.33	2.08	1.50	2.05	2.34
Extreme poverty in the country	1.91	2.56	2.20	1.93	1.56	1.00	1.42	2.43***
Inadequate and poorly developed systems of basic health care or social services	1.83	2.40	2.00	1.96	1.48	1.00	1.41	2.29***
Country's dependency on foreign investment to sustain its local economy	1.67	2.20	1.90	1.79	1.29	1.00	1.27	2.12***
Overwhelming # of children living on their own	1.45	2.30	1.70	1.42	1.08	1.00	1.14	1.79***
Social Norms								
General support for the use of corporal punishment/physical discipline of children	2.23	2.40	2.30	2.21	2.08	3.00	2.11	2.35
Strong sense of family privacy and parental rights to raise children as they choose	2.21	2.20	2.30	2.42	1.96	2.50	2.05	2.38*
Lack of commitment or support for children's rights	2.17	2.22	2.10	2.29	2.00	3.00	2.11	2.24
Public resistance to supporting major change or program expansion in this area	1.65	1.70	1.50	1.67	1.68	1.50	1.43	1.88**

Notes: Responses are the average across countries on a 1-3 rating scale where 1 = not an important factor, 2 = of moderate significance and 3 = of major significance in limiting prevention potential. The number of respondents commenting on the impact of each challenge in their country ranged from 70-72.

* $p < .05$; ** $p < .01$; *** $p < .001$ for t-test of developed vs. developing countries.

Figure 4. Limiting Factors to Child Abuse & Neglect Prevention by Developmental Status

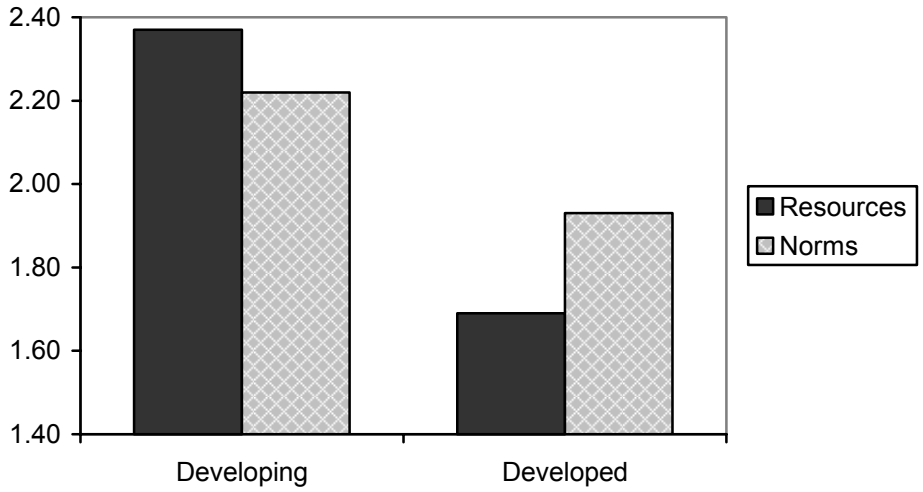


Table 13. Correlations with Under-Five Mortality Rate

Variables	Univariate (r)
Country Context	
Developmental status (0 = Developing; 1 = Developed)	-.56***
# of resource barriers that interfere with child abuse and neglect prevention (see Table 12)	.57***
# of social norms that interfere with child abuse and neglect prevention (see Table 12)	.22*
# of parent services/interventions available (see Table 8)	-.52***
# of general services/interventions available (see Table 8)	-.68***
# of child services/interventions available (see Table 8)	-.45***
Policy Elements	
Maintenance of a child abuse registry (0 = No; 1 = Yes)	-.22*
Mandatory reporting policy (0 = No; 1 = Yes)	-.12
Voluntary reporting (0 = No; 1 = Yes)	-.03
Specific time frame for responding to reports (0 = No; 1 = Yes)	-.29*
Policy includes criminal penalties for abuse (0 = No; 1 = Yes)	.17
Policy provides child separate attorney (0 = No; 1 = Yes)	.15
Development/support for prevention services (0 = No; 1 = Yes)	-.05

* $p < .07$; ** $p < .01$; *** $p < .001$

Table 14. Multivariate Predictors of Under-Five Mortality Rate (N = 46)

Variables	Step 1 Beta	Step 2 Beta
Social Context		
Resource barriers to child abuse prevention	.31*	.30*
Social norm barriers to child abuse prevention	-.03	-.03
Total services	-.47**	-.43**
Policy Context		
Maintenance of a child abuse registry	--	-.09
Specific time frame for responding to reports	--	-.07
Variance Accounted For		
R^2	.46	.43
Adjusted R^2	.48	.41

* $p < .05$; ** $p < .007$

SUMMARY

Similar to previous reports, the goal of this report was to provide a snapshot of child abuse and neglect in terms of country-level definitions, responses (e.g., policies and services) and barriers to prevention. Although these data have several limitations, we can draw preliminary conclusions about the state of surveillance, public awareness, policy enactment, service availability and capacity, and barriers faced within the countries in our sample.

As we have observed in past surveys, there is global agreement emerging on the major behaviors that constitute child abuse and neglect (e.g., sexual abuse, physical abuse, children living on the street, child prostitution). Although some differences continue to exist between the definitions embraced in developing versus developed countries and local social conditions frame the relative emphasis professionals may place on various behaviors, those working in diverse contexts are working with cases involving many of the same characteristics. Children who have experienced physical mistreatment, sexual abuse and parental or societal neglect can be found in many countries around the world, regardless of a country's economic conditions.

Regarding surveillance, most countries have instituted some type of systematic surveillance to understand the magnitude of the problem. Along with increased surveillance, increased public awareness of child abuse and neglect was nearly universally reported. The causal link between increased surveillance efforts and increased awareness is not clear; either one could be causing the other, or a third factor could be causing both (policy enactment). In fact, there is some evidence, from research on violence against women, suggesting that policy enactment motivates changes in awareness, which could also affect the importance placed on conducting incidence and prevalence studies. In this sample, as we have observed in the past, there appears to be an increasing trend for countries to have policies on CAN. However, it may not simply be the presence of a policy that drives awareness and a subsequent response to child abuse and neglect, but critical elements of the policy. The most common policy elements identified in our sample addressed the criminal justice response to child abuse and neglect, and service provisions being less frequently included. And, as we have observed, such policy elements are not correlated with reduced rates of child mortality. Indeed, such policies are more common in countries with higher child mortality rates.

The reasons for this lack of correlation are unclear, but the implications are potentially profound. By defining child abuse as a criminal act, the primary policy interest may become determining guilt and prosecuting offenders as opposed to better understanding the circumstances both within the family and the culture that contribute to abusive or neglectful behaviors. This type of response may reduce the likelihood that local communities and countries will develop and support the broad array of therapeutic and preventive services most certainly needed to reduce maltreatment levels. In addition, this approach may allow countries to define child abuse solely as a failure of an individual parent rather than recognizing the role community context can play in the array of supports and normative incentives available to parents to help them avoid maltreatment. On the other hand, the absence of any legal

consequences for seriously mistreating a child may lead some to view these behaviors as less serious than we know them to be and fail to afford children the same rights provided adults in a given society.

The goal of policy statements is to direct programmatic efforts. Ideally policies will direct efforts toward strategies that are shown or at least perceived to be effective prevention or intervention strategies. However, many of the strategies respondents viewed as potentially effective in reducing the incidence of maltreatment and/or enhancing public awareness of the issue were not included in the national policies emerging within the sample countries. Indeed, reports of both the availability of services, and the adequacy of those services, indicated great variability among countries and, in particular, between developed and developing countries. In developing countries, even where services exist, they are often not widely available nor provided in a consistent or high quality manner, thereby limiting their ability to effectively address the child abuse and neglect problem. We have suggested that a country's response to child abuse and neglect, including surveillance, public awareness, policy, prevention strategies, and service provision, should be linked.

Surveillance should inform policy decisions, prevention strategies, and service provision. It is important that these activities be empirically driven to the maximum extent possible. This is often difficult in countries where many different systems may handle different aspects of the response to child abuse and neglect. In light of the interdisciplinary nature of how response systems are being established, it is particularly encouraging to see the positive perceptions respondents in developing countries had toward professional education efforts. Developing a well-educated core of medical, mental health, law, and social work professionals is a central component of ISPCAN's work in several Asian, African, South American and Eastern European countries.

Much of the world's response to child abuse and neglect is inextricably linked to funding. Survey results indicated that a variety of funding sources are involved in CAN funding, with notable differences based upon countries' developmental status. Developing countries were more reliant on international relief agencies and NGOs than developed countries, which received greater funding from governmental organizations. In addition to fewer overall resources, developing countries may have a greater number of social problems competing for that money, problems that may be more pressing than child abuse and neglect, such as HIV/AIDS. Consistent with this is the finding that social conditions such as poverty and limited resources were cited as barriers to CAN prevention more often by developing than developed countries.

Finally, it appears that there are concerted efforts to address the problem of child abuse and neglect, despite the significant barriers faced by resource poor countries. As noted in several of the practice and policy briefs included in the following section, developing countries are improving their ability to document the incidence of maltreatment and to provide effective avenues for children or families, living in violent and resource poor communities, to articulate their concerns and assist professionals in shaping the policy and practice context. Respondents in our sample, as in previous samples, continue to focus on structural-level changes, as well as on providing individual-level services, and recognize the need for both as they continue on the path toward reducing the prevalence and detrimental effects of child abuse and neglect. As a next step, formal evaluations of these different levels of interventions will need to be conducted in order to provide advocates the information they need to make efficient use of the resources they have available.

SECTON II: SELECTED ISSUES AND CONCERNS

OVERVIEW

The development of child abuse policy and practice reforms around the world is complex and diverse. Each country's response to maltreatment reflects its comfort in labeling certain behaviors as child abuse and its capacity to generate the resources necessary to systematically measure the scope of the problem and establish a specific response. As such, professionals incorporate a variety of strategies in raising public awareness, crafting an interdisciplinary response, and building service systems. In order to capture this diversity, ISPCAN solicited brief commentaries from its members on innovative studies or major issues they have faced in developing their local child abuse prevention systems. Specifically, we requested commentaries in areas dealing with measuring the scope of the problem, its impacts on children, and implementing strategies to improve public awareness and professional collaboration.

Overall, a total of 16 commentaries were submitted. In terms of research, some of the commentaries reflect a broad, multi-national attempt to standardize the definition and develop global assessments of the number of children experiencing violence. In other instances, the commentaries reflect the efforts of researchers, within a single country, to implement empirical frameworks on which to base policy and practice reforms. In still other instances, the commentaries address local efforts to craft a programmatic or institutional response that will guarantee the rights and safety of all children. This year a number of the commentaries specifically note the importance of incorporating the voice of children in both research and policy.

The comments in each of these briefs represent the opinions of the authors and do not necessarily reflect ISPCAN's official position or policy. Those with questions about a particular commentary should feel comfortable contacting the author directly.

MULTI-NATIONAL ASSESSMENT EFFORTS

The United Nations Secretary General's Study on Violence Against Children: Breaking the walls of silence and proposing concrete action

Dr. Amaya Gillespie, Secretariat for the UN Study on Violence Against Children

Overview

Although violence against children is one of the most frequently condemned forms of violence, it remains too common, unrecognized, and invisible. It is present in every country, and cuts across boundaries of culture, class, education, income, ethnic origin and age. The United Nations Secretary General's Study on Violence against Children was conceived not only to gather information, but to break down the walls of silence that frequently surround the problem of violence against children, and to develop feasible recommendations on how to address and prevent the occurrence of violence against children.

Historical Context

In 2000 and 2001, the Committee on the Rights of the Child devoted two days of general discussion on the theme of violence against children. As a result of this discussion, the Committee recommended that the Secretary-General be requested, through the General Assembly, to conduct an in-depth international study on violence against children. This recommendation was supported by the General Assembly and the Commission on Human Rights in subsequent resolutions. In February 2003, the Secretary-General appointed Mr. Paulo Sérgio Pinheiro as the Independent Expert to lead the Study, in collaboration with OHCHR, UNICEF, and WHO. An inter-agency Secretariat was established in Geneva to support the Independent Expert in his task.

Study Objectives

The UN Study on Violence Against Children objectives are to provide an in-depth and global picture of violence affecting children (up to the age of 18 years) and to propose clear recommendations for the improvement of legislation, policy and programs relating to the prevention and responses to such violence. The study will document the magnitude, incidence and consequences of various types of violence against children by looking at the different settings in which violence occurs. These settings include the home and the family; schools; other institutions,

including those serving children involved in legal conflicts; community; and the workplace. The challenges presented by various underlying conditions such as poverty, gender, and globalization are also being examined. [3]

The Study is guided by international human rights treaties, in particular the Convention on the Rights of the Child and the jurisprudence of its Committee on the Rights of the Child and other human rights treaty bodies. Although the study will focus primarily on children as victims of violence, examples of children as perpetrators will be included. The issue of child perpetrators in itself highlights the many failures of adults to prevent such situations, especially by not ensuring the rights of children in the first place. The study will identify effective prevention strategies and the characteristics of these strategies that constitute "best practice" standards, including those features of greatest importance to and designed by children. Building on these strategies, specific recommendations will be offered as to how countries can better address the problem of violence against children.

Study Methods

The Study relies on existing knowledge and resources; new research or programs are not being commissioned as part of the Study. The main data sources are government questionnaires; regional consultations and related outcome documents including regional reviews, situational analysis, cases studies and recommendations; public submissions; expert consultations and thematic meetings on the possible outcomes of the Study Report; the explicit participation of children and young people; and country reports submitted in response to the CRC and the work of the Special Rapporteurs, and other treaty bodies.

In March 2004, the Independent Expert sent questionnaires to Government officials who were asked to provide information on their legal framework, institutional framework and resources to address violence against children; the role of civil society and children as actors in addressing violence; current public policies and programs targeting the problem; available administrative data on these efforts and the scope of the problem; and public awareness, advocacy and training initiatives. As of mid-2005, 117 responses to this request have been received by OHCHR. In several countries, the preparation of the formal Government response generated national debate and action about the question of violence against children.

Between March and July 2005, nine regional consultations have been held and are summarized in the table (Table 1) below. The consultations (averaging about 350 participants) brought together government representatives, representatives of UN agencies, regional and other intergovernmental organizations, NGOs, national human rights institutions, and other parts of civil society including the media and religious organizations, and children. These consultations focused increased attention on the issue, and mobilized political will to strengthen partnerships and networks concerned with violence against children. In several instances, strong declarations of commitment and recommendations followed these events. For example, the East Asia and Pacific consultation will take the recommendations from the Bangkok meeting to the regional ministerial consultation for action early in 2007. At the South Asia regional consultation, the South Asia Forum for Ending Violence Against Children was established to facilitate regular meetings of Governments in the region to follow up on the recommendations related to the study. The group also called on the support of the South Asia Coordinating Group against Commercial Sexual Exploitation and Trafficking of Children and Women in South Asia and the South Asia Association for Regional Cooperation (SAARC). At the end of the regional consultation for The Americas, the Buenos Aires Declaration on Violence Against Children and Adolescents was signed by those ministers attending. On the closing day of the regional consultation for the Middle East and North Africa region, a declaration was adopted and another Child Helpline in the region was established. Participants at the consultation for Europe and Central Asia adopted the Ljubljana Final Conclusions. At the regional consultation for Eastern and Southern Africa it was proposed to present an All Africa Statement on violence against children to the African Union early in 2006 which would unite the three consultative processes held in Africa.

[3] Armed conflict will not be directly addressed in this Study because it was the focus of the Graca Machel study. However, conflict and related issues will be considered indirectly as an underlying condition.

Table 1: Regional Consultations

Region	Host	Dates
Caribbean	Trinidad/Tobago (Port of Spain	March 10-11, 2005
South Asia	Pakistan (Islamabad)	May 17-20, 2005
West and Central Africa	Mali (Bamako)	May 23-25, 2005
Latin America	Argentina (Buenos Aires)	May 30-June 1, 2005
North America	Canada (Toronto)	June 2-3, 2005
East Asia/the Pacific	Thailand (Bangkok)	June 14-16, 2005
Middle East/North Africa	Egypt (Cairo)	June 27-29, 2005
Europe/Central Asia	Slovenia (Ljubljana)	July 5-7, 2005
Eastern/Southern Africa	South Africa (Johannesburg)	July 18-20, 2005

The participation of children so far has been a highlight of the Study. More than 260 children provided input at the regional level and participated in preparatory meetings held just prior to each of the regional consultations. Child participation was facilitated by the Save the Children Alliance and partners, who developed special tools for the involvement of children in the Study process.

Expert Thematic Meetings also have been an important source of information for the Study. These meetings have focused on aspects of violence against children, bringing together a small group of experts from around the world to debate and propose possible recommendations for addressing violence against children in that context. Thematic meetings have been held, for example, on violence against children in conflict with the law, schools, sexual exploitation and virtual settings, violence against children in the home and family, and violence against children with disabilities.

In addition, civil society organizations, academic institutions, professionals working with children and others, have been called upon to submit information to the Study. The call for public submissions, which closed on June 30, 2005, generated over 230 submissions many of which included clear recommendations for action. The Study also continues to receive other relevant information such as Government documents, journal articles, referenced texts, and various study reports.

In the course of examining these data, the Study team has identified a number of important issues. These include violence against the girl child and the impact of various traditional practices such as female genital mutilation/cutting; corporal punishment; various forms of humiliating treatment and bullying; and sexual abuse. With regard to responses to violence against children, these data underscore the importance of legal frameworks which explicitly address the issue and the existence of comprehensive and holistic responses for children. Monitoring and reporting systems, capacity building efforts to improve the professional response to these issues, and the active participation of the media also have emerged as important vehicles for change.

The lack of reliable international data on violence against children presents a serious obstacle to effective prevention and responses. To address this issue, ISPCAN has been working closely with the Study secretariat and partners. Specifically, ISPCAN has provided important leadership in developing and pilot testing common survey tools to provide a more systematic and uniform framework to measure levels of violence toward children across countries. These instruments will provide an important adjunct to the Study's summary of country-specific information.

Final Products

The Independent Expert, Paulo Sérgio Pinheiro, is leading the development of the Study Report with the support of an Editorial Board. The Editorial Board consists of individuals from all regions of the world with expertise in child rights, public health, and child protection as well as a wide range of organizational experience (e.g., NGOs, UN, etc). Under the guidance of the Editorial Board, chapter coordinators are responsible for drafting outlines of the main chapters, in collaboration with co-authors and peer-reviewers. Once all of the chapters and related materials have been developed the document will be reviewed by a single writer/editor to insure its overall coherence.

The final report will be provided by the Secretary General to the General Assembly at the end of 2006. The report to the General Assembly will be a brief policy oriented document with a particular focus on specific policy and programmatic recommendations. In addition, a child-friendly version of the document will be produced, as well as a

more elaborate and explanatory publication which will contain more detailed information, best practices and case studies, and country examples.

Dissemination and Application

The Study on Violence Against Children, the first global report on the issue of violence toward children, offers unique opportunities for the strengthening of child protection efforts. The Study report will serve as a source of knowledge about the scope of violence against children and offer specific policy recommendations. The Study will also be useful for advocacy purposes in mobilizing political will, in generating greater support from donors, and in influencing policies and decisions at the strategic level. In particular the report can be used to attract increased support for intensified and more effective programming at the country level, thereby directly improving outcomes for children.

One of the Study's most important potential achievements will be galvanizing partners around a common agenda. Organizations such as ISPCAN are encouraged to widely disseminate the final Study Report to its members and to hold joint events related to the Study's activities, particularly around the time the report is released to the General Assembly. It will be especially important that partners with the related expertise in this area take up the issues and recommendations outlined in the final report in order to maximize the Study's impact on children in every region of the world.

For more information: Those wishing additional information on the study may contact the UN Study on Violence Secretariat for the study either via e-mail Secretaria@sgsvac.org or the study's web site www.violencestudy.org

UNICEF's Indicator and Participatory Assessment Development for "Violence against Children at Home" and "Violence against Children at School"

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Overview

Despite an urgent need for data, a dearth of information exists on valid and globally applicable indicators able to provide insights into the issue of violence against children. Although a number of high-quality indicators are currently in use, most of them are not comparable (e.g., focus on different target populations or employ different definitions of abuse and violence). In addition, most surveys and scientific activity focus on the situation of children in Western Europe or North America despite the fact that violence against children is a global dilemma.

To improve the availability of these data, UNICEF initiated two projects: to identify and deliver by the end of 2005 a set of valid core indicators of violence toward children and to develop and disseminate a novel participatory assessment methodology to measure levels of violence against children in the home and in school. In developing these methodologies, particular attention was paid to ensure that these efforts will be culturally independent and fit for global use.

Indicator Development

To provide a general overview of the current scientific mainstream in this area, initial research identified existing indicators through a comprehensive literature review including an analysis of existing surveys and consultations with experts in the field addressing this topic. Because most of the existing indicators on violence stressed the question of incidence and/or prevalence, other groups of indicators were examined to complement these data. These additional indicators were deemed suitable for measuring the eight different elements embraced by UNICEF's "Protective Environment" framework. This expanded framework allows one to assess, in a pragmatic manner, the specific strengths and weaknesses in a child's life that prevent or lead to violence and abuse.

These preliminary lists of indicators were presented, discussed and refined during 2004 and 2005. The key indicators emerging from these consultations were ranked by experts using a specific questionnaire that was distributed during several meetings including the Regional Consultation of the Violence Study in Buenos Aires in May 2005. The results were then analyzed and the list of candidate indicators further reduced to a set of factors suitable for global use. At the end of 2005, the final list was presented at several ISPCAN conferences, including regional meetings in Berlin and Singapore.

In general, these indicators cover five dimensions: incidence of victimization experiences; attitudes towards violence against children; effectiveness of law enforcement in case of victimization; children's life skills; and the existence and capacities of recovery and support services. Collectively, these five areas offer a comprehensive assessment of a child's environment and provide clarity regarding those elements of the environment that prevent or contribute to violent behaviors toward children.

In addition to the indicators themselves, the project developed a detailed set of guidelines, outlining the project's overall methodology and background, and method of measuring each indicator to ensure that those adopting these indicators will use comparable methods in measuring them within their specific country. Before being widely promoted, these indicators, as well as the proposed measurement strategies, will be verified in upcoming field tests managed by several UNICEF Country Offices.

Participatory Assessment Toolkit Development.

Researching violence against children is relatively new in most developing countries. Cost concerns, as well as methodological and ethical dilemmas surrounding sensitive issues such as violence and abuse, have presented significant barriers in countries unfamiliar with a broad range of research methods. To address these problems, UNICEF launched an initiative to enhance global studies of violence against children using a participatory approach.

The participatory approach stresses the involvement of the studied communities themselves, including children, when addressing topics that have significant impact on a community's functioning and well-being. By ensuring that the views of children as the primary stake holders in this issue are taken into account, this method guarantees the relevance and appropriateness of the research. In addition, the participatory approach promotes accountability and sustainability of policy interventions by focusing on the perspectives of children and of duty bearers (e.g. parents and key community leaders). Adopting a participatory approach is based on the recognition that empowerment, as a basic component of a protective environment, requires bringing in the voices of the weak and the marginalized.

During 2005, UNICEF organized several pretests of the participatory assessment strategy, hosting efforts in India, Serbia-Montenegro, Dominica and Egypt. These pretests confirmed that the methodology can access critical information and that such information can be obtained in a standardized and culturally neutral manner.

In addition to collecting data, UNICEF used these pretest opportunities to stimulate a broader discussion about the issue of violence and the need for an open and ethically sound way to monitor its existence and impacts. Although participatory assessments should be very flexible, it became obvious during the pretest process that structured sessions and a fixed succession of issues that slowly lead into the sensitive issue of violence, are an important asset in obtaining useful and reliable results.

Figure 1 illustrates the stages one might go through in conducting a participatory assessment of a community. As this figure notes, the process begins with a very general discussion of issues and gradually moves toward more sensitive topics. Subsequent steps lead deeper into the issue of violence, asking the children first about what they think about violence and how they would define it, their feelings towards violence in general, and finally empowering children to analyze their situation and share coping mechanisms. To ensure that the session ends on a positive note rather than leaving children alone with the issue, a "healing" and thank you period concludes the workshop. This framework and succession of issues was found to be optimal to getting slowly and almost "naturally" in and out of the issue.

Figure 1: Participatory Assessment Process

WELCOME

ICE BREAKER

REFLECTION ON VIOLENCE

FEELINGS TOWARD VIOLENCE

ALTERNATIVES TOWARD VIOLENCE

COPING MECHANISMS

"HEALING" and THANK YOU

Although this framework is fixed, researchers can customize their project by choosing and adapting modules within this framework. For example, in one culture or for very young children, an open discussion about violence might not be possible. In such cases, the researchers can choose from different –more indirect - approaches and instruments such as role plays or scenarios that were reviewed as part of the pilot tests. This type of modular design also allows researchers to incorporate standardized measures for key concepts when appropriate.

For further information: Those wishing additional information on the study may contact Gopalan Balagopal at gbalagopal@unicef.org

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Improving Instruments for International Research into Child Abuse

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Principal collaborators for research with adolescents: Jingqi Chen (China); Clemencia Ramirez (Colombia); Marcel Tshibangu (DR Congo); Randa Youssef (Egypt); Dipty Jain (India); Inna Andreeva and Nurgul Mamyrova (Kyrgyzstan); Bernard Gerbaka (Lebanon); M. Sham Kasim and Claire Choo (Malaysia); Elena Volkova and Oksana Isaeva (Russia); Thanh Huong Nguyen (Vietnam), and Des Runyan (USA).

Overview

Most child abuse research has been conducted in affluent, western countries. Researchers in Asia, Africa, Russia, South America and the Middle East have only recently developed and reported studies on the prevalence of abuse and the social contexts in which these behaviors occur.

There are many reasons for this lack of data, including serious limits to funding and human resources, as well as political and cultural reluctance to officially document maltreatment and violence toward children. These conditions are gradually changing, due in large part to the efforts of local community groups, pediatricians, social scientists and child rights workers, including many ISPCAN members. In addition, formal organizations such as UNICEF, Save the Children, ISPCAN, philanthropic trusts and special initiatives such as the current UN Secretary-General's Study are serving as important change agents.

Another significant barrier to research worldwide has been a lack of suitable tools to use in local surveys with children and young people. Some researchers working in non-English speaking countries have used standardized tools, mainly developed in the USA. A few such tools have been used in international comparative studies (e.g., Runyan, 2004; Sebre et al, 2004). It is more common, however, for local researchers to develop their own instruments, combining questions from multiple existing tools with new items generated by the researchers themselves. One outcome of this process is that these data cannot systematically be compared across cultures, time or between research groups even when such groups operate within the same country or use the same language.

Project Objectives

In collaboration with the UN Secretary-General's Study on Violence Against Children, ISPCAN has initiated a process for developing new tools for use in community-based surveys. Three populations have been identified for these tools: adolescents and young adults (ages 18-24 years); children under 18 years; and parents and other adults. These instruments are designed to serve as screening tools rather than as exhaustive checklists of the many and varied ways in which violence can be perpetrated on children.

In this brief we describe the specific process we followed in developing a retrospective questionnaire for use in surveying older adolescents and young adults. The procedures outlined in this brief also have been followed in developing the other two screening tools. These procedures are summarized here in the interest of brevity. However, those wishing more detailed information on these other tools are encouraged to contact the authors.

Research Method

Consultation to develop draft tools: ISPCAN coordinated a workshop in Brisbane, Australia September 22nd-24th 2004, following the ISPCAN Congress involving several dozen participants that included academics, clinicians and community-based advocates. During the workshop, participants were asked to identify the key features a survey tool would need to employ in order to generate reliable assessments of child maltreatment across diverse cultures.

Central to the task was identifying a strategy for introducing the topic to respondents in a sensitive and culturally respectful manner. The primary objective was to construct multiple sets of core questions which could be incorporated wholly or partly into future studies conducted in a number of countries, thereby generating an accumulation of comparable international data over time.

The countries represented at this initial workshop included Argentina, Australia, Brazil, Canada, China, Colombia, Democratic Republic of Congo, Estonia, Ethiopia, France, Germany, India, Jordan, Lebanon, Syria, South Africa, New Zealand, Philippines, South Korea, Spain, Switzerland, United Kingdom, Kenya, Pakistan, Palestinian Territory, Poland, Thailand, Uganda, Vietnam and USA. In addition to the ISPCAN leadership, representatives from a number of international organizations also attended including, among others, UNICEF, the Secretary General Study on Violence Against Children, Save the Children-UK, Save the Children-Sweden, African Child Policy Forum, African Network for the Protection and Prevention of Child Abuse and Neglect (ANPPCAN).

Two sub-groups at the workshop focused on retrospective measurement of violence experienced in childhood. These sessions were chaired by Muhammad Haj-Yahiya from Israel and Assefa Bequele from Ethiopia. There was general agreement between the two groups on the content of the primary questions. Shortly after the workshop, the first draft of the screening tool for adolescents and young adults was constructed with 21 "stem" items. Each of these items referred to experiences that may have occurred before age 18, and was phrased in a behaviorally-specific way. For example, we asked: "*When you were growing up (before age 18) did anyone ever beat you with an object like a stick, broom or belt?*" Each stem item was followed by a series of "leaf" questions, asking respondents to recall approximately how many times this behavior occurred and at which periods of their life it occurred (e.g., under 5, between 5 and 9 years of age, between 10 and 13 years of age, or between 14 and 17 years of age). Respondents would then be asked to select from a long list of categories of individuals who might have been responsible for this abuse (e.g., mother, sister, adult female neighbour, female teacher, other type of relationship to the child, etc.). An important difference between the structure of this new questionnaire and most tools currently available for this type of research is that we ask about the abusive experience before asking about the context, such as the characteristics of the perpetrator or when the event occurred.

The basic format of the questionnaire was adapted from tools developed over the past six years for research with adolescents in China (See Chen, Dunne and Han, 2004), Vietnam (with Thanh Huong Nguyen, Hanoi School of Public Health) and Malaysia (with Claire Choo, University of Malaya). However, the specific content of questions in the new draft tool were derived mainly from consultations with international experts at the ISPCAN workshop.

Delphi study of experts' opinions: We began systematic consultation with experts by contacting academics, clinicians and community-based child rights workers around the world. Recognizing that most researchers and practitioners in this field are from affluent, English-speaking countries, we decided to bias our selection process to ensure that most participants were from non-English speaking and developing countries. A list of 122 names and email addresses was constructed. Experts were selected in the following ways:

- Researchers outside the USA, Canada, UK, Australia and New Zealand who had published a paper in *Child Abuse and Neglect* between January 2003 and February 2005;
- Members of the ISPCAN Faculty who had identified themselves as academics or researchers or had university affiliations and who were living outside of the countries listed above;
- Members of the UN Secretary-General's Study on Violence Against Children research working group;
- Individuals who were nominated by the UN study's Secretariat to participate in regional consultations during 2004-2005;
- Individuals with outstanding reputations in the field who were nominated by the research working group executive; and
- Individuals from developing nations who have been active on the ISPCAN listserve during 2004.

Of the original 122 experts identified, 61 were randomly selected and invited to serve as expert reviewers of the questionnaire for young adults. Of this group, 51 (84%) agreed by email to participate in this process. Only three experts explicitly refused to participate. The remaining seven did not respond to the initial or multiple follow-up requests.

The Delphi study was completed in two stages, based on standard Delphi procedures (Adler & Ziglio, 1996). During the first phase, conducted in early 2005, respondents were asked to rate each question on two dimensions: how important each individual question was for assessing child maltreatment (using a 5 point scale) and the ease with which each item could be translated into local languages (using a 4 point scale). The experts also were asked to

provide open-ended comments and criticisms, and to identify any item that should be removed or modified to better accommodate local populations.

Thirty-seven (73%) of the reviewers completed this phase of the process. Those responding included a mix of researchers, clinicians and NGO/health service managers. They were based in 23 countries and worked in 14 languages. They represented all regions, including Africa (5), Middle East (4), East and South Asia (7), Central/South America (4), North America (5), Europe (7), Russia/Baltic (3). More than 80% of the experts had 10 or more years experience working in the field of child abuse and neglect, and one-third had been working for more than 20 years. Among those 14 who did not complete the Delphi process, the most common reason given was lack of time.

In incorporating the comments from the reviewers in revising the tool, we retained items (75% or more of the experts) regarded as "very" or "extremely" important for measuring maltreatment. Based on this standard, eight original questions were deleted. In response to multiple suggestions, we also added a new item on severe shaking and/or choking of a child and split another item into two parts. Most of the retained questions were regarded by the experts as easy to translate; however, where clear guidance was given, we modified the wording of individual items to improve translatability. The experts also made suggestions for improvement to the leaf questions (e.g., redraft the list of possible perpetrators to make it more appropriate to local societies). At the end of the first phase of the Delphi study, the questionnaire contained 15 stem questions; five each in the domains of physical, psychological and sexual abuse.

During the second phase, conducted in late 2005, 31 of the original 37 reviewers provided further comments on the revised questionnaire. All 15 stem questions were retained, although two were simplified. Additional questions about physical injuries to the victim, and the young person's perceptions about whether these experiences were abnormal and unjust, were added based on suggestions from several experts. Further minor refinements to the leaf questions were suggested. Overall, feedback was positive with few changes recommended. As such, the steering committee decided that the Delphi study for this instrument was complete and a proposed third wave of expert review was cancelled.

Translation and back-translation into seven languages: The Delphi study focused mainly on structure and content of the tool. The next steps were to prove that the revised questionnaire could be translated satisfactorily into multiple languages, and to make further refinements based on feedback from translators and back-translators. At present, the instrument has been translated in Arabic, French, Hindi, Malay, Marathi, Russian and Spanish.

Our procedures for translation and back-translation followed the recommendations of Behling and Law (2000). The revised questionnaire was sent to bi-lingual experts in child maltreatment who were ask to translate conceptually rather than literally, as the latter often is difficult for sensitive terms, especially description of sexual acts and emotional states. Back-translation was performed by a different bilingual speaker. Finally, the English back-translations were drawn together for six of these seven languages (French was excluded from this stage as we did not receive the back-translation in time).

The instrument's lead author (Dunne) reviewed each back-translated document against the original. Across the translations from six languages there was reasonable consistency, and those parts of the questionnaire that had imperfections in one language tended to have problems in the other languages. Numerous small changes were made to the wording of the English version to ensure equivalence. Detailed comments about modifications were sent to translators, and the final version (prior to field test) was modified accordingly in each language.

Field tests: In order to gain critical feedback from young people in a diverse range of communities, field tests were conducted in 2006 with 963 young people aged 18-24 years in each of eight countries (about 120 each in Colombia, DR Congo, Egypt, India, Kyrgyzstan, Lebanon, Malaysia and Russia). In each country, roughly equal numbers of participants were recruited from various social sectors (e.g., university students, street youth, clinic attendees, people in detention, workers at factories, members of religious groups, etc.). The primary objective of this sampling strategy was diversity rather than a fully representative sample of all young people in these countries.

Each participant completed the questionnaire. The administrator recorded the time each respondent took to complete the survey and documented any spontaneous complaints or suggestions. After completing the survey, the participants placed the unsigned questionnaires into envelopes, sealed it and gave it to the administrator. In some field sites, the respondents also completed a feedback form that asked them to rate the qualities of the tool and to make any suggestions for change. In each site, focus groups, consisting of 5-8 young people, were conducted

during which participants were asked a discuss the strengths and limitations of this tool using a set of general questions provided by the facilitator.

The steering committee provided a data entry template for each site (using EpiInfo software) and the data were sent by email to Queensland University of Technology in Brisbane. In one case, (Kyrgyzstan), the paper data were sent by post. At present, data analysis is underway to determine the extent of missing data, out of range values, logical inconsistencies and other anomalies. This information, along with feedback from the focus groups, will guide the final revision of the tool.

Next steps

The aim of this project is to generate new instruments that will be useful in research practices in the future as worldwide efforts to improve the evidence base for child protection. In this brief report we described only the development of the tool for gathering retrospective reports of the child abuse experiences of adolescent and young adults. All three tools have undergone somewhat different, but nevertheless rigorous development processes.

We have now engaged hundreds of children, young people and parents around the world, in field tests seeking their critical comments and suggestions for improvements. When drawn together, this process should improve the face validity, refine the language and structure and ultimately make the tools as user-friendly and culturally appropriate as possible.

Assuming that the latest versions of these questionnaires survive the field tests, the new instruments will be published as soon as possible. The final product will be available on the ISPCAN web site. The working acronym for this project is ICAST (ISPCAN Child Abuse Screening Tools).

For more information: Those wishing additional information on the study may contact Michael Dunne at m.dunne@qut.edu.au. The following references also may be of interest.

Adler, M. & Ziglio, E. (1996) *Gazing into the Oracle: The Delphi Method and its Application to Social Policy and Public Health*. London: Jessica Kingsley Publishers.

Behling, O., & Law, K.S. (2000) *Translating Questionnaires and other Research Instruments*. Thousand Oaks: Sage.

Chen, J.Q., Dunne, M.P., & Han, P (2004) Child sexual abuse in China: A study of adolescents in four provinces. *Child Abuse and Neglect*, 28, 1171-86.

Runyan, D.K. (2004) WorldSAFE: World Studies of Abuse and the Family Environment. In Daro, D (Ed.). *World Perspectives on Child Abuse (6th Edition.* Chicago: ISPCAN, pp 47-49.

Sebre, S., Sprugevica, I., Novotni, A., Bonesvski, D., Pkalniskiene et. Al. (2004) Cross-cultural comparison of child-reported emotional and physical abuse: rates, risk factors and psychosocial symptoms. *Child Abuse and Neglect*, 28, 113-127.

ISPCAN Working Group on Child Maltreatment Data (ISPCAN-WGCMD)
Lil Tonmyr, Health Surveillance and Epidemiology Division, Heath Canada
Jenny Gray, Department for Education and Skills, United Kingdom
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Overview

Strong sustained national data programs on child maltreatment are essential for developing a clearer understanding of the problem and the effectiveness of interventions and services. A global perspective on these data is ultimately needed to understand the scale of the problem the intervention community is addressing, the gaps in those systems, their successes and challenges, and relevant trends. To achieve this global perspective, a group of researchers from several countries recently established the ISPCAN Working Group on Child Maltreatment Data.

The purpose of the Working Group is to develop areas of common interest for organizations and individuals who are actively working with child maltreatment data collection programs directly sponsored by governmental entities. It is assumed that such publicly supported data bases are sustainable and intended to be long term. In addition to countries that have implemented child maltreatment data systems, countries which are involved in planning and

developing such systems also are invited to participate in this group. The purpose of this brief is to provide a summary of the Working Group's goals, structure and planned activities.

Initial Goals

Because the working group is newly established, the development of goals is still evolving. However, several preliminary goals have been articulated based upon the group's initial assumptions as to what might be accomplished. These goals include:

- To recruit countries and participants with existing or planned data programs in order to expand the international community of interest.
- To help develop and promote the goals of national child maltreatment data collection through the ongoing support of presentations, workshops, pre-sessions, and post-sessions on the topic at various forums and conferences.
- To use aggregated data to inform policy development at a national and international level.
- To promote the expanded development of national data collection programs either through efforts that support the improvement of existing systems or the creation of new systems.
- To provide professional assistance to developing nations in creating and sustaining appropriate data collection programs through the collaborative efforts of the workgroup membership.

Implementation Challenges

Since the 1996 International Congress on Child Abuse and Neglect held in Dublin, a small but growing group of ISPCAN members have organized a session at each subsequent Congress on national child maltreatment data collection. The primary objectives of these sessions have been to identify and share key methodological approaches in analyzing administrative data to inform policy development and findings, and to explore areas of difference and comparability across countries. A secondary objective has been to develop a network of professional researchers who are involved in developing systematic national data collection programs. Each session has generally included presenters from three to four countries, and initially included representatives from Australia, Canada, England and the United States.

Participants involved in these early presentations believed that the development of something like the working group would be beneficial in providing a more consistent focus on this issue, and would sustain interest in the topic between the bi-annual Congresses. A key challenge in moving forward on the project has been the inclusion of countries representing a broader diversity of cultures, approaches to service delivery, languages, and methodologies.

Achieving more diverse representation is complicated by the difficulties of identifying key governmental representatives who are involved in national data collection. In some cases, the data collection program may be marginal to the typical child protection or law enforcement agency; it may be housed in another agency with a broader mandate for national data collection of various kinds. Further, in countries where such programs are only in the planning or early implementation phase, identifying key participants is even more complex. The relatively high turnover of governmental staff who may not occupy positions involving child maltreatment data collection for an extended period also presents a barrier to identifying consistent participants.

Even when it is possible to identify individuals or organizations involved in data collection, it is sometimes difficult to bridge the inevitable cultural, linguistic and financial barriers. Also, it is sometimes difficult for potential participants to be confident that they are in contact with a credible group of professionals that share the Working Group's overall goals.

In many developing countries, the social and legal infrastructure necessary to support children and families involved in child maltreatment are not present or are just emerging. The additional requirements to develop a data collection infrastructure may pose a range of challenges in terms of awareness of its value, knowledge of the skills required to build such a system, and the resources necessary to sustain and effectively use these systems.

Partly as a consequence of these concerns, the original participants approached ISPCAN to see if the organization would support the formation of the Working Group under ISPCAN sponsorship. After reviewing the proposal, ISPCAN agreed to formally sponsor the process beginning in 2006. The first meeting of the group under this new organizational leadership will be at the York Congress.

2006 Planned Activities

The purpose of the first working group meeting is to introduce our programs and ourselves, establish our mission and goals, develop our organizational framework, and consider plans for future activities. Participants attending the meeting will engage in a discussion of various strategies to advance the working group's goal and establish a work plan for accomplishing these objectives over the coming year. Immediately following the meeting, experts from the Working Group will meet with representatives of countries involved in developing data collection programs in order to provide technical assistance.

Among the activities already underway is the development of a web page for the Working Group that will be located on the ISPCAN website. In addition to providing information about the group and its activities, the web page will include links to the websites of the participating countries' programs and a copy of the joint presentation on data systems delivered at the York Congress.

For additional information: Those interested in learning more about the ISPCAN-WGCMD may contact any of the following members: Lil Tonmyr (Lil_Tonmyr@hc-sc.gc.ca); Jenny Gray (Jenny.Gray@dfes.gsi.gov.uk); or John Fluke (jfluke@wrma.com).

COUNTRY SPECIFIC RESEARCH

Eight of the commentaries report on country-specific research designed to document the incidence of various forms of violence toward children. These commentaries include efforts underway in both developed countries (Australia, Canada, and Singapore) as well as developing countries (Brazil, Cambodia, China, and India). In many cases, the authors have directly involved children in their research, often providing young people the first opportunity to comment on their conditions and how they cope with various forms of violence.

An Examination of Children's Work in New South Wales, Australia

New South Wales Commission for Children and Young People

Overview

No information on children's paid and unpaid work activities are routinely collected in New South Wales (NSW). Despite this lack of information, a number of common myths have emerged regarding the role work plays in children's lives. In part, these myths have arisen from debates that seek to differentiate between child work and child labour and debates between those who see work as either entirely positive for children or entirely detrimental. In Australia, little evidence has been provided to test these arguments and consequently these positions have tended to obfuscate public debate on children's work.

To address this absence of empirical data, the New South Wales Commission for Children and Young People conducted research aimed at providing detailed data on children's work. This study obtained information from a sample of youth on the extent of participation in paid and unpaid work; on the activities that constitute work; the conditions that children work under, including whether it is hazardous work; the impact of work on other activities in a child's life; and the impact of work on a child's significant relationships.

Methods

A questionnaire was distributed to students who were enrolled in Years 7 to 10 at New South Wales secondary schools. A representative sample of 10,999 children between the ages of 11 and 16 years from 22 different locations across NSW was enrolled in the study. The questionnaire contained three main sections, demographic characteristics of the participant, questions on work, and questions on the child's quality of life.

Key Findings

Extent of work: Most children (56%) had been involved in some form of work, although this participation rate differed across various subgroups of children. Females were slightly more likely to work than males, reflecting their increased involvement in the care of younger children. As might be expected, the rate of participation increased with a child's age. Somewhat counterintuitive, children living in the more privileged areas were more than twice as likely to be employed as children living in the most disadvantaged areas. This finding indicates that most children in New South Wales do not work out of economic necessity and that access to job opportunities, just as in the adult labor market, is uneven across socio-economic groups.

Type of work children perform: The most common jobs for children are found in the areas of sales (23.3%), the care of other children (21.2%), leaflet and newspaper delivery (6.8%); cleaning (6.9%) and general farm labor (6.0%). A significant proportion of the jobs children hold involve lower end labor market work, such as cleaning, factory labour and clerical work. However, a considerable number of these jobs are trade-related or require quite specific skills and knowledge, such as teaching and instruction, painting and decorating, working as an electrician's apprentice, and information technology. Work patterns tend to be gender specific with care and service work primarily being done by females and physical labor jobs being done by males.

Work conditions: Most of the work that children undertake falls into what has been described as 'secondary labor markets' frequently characterized by low levels of stability, little on-the-job training, high levels of turnover, irregular work hours and non-standard shifts. Children in the more privileged areas are far more likely than disadvantaged children to be employed in jobs that involve more consistent shifts, reasonable levels of pay and moderate hours. For children in the most disadvantaged areas, work is more likely to be of poorer quality in terms of regularity and security. As with the type of work children perform, work conditions are also segregated by gender. Females are more likely to work for informal employers with fewer guaranteed benefits including no pay or lower pay rates.

Work is undertaken across a variety of contexts. In this sample, almost two-thirds of the respondents reported that their jobs are in the formal labor market and about 25% report their jobs involve working for their immediate family. As might be expected, work in the formal labor market is more likely to be regular and ongoing, with regulated conditions, formal training and supervision. Work organized through informal networks or family members is more likely to be casual, informal and flexible.

Over three-quarters of the work children do is paid, with around 11% unpaid. Hourly rates of pay for children vary markedly but are relatively low compared with adult pay. However, the average pay rate for children reported in this sample (6-8 Australian dollars per hour) is comparable with the mean average rates for 15 to 19 year olds engaged in full-time employment. This parity may reflect the effectiveness of an "awards-based system" operating in New South Wales.

Most children undertake work that can fit around their other activities -- 56% work five hours or less per week and 26% work between 6 to 10 hours per week. However, nearly one in ten work more than 15 hours a week. This is a considerable commitment given that all the participants in this survey were also attending school for 30 hours per week.

Work satisfaction: Most children view their work favourably. Four elements of job satisfaction were identified: *recognition* of the value of work; *support* provided to do their work; amount of *control* over work conditions; and adequacy of *income*. Despite many conditions being less than favourable compared with adult work, children indicate high levels of satisfaction. This suggests that work can provide significant objective benefits to children, and may reflect the fact that working has a positive impact on a child's sense of self and social status. Work can provide independence, autonomy and economic benefit, attributes generally denied children.

Quality of Life: Three issues were examined with respect to how children viewed their overall level of satisfaction -- how satisfied children said they were about different aspects of their life; how much time they spent doing household tasks and homework; and how rushed they felt.

None or only moderate effects of work were observed on a child's overall quality of life. Working appears to have neither a positive or negative impact on how children feel about their life generally. The amount that children currently work does not compromise the time they spend on homework and household tasks. In fact, children who work frequently spend more time on these tasks than those who do not work. Roughly equal proportions of respondents who worked reported either that they felt rushed "all the time" or that they never felt rushed. This finding is partially explained by other underlying factors such as the time spent on homework and household tasks, and the respondent's age and gender.

Injury*:* Approximately 40% of the respondents who were employed sustained a work-related injury and 7.4% of these cases reported a serious work-related injury (defined using WHO standards). The level of work-related injury and hospitalizations sustained by children is likely to be comparable, if not higher, than those sustained by adults in Australia. Agricultural and horticultural work, labouring, food preparation and delivery work have an increased likelihood of injury. Agricultural work and labouring are the most likely to cause serious injury. These types of jobs also involve exposure to specific hazards.

Harassment*:* Just under half of the children reported verbal harassment at work, most commonly being shouted at, sworn at, and made fun of. About one-fifth of the children reported experiencing some form of physical harassment at work such as having tricks played on them, being threatened and intimidated, being physically hurt or pushed, having personal possessions damaged or being touched in an uncomfortable way. Children who work in food preparation, food service and sports-related work have an increased likelihood of being verbally harassed. This may be due to a greater emphasis on efficiency and mistake-free work in these environments. Work-related harassment and intimidation also may be influenced by the differences in power. Children's junior status and relative lack of workplace experience may mean that they are targeted for abusive behaviors or unfair treatment.

Lessons Learned

The study highlights the benefits of doing child-centered research. By obtaining children's views about work, we obtained a new and better understanding of the issues related to their work. Consequently the myths that prevail about children who work in developed economies have been challenged. Most children do some form of work and enjoy it. The sorts of activities they undertake are diverse and defy the idea that there are child-specific jobs.

The diversity of children's work calls for careful and varied responses. Strategies that rely on a single approach will unlikely reach many young workers. Blanket prohibitions may be ineffective or diminish the considerable benefits children derive from work. The policy response may need to shift away from prohibition to identifying those employment conditions that promote a good quality work experience for a child, and high worker satisfaction. Responses also need to recognize that different groups of children have unequal access to work opportunities.

Any response needs to directly address the rate of work-related injury and harassment. Young workers may be aware of their workplace safety rights or of procedures that need to be followed if they are injured. Effective strategies to improve children's safety need to be tailored to each specific work context. A number of strategies may be required to deal with work-related harassment of children. In part, these must target the conditions which promote such behavior at a structural level, as well as provide specific training to managers in a position to directly impact work behaviors.

Insuring that research influences subsequent policy is an important objective of the Commission. As such, this research led to the establishment of a task force charged with bringing together key policy and decision-makers such as peak employer groups, unions, other relevant non-government organizations and young people. In addition, those who conducted the research also serve on the Task Force. It is expected that the Task Force will develop practical, regulatory and policy initiatives to address the issues identified in this research.

Further information: The full version of the report can be downloaded at http://www.kids.nsw.gov.au/publications/kidsatworkdescription.html. Further inquiries can be emailed to kids@kids.nsw.gov.au.

Risk and Protective Factors Identified in Juridical Processes

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Overview

Sexual violence against children and adolescents is a major public health concern because of its high frequency and devastating impacts on child and youth development. The dynamics of this violence is complex and involves a range of psychological, social and legal issues. As such, an effective response requires a coordinated intervention involving a wide range of institutions.

For purposes of this paper, sexual violence includes all acts or sexual play, heterosexual or homosexual relationships, where the offender is at a more advanced psychosexual developmental stage than the child or adolescent. The offender's objective is to stimulate or to use the child or adolescent to obtain sexual stimulus. These erotic and sexual practices can be imposed on the victim by physical violence or threats. They include actions where there is no physical contact (e.g., siege, voyeurism, and exhibitionism), actions with physical contact but no penetration (e.g., touches, oral sex) or actions with penetration (e.g., digital, with objects, genital or anal intercourse). Sexual violence includes acts of sexual exploitation such as prostitution and pornography (Gomes, Junqueira, Silva, & Junger, 2002; Kaplan & Sadock, 2002).

The impacts of the sexual abuse on the victim's development are widespread. Some negative consequences are particularly severe for children who lack an available social and affective support network (Saywitz, Mannarino, Berliner, & Cohen, 2000). Although the impacts of child sexual abuse are not uniform for all victims, the experience is considered an important risk factor for subsequent depression, anxiety, dissociative and post traumatic stress disorder (Cohen, Mannarino, & Rogal, 2001; Habigzang & Caminha, 2004; Runyon & Kenny, 2002). In addition, children may show behavioral, cognitive and emotional difficulties, such as feeling they are to blame, troubles with peer relationship, distrust, over sexualized behavior, poor school performance, substance abuse, suicidal thoughts, social segregation and rage (Amazarray & Koller, 1998; Cohen & Mannarino, 2000; Cohen et al.; Habigzang & Caminha; Jonzon, & Lindblad, 2004).

Considering the negative impact of sexual violence, as well as the social, legal and psychological dimensions that involve this complex phenomenon, successful intervention depends on the synchronized action of multiple professional groups and institutions (Amazarray & Koller, 1998; Gomes, Junqueira, Silva, & Junger, 2002; Gonçalves & Ferreira, 2002; Habigzang & Caminha, 2004). Child and adolescent protective institutions, like the Council of Rights and others (e.g., schools, health services, hospitals, and shelters) are the social support network for victims and their families. This study presents the mapping of risk and protective factors for the family, and the

available service network to children and adolescent victims of sexual violence as identified between 1992 and 1998 in the juridical processes of the public prosecution service of Rio Grande do Sul State/Brazil,.

Methods

A total of 71 juridical processes involving 94 sexual violence victims were analyzed. The material was based on the cases served by the public prosecution service of Rio Grande do Sul State/Brazil between 1992 and 1998. A protocol was prepared by the researchers to collect information about the victim, the sexual violence episode, and the offender, as well as the victim's family members and institutions that comprised the victim's service network and source of support.

Using this protocol, each process was analyzed by a researcher from the Center for the Study of at Risk Youth (CEP-RUA). Each protocol was then reviewed by another researcher and, in some cases, by a third researcher, until acceptable levels of inter-rater reliability were achieved and all major disagreements were resolved.

Key Findings

These juridical reviews found that girls are more frequently sexually victimized than boys (i.e., 80.9% of the selected cases involved female victims while 19.1% involved males). Moreover, the major incidence in these cases occurred when the victims were between 5 to 10 years of age but disclosure generally did not occur until the victims were adolescents. Almost all of the perpetrators were male (98.8%) and 94.6% had a close relationship with the victim; often involving significant child care responsibilities.

The results point out that the domestic environment constituted the main context (66.7%) in which these children and adolescents were victimized. Among the primary risk factors identified for these incestuous families were the presence of a stepfather in the family; alcohol and drug abuse; unemployment; a passive or absent mother; and financial difficulties. Other important aspects identified in these cases were the presence of other violence in the familial context, such as neglect, physical abuse, or psychological abuse against the children as well as domestic violence. Moreover, these data found that the disclosure of the sexual violence changed the family configuration, either because the parents divorced or the child was removed from the home.

In the majority of cases, the offender either denied the abuse (56.3%) or accused the victim of initiating the relationship (10.9%). In 59.4% of the cases, the mother was a protective figure and the primary source for reporting the case to local officials. Despite the willingness of the victim and often the mother to report the abuse, the lack of material or other supportive evidence often resulted in cases being dropped. In such cases, the children might be considered double victims, first by an incestuous family dynamic and second by juridical procedures and standards of evidence that make it difficult to address the psychological and social dynamics of abuse in the absence of a formal conviction. In most cases, the judicial process and development of a service response took over one year. On the one hand, this finding reflects the complexity of these cases and the importance of sustaining professional involvement with the victim and families for an extended period of time. On the other hand, the finding may reflect the inability of the system to respond as quickly as might have been appropriate given the victim's level of need.

The case reviews identified several institutions that played a significant role in providing support and protective services to the victim and his/her family. Among these institutions, the Protective Council appeared most involved in identifying cases and following these charges through the legal system. This finding underscores the importance of this institution within the overall community response to child sexual abuse. However, the performance of this institution was not consistent across all cases. The reviews found that in those cases where the Protective Council was less attentive, the case was less likely to receive a positive response from the prosecution, the child, and youth judge ministry.

The main protective intervention adopted by the local service network was to separate the victim and perpetrator. Although the case plan often called for the provision of psychological counseling for the victim, relatively few cases received this type of assistance. In the majority of the cases, the victim was removed from home and placed with other relatives, an outcome which the victims may have viewed as further punishment and confirmation that they were in some way responsible for the abuse (De Antoni & Koller, 2000; Habigzang & Caminha, 2004).

The long term outcomes for both the victims and their families were often negative. Although about one-third of the cases eventually resulted in family reunification, the victim and her siblings often remained separated (35.5% of the cases) or the parents got divorced (28.9%). In about one-quarter of the cases (27,6%), the victims continued to live with their mothers. In a small proportion of the cases, the victims ran away from their foster or group homes (13.6%) or from their birth homes (6.2%). Five of the victims were believed to be living "on the street" with no permanent shelter. Four of these five were subsequently involved in criminal behaviors including thefts or sexual exploitation. Although the offenders were generally ordered to have no further contact with the victims, this was not

always the case. New charges of sexual abuse were documented in 21.1% of the families following the completion of the service program developed in response to the initial abuse.

Lessons Learned

This research documented a set of risk and protective factors associated with sexual violence and the impact these factors may have on how a case is treated. The protective factors that were most commonly associated with progress include the removal of the victim from the abusive context; the disclosure of the sexual violence; strong attachment among family members, particularly between the mother and child; and the presence of a social network of support and formal services. The risk factors that contributed to more negative outcomes include the lack of supervision of the offender following separation from the victim; the lack of an effective service network; the refusal of the family to admit to the sexual violence; the standards of evidence required to take action against the offender or to require services; alcohol and drug abuse; the family's economic dependence on the offender; and the presence of other forms of violence (e.g., physical and psychological abuse and neglect) within the family and community context.

The findings suggest the urgent need to create specific and targeted interventions for victims and their families. It is important for all institutions involved in these cases to work together to form a network of services capable of conducting effective assessments and investigations of all allegations, and to provide effective preventive and therapeutic interventions for children and adolescents and their families. Equally important is the training of all professionals who work with children sexually abused and their families to insure that these professionals are able to identify and diagnose sexual violent behavior.

For more information: Those wishing additional information on this research may contact Silvia Koller at skoller@vol.com.br or refer to the following references.

Amazarray, M. R. & Koller, S. H. (1998). Alguns aspectos observados no desenvolvimento decrianças vítimas de abuso sexual [Children victims of sexual abuse: Some aspects observed in their development]. Psicologia Reflexão e Crítica, 11(3), 559-578. Available at www.scielo.br/scielo.php?script=sci_arttext&pid=S0102-79721998000300014&lng=en&nrm=iso

Cohen, J. A, Mannarino, A. P. & Rogal, S. (2001). Treatment practices for childhood posttraumatic stress disorder. Child Abuse & Neglect, 25, 123-135.

Cohen, J. A. & Mannarino, A. P. (2000). Predictors of treatment outcome in sexually abused children. Child Abuse & Neglect, 24(7), 983-994.

De Antoni, C. & Koller, S. H. (2000). A visão sobre família entre as adolescentes que sofreram violência Intrafamiliar [The family perception of adolescents that suffered intrafamilial violence]. Estudos de Psicologia, 5, 347-381. Available at www.scielo.org

Gomes, R., Junqueira, M. F. P, Silva, C. O. & Junger, W. L (2002). A abordagem dos maus-tratos contra a criança e o adolescente em uma unidade pública de saúde [The approach to bad treatment against children and teenagers in a public health-care unit]. Ciência & Saúde Coletiva, 7(2), 275-283. Available at www.scielo.br/scielo.php?script=sci_arttext&pid=S1413-81232002000200008&lng=en&nrm=iso

Gonçalves, H. S. & Ferreira, A. L. (2002). A notificação da violência intrafamiliar contra crianças e adolescentes por profissionais da saúde [Health professionals' reporting of family violence against children and adolescents]. Caderno de Saúde Pública, 18(1), 315-319. Available at www.scielo.br/scielo.php?script=sci_arttext&pid=S0102-311X2002000100032&lng=en&nrm=iso

Habigzang, L.F & Caminha, R.M. (2004). Abuso sexual contra crianças e adolescentes: conceituação e intervenção clínica [Sexual abuse against children and adolescents: Definition and clinical intervention]. São Paulo, Brazil: Casa do Psicólogo.

Jonzon, E. & Lindblad, F. (2004). Disclosure, reactions and social support: Findings from a sample of adult victims of child sexual abuse. Child Maltreatment, 9(2), 190-200.

Kaplan, H. I. & Sadock, B. J. (2002). Synopsis of psychiatry: Behavioral sciences/clinical psychiatry (9th Ed.). New York: Lippincott Williams & Wilkins.

Runyon, M. K. & Kenny, M. C. (2002). Relationship of attributional style, depression and posttrauma distress among children who suffered physical or sexual abuse. Child Maltreatment, 7(3), 254-264.

Saywitz, K. J., Mannarino, A. P., Berliner, L. & Cohen, J. A. (2000). Treatment for sexually abused children and adolescents. American Psychologist, 55(9), 1040-1049.

Stop Violence Against Us: Cambodian Children's Perceptions of Violence
Glenn Miles, Children at Risk Facilitator, Tearfund

Overview

To date, minimal research has been completed regarding the prevalence of violence to Children in Cambodia or how the young victims of such violence perceive its impact on their childhood and their future. Such research is particularly timely at the moment as the Cambodian government struggles to respond to the UN Study on Violence Against Children's request for specific information on the forms, causes and impact of violence which affects children within their country. Research on this topic also could help the country document how it is moving forward on efforts to achieve children's rights, as indicated in the UN Convention of the Rights of the Child.

Within this context, the current research focused on documenting prevalence information regarding six aspects of the problem of violence against children – sexual abuse, trafficking, domestic violence, corporal punishment, bullying, and violence from children to adults. Central to this effort was capturing the children's own perceptions about these issues and exploring with them ways to address violence.

Methodology

The research utilized both qualitative and quantitative methods designed to provide Cambodian children an opportunity to express what they felt about violence against children and to offer estimates of the prevalence of such acts. Two specific research strategies were developed.

Role Play Focus Groups: Seven focus groups, each consisting of 5 boys and 5 girls aged 11-13 years, were engaged in a half day workshop. The children were shown a series of pictures that were drawn by a Cambodian artist illustrating different scenarios of violence against and by children (e.g., children bullying a disabled child; a teacher beating a child; a drunken step-father beating a child; a child being sold or trafficked; a rape of a child by an adult; and a woman being robbed at gun-point by a teenager).

Each picture was presented separately to the full group. In each group, the children selected a leader and volunteer "actors" who then acted out the scenario in a role play including what might have occurred before the incidence and what might have occurred after the incident. A video-tape recording was made of role play and shown to the group. A discussion was then held with children about their understanding of these events. To facilitate subsequent analysis, these discussions also were recorded.

Written Questionnaire Survey: In order to understand how representative the responses were in the focus groups it was decided to conduct an anonymous survey questionnaire with a representative sample of children from every province in Cambodia. Information from stage one was used in developing a survey using the same line drawings presented to the focus groups as prompts.

After 18 months of negotiations with the Ministry of Education, the Ministry agreed to support the project and assigned an official to be involved in securing official permission from each Provincial Education Office. Five schools were selected from each of the 24 provinces. At each school, ten students (5 boys and 5 girls) aged 13 to 14 years of age were selected by each provincial education office. A total of 100 children were selected from 10 schools in Phnom Penh as this has a different demography than the more typical rural province.

Each provincial education office was requested to provide a representative sample of children. In order to insure a representative sample, the research team requested that the provincial education office provide children from three primary schools and two secondary schools, thereby including youth 13 and 14 years of age who were still in primary schools because they had to repeat a grade. Also, it was requested that the sample include children with a range of abilities, including children with disability if they were available.

The final sample included children as young as 12 and as old as 17, although the majority were in the targeted age group. This distribution resulted from the fact that children were selected for the study based on the age recorded at the time of registration, a fact which proved, in some cases, to be inaccurate. As such, the age of all children was confirmed by the children themselves at the time of the survey. Students 16 and 17 years of age were excluded from the analysis, while youth between 12 and 15 years of age were retained.

All surveys were collected in the classrooms. Teachers were asked to leave the room in order to insure that the children had privacy in completing the survey. Children were assured of individual confidentiality and that parents,

teachers and others would not be given their papers to read. Also, no names were provided on the survey. Children were informed at the beginning of the survey that they could skip any question that made them uncomfortable or that they did not wish to answer. In most cases, the children answered all of the questions, including the open-ended questions.

Survey Results

The survey sample consisted of 1,314 children, 671 girls and 639 boys. Although the majority of these respondents were in the targeted age range, 7.6% of the sample (100 respondents) was 12 years of age and 9.1% of the sample (119 respondents) was 15 years of age.

Almost two-thirds of both the female (63.5%) and male (64.0%) respondents indicated that they know children who have been raped. Almost one-quarter of the females (21.4%) and males (23.5%) said they have witnessed the rape of a child by an adult. A total of 13.5% of girls and 15.7% of boys indicated that they had been sexually touched on the genitals before 9 years of age, and 13.5% of girls and 18.9% of boys indicated that they had been sexually touched on the genitals after 9 years of age. In general, the respondents had a good understanding of the consequences of rape and the importance of dealing severely with the perpetrator.

Half of the boys (50.5%) and 36.4% of the girls admitted to having been beaten by their parents. Over 80% of both the boys and girls reported that they have seen other children being beaten by their parents. Children again had a good understanding of the importance of non-violent alternatives to discipline, though half felt that beatings were sometimes the appropriate disciplinary response. Children also felt that parents needed advice and support if they are expected to consider and use alternatives to violence.

Nearly one quarter (24.1%) of girls and 34.7% of boys said that they had been beaten by their teacher in school. Some of the descriptions of corporal punishment used by teachers that children described in the focus groups are disturbing, and if used on adults might be considered torture. Nearly half the children (47%) said they knew other children who had been sold, and 92% of them said it was extremely serious for adults to do so. A third (34.5%) of the girls and 40.6% of the boys said they had been bullied, and 44.9% said it was extremely serious.

Two thirds (66.9%) of the children said they had heard of a teenager robbing someone and 33.4% of the girls and 45.2% of the boys said they had seen an adult being robbed by a youth. A small number (3.4% of girls and 5% of boys) admitted to having robbed an adult themselves.

Dissemination Efforts

The research findings were presented to both the adult and children working sessions at the National Conference on Violence and Children held in March 2005. Those attending the conference included the Deputy Prime Minister and representatives from the Ministries of Education, Health and Social Affairs, Women's Affairs, Justice and Interior of the Royal Government of Cambodia. In addition, the UNDP, UNICEF, UNESCO and the NGO community were represented through the Child Welfare Group, ECPAT, COSECAM and Chab Dai coalition. A list of recommendations for the various Government departments, researchers and NGOs were included in the preliminary report made available to all the above in Khmer and English. Copies also were available on the website: www.kone-kmeng.info. A second report will be completed before the end of the year.

At the earlier National Consultative Meeting on Rights-Based Education in Cambodia, held in February 2005, and organized by the Ministry of Education in collaboration with UNESCO and the office of the United Nations High Commissioner for Human Rights, the preliminary results on corporal punishment in schools were presented. This presentation contributed to a general discussion around the new education law currently being developed in Cambodia.

A further presentation was made to key stakeholders in the Government just before the Regional Consultation of the UN Study on Violence, and then a further presentation was made to the consultation itself which was held in June 2005 in Bangkok, Thailand.

In addition to presenting the findings to key stakeholders within the national government and NGO community, the findings also were used to develop two Safe Children karaoke video training packs – one for children ages 7-11 and one for youth ages 12-17. These products, launched in May 2005, were developed in partnership with Tearfund and Resource Development International with funding from the British Embassy. A TV slot and accompanying poster addressing the issue of corporal punishment in the home was also developed and disseminated.

Several NGOs and children themselves were involved in the development of this product, which uses the popular medium of karaoke in a series of children's clubs to educate children and youth about protecting themselves from violence. Over 500 people from NGOs and churches throughout the region were trained in using the karaoke video packs with groups of children and to train others in their use. The Ministry of Education, for example, trained an additional 100 teachers in using the material with their students.

Lessons Learned

Although the project was time consuming, taking over four years to complete, the process demonstrated that it is possible for a relatively small organization with limited resources to do useful research. Local organizations do not need to wait for an international organization to gather data.

Also, the project underscores the value children have as key sources of information on those issues that most affect them. If given the opportunity to contribute, children can be very articulate in understanding many of the causes and consequences of violence and some of the solutions.

The research suggests that a paradigm shift is needed for the Cambodian public to realize that violence is not the way to deal with every problem. It may be difficult to convince parents of this, but efforts must be made. Most immediately, it will be important to work with the children and youth as future parents as well as potential victims, laying the groundwork for more appropriate adult-child interactions on the part of the next generation. This realization underscored the reason the project included the development of a TV spot and karaoke video training packs for children and youth, and making the materials widely available to local NGOs and schools. A change in people's attitudes to violence will only happen, however, when there is better collaboration among a wide range of Government, International Organizations and NGOs who have a vested interest in seeing a Cambodia free of violence.

For more information: Those wishing additional information may contact Glenn Miles at glenn@gmmeiles,co.uk or visit the project web site at www.kone-kmeng.info.

Canadian Incidence Study of Reported Child Abuse and Neglect: 1993, 1998, 2003

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Overview

The Canadian Incidence Studies of Reported Child Abuse and Neglect (CIS) are part of the Public Health Agency of Canada's (PHAC) child maltreatment surveillance system. The CIS series is designed to examine the scope and characteristics of reported child abuse and neglect across Canada and to monitor the short-term outcomes of these investigations, including substantiation, placement, child welfare court and criminal charges. The studies are conducted every five years. The first national study was conducted in 1998 The second cycle of data collection was initiated in 2003 (CIS 03) and results were released in October 2005.

There is inadequate information about children and families receiving child welfare services in Canada. The CIS is the only source of national statistics. Beyond the CIS, very limited information is available at the provincial and territorial levels, which are responsible for delivering child welfare services. Child welfare authorities in Ontario, Alberta, and Yukon Territory have funded over sampling in the CIS 2003 data collection cycle to generate comparable provincial or territorial information. The 2003 cycle also includes over sampling of Aboriginal child welfare authorities.

Methods

Using an approach adapted from the CPS portion of the United States National Incidence Study, the CIS collects information directly from child welfare workers about children and their families investigated because of reported child maltreatment. A multi-stage sampling design is used, first to select a representative sample of child welfare service areas across Canada, and then to track child maltreatment investigations conducted by the selected sites during the fall (October to December) of the study year. The 2003 cycle tracked investigations in 63 child welfare service areas, yielding a final sample of 14,200 investigations involving children under the age of 16.

The CIS is limited to cases reported to child welfare authorities and therefore excludes: (1) incidents that are not reported to child welfare authorities, (2) reported cases that are screened out by child welfare services before being fully investigated, (3) new reports on cases already open by child welfare services, and (4) cases that are only investigated by the police. Children investigated for maltreatment on more than one occasion during a year are counted as separate investigations; thus, the unit of analysis is the child maltreatment investigation as opposed to the investigated child (see Trocmé et al., 2001 for a discussion of case duplication in the CIS).

A significant challenge for the study is to overcome the variations in definitions of maltreatment used by different jurisdictions. The CIS uses a common classification system across all jurisdictions that include several forms of maltreatment that are not specifically included in some provincial or territorial child welfare statutes (e.g., educational neglect and exposure to family violence). All CIS maltreatment definitions also use a harm or substantial risk of harm standard that includes situations where children have been harmed, as well as situations where children have not yet been harmed but are considered to be at substantial risk of harm.

Key Findings

The 2003 study found that an estimated 235,315 child maltreatment investigations were conducted in Canada in 2003--a rate of 38.33 investigations per thousand children. Forty-nine per cent of investigations were substantiated, and in an additional 12% of investigations maltreatment remained suspected. Physical abuse was noted in 23% of substantiated cases, sexual abuse in 3% of cases, neglect in 34% of cases, emotional maltreatment in 14% of cases, and exposure to domestic violence in 28% of cases.

The CIS 2003 documented a dramatic increase in the incidence of substantiated maltreatment, from a rate of 9.24 investigations per thousand children in 1998 to 18.67 investigations per thousand children in 2003. This change varies considerably by form of maltreatment: rates of physical abuse and neglect have followed the overall pattern of increase; rates of emotional maltreatment and exposure to domestic violence have increased more than 350%, while rates of sexual abuse have decreased.[4]

Use of the Study

As the only comprehensive source of child welfare statistics in Canada, the CIS series of studies is playing a key role in supporting policy development. The studies have drawn attention to the shifting profile of children coming into contact with child welfare systems, and in particular, to the scope of neglect, exposure to domestic violence and emotional maltreatment. Extensive references to CIS findings are included in provincial policy and legislative reform documents in three of the largest Canadian provinces, and it provided the rationale for a major redesign of services in a number of provinces.

The CIS has also been instrumental in the development of a common terminology across jurisdictions. Finally, the CIS has been an important dataset for researchers wanting to pursue more focused analyses of specific forms of maltreatment. PHAC provides access to the dataset to researchers and has also funded a number of analyses. These analyses have resulted in at least 30 publications to date. Topics currently being analyzed include service responses to Aboriginal children, corporal punishment and exposure to domestic violence investigations.

Lessons Learned

Sample survey techniques provide a cost-effective and timely method for collecting administrative data from multiple jurisdictions. (The cost per study is less than $1 million Canadian.) By embedding the CIS in a cyclical health surveillance strategy, PHAC provides a national framework that sidesteps the complexities inherent in trying to harmonize information systems across jurisdictions. By keeping the CIS data collection form short (i.e., an administrative fact sheet, a family information sheet and a child information sheet, with 95% of questions being fixed response check boxes) and clinically relevant, the study team has maintained very high participation and item completion rates.

For More Information: Those interested in learning more on the Canadian Incidence study may contact Barbara Fallon at barbara.fallon@utoronto.ca or refer to one of the publications listed below.

[4] Incidence rates for substantiated maltreatment do not include the province of Quebec.

Trocmé, N., Fallon, B,. MacLaurin, B., Daciuk, J., Felstiner, C, Black, T, et al. (2005). *Canadian Incidence Study of Reported Child Abuse and Neglect - 2003: Major Findings.* Ottawa, ON: Minister of Public Works and Government Services Canada. Available from http://www.phac-aspc.gc.ca/ncfv-cniv/familyviolence/index.html

Trocmé, N., MacLaurin, B., Fallon, B., Daciuk, J., Billingsley, D., Tourigny, M., et al. (2001).

Canadian incidence study of reported child abuse and neglect: Final report. (Scientific Report.) Ottawa, ON: Minister of Public Works and Government Services Canada. Available from http://www.hc-sc.gc.ca/pphb-dgspsp/publicat/cisfr-ecirf/

Tourigny, M., Mayer, M., Wright, J., Lavergne, C., Helie, S., Trocmé, N., et al. (2002). *Etude sur l' incidence et les caracteristiques des situations d'abus, de negligence, d'abandon et de troubles de comportement serieux signalees a la Direction de la protection de la jeunesse au Quebec (EIQ)*. Montreal, QC: Centre de liaison sur l'intervention et la prévention psychosociales (CLIPP).

Trocmé, N., Fallon, B., MacLaurin, B., & Copp. B. (2002). *The changing face of child welfare investigations in Ontario: Ontario incidence studies of reported child abuse and neglect (OIS 1993/1998).* (Scientific Report.) Ottawa, ON: Centre of Excellence for Child Welfare, Faculty of Social Work, University of Toronto. Available from http://www.cecw-cepb.ca/Pubs/PubsOIS.shtml

Trocmé, N. M., Tourigny, M., MacLaurin, B., & Fallon, B. (2003). Major findings from the Canadian incidence study of reported child abuse and neglect. *Child Abuse and Neglect, 27*(12), 1427-1439.

Childhood Maltreatment Experiences: A Study in Six Chinese Provinces

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Overview

A considerable amount of social research suggests that violence against children is a worldwide problem. Many children are exposed to violence and it is clear that this is associated with mental and physical health problems, some of which persist throughout life. Most systematic research has been done in western nations. Relatively little is known about the situation in China. The aim of this study was to estimate the prevalence of childhood violence experiences among adolescents who attend schools or colleges and to examine the direction and magnitude of the relationship between violence and mental health status. We believe this information will be helpful in both raising public awareness regarding the issue and highlighting ways to promote and improve child protection policy and programs.

Methods

A cross-sectional survey was conducted among a convenience sample of students attending technical secondary schools and college or universities in Guangdong, Zhejiang, Hubei, Shanxi, Heilongjiang and Beijing. The study was conducted in March and April 2005. A total of 4,327 students were invited to participate in the study, of which 3,577 completed the anonymous questionnaire (a response rate of 82.7%). The questionnaire asked respondents a number of demographic or descriptive questions; a series of questions soliciting incidents of childhood maltreatment (e.g., occurring before the participant turned 16); a series of questions on current health-related risk behaviors; the General Well-Being Schedule (GWB); and the Center for Epidemiologic Studies Depression Scale (CES-D).

Maltreatment during childhood (before age 16 years) was assessed with 17 questions, that asked about specific violent acts, including physical abuse (4 questions), psychological abuse (7 questions) and sexual abuse (6 questions). It is important to note that the questions covered a wide range of experiences. Some represent relatively mild forms of aggression or mistreatment and are likely to be common experiences for young people (such as humiliation), while others are very severe and would be regarded in every culture as illegal and very harmful (such as being intentionally burned or stabbed or being forced to have sexual intercourse against the person's will).

Among the 3,577 students, 1,643 (45.9%) were male and 1,934 (54.1%) were female. In this preliminary analysis, we summarize the percentages of young people who report each violent or abusive experience and then examine the links between violence and poor mental health and social well-being.

Child Maltreatment Results

Physical Abuse: The prevalence estimates for the four types of physical maltreatment (male vs. female) were as follows: the child had been hit, or kicked or pushed very hard on the head or body by someone with an open hand (54.6% vs. 32.6%); beaten by someone with an object like a stick, broom or belt (39.0% vs. 28.5%); locked up in a

small place, or tied up by somebody with rope so that the child could not move (4.3% vs. 2.4%); choked, or burned, or stabbed with a sharp object (3.8% vs. 1.9%).

Psychological maltreatment: The prevalence estimates (males versus females) were: the child had been humiliated in front of other people (35.9% vs. 29.9%); been forced to give away money or possessions the child owned to other people (24.6% vs. 6.2%); been threatened that they would be hurt because of their ethnic background, or religion (0.7% vs. 0.4%); been told by a family member that they wished they had never been born, or was dead (10.5% vs. 10.3%); been threatened by somebody in the household that they would be abandoned or banished from the house (13.6% vs. 10.5%); witnessed very violent things like severe hitting or beating of people in their family or very close to them (32.4% vs. 33.7%); and been personally threatened that they would be badly hurt or killed (7.5% vs. 2.4%).

Sexual abuse: The prevalence estimates for each type of act (male versus female) were: someone had spoken to the child in an obscene or sexual way (12.2% vs. 13.8%); someone had exposed their genitals to the child when the child did not want them to (6.5% vs. 11.9%); someone had touched or fondled their private parts (breast, sexual organ) when they did not want them to (9.7% vs.13.5%); someone had forced the child to touch the perpetrator's private parts (breast, sexual organ) when the child did not want to (1.9% vs. 2.7%); someone had tried against the child's will to have sex with the child but had not completed the act (1.3% vs. 5.3%); and someone had had sexual intercourse with the child against their will (1.7% vs. 2.1%).

If we consider all of these acts together, we see that some are more common than others. Also, there are differences in the apparent severity of these events. For example, forced sexual intercourse is very serious, but is much less common than is "being spoken to in an obscene or sexual way". Unfortunately, there is no simple method for determining which violent acts cause the most harm to children and which are unpleasant but not particularly damaging for mental health.

One way to measure the severity of child maltreatment is to add up the types of events reported by the adolescents. When we do this, we find that 25.2% of the sample reported no abusive events at all, while a further 36.5% said that only one or two of these 17 possible events had happened to them. *Thus, about two-thirds of the sample had no or only a few abusive experiences in their childhood.* However, we found that 22.2% reported three or four types, while 10.4% said they had five or six types of abusive acts. Almost 6% of the respondents reported that they had experienced seven or more types of abuse during their childhood years.

Relationships between childhood maltreatment and mental health

There was a clear association between history of child maltreatment and negative mental health outcomes. Adolescents with multiple maltreatment experiences had significantly lower scores on the scale for general well-being, higher levels of depression and more suicidal intention, compared with students who had no such maltreatment or abuse. It is also very clear that the probable impact of these events is quite similar for males and females.

Relationships between childhood maltreatment and health-related risk behaviors

The results showed that child maltreatment is strongly associated with the likelihood that adolescents have behaviors that are dangerous for health and social well-being such as drinking alcohol, smoking tobacco, involvement in fighting, and self-harm. The adolescents who reported multiple types of abuse had significantly higher rates of most risk behaviors, and this is especially true of those with seven or more types of abuse. Comparing the behaviors of those with the highest number of abuse experiences to those who reported no childhood maltreatment, the following patterns were observed:

- The risk of having been drunk in the past 12 months was 4.1 times higher for these multiply abused males and 6.1 times higher for multiply abused females.
- The risk of ever being accidentally injured while drunk was 10.7 times greater for these males and 19.3 times greater for these females.
- The risk of being involved in fighting in the past 12 months was 6.1 times greater for abused males and 16.5 times greater for abused females.

Study Implications

This survey is a preliminary assessment of the situation and is limited by the fact that we only recruited young people in schools or colleges in six provinces. The results cannot be generalized to all Chinese communities or populations, particularly given the absence of respondents who do not attend high school or college. Despite this limitation, we believe the sample is quite diverse, as it includes young people who grew up in rural villages, county towns and major cities. Their parents' education ranged from primary school only to completion of university.

The study demonstrates that child maltreatment is an existing problem in China. A small but important minority of young people (5.7%) reported seven or more types of abuse, often of the most damaging nature. This means that one or two children in an average school class may be victims of serious child abuse. About one in ten students have had five or six types of adverse events in their early years.

Males are more likely to suffer physical and psychological maltreatment than are females, while females are more likely to be sexually abused than boys. It is important to note, however, that the differences between genders on most items are not large; substantial numbers of males reported unwanted sexual experiences, and some females reported being severely beaten.

The impacts on mental health that we observed are entirely consistent with findings from research in many countries. The findings of very high rates of suicidal intention, alcohol use and alcohol-related injury, violent behavior and other harmful behaviors among adolescents with multiple types of abuse are important. The data provide a clear signal to parents, doctors, and teachers – indeed anyone who is responsible for the welfare of children – that an underlying cause of psychological and social problems might be a hidden history of maltreatment.

Protecting the mental health of young Chinese people is a major priority for this new century. This research strongly suggests that national programs to raise community awareness and prevent child maltreatment are necessary and urgent.

For more information: The study was coordinated by the All-China Women's Federation, conducted by Professor Jingqi and her students from Peking University, and Associate Professor Michael Dunne from the International Society for Prevention of Child Abuse and Neglect. The project was supported by UNICEF China. Those wishing additional information may contact Dr. Jingqi at g3jing-qi@bjmu.edu.cn

Socio-Economic Profile and Cognitive Ability of Street Children
Kathakali Mitra and Dr. Sibnath Deb, Calcutta University

Overview

The phenomenon of street children is rather universal within all cities in the third world. In general, street children can be divided into the following categories (Ghosh, 1992).

- Children belonging to the families who have migrated permanently;
- Children belonging to the families who have migrated temporarily and would go back to their homes after some time;
- Children who come from suburbs and adjoining villages of the city in the morning, following some vocations during the day and go back in the evening;
- Children of very poor families lacking care and protection;
- Child workers;
- Unattached children who include orphans, abandoned children, maladjusted children, delinquent children, or runaways.

According to one estimate, there is a staggering 30.8 million children in India today, who have been disowned by their parents or relatives because of poverty, unwanted or out of marriage birth, and death or desertion of one or both parents. For normal and healthy development of the mind and the body, a child needs a congenial environment and basic facilities like adequate nutrition, basic education, safe shelter, minimum medical facilities and love and affection. Unfortunately, the children living on the pavements are deprived of all these basic facilities and grow up in a stressful and hostile environment.

Although a few non-governmental organizations (NGOs) have started working with the pavement dwellers/street children, available services are generally inadequate for addressing the vast number of needs presented by these children. There is an urgent need to develop accurate data that will document the characteristics of these children and their cognitive and mental disposition. The purpose of this study was to examine the socio-economic background, history of maltreatment and aspirations of a sample of these children and to compare their cognitive ability to a group of similar aged children living with their parents.

Methods

A random sample of 160 street children currently being served by two NGOs in the metropolitan region of Kolkata (i.e., Rainbow School at Loreto Day School Sealdah, Kolkata and Liberal Association for Movement of People (LAMP*),* Kolkata) were selected for this study. The sample was drawn to reflect equal proportion of children who had been deserted with no knowledge of their parents, and those children who had one or both parents but were currently living on the street either by themselves or with family members. All of the children were between the ages of 12 and 16.

A comparison sample of 160 "normal children" or children who were living with their parents were randomly selected from those enrolled in one of two secondary schools in the same metropolitan area (i.e., the Assembly of God Church School and South Point School). These children also were between the ages of 12 and 16.
All of the street children were interviewed at the NGO after being informed of the study and the nature of the questions that would be asked. Children were asked to provide descriptive information about themselves and their families; their educational history; their perceptions of their current situation and services; their future aspirations; and their experience with child abuse and other forms of violence. Both groups of children completed a standardized measure to assess their cognitive abilities (i.e., the Raven's Standard Progressive Matrices).

Key Findings

The majority of street children in this sample were 13 to 15 years of age. Unlike street children who have no contact with local NGOs, the street children in this sample were likely to be enrolled in either secondary level classes (55% of the sample) or primary level classes (45% of the sample). Less than 2% of these children were found to be illiterate and unable to either read or write. Because the majority of these children were living at the NGO facility, they report feeling generally safe and well cared for. As two of the children noted:

> *I consider myself to be in heaven at this center while other children live all in hell.*
>
> *Sister is my mother who gives me everything which I demand like chocolates, pastries and cakes, birds poster, crayon colors … I will never leave them.*

In describing the conditions that led them to living on the street, the children generally reported that their parents were unable or unwilling to care for them. About 42% of the children said their families were very poor and their parents unemployed. Alcohol and substance abuse were prevalent in about one-quarter of the families, a factor that forced children to prefer street life to remaining in their homes. In about 10% of the cases, the children indicated that the death of a parent led to them living on the street. An equal proportion of children indicated that they had left home to avoid further physical abuse. Among the specific comments children offered on their home environments were the following:

> *My parents have no time for me; they always seek their own comfort. For this reason I am unwanted to them.*
>
> *Had my mother lived, I wouldn't have been thrown out of the house by my grand parents.*
>
> *I consider myself very fortunate to stay with other children of my sort because I am away from my parental quarrel and abuse.*

With respect to health status, these children reported that they had experienced a number of illnesses over the past six months including such things as malaria; high fever including cough and cold; jaundice; diarrhea; skin infections and chicken pox. In most cases, the children reported that they had received the appropriate health care services and medicines from the NGO.

When asked about their life goals, about one-quarter of both the boys and girls indicated that they would like to become teachers. An additional 15% of the children said they would like to become social workers, Catholic nuns, or missionary sisters in order to provide education, medicine, food and other services to disadvantaged children like

themselves. Other potential careers identified by this group of children included doctors, actors, sales person, driver, Minister or engineer. Some of the specific comments the children made regarding their future occupations included the following:

> *I want to be like jokers and make people laugh and giggle with my amusing acts and help them to remove all sadness from their heart*.
>
> *Sisters are the angels on this earth, I want to be one such angel when I will grow up and educate children of our sort.*
>
> *I want to be a driver so that I can go to far off places with my truck.*
>
> *My 'bhanudada' (local dada) does all good things for children like us, I need to join hands with him and help his mission.'*
>
> *Since I love to paint, I want to be a drawing teacher and put the colors to canvas of life.*
>
> *I prefer to be a Minister who has all power to destroy the country.*

These street children were the subject of various forms of abuse by a variety of individuals in their lives. In addition to the abuse they had experienced in their homes, almost three-quarters of these children reported regular abuse by various individuals since they began living on the street. Most of these children (58%) were physically abused or tortured for minor offences by adults or commuters who accused them of pick pocketing when they would stop on the street to beg. Others reported mistreatment by other street children. None of these children reported sexual abuse. Specific comments the children made on these abusive episodes included the following:

> *My employer used to throw on me sharp pebbles and stones when I used to fall asleep.*
>
> *Police dada used to push me with his stick and use slang words when I used to sleep on his traffic stand.*
>
> *My maternal uncle used to beat me because my father ran away with another woman and left my mother alone.*

As might have been predicted, the average cognitive ability of this group of street children was significantly lower than the abilities recorded by the comparison sample. As summarized in Table 1, those children who were currently living with their parents and attending a secondary school scored almost 10 points higher, on average, than this group of street children. These differences were equally true when the sample was examined in terms of gender.

Table 1: Raven's Standard Progressive Matrices: Street Children and Normal Children

Sample	Mean	SD	Skeweness (SK)	Kurtosis (K)	T-test	Level of Significance
Street Children N=160	32.3	9.3	-.52	.09	-1.03	$p < .05$
Normal Children N=160	42.4	9.6	–1.07	.99		

Conclusion

India has the largest number of street children in the world and the number of street children is increasing daily in all metropolitan areas. The broad objective of the present study was to understand the socio-economic background, aspiration and nature of abuse experienced by street children and to compare their cognitive abilities to those of a group of similarly aged children living with their parents. It is hoped that this information will be used in shaping policy and in expanding service options for these children.

On the basis of these findings, the following steps are recommended for addressing the problem of street children in India:

- More consistent efforts to identify street children and to bring them into the rehabilitation programs run by local NGOs. Such efforts need to be undertaken for both the very young children as well as those entering adolescents.

- Even if these children cannot be enrolled in residential programs, all street children should be involved in various daily indoor and outdoor group activities for the purpose of building trusting relationships. In addition, psychological and/or emotional counseling should be provided to these children as needed.
- If possible, contact should be established between the street children and their birth parents or family members to enhance their social and emotional development.
- Arrangements should be made to enroll street children in formal schooling at least through the primary levels and longer, if possible, as a way to maximize their cognitive development. In addition, youth should be provided viable vocational training to insure the optimum utilization of their talents.
- Reward systems should be established to encourage all welfare and rehabilitation programs to enroll and retain disadvantaged children. To insure funds for such programs, industrial houses and/or profit making commercial organizations should be invited to support welfare and rehabilitation programs. In addition, retired persons might be recruited to increase the staff capacity at these programs.
- To strengthen the performance of those programs run by NGOs, a formal network should be established to encourage coordination among these NGOs and facilitate the sharing of core resources and emerging knowledge with respect to best practices. Also, the NGOs involved in this work need to educate their peer organizations on the various government supports available for this work and encourage them to develop programs in this area.
- Awareness about *CHIDLINE* should be created among all disadvantaged children. *CHILDLINE (1098)* is a national 24-hour toll free phone emergency outreach service for children in need of care and protection.

For further information: Those wishing additional information on the study may contact Dr. Deb at sibnath23@rediffmail.com

A Study on Psychological Trauma of Young Trafficked Women
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Overview

With the rampant violation of child rights across the globe a special evil in the form of child exploitation has emerged particularly in developing countries. Although child exploitation in the form of child labor is a much-discussed issue, the booming industry of child trafficking has yet to receive adequate attention from social activists, researchers and academicians. Indeed, commercial sexual exploitation of children has been defined by the United Nations as the use of a child for sexual purposes in exchange for cash or in-kind favors between the customer, intermediary or agent and others who profit from the trade in children for these purposes (parent, family member, procurer, teacher etc.).

Young women and children who have been forced to work as prostitutes are likely to continue to experience the physical and psychological consequences of their entrapment; repeated physical and sexual abuse; uncertainty, fear and the absence of personal control; poor health care and working conditions; and infection from STDs including HIV/AIDS. Consequences include anxiety and depressive states, an attitude of hopelessness and helplessness in relation to future decisions; social stigma and discrimination especially if HIV positive, sterility; and physical illness. Compounding the original abuse, a proportion of girls may feel compelled to return to or stay in prostitution because of the shame of having worked as a prostitute. Marriage prospects are very low and the likelihood of discrimination is high in cultures where virginity and sexual inexperience is prized.

This brief reports on a study conducted in India on a group of young women who had been taken into custody following a charge of trafficking or prostitution. Thirty-five women between the ages of 14 - 22 were interviewed as part of this study and assessed using the Trauma Symptom Inventory (TSI) (Briere 1991). Although the sample is small and utilizes subjects who had been taken into custody and were awaiting case disposition, the study is one of the first in India to collect standardized assessment data on trafficked women.

Methods

The study drew a convenience sample from young women taken into custody for trafficking or prostitution by police and placed at one of two residential programs for women – a government sponsored group home and a home run by a local NGO **--** in West Bengal, India. Criteria for selection into the study included the following:

- Women between the ages of 14 and 22.
- Women who had a history of trafficking or forced to act as prostitutes
- Women who had been brought to the home after being rescued by police from the local red light district
- Women who reported a history of physical or sexual abuse

During the study's enrollment period, 35 young trafficked women were identified and agreed to participate in the study. Interviews were completed between July and December 2004.

Data collection protocols consisted of an open-ended, in-depth interview regarding the respondents past history and current living conditions as well as the administration of the Trauma Symptom Inventory (TSI), a 100-item test of posttraumatic stress and other psychological sequelae associated with traumatic events. Developed by John Briere at the University of Southern California, it is intended for use in the evaluation of acute and chronic traumatic symptomatology, including, but not limited to, the effects of rape, spouse abuse, physical assault, combat, major accidents, and natural disasters, as well as the lasting sequelae of childhood abuse and other early traumatic events. The various scales of the TSI assess a wide range of psychological impacts. The TSI contains three validity scales (i.e., response level, atypical response, and inconsistent response) and ten clinical scales (anxious arousal, depression, anger/irritability, intrusive experiences, defensive avoidance, dissociations, sexual concerns, dysfunctional sexual behavior, impaired self-reference, tension reduction behavior).

Key Findings

The study population consisted of 35 female participants between the ages of 14-22 years, with a mean age of 19 years. More than half of these women (57%) were illiterate with no writing skills and negligible reading skills. All came from lower socio-economic backgrounds. Of these 35 subjects, 91% reported a history of sexual abuse, with the majority of this abuse beginning after they turned 12 years of age. All of the women reported a history of physical abuse and 11% of the women (4 cases) were HIV positive.

Table 1 summarizes the percentage of cases reporting clinically significant symptoms in each of the ten domains captured by the TSI. As this table indicates, the proportion of the population with significant problems in each of the areas ranged from a low of 13% (anxious arousal) to a high of 63% (defensive arousal).

Table 1: Incidence of the Sample on the Domains of TSI

Clinical Domains	**Cases with Clinically Significant Symptoms**	
	Frequency	**Percentage**
Anxious arousal	4	13.3
Depression	9	30.0
Anger/ irritability	7	23.3
Intrusive experiences	9	30.0
Defensive arousal	19	63.0
Dissociation	12	50.0
Sexual concerns	17	56.0
Dysfunctional sexual behavior	16	53.0
Impaired self reference	5	16.7
Tension reduction behavior	9	30.0

Base: All Young Trafficked Women (N=35)
Note: The TSI considers a score of 65 and above in any clinical domain as clinically significant.

Anxiety arousal scale**:** The four participants identified in the clinical range on this scale reported frequent periods of trembling or shaking, nervousness, jumpiness, and feeling on edge, excessive worrying, and fears of bodily harm. They described themselves as tense and reported reacting to stress or sudden intrusive stimuli with fearfulness or an exaggerated startle response.

Depression scale: Almost one-quarter of the subjects obtained clinically significant scores in the depression domain. These subjects reported frequent feelings of sadness and unhappiness and a general sense of being depressed.

Anger/irritability scale: Anger or irritability, identified by 23% of the respondents, is closely related to PTSD or a more chronic angry state. There is the presence of not only the internal experience of anger or irritability but also the presence of cognitions (telling someone off) and angry behavior (e.g. yelling, argumentativeness, and picking fights). Some of these individuals described anger as an intrusive and unwanted experience over which they have little control. These respondents also described pervasive feelings of irritability, annoyance or bad temper such that minor difficulties or frustrations provoke contextually inappropriate angry reactions. Most respondents reported thoughts or fantasies about hurting someone, but generally limited these feelings to the person who sold them into trafficking.

Intrusive experiences scale: About one-third of the subjects presented clinically significant scores in this domain including nightmares and flashbacks (e.g., sudden, intrusive sensory memories of a previously traumatizing event) and repetitive thoughts of an unpleasant previous experience that intrudes into awareness.

Defensive arousal scale: A high number of cases (63.0%) obtained clinically significant scores in this domain. These subjects were found to possess aversive internal experiences that they repeatedly sought to avoid. They also reported frequent attempts to eliminate painful thoughts or memories from conscious awareness (e.g., 'stopping yourself from thinking about the past' or 'pushing painful memories out of your mind'). These specific strategies reflect a conscious intentional cognitive and behavioral process to manage posttraumatic distress. The high percentage of respondents showing clinically significant scores on this scale may be attributed to the abusive nature of their memories in connection to their recent experiences with prostitution.

Dissociation scale**:** Half of the subjects reported dissociative experiences such as cognitive disengagement, depersonalization and de-realization, as well as emotional numbing.

Sexual concerns scale**:** Almost 60% of the respondents indicated sexual distress, sexual dissatisfaction, negative thoughts and feelings during sex, confusion regarding sexual issues, sexual problems in relationships, unwanted sexual preoccupation, and shame regarding sexual activities and responses.

Dysfunctional sexual behavior scale**:** Over half of the subjects (56%) reported indiscriminate sexual contact (under compulsion), getting into trouble because of their sexual behavior, but rarely reported using sex to combat loneliness or internal distress, flirtation or seductiveness for non-sexual reasons and sexual attraction to potentially dangerous or dysfunctional persons. High scores on this scale also are indicative of sexual risk taking and involvement in unsafe sex practices.

Impaired self-reference scale: Slightly more than 16% of the subjects reported an inadequate sense of self and personal identity. They expressed an inability to understand ones own behavior, an internal sense of emptiness, a need for other people to provide direction and structure for them, and difficulties resisting the demands of others. Those scoring high in this area had less self-knowledge and self-confidence than others in the sample.

Tension reduction scale: One-third of the subjects exhibited a tendency to externalize distress through suicidal thoughts, aggression, inappropriate sexual behavior, self-mutilation, and activities intended to forestall abandonment or aloneness.

Conclusion

These data point to high levels of trauma in all domains among young women involved in trafficking and prostitution. The high illiteracy and poor economic conditions may have made these women particularly vulnerable to men who offered them a better way of life. With little understanding of the world outside their small communities, these women may have found themselves in a life style from which they were unable to retreat once the true nature of the jobs they were being offered became clear. Further, a prior and continuing history of abuse, both physical and sexual, underscores the mistreatment that can await those who try to resist working once they are in a brothel. The four cases of HIV noted in the sample is cause for serious concern as it indicates a lack of adequate contraception or protection. India's HIV status is increasing at an alarming rate, and it is becoming clearer that adequate and effective measures are required to combat this problem.

Analysis of the TSI data revealed that at least 20% of the subjects experienced dysphoric mood, which is identified by states of anger/irritability, depression, and anxious arousal. The fact that those experiencing significant psychological trauma often encounter dysphoric mood states has been repeatedly documented in literature. The subjects experiencing dysphoric mood reported a recurrence of anxious arousal (e.g., jumpiness and excessive worrying). Participants also reported anger/irritability with cognitions (e.g., telling someone off) and angry behavior such as yelling, argumentativeness, picking fights. Suicidal and self-injurious behavior was present in all the seven cases presenting this problem.

The participants experiencing post-traumatic stress (43% of the full sample) reported intrusive experiences in the form of sudden sensory flashbacks of the previously traumatizing event. The most common defense employed by this group of women to cope with this trauma was defensive avoidance whereby the participants reported frequent attempts to eliminate painful thoughts and memories from conscious awareness and avoid events or stimuli in their environment that might generate upsetting thoughts and memories.

The prevalence of self-dysfunction (43% of the cases) is to be expected given the history of these women. Indeed, it was somewhat surprising that the proportion of respondents externalizing distress through suicide, aggression, inappropriate sexual behavior, self-mutilation, and other activities intended to forestall abandonment or aloneness was not higher.

For further information: Those wishing additional information on the study may contact Dr. Deb at sibnath23@rediffmail.com

Parenting Project- A Survey on Disciplinary Practices, Child Care Arrangements and Parenting Practices in Singapore

Shum-Cheung Hoi Sham, Singapore Children's Society

Overview

The Parenting Project was developed by the Singapore Children's Society to find out more about parents' and children's perspectives on disciplinary practices, child care arrangements and parenting practices. Examining children's perspectives almost always yields very interesting data, especially when children are at the receiving end of disciplinary practices and child care arrangements.

Sample

A total of 500 parents (250 mothers, 250 fathers) and 500 children ages 10 to 12 (250 boys, 250 girls) were recruited for this study. Participants were recruited through various means, such as parent-support groups held at local primary schools and a recruitment notice posted on a local classified paper. Each parent-child pair belonged to the same household, and only one parent and one child from each household participated. The percentage distribution of participants from the various income groups and races were matched with that of the Singapore population in order to generate a more representative sample. The four major races in Singapore are Chinese, Malay, Indian and others including Eurasians. This last category is a small minority within in the local population.

Methods

Two sets of questionnaires were designed, one for parents and one for children. Although both surveys addressed similar topics, the language in the child questionnaire was simplified to ensure that the questions could be easily understood by children from ages 10 to 12. Both sets of questionnaires were subject to two pilot tests to be certain that they were comprehensible to the participants.

The questionnaires were then administered to parent and child participants through face-to-face interviews, conducted by trained interviewers. The parents and children were interviewed separately. Each interview took no more than 30 minutes to complete.

Three issues are address in each questionnaire.

Disciplinary practices: The disciplinary practices section includes eight scenarios of child misbehavior on which parents and children were asked to comment. These misbehaviors can be broadly classified as either moral or

social-convention transgressions. Moral transgressions consist of actions that have a negative psychological or physical impact on others (Lopez, Schneider & Dula, 2002). Examples of moral transgressions are fighting with others and vandalizing objects. On the other hand, social-convention transgressions involve violations of common social rules (Lopez et al., 2002), such as refusing to obey instructions and being impolite to others. The scenarios of child misbehavior were either created specifically for this study or adapted from scales used in past research (e.g. Papps, Walker, Trimboli & Trimboli, 1995; Lopez et al., 2002, Kelley & Power, 1992). The scenarios were chosen based on their relevance to the local culture and represented misbehaviors constituting different severity levels.

Along with the eight scenarios of child misbehavior, parents and children were also shown a list of six disciplinary practices that parents usually adopt when disciplining their children. These disciplinary practices include the use of physical punishment; showing anger towards the child; taking away some of the child's privileges; explaining to the child what he/she has done wrong; isolating the child; and telling the child that he/she is not loved. These practices can be categorized under power assertion, love withdrawal and induction. An additional option "do nothing" was also included with the list of six disciplinary practices. This option allowed parents who do not do anything to discipline a child, even when the child has misbehaved, a valid response option.

After viewing each of the scenarios, parents and children were asked to respond to the following questions using a 5-point Likert scale:

Parents:

- How effective do you think each of the disciplinary practices is in dealing with a child who has (e.g. quarreled with others)?
- How often does your child (e.g. quarrel with others)?
- How often have you used each of the disciplinary practices to discipline your child for (e.g. quarrelling with others)?

Children:

- If a child (e.g. quarrels with others), how fair is it for parents to use each of the disciplinary practices?
- How effective do you think each of the disciplinary practices is in dealing with a child who has (e.g. quarreled with others)?

For the parents' questionnaire, an additional sub-section was included that listed 15 qualities frequently used to describe children (e.g., being honest, getting along with others, being obedient, etc.). For each quality, parents rated the importance of each on a 5-point Likert scale.

The data obtained from the disciplinary practices component will help the Society identify some of the most frequently-used disciplinary methods by Singapore parents with children aged 10 to 12, and whether parents considered these methods effective. Data from the children will identify the extent to which there is a match or mismatch between parents' and children's perceptions in the effectiveness of these discipline practices. The relationship between children's judgment on fairness of disciplinary practices and parents' perceptions of their effectiveness will also be explored. Finally, the researchers will examine the relationship between certain child misbehavior and the use of a certain disciplinary method (e.g. power assertion).

Child Care Arrangements**:** The aim of this component is to understand more about the care arrangement of children at different ages. Parents were asked to identify their children's main caregiver when the children were between ages 0 to 3; 4 to 6; 7 to 9 and age 10 and older. Children were asked the same questions, except that they did not have to respond to questions pertaining to age 0 to 3. In addition to describing the main child care arrangements across ages, parents and children were also asked to indicate to what extent they were or are happy with their care arrangements and which care arrangements they would have preferred to have changed.

Parenting Practices**:** Parents and children were provided a list of 20 parenting practices, which represent categories such as training/guidance, encouragement of modesty, shaming, parental participation, warmth/acceptance, parental control and religiosity. Most of these parenting practice items were adapted from past research (e.g. Block, 1965; Chao, 1994); religiosity was created for this study to suit the local culture. Parents were also asked how often they have carried out the various parenting practices in the process of raising their children. These child participants are asked to indicate how often their mothers and fathers have adopted those parenting practices. A 5-point Likert scale was used.

Current Status

Fieldwork was complete by mid October 2005 and preliminary data on the disciplinary practices component was presented at the 6th ISPCAN Asian Regional Conference to be held in Singapore in November 2005.

For further information: Please contact Mrs Shum-Cheung Hoi Shan at hscheung@childrensociety.org.sg or refer to the following references

Block, J. H. (1965). The Child-rearing Practices Report (CRPR): A Set of Q items for the Description of Parental Socialization Attitudes and Values. Institute of Human Development, University of California, Berkeley.

Chao, R. K. (1994). Beyond parental control and authoritarian parenting style: Understanding Chinese parenting through the cultural notion of training. *Child Development, 65*, 1111-1119.

Kelley, M. L., & Power, T. G. (1992). Children's moral understanding: Developmental and social contextual determinants. In L. T. Winegar & J. Valsiner (Eds.), *Children's Development Within Social Context Volume 2 Research and Methodology*. New Jersey: Lawrence Erlbaum Associates, Inc.

Lopez, N. L., Schneider, H. G., & Dula C. S. (2002). Parent discipline scale: Discipline

choice as a function of transgression type. *North American Journal of Psychology, 4*(3), 381-393.

Papps, F., Walker, M., Trimboli, A., & Trimboli, C. (1995). Parental discipline in Anglo, Greek, Lebanese, and Vietnamese cultures. *Journal of Cross-Cultural Psychology, 26*(1), 49-64.

INNOVATIVE EFFORTS TO BUILD CAPACITY

Finally, four commentaries discuss efforts to either evaluate existing programs or to expand national capacity to respond to child abuse and other forms of violence toward children. Again, these efforts are underway in countries as diverse as Australia, Brazil, Lebanon and Bahrain. As illustrated in all of these briefs, local professionals are working across sectors and disciplines to confront long-standing institutional and cultural barriers which limit a society's ability to recognize and address the problem of child abuse.

Advancing Children's Well-being through Influence - the New South Wales Commission for Children and Young People

Gillian Calvert, NSW Commission for Children and Young People

Overview

Promoting the safety and well-being of young people and preventing abuse and neglect require responses and interventions from many disciplines and parts of society. In Australia's largest state, New South Wales (NSW), a Commission for Children and Young People was established in 1999 as a voice for the state's 1.6 million children under 18. Its legislation gives it a broad role in promoting children's well-being. The purpose of this brief is to outline the process followed in developing the commission and its current role with respect to shaping youth policy.

Historical Context

Throughout the 1990s a range of non-government and professional organizations had recommended the creation of an independent body to advocate for children and young people. The catalyst for the current effort came from an investigation into corruption in the state's police force regarding allegations that the local police were involved in organized paedophile activity. Widespread public concern over the issue led to a broader investigation that examined the possibility of organized paedophile activity throughout the community.

Although this three-year investigation found no evidence of any current organized paedophile networks, it did identify a number of serious systematic failures that placed children at risk. Specifically, the investigators determined that children were vulnerable because there was no single voice speaking out for their interests in New South Wales. As a result, their voices were often not heard by the government or the community at large. To correct this situation, the investigation recommended the establishment of a commission for children that would advocate for their safety and welfare.

In consultations leading up to the establishment of the Commission, children referred to the Commission as "their" organization and wanted "their" organization to consider the full range of issues that affect their lives – to focus on their total well-being, not just safety and welfare. Children and young people also gave a clear message about how they saw their world. They saw themselves as citizens who wanted to have a say in building their world and they wanted a Commission that would help them do so. Most importantly, they wanted to have their say and be taken seriously.

In response to these concerns, the Parliament unanimously passed authorizing legislation to establish an organization with a much broader role than that originally recommended. In cases where the draft legislation suggested a more expansive role for the Commission than originally proposed, these changes generally reflected the views expressed by children during the planning period.

In 1999, there was only one Children's Commission in Australia and its role was much narrower than the new NSW Commission's. Now, most Australian jurisdictions have established or are in the process of establishing a Commission, many of which are based on the NSW model.

Key Characteristics

The Commission for Children and Young People is an independent organization which is responsible to government only for financial management and administrative issues, but not for its directions or priorities. Its work is overseen by a cross-party Parliamentary Committee, which has a review and monitoring role but not a controlling or directive one.

Legally, the Commission's work is governed by the principle that the safety, welfare and well-being of children are to be its paramount consideration. In meeting its mandate, the Commission embraces the concept that children are to be taken into account in all decisions, and that children need co-operative relationships with their families and communities.

Its legislated functions include promoting children's participation in decisions that affect their lives; making recommendations on legislation, policies, practices and services affecting children; conducting, promoting and monitoring training, public awareness activities and research on issues affecting children; and developing and maintaining a system of screening for people working in child-related employment. In exercising these functions, the Commission gives priority to the interests of vulnerable children. Within these broad principles and functions, the Commission is free to determine its specific priorities and work plans.

Independence does not guarantee influence; influence is based on credibility, reputation and a strong network of relationships which the Commission has been building since its inception. As a small organization with no direct service delivery role or legislative authority to direct change, it has to rely on influencing others as a way of making NSW a better place for children and young people.

Early Challenges

Since its inception, the Commission has faced major challenges in meeting the accumulated expectations of other (adult) advocates for children. In particular, during the early stages of the Commission's development, it had to manage a diverse set of expectations including a primary focus on issues relating to the child protection system and projects solely targeting vulnerable children and young people or base its work exclusively on children's rights. The Commission has worked extensively on child protection and vulnerability issues, and all its work is and has been about rights, but some people expected these matters to have been its sole focus. Also, since the Commission's mandate extends to any social, economic or environmental issue of concern to children up to 18 years, it must carefully in prioritize its work to manage stakeholder expectations, and achieve the desired outcome every time it tackles a specific issue.

In other cases, the Commission has to educate the community about the limitations of the changes it has achieved. For example, the screening system for people who work with children, the Working with Children Check, has created challenges in managing a false sense of security. Many organizations began to assume that if their staff members pass this safety the check, the children they serve were guaranteed to be safe. The Commission has since developed a series of initiatives to help organizations operate in ways that are safe and friendly for children, as a complement to the checking system.

Influencing through Research

Robust research evidence can be a powerful tool for change if it is managed effectively. The Commission has been successful in using research to influence issues affecting children because it has credibility and is recognized as one that brings a fresh perspective and approach to public discussions. The Commission's broad scope and independence allows it to commission or undertake unique research as well as broker joint research projects among agencies or across disciplines that might otherwise not work together. Given its direct link to the voice of children, the Commission can identify knowledge gaps and the need for research which may not be apparent from the traditional adult perspective. For example, a research project on what "well-being" means to children themselves is now underway. The Commission also educates researchers on how to engage children in developing research questions and in conducting effective research with children.

Influencing through Information

There is surprisingly little information available about children and young people's views regarding their world and their place in it. For example, a child's relationship with her family, friends, care organizations, schools and neighborhoods, form the lens through which she will experience the world. Children are happier and safer when they have positive relationships with their families, schools and communities. This may be obvious, but it has rarely informed public policy making or planning services for children and young people.

To address this gap, the Commission has developed a publication series, *Ask The Children*, to inform the community and decision makers about children's opinions, largely using children's own words, on issues as disparate as help-seeking, employment, schools and pharmacists. Further, the Commission is strategic in selecting forums, methods and target audiences for disseminating information to promote or prevent change. Sometimes, as

in smaller rural communities, the Commission initiates an event, to serve as a platform for disseminating information.

Influencing through Modelling

Although NSW has a long tradition of acknowledging the importance of listening to and considering children's views, the commitment was only occasionally reflected in actual policy development or practice. In addition to producing tools and delivering training to help organizations make their practice more inclusive, the Commission has been able to model participatory practice in strategic planning, human resource policy and management, communications and advocacy. It has demonstrated that even a small organization with a large agenda and limited resources can live the participation rhetoric. As a result, large government and non-government organizations have sought the Commission's assistance in providing a meaningful role for children in high profile events and major policy development projects. These experiences have convinced many people of the value of having young people at the table when decisions are being made.

Influencing through Transferring Skills and Knowledge

Theoretical and practical knowledge about how to make the world a better place for children is rapidly expanding. Few of us have the time or ability to keep up with important developments in all of the relevant fields. To address this issue, the Commission offers a seminar program which introduces key local and overseas presenters to audiences of policy makers and practitioners. Recently, two urban geographers presented their research to an audience including social workers, lawyers, midwives, architects and an economist. In addition to these larger learning opportunities, the Commission also has brokered more focussed workshops for international experts with small groups of agency Chief Executives and other key decision makers.

Impact

The Commission has been successful in generating an understanding that children's views are important when responses are being planned to issues that affect them - for example the Commission was invited to conduct consultations with children to support Australian's next National Plan of Action to implement the United Nations Convention on the Rights of the Child, and the long term strategic plans for the state's health and education systems. There is also an emerging understanding that participatory and inclusive practices protect children and generate more effective services.

The Commission has influenced changes to policy and practice in systems as diverse as child protection, road safety, education, health, criminal justice and fair trading. And it has had some success in eliciting legislative change. While initially the perception of the Commission was limited to that of a participant in social debates, that perception changed as the organization addressed issues of children and young people as participants in the economy and the workforce, and as participants in the natural and built environment.

Lessons Learned

In reflecting on the Commission's achievements and failures, some factors emerge which appear to have contributed to its successes:

- independence from government, sectoral and other interests;
- credibility, based on its child-focus practice and ability to bring the child's perspective to public discussions;
- a broad mandate across the entire lives of children and young people, with a range of available responses (e.g., training, accreditation, advocacy, research, education);
- building strategic networks in many sectors;
- ability to target communication effectively to diverse audiences;
- ability to identify and respond to opportunities as they arise;
- commitment to evidence and a rigorous approach to its own research;
- reflective practice and learning from its mistakes.

For further information: Those wishing additional information on the commission and its work may contact Gillian Calvert and Gillian.Calvert@kids.nsw.gov.au

Brazilian Teachers as Agents to Prevent Child Sexual Abuse: An Intervention Assessment

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Overview

During the 1990s, there was a 39% decline in child sexual abuse cases (CSA) reported to child protective agencies in the United States (Jones, Finkelhor & Kopiec, 2001). Possibly, such data reflects that the investment in prevention programs during the 1980s and 1990s can effectively protect children from sexual abuse (Jones & Finkelhor, 2003).

According to Finkelhor's model of sexual abuse, certain preconditions must be met before abuse can occur. The author's model is useful in developing primary, secondary and tertiary prevention programs (Finkelhor, 1984). The present study developed an intervention program based on such a model. In addition to Finkelhor's work, the program also draws on Benetti's claims that the most effective prevention actions are educational interventions (Bennetti, 2002). These and other efforts suggest that mothers, if properly informed, can play an important role in protecting their children. Specifically, programs can train mothers in recognizing CSA symptoms, in evaluating risk situations and potential offenders, and in taking action when needed to protect their child. Children can be trained to recognize adult inappropriate behavior, act quickly, leave the situation and find help.

Brino and Williams (2003a; 2003b) have analysed child sexual abuse interventions from the point of view of secondary and tertiary prevention. The purpose of this paper is to apply these evaluation methods to an educational prevention program targeting early education teachers and their students. Specifically, the program seeks to equip early education teachers in instructing children in self-protective skills and to teach family members to recognize early signs of CSA, and adopt a number of safety measures.

Methods

The study enrolled 101 early-childhood educators (97 female and 4 male) from the public school system in the city of São Carlos, a mid size city in the State of São Paulo, Brazil. In addition to the teachers, 96 children ages 4-6 years and 101 family members of pre-school children also participated in the research.

The measures utilized in this study included the following:

- Child Sexual Abuse Indicators (Indicadores de Abuso Sexual – IAS) – (Flores et al., 2001). This instrument was developed in Brazil and includes 35 symptoms and signs which may be associated with CSA. IAS data were obtained from teachers at three different points in time – before the intervention with the teachers, after the sixth session and at the end of the full intervention. IAS data also were obtained from a sample of family members before and after the teachers presented the intervention.
- Teachers Drill on Child Sexual Abuse Identification. The drill consisted of a vignette in which a case of suspected CSA was presented, and teachers were instructed to write down how they would respond. Teacher responses were obtained both before and after the intervention for only those teachers assigned to Group 2, as described below.
- Parental Drill on Child Sexual Abuse Identification. The drill consisted of a vignette in which a case of suspected CSA was presented, and family members were instructed to write down how they would respond. Teachers colleted data from family members before and after providing them the intervention.
- Drill on Self-Protective Skills Acquisition for Children. The drill consisted of a vignette in which someone behaved inappropriately towards a child, and children were asked to tell the teachers what they would do under various circumstances (e.g., what to do in a situation that you don't like, what to do when you are threatened, what to do when an adult asks you to keep a secret, and name one person who could help you). Teachers obtained data from the children before and after they provided them the intervention.

The University Ethic's Committee approved the present study. Those teachers recruited for the study were divided into two groups (Group 1 = 52 teachers; Group 2 = 49 teachers), with each of the two groups further divided into three groups for purposes of obtaining the teacher training program. This program consisted of 12 weekly meetings, four hours each. Each session included lectures, group discussion, video presentations and role-play covering descriptive and theoretical aspects of CSA as outlined in the literature.

The intervention with family members consisted of workshops that were planned during the intervention with the teachers. As part of this intervention, family members had the opportunity to role-play various family activities with the first author. The intervention with the children was provided by the teachers during the school day and involved teaching students general protective measures (e.g., assertiveness, saying no) rather than specific information about CSA.

Key Findings

Teachers: The teachers' IAS scores at the three data collection points are summarized below. Figure 1 presents the data for the three subgroups in Group1 and Figure 2 presents the data for the three subgroups in Group 2. Total scores for the IAS can range from 23-115. As these figures indicate, the scores for both groups of teachers at all three points, including prior to the intervention, were at the high end of the scale.

Figure 1: Teachers' IAS Scores- Group 1

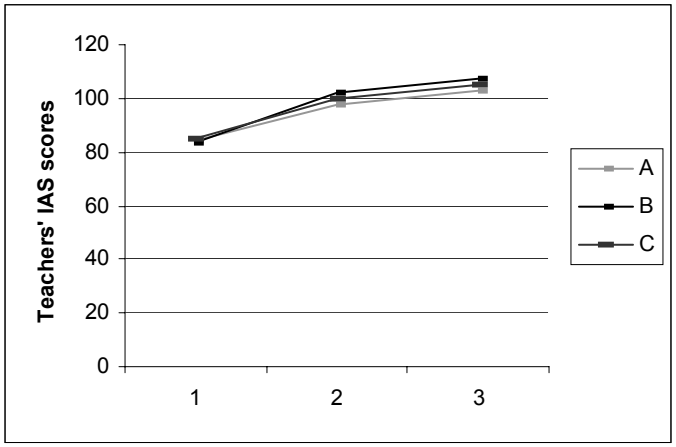
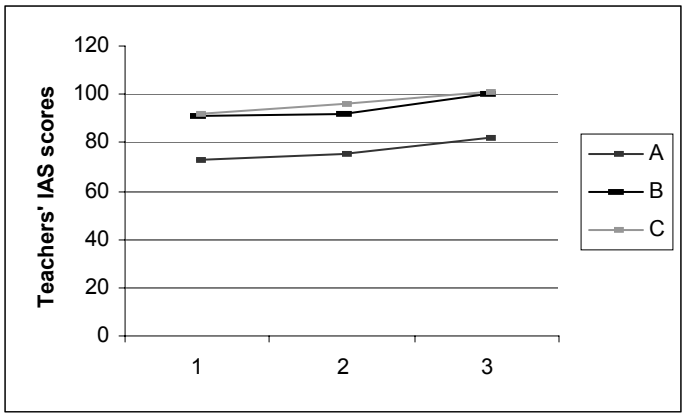
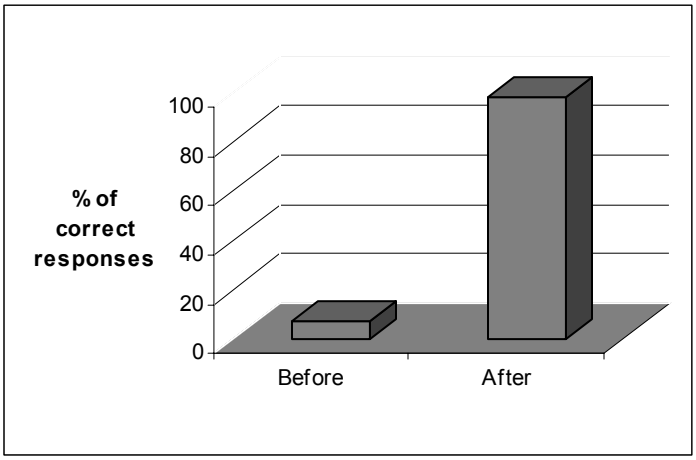


Figure 2: Teachers' IAS Scores – Group 2



Teachers' performance in the Teacher Drill on Child Sexual Abuse Identification is summarized in Figure 3 below. As this figure indicates, the proportion of correct responses increased notably between the two data collection points.

Figure 3: Teachers' Performance on the Teacher Drill – Group 2



Family Members: Family Members' IAS scores are summarized in Figure 4 and their responses to the CAS vignettes are summarized in Figure 5. As with the teachers, family members generally scored at the high end of the IAS scale at both data collection points but provided a greater number of appropriate responses to the CAS vignettes only after receiving instruction.

Figure 4: Family Members' IAS scores

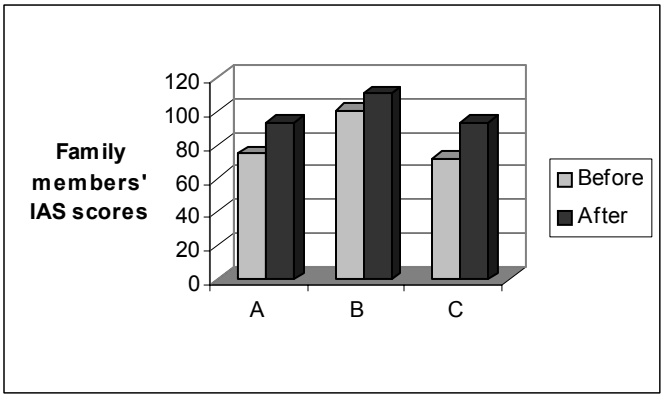
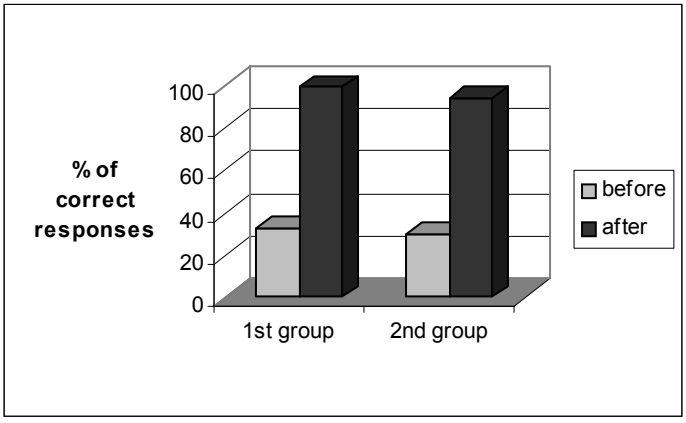
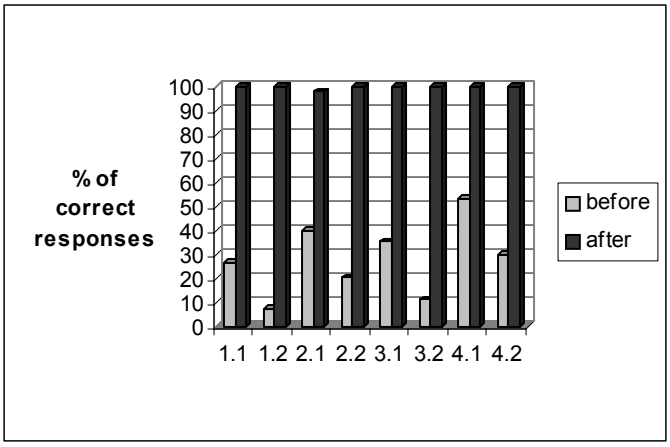


Figure 5: Family Members' Response to CSA Drill



Children: Children's performance in the Drill on Self-Protective Skills Acquisition for Children is described in Figure 6 below. As this figure indicates, children in all groups demonstrated a sizable improvement in their response to these cases following the intervention.

Figure 6: Children's Performance on Self-Protective Skills Drill



Lessons Learned

Data analysis shows a significant increase in the IAS scores for teachers and family members following the intervention. There also was a significant increase in the percentage of appropriate answers and a decrease in the percentage of inappropriate answers from teachers, family members and children in response to the various vignettes after the intervention. In general, these results suggest that the intervention program has been successful. These types of educational methods may offer a promising strategy for reducing a child's risk for CSA and for improving the response children at risk will receive from teachers and family members. These results are encouraging and the intervention has been well received by the educational system in Brazil.

For additional information: Those wishing additional information on the study's methods or findings may contact Lucia Williams at lucawi@terra.com.br or refer to the following references.

Benetti, S.P.C. (2002) Maus-tratos da Criança: Abordagem Preventiva [Child Maltreatment: Preventive Approach]. Em: C.S. Hutz (org.) Situações de Risco e Vulnerabilidade na Infância e na Adolescência – Aspectos Teóricos e Estratégias de Intervenção. São Paulo: Casa do Psicólogo.

Brino, R.F. & Williams, L.C.A. (2003a). Concepções da professora acerca do abuso sexual infantil [Teachers' conceptions about child sexual abuse]. Cadernos de Pesquisa – Fundação Carlos Chagas, 119, 113-128.

Brino, R.F. & Williams, L.C.A. (2003b). Capacitação do educador acerca do abuso sexual infantil [Training teachers on child sexual abuse]. Interação em Psicologia, 7, 02, 1-11.

Finkelhor, D. (1984). Child Sexual Abuse. 53-68. New York: Free Press, Macmillan.

Jones, L.M., Finkelhor, D. & Kopiec, K. (2001). Why is sexual abuse declining? A survey of state child protection administration. Child Abuse & Neglect, 25 (9), 1139-1158.

Jones, L.M., Finkelhor, D. (2003). Putting together evidence on declining trends in sexual abuse: a complex puzzle. Child Abuse & Neglect, 27 (2), 133-135.

The Lebanese Intersectoral Committee for Child Rights (LibanCAN)
Bernard Gerbaka and Sana Awada, Higher Council for Childhood in Lebanon

Overview

Despite ongoing efforts by many organizations in Lebanon to address the problem of child abuse and neglect, children from different communities and diverse family settings continue to suffer maltreatment. Efforts to address the problem face a variety of social and professional barriers as well as a hectic social context in which sustainable democracy, safety and peace are continuously being sought but often not achieved.

Following the regional meeting of the UN Secretary General's Study on Violence Against Children in 2005, local professionals established the Lebanese Intersectoral Committee for Child Rights (LibanCAN). This brief reports on the efforts of this grassroots initiative to facilitate collaboration between health and educational professionals. The effort is based on the Committee on the Rights of the Child (CRC) matrix that incorporates children's rights, professional evidence, relevant social factors, and intersectoral responsibilities in a coordinated effort to prevent child abuse and neglect. The report illustrates how progress can made even within countries that lack a strong social service infrastructure and struggle with high levels of violence and unrest.

Background and Structure

Lebanon has a history of establishing interdisciplinary task forces that bring together a number of key professional groups including law enforcement personnel, child welfare and mental health specialists, academic researchers and medical professionals. Although these types of collaborative efforts had achieved a notable reduction in some areas, such as infant mortality in Beirut, it became clear that reducing child abuse and other forms of violence toward children would require a more focused effort, one that directly addressed the lack of information about the scope of the problem, the need for professional training and the variety of contextual issues facing the Arab region (e.g., unemployment, poverty, divorce and family conflicts, drug abuse and exposure to armed conflicts).

Although there is no mandatory reporting system in Lebanon for suspected cases of child abuse, many professionals frequently encounter it. In response to this situation, local professionals established LibanCAN for the purpose of designing a child protection system that would offer an effective response to child abuse and embrace all elements of the CRC. Within that vision, LibanCAN relies on professionals and institutions serving children to provide or generate the resources necessary to create all elements of this system and to offer specific opportunities for youth participation.

LibanCAN's specific objectives include the following:

- To identify valuable resources and key persons working with children
- To develop and improve models for detecting child abuse and neglect, and manage the professional response to identified cases
- To increase public awareness with respect to the definition, recognition and prevention of child abuse and neglect
- To design and facilitate educational and training materials for professionals and NGOs working in the area of CAN
- To support municipal and governmental cooperation, encourage the Arab region (MENA), and promote global efforts in child protection
- To help launch specialized centers for research regarding the causes and consequences of maltreatment
- To ensure adequate and independent surveillance and monitoring of the extent of child maltreatment within the country

LibanCAN's overall mission is directed by a core steering committee that includes representation from various subcommittees that have been formed to address specific tasks. Subcommittees or working groups have been established in each of the following areas: legal framework[5]; professional training needs[6]; research on all types of maltreatment[7] and public awareness and civic engagement including working with the media[8]. Two additional workgroups have been formed to focus specifically on the problem of child sexual abuse and exploitation[9] and physical abuse and neglect.[10]

Challanges

Despite the efforts of LibanCAN and local professionals in pressing for change, a variety of issues present formidable challenges in moving forward and achieving LibanCAN's mission. Among the most pressing demands facing the organization are the following:

Culture: Some forms of violence toward children, such as corporal punishment, are still perceived as effective disciplinary measures and are behaviors that are generally viewed as a matter of "family privacy." To raise awareness

[5] Mission: Extract the legal provisions about CAN within the legislative framework in Lebanon. Provide the legal modifications of Law towards stopping corporal punishment. Prepare, with the Institute for Human Rights and the Lebanese Institute for Child Rights, the Child Ombudsman project. Advocate for Child protection Laws.
[6] Mission: Define the training needs for professionals in CAN. Provide the relevant training tools for professionals working with children. Set guidelines for intervention and algorithms for professionals. Prepare prevention-oriented material.
[7] Mission: Prepare an overview, in collaboration with the UNICEF desk research and the emerging child observatory, on the status of CAN in Lebanon. Provide a frame for case analysis and the need for qualitative studies. Set, on a priority level, the urgent needs in knowledge base.
[8] Mission: prepare for a workshop on the role of Media in addressing violence against children that would include: Providing the media and journalists with relevant information on CAN. Involving the public in the process of awareness rising and the preventive strategies. Set a child friendly environment and an ethical code of exercise.
[9] Mission: Provide socially accepted definitions for the different aspects of CSA, with compliance to the CRC. Advocate for child protective strategies within the family and in the Society as a whole. Improve the quality of interventions and upgrade the capacities of professionals working with children at risk or affected by CSA.
[10] Mission: Define the different aspects of maltreatment and neglect. Raise the awareness of the Lebanese society concerning the individual and social effects of M&N. Provide effective tools for complaints, interventions and follow-up.

in this area, LibanCAN and the Higher Council for Childhood sponsored a workshop in Beirut in 2005, under the patronage of the Minister of Education and with the participation of the Minister of Social Affairs. Additional financial support was provided by the René MOAWAD foundation and Save the Children Sweden. This workshop addressed the issue of corporal punishment in both public and private schools, and offered clear recommendations with respect to modifying existing laws and educating teachers on the use of alternatives to violence.

Education: A general lack of awareness about child rights among families, educators and child caregivers, remain a challenge. A school based initiative is being developed to address this issue.

Structure: The lack of a consistent and well-funded monitoring system regarding the identification of child abuse and insuring an appropriate response remains a major obstacle to protecting children. Efforts are ongoing to establish a single agency responsible for monitoring child abuse (i.e., the establishment of a Child Observatory). If funding can be secured, this agency would ideally function independently from other institutions and offer important guidance to the Higher Council for Childhood and the Child Ombudsman on how best to establish appropriate and timely interventions. Also, efforts are underway to coordinate the country's Hotline /Childline project with other relevant Lebanese institutions, including the Ministry of Justice.

Legislation: Weak enforcement of legal provisions included in the CRC, as well as discrepancies within national legislation remain a major concern. Although some progress is being made within the Ministry of Justice with respect to improved interagency participation and enforcement of existing laws that protect children, enormous gaps exist within the country's juvenile justice system. Reforms in this area were the subject of a workshop held in Beirut in February 2006. The workshop led to recommendations on compensation, reintegration and restoring justice. Legislation and capacity building also is needed in the area of street children, a growing problem in Lebanon and the rest of the Arab world. A workshop on this issue was hosted in March 2006 under the joint leadership of the Higher Council for Childhood and the Arab Council for Childhood and Development.

Training and capacity building: Professionals, while often interested in working to improve conditions for children, frequently lack the information and skills necessary to improve their practice. In addition, certain structures within governmental agencies can impede the ability of staff to work across sectors. To address this issue, a workshop is being planned for staff from NGOs working with children to encourage the participatory process and to increase the capacities of the informal sector to build networks for interventions and collaboration.

Conclusion

Increasingly, it is becoming accepted that responsibility for confronting violence against children rests with the entire society. The emerging child protection movement is continuously growing and expanding, and we hope it is becoming more inclusive and participatory in its design. As part of this process, LibanCAN and the Higher Council for Childhood are working with state and local authorities to develop procedures to improve accountability for implementing reforms, establishing new legislative directives, and providing needed resources. Underlying all of these efforts is a commitment to ensure that the rights of children are recognized and respected in all decision-making and that the children themselves, who are subjected to violence, become involved in the development and evaluation of new policies. To this end, a child and youth subcommittee has been integrated in the general assembly of the taskforce with representation on the central steering committee. A similar committee has been established for children with special needs.

In addition to the progress being made with governmental agencies at the national level, there is a growing interest in addressing the child abuse problem among local municipalities, several of which have created their own child and youth commissions. Also, local academic institutions and research institutes are conducting new studies on the causes and consequences of child abuse. Finally, the local mass media and opinion leaders, including those working in key NGOs throughout the country, are joining efforts to share responsibility for advocating this new vision in child protection.

For additional information: Those wishing additional information on LibanCAN and its various activities may contact Dr. Gerbaka at the Higher Council for Childhood in Lebanon (hccleb@mosa.gov.lb, or hccleb@idm.net.lb)

Be Free: A Child Abuse and Neglect Prevention Program in Bahrain
Bahrain Women Society

Overview

Be Free is the first program of its kind serving the Middle East region. Established by the Bahrain Women Society in 2002 with the full support of the Human Rights High Commissioner, Mrs. Mary Robinson, the program seeks to create a generation free of child abuse and neglect. Be Free activities target three groups – children, parents and professionals working with children. The purpose of this brief is to summarize the activities and materials developed for each of these target populations, as well, as present related strategies being developed in the areas of research and public awareness.

Educational Activities Targeting Children

Be Free has developed a variety of educational programs and related activities to improve the ability of children to resist various forms of child abuse and, if victimized, to understand the importance of reaching out for help. Program staff estimates that over 3,000 children have been trained throughout the country via one or more of these activities. Specific program efforts include the following:

- Workshops designed to empower children and improve their self-esteem are provided directly to children in school settings and other places children gather.
- A web site (www.be-free.info) which children can access to obtain specific information about abuse as well as how to respond if they are being victimized. The site includes an e-mail system in which children (or adults who were victimized as children) can write and receive online counseling and support. Since launching this feature, the program has received an average of 300 e-mails per month.
- A written publication that teaches children basic skills on how to protect themselves and what to do when they feel that they are at-risk or have been mistreated.
- Articles to children's sections in daily newspapers and magazines in Bahrain as well as throughout the Gulf region. Participants in child radio programs, offering counseling and advice to those children calling in with problems.
- A 5-month training program to prepare children to work as peer counselors around the issue of child abuse. As part of the training, children receive information on child abuse as well as public speaking skills. The first group of children participating in this program ranged from 9 to 16 years of age and completed their training in June 2005.

Education Activities Targeting Caregivers and Parents

In addition to their work with children, the program has developed a complementary array of educational and outreach programs for caregivers. These efforts include:

- A bilingual (Arabic and English) section on its web page to introduce caregivers to the concept of child abuse, how to identify it, how to protect children from maltreatment, and how to avoid abusive behaviors when interacting with or disciplining their own children.
- A live radio show on Bahrain Radio every Sunday morning. The show, on-air three-years, is designed to raise awareness about abuse and provide information on general parenting skills including building a strong relationship with adolescents. In addition to this specific show, program staff also participate in other radio program broadcasts to the broader Gulf region through a variety of outlets including the BBC, Mont Carolo, and Al Sharija.
- Special workshops on child abuse and prevention are conducted for caregivers in the schools, clubs, and worship centers. To date, the program has trained more than 2,700 adults.

Educational Activities for Professionals

The program offers a range of opportunities for training professionals, particularly teachers. Key programs include the following:

- Workshops for social workers, university students and faculty members to address a wide range of topics that might be taught to other adults or children regarding child abuse as well as positive child development. Topics for these workshops have included basic life skills, how to improve understanding between adults and adolescents, and training other professionals on how to recognize and prevent child abuse.
- Two curriculum guideline manuals that can be used by teachers in classroom. These guidelines cover (1) Basic Life Skills for Emotionally Intelligent Children, as defined by UNICEF and (2) the UN Convention on the Rights of the Child. A number of schools in both Bahrain and Saudi Arabia have adopted both curricula and are currently training their teachers on how to use them with their students.

Research Activities

In addition to its education program, Be Free also conducts a variety of research projects and presents its findings at various conferences and international meetings. Often working in partnerships with local academics, the program has addressed such issues as society's view about child abuse and its victims; the parent's role in preventing child abuse; effective intervention programs; the relationship between child abuse and domestic violence, and the role of the NGO in reducing global violence.

Community Awareness

One of the main goals of Be Free is to increase awareness about child abuse within all sectors of society. As part of this mission, the program has launched a series of public outreach efforts centering on the case of a missing 11-year-old girl who disappeared in 2002 after she ran away from an abusive father. In addition to providing ongoing support and counseling to the girl's siblings who also experienced extreme physical abuse, the program has maintained public interest in the case through a series of media presentations, community workshops, and distribution of leaflets asking those with information about the child to contact authorities. Although the child remains missing, the program feels its outreach and education efforts have contributed to an elevated understanding of the child abuse problem throughout Bahrain and the wider Gulf Region.

For more information: Those wishing additional information on any of these programs can contact Be Free at contract@be-free.info or visit the program's web site at www.be-free.info.

SECTION III: ANNOTATED BIBLIOGRAPHY

OVERVIEW

This annotated bibliography summarizes 60 articles and policy papers that have been published over the past two years on child abuse, organized by the 23 countries in which the research has been conducted. Prior to the country-specific research, two studies that have examined child abuse incidence or policies in multiple countries are presented. In order to maximize our ability to reference research from as wide an array of countries as possible, we limited our search to that conducted outside the United States. Research in the US is included only if the country was part of a multi-national, comparative study. Specific topics addressed in this array of articles include issues related to the identification and treatment of child sexual abuse; the identification and response to child physical abuse; child exploitation, street children and the effects of war on children; children in institutional care; familial and environmental factors that impact child safety and well-being; and professional issues and attitudes in responding to child maltreatment.

This document is not intended to be an exhaustive listing of all recent published research covering the topic of child abuse or child exploitation. Rather, it represents a body of research that examines a variety of topics and employs a variety of research methods, including quantitative and qualitative techniques.

CROSS-NATIONAL AND INTERNATIONAL STUDIES

Geeraert, L., Van den Noortgate, W., Grietens, H. & Onghena, P. (2004). The effects of early prevention programs for families with young children at risk for physical child abuse and neglect: a meta-analysis. *Child Maltreatment*, *9(3)*, 277-291.

This meta-analysis looks at a wide-range of literature on early prevention programs as published in the professional literature in four languages: English, French, Dutch and German. The authors identified the main characteristics of the programs selected for inclusion in the study. The authors then conducted a meta-analysis of the results of the programs. They found that, while the effects between the programs varied considerably, the overall effect was primarily positive. The authors conclude their article with suggestions for further research.

Straus, M. & Savage, S. (2005). Neglectful behavior by parents in the life history of university students in 17 countries and its relation to violence against dating partners. *Child Maltreatment, 10(2),* 124-135.

This cross-cultural study of neglect looked at three areas of inquiry. The first is whether neglected children grow up with psychological damage and difficult social relationships with others, the second is to determine the extent of neglect in the targeted 17 countries and the third is to examine whether there is a link between the experience of neglect in childhood and subsequent violence by dating partners. The study found high rates of neglect in both developed and underdeveloped countries, including among the wealthiest segments of the populations studied. They found evidence of a link between the experience of neglect and dating violence. The authors conclude societies should address the issue of parental neglect, in order to mitigate against subsequent violent behaviors among dating partners.

Indian Subcontinent

Maiter, S. & Trocme, R. (2004). Perceptions of child maltreatment by parents from the Indian subcontinent: challenging myths about culturally based abusive parenting practices. *Child Maltreatment, 9(3),* 309-324.

This study examines norms of parenting in the Indian subcontinent and identifies additional effects that may be experienced upon immigrating to North America. The purpose of this study was to provide child protection workers in North America with a more nuanced view of attitudes towards parenting and the potential effects of immigration upon those attitudes and practices. The authors conclude the article with a discussion of the conflict for child protection workers, and between culturally sensitive practices and an insistence upon a standard of parenting reliant upon the norms established in North America.

Sub-Saharan Africa

Lalor, K. (2004). Child sexual abuse in sub-Saharan Africa: a literature review. *Child Abuse & Neglect, 28(4),* 439-460.

This literature review examines the English-language literature on child sexual abuse in sub-Saharan Africa, focusing on sexual abuse in the home and/or community. The author found that, aside from South Africa, not much had been published in the region. Further, the author concluded that the rates of sexual abuse are similar to those in other regions, contrary to the widely held view that it is rare in Sub-Saharan Africa.

Lalor, K. (2004). Child sexual abuse in Tanzania and Kenya. *Child Abuse & Neglect, 28(8),* 833-844.

This study looked at the informal, non-published reports and commentaries on child sexual abuse in Tanzania and Kenya (since most research from these two countries is not published). The researcher made contact with universities, governmental officials, NGOs and UN agencies, followed by field work, with interviews and examination of the reports. Tanzania has little empirical data on child sexual abuse, while Kenya has slightly more. He concludes that the topic is under-researched in both countries and notes that where the research does exist, it tends to focus on commercial sexual exploitation of children rather than the more pervasive abuse in children's own communities and families. Noting a general belief that child abuse is increasing due to AIDS sufferers' attempts to cleanse themselves, he urges that more be done to determine whether the epidemic is increasing the risk of rape or incest for children.

American Indian

Limb, G., Chance, T. & Brown, E. (2004). An empirical examination of the Indian Child Welfare Act and its impact on cultural and familial preservation for American Indian children. *Child Abuse & Neglect, 28(12),* 1279-1289.

This study examined whether the Indian Child Welfare Act (ICWA) promoted cultural and family preservation for Indian children (the act's stated aim). The authors studied records in one southwestern state. This review confirms that in the majority of cases, the Indian children were placed according to the ICWA's stated preferences, thereby demonstrating that the act had achieved its intended consequences. It also found that there were some knowledge and perception gaps between state and tribal workers regarding the act's purpose, with state workers reporting limited understanding of the ICWA's requirements. The authors conclude that, although the state and tribal officials reported working well together, the goals of ICWA would be furthered if the state allowed tribal officials to take the lead in these cases.

Australia

Buckle, S., Lancaster, S., Powell, M. & Higgins, D. (2005). The relationship between child sexual abuse and academic achievement in a sample of adolescent psychiatric inpatients. *Child Abuse & Neglect, 29(9),* 1031-1047.

This study examined the relationship between academic achievement by psychiatric inpatients with a history of child sexual abuse. The study compared the academic achievement and intelligence of 81 teen psychiatric inpatients with their self-reported experiences of maltreatment, parenting, socio-economic status, substance abuse and psychopathology. The authors found that intelligence was the main predictor of academic achievement. Other factors influencing achievement were identified as substance abuse, and a range of externalizing and internalizing behavior problems. The authors discuss the difficulty in examining the impact of sexual abuse on academic achievement because it is typically accompanied by a range of other risk factors, such as poverty, family dysfunction and more specific types of maltreatment. They found co-existence between sexual abuse and other maltreatment, as well as, parental overprotection. The authors end the article with a discussion of the need for more complex models of research that more accurately capture the experience of abused children.

Darlington, Y., Feeney, J. & Rixon, K. (2005). Interagency collaboration between child protection and mental health services: Practices, attitudes and barriers. *Child Abuse & Neglect, 29(10),* 1085-1098.

This study looked at practices, attitudes and barriers that hinder (or facilitate) interagency collaboration between child protection and mental health services. The authors used a self-administered, cross-sectional survey of workers in child protection, adult, child and youth mental health and SCAN teams in Australia. With 232

questionnaires returned, the overall response rate was 21%. The authors found that, although workers believed in collaborative practice, their ability to act in a collaborative manner was often impeded by poor supportive structures and practices on the part of the organization in which they worked. Factors which influenced the workers attitudes towards other workers included poor training, positive regard for CPS and mental health workers, and mutual mistrust. Five organizational factors which were found to contribute to barriers were inadequate resources, confidentiality requirements, gaps in interagency processes, unrealistic expectations and the boundaries of professional knowledge.

Martin, G., Bergen, H., Richardson, A. & Roeger, L., Allison, S. (2004). Sexual abuse and suicidality: gender differences in a large community sample of adolescents. *Child Abuse & Neglect, 28(5),* 491-503.

This study surveyed 2,485 students (average age = 14) from 27 schools in South Australia on their history of sexual abuse and suicide attempts, as well as measures of depression and family functioning. The researchers found that for boys, regardless of the presence of depression and hopelessness, a history of sexual abuse greatly increases the risk of suicidal behavior and attempts. For girls, the presence of distress, depression and hopelessness following sexual abuse can lead to increased risk of suicidal behavior.

Belgium

Grietens, H., Geeraert, L. & Hellinckx, W. (2004). A scale for home visiting nurses to identify risks of physical abuse and neglect among mothers with newborn infants. *Child Abuse & Neglect, 28(3)*, 321-337.

The researchers developed a scale to help home visiting nurses identify risks for child physical abuse and neglect among the mothers visited. The purpose of the study was to test the scale's reliability and validity. The authors developed a 71-item scale based on a literature review and focus group sessions with nurses and paraprofessionals with experience working with under-privileged families. This scale was then tested in a random sample of 40 home visiting nurses. Data was collected from a sample of 373 non-abusive and 18 abusive/neglectful mothers. The authors eliminated items with prevalence rates below 5% and those which had no significant difference between abusive and non-abusive mothers. The final scale had 20 items, which focused on three areas: social isolation, communication difficulties and psychological problems. The authors found that focusing on these three areas among mothers, helped identify those at risk for subsequent physical abuse and neglect of their newborn.

Canada

Alaggia, R. (2004). Many ways of telling: expanding conceptualizations of child sexual abuse disclosure. *Child Abuse & Neglect. 28(11),* 1213-1227.

This study looked at the ways child sexual abuse victims reported their experience as compared to the ways child sexual abuse is reported upon in the professional literature. Twenty-four adult victims participated in the study. The Long-Interview method was used to trace disclosure processes. Transcriptions of the interviews were analyzed by hand and a computerized data analysis. The author used a variety of techniques to ensure data trustworthiness, including prolonged engagement, persistent observation, negative case analysis and peer debriefing. The author found that the three most commonly used categories of reporting, as derived from a review of the literature on child sexual abuse disclosure, were accidental, purposeful and prompted/elicited. Yet, these categories only accounted for 42% of the disclosures among her subjects. In analyzing the way the literature discusses disclosure, the author identifies the fact that it is often unclear whether "disclosure" in other studies refers to telling another person or reporting the abuse to an official, authoritative body. She concludes with a discussion of the need to supplement the existing definitions, most commonly used today, and expand them to include a broader range of types of reporting by children, including "behavioral and indirect verbal attempts, disclosures intentionally withheld, and disclosures triggered by recovered memories. The author believes expanded definitions will broaden the framework professionals use when working with child sexual assault victims and lead to more effective reporting.

Ateah, C. & Durrant, J. (2005). Maternal use of physical punishment in response to child misbehavior: implications for child abuse prevention. *Child Abuse & Neglect, 29(2),* 169-185.

This study sought to identify the key maternal factors that contribute to a parent's decision to use physical punishment. A literature review identified the cognitive and affective predictors of physical punishment. Next, the authors interviewed 110 mothers of 3-year-old children regarding disciplinary situations that had occurred in the previous two-week period. Logistic regression was used to identify the predictors of physical abuse. The authors

found that maternal attitude toward physical punishment, maternal perception of the seriousness of the child misbehavior and maternal anger all played roles in predicting whether physical punishment would be used. The authors conclude with a discussion about using these cognitive and affective factors when structuring parenting education programs aimed at decreasing the rates of child physical punishment.

Clement, M. & Bouchard, C. (2005). Predicting the use of single versus multiple types of violence towards children in a representative sample of Quebec families. *Child Abuse & Neglect, 29(10),* 1121-1139.

This study examined the distinctive characteristics among parents who use single versus multiple types of violence with their children. They found that a mother's attitude towards violence and experience of childhood violence are the two strongest predictors of whether she will use one or more types of violence with her children. The study used data from a Quebec telephone survey of a representative sample of 2,469 mothers of children ages 0-17 years of age. Topics covered during the interview included the mother's experience of childhood violence, the mother's attitude towards violence against children, marital discord and socioeconomic factors. Using a discriminate function analysis, the mothers were put into one of five groups: 1) no violence reported, 2) psychological aggression only, 3) minor physical violence only, 4) psychological aggression and minor physical violence and 5) psychological aggression, minor and severe physical violence. The groups differed significantly on a number of factors including the child's age and gender, mother's attitudes and experience of violence, level of marital discord and number of children in the household.

Conway, M., Mendelson, M., Giannopoulos, C., Csank, P. & Holm, S. (2004). Childhood and adult sexual abuse, rumination on sadness, and dysphoria. *Child Abuse & Neglect, 28(4),* 393-410.

This study examined the hypothesis that adults who have experienced sexual abuse (either as a child or adult) are more likely than non-sexual abuse victims to ruminate on sadness and experience dysphoria. The sample included 100 male and 101 female undergraduate students who returned a packet of questionnaires which were distributed at a college campus booth. Originally, 560 students took the questionnaires, but only 201 returned them, for a response rate of 35.9 percent. The questionnaires captured information on childhood and adult sexual abuse and included the Rumination on Sadness Scale and the Beck Depression Inventory. The researchers confirmed their hypothesis, noting that those who experienced more abuse reported ruminating more on sadness, and experienced dysphoria more than those who had not been abused. They found that rumination on sadness by victims can lead to depression in adulthood and, alternatively, that victims can become depressed through other means, and that the depression fosters rumination.

Drapeau, M, & Perry, J.C. (2004). Childhood trauma and adult interpersonal functioning: a study using the Core Conflictual Relationship Theme Method (CCRT). *Child Abuse & Neglect, 28(10),* 1049-1066.

This study looked at the effect childhood trauma may play in adult interpersonal functioning. The sample of 119 subjects was derived from the Austen Riggs Follow-along Study. The authors used the Traumatic Antecedent Interview scoring method to assess 10 types of childhood trauma, as well as the Core Conflictual Relationship Theme Method to identify interpersonal patterns in adulthood. Researchers found that childhood trauma played a role in the victim's adult interpersonal functioning and that this relationship varied depending upon the type of abuse experienced. For example, those experiencing physical abuse had a higher prevalence of the wish to be hurt, and experienced others as strict and stern. In contrast, those who experienced physical neglect had more of a need to be comforted, and those who experienced separations during childhood later felt less self-confident in various interpersonal situations. Finally, the results showed that when the child had regular access to a caretaker or confidant, they had less of a need for love as an adult.

Dumbrill, G.C. (2006). Parental experience of child protection intervention: A qualitative study. *Child Abuse & Neglect, 30(1),* 27-37.

This study examines the experiences of parents in child protection intervention programs in order to help child protective service workers engage parents in a more meaningful way, as well as, to provide policy makers with information to help them design better services. The author used a qualitative grounded theory approach, with in-depth qualitative interviews. Grounded theory, an approach that identifies a core category to tie together all the themes emerging in a particular study, identified patterns of the parents' experiences with intervention. Recruitment for the study began with two Ontario child protection agencies which yielded 18 parents who agreed to participate in the study. The major finding of the study is that workers have power and how the worker wields that power (in a partnership, as an authoritative figure, etc.) is the main factor shaping how a parent views and reacts to child

protection intervention. The authors end the study with a discussion of the implications of their findings for caseworkers.

Ethier, L., Lemelin, J. & Lacharite, C. (2004). A longitudinal study of the effects of chronic maltreatment on children's behavioral and emotional problems. *Child Abuse & Neglect, 28(12),* 1265-1278.

This six-year study looked at the links between chronic maltreatment and a child's emotional/behavioral problems. The sample size was 49 maltreated children (32 victims of chronic maltreatment, 17 of transitory maltreatment). Over the six years of the study, the children were examined in their homes three times (at recruitment, and at the three-year and six-year point). Child Protection Services files were also reviewed at each assessment point. The authors found that children who experience maltreatment over an extended period of time were more likely to experience emotional and behavioral problems than those whose maltreatment was during a more limited period. The authors also suggest that the problems experienced by chronically maltreated children appear more severe, often demonstrating clinically significant scores on various measures of personal functioning. Finally the authors found that the reduction or elimination of maltreatment resulted in improvement in the behavior of the children. However, this improvement was not immediate, but occurred gradually after the decrease in maltreatment. The authors conclude the study with a discussion of the need for the findings to be replicated before results and conclusions can be generalized. They site the small sample size, which yielded low statistical power, the fact that they assessed the children's problem behaviors only from the mother's perspective, and that the families in the study may not be representative of all CPS families.

Gagne, M.-H., Lavoie, F., Hebert, M., (2005), Victimization during childhood and revictimization in dating relationships in adolescent girls, Child Abuse & Neglect, 29(10), 1155-1172.

This study examines whether and what type of violent experiences during childhood are risk factors for revictimization during dating in adolescence. The study examined 917 teenage girls from 5 low to middle socieoeconomic high schools. Each participant completed a self-administered questionnaire, with more analyses conducted on the 622 participants who reported having at least one dating partner in the past year. The study found that violence outside the family carried a greater risk of subsequent revictimization during adolescent dating than familial violence did. The authors conclude with a discussion of the importance of programs to help identify and prevent adolescent dating violence.

Hughes, J, & Gottlieb, L. (2004). The effects of the Webster-Stratton parenting program on maltreating families: fostering strengths. *Child Abuse & Neglect, 28(10),* 1081-1097.

This study, using a randomized control trial, examined the effects on parenting skills and child autonomy the Webster-Stratton parenting program had on families in the program. The sample included 26 maltreating families who were randomly assigned to either a 16-hour weekly intervention group or a 4-month wait list control group. Pre and post-intervention assessments relied on a home visit during which the mother-child interactions were videotaped. The authors found that mothers who received treatment demonstrated improvement in involvement and autonomy, but not in structure. Treatment children showed no improvement in autonomy compared to the control group. The authors conclude that the parenting program is effective when used with abusive parents and that further study is merited.

Labbe, J. (2005). Ambroise Tardieu: The man and his work on child maltreatment a century before Kempe. *Child Abuse & Neglect, 29(4),* 311-324.

This article highlights the contributions of a French forensic physician, Ambroise Tardieu, who studied and identified almost all the conditions of child abuse and neglect during the mid-19th century. The article provides an overview of his most important work, from problems associated with child labor to physical signs of child abuse and his description of the battered-child syndrome.

McLewin, L. & Muller, R. (2006). Attachment and social support in the prediction of psychopathology among young adults with and without a history of physical maltreatment. *Child Abuse & Neglect, 30(2),* 171-191.

This study examines whether social support and attachment security can predict lower levels of psychopathology among young adults who experienced physical abuse and those who did not. The sample consisted of 956 undergraduate students at an urban Canadian university, with 82% of the participants being female. The researchers used the following assessments: Relationship Scales Questionnaire, Relationship Questionnaire, Multi-

Demensional Support Scale, Record of Maltreatment Experiences, Self-Report, Young Adult Self-Report, and the Trauma Symptom Checklist-40. The study found that irrespective of abuse experiences, greater attachment security, particularly when accompanied by a positive view of self, was the strongest predictor of lower levels of psychopathology. Social support also emerged as a significant predictor of psychopathology, but the interaction between social support and attachment did not predict functioning. Finally psychological abuse was the largest predictor of psychopathology within the survivors of an abuse cohort. The authors conclude with a discussion of the study's limitation and the need for therapy to address "self," particularly with those who have experienced abuse.

Paivio, S. & McCulloch, C. (2004). Alexithymia as a mediator between childhood trauma and self-injurious behaviors. *Child Abuse & Neglect, 28(3),* 339-354.

The researchers tested a hypothesis that alexithymia (the inability to attend to, identify and communicate emotional experience) is the mediating factor between self-injurious behaviors (SIB) and childhood trauma. They studied a randomly selected group of 100 female undergraduate students, as this is the group most likely to engage in SIB. Measures used in the study included the Childhood Trauma Questionnaire, the Toronto Alexithymia Scale-20, and the Self-Injurious Behaviors Questionnaire. Forty-one percent of respondents reported engaging in SIB, with self-cutting being used most frequently. The authors conclude that the study results confirmed their hypothesis.

Paivio, S. & Cramer, K. (2004). Factor structure and reliability of the Childhood Trauma Questionnaire in a Canadian undergraduate student sample. *Child Abuse & Neglect, 28(8),* 889-904.

This study aimed to determine the factor structure and reliability of the childhood Trauma Questionnaire using a group of 470 undergraduate students in a Canadian university. The study used principal component analyses, coefficient alpha and correlations to analyze the data from the students. They found that all factors (emotional, physical and sexual abuse, and emotional and physical neglect), with the exception of physical neglect, showed good internal consistency and reliability. The rates of reported childhood trauma were comparable to those reported for the community and students in North America. The authors conclude that the Questionnaire is a valid measure of abuse and neglect in students.

Tardif, M., Auclair, N., Jacob, M. & Carpentier, J. (2005). Sexual abuse perpetrated by adult and juvenile females: an ultimate attempt to resolve a conflict associated with maternal identify. *Child Abuse & Neglect, 29(2),* 153-167.

This study examined the characteristics of a sample of 13 adult sexual abuse offenders and 15 juvenile sexual abuse offenders. A high proportion of both groups presented poor or abusive relationships with their parents. Adult female offenders included a significant proportion of those who had a sexually and physically abusive father while juvenile offenders frequently reported an absent or non-involved father. The authors also found that both the adult and juvenile female offenders had a disturbed relationship with their mother. The authors conclude that there is a pattern of poor relationships and a history of victimization among the females who sexually abuse others.

Tonmyr, L., DeMarco, R., Hovdestad, W. & Hubka, D. (2004). Policy makers' perspectives on the utility of a national study of child maltreatment. *Child Maltreatment, 9(3),* 304-308.

This study summarizes the discussions, occurring during a forum held in Canada, about the usefulness of a national incidence study of child abuse and neglect. In general, the policy-makers believed the current system was important, but that it should be augmented with additional, more contextual information. Another important point to emerge was the need to further develop the relationship between researchers and policy-makers.

Ward, M., Bennett, S., Plint, A., King, W.J., Jabbour, M. & Gaboury, I. (2004). Child protection: a neglected area of pediatric residency training. *Child Abuse & Neglect, 28(10),* 1113-1122.

This study examined the extent of child protection/maltreatment training during pediatric residencies. The researchers surveyed pediatric program directors, the child protection program directors and the pediatric residents of all 16 Canadian pediatric academic centers Responses were received from 15 of the 16 child protection program directors and 54.6% of the residents. They found that, overall, the residents' exposure and training in child protection/maltreatment were fairly limited and, as a result, the pediatric residents feel poorly trained. They conclude the article with a discussion of the need to develop and implement better training programs for residents.

Williams, S., Wiener, J. & MacMillan, H. (2005). Build-a-Person Technique: An examination of the validity of human-figure features as evidence of childhood sexual abuse. *Child Abuse & Neglect, 29(6),* 701-713.

The use of draw-a-person method to identifying child victims of sexual abuse has been widely debated, with both proponents and opponents publishing strong arguments for their positions. The purpose of this study was to examine these divergent opinions within the framework of a signal study. The researchers designed this study to examine whether specific human-figure features were, in fact, indicators of child sexual abuse. Sixty-four children (19 sexually abused, 26 non-sexually abused, emotionally/behaviorally troubled, and 19 non-abused, non-clinical children) built male and female figures using groups of prefabricated pieces of human-figure body parts. Included in each group of parts (but unbeknownst to the children) was a potential sexual abuse feature. The authors found that the individual human features most commonly claimed to be associated with child sexual abuse did not, in fact, identify those children in the study who were and were not abused.

Wolfe, D., Francis, K. & Straatman, A-L. (2006). Child abuse in religiously-affiliated institutions: Long-term impact on men's mental health. *Child Abuse & Neglect, 30(2),* 205-212.

This study developed psychological and diagnostic test results of a sample of 76 men who were severely abused as children by male caregivers in religiously-affiliated institutions and were subsequently suing. The study examines the extent of PTSD, mood and substance use disorders, as well as adjustment problems. The assessment was conducted as part of the court settlement. The authors used the Trauma Symptom Inventory and the Structured Clinical Interview for DSM-IV, Clinician Version. The authors found that men who experienced the abuse in a residential setting demonstrated severely disrupted mental functioning, such as alcohol abuse, PTSD, mood disorders. They were also more likely to have criminal histories, sexual orientation confusion and dysfunction. Those who experienced the abuse in community settings were more similar to findings of those who experience abuse in the family. The authors note a few distinctions, such as the importance of the institution and perpetrator within the community which often led to severe resistance in acknowledging the abuse.

China

Chen, J.Q., Dunne, M. & Han, P. (2004). Child sexual abuse in China: a study of adolescents in four provinces. *Child Abuse & Neglect, 28(11*), 1171-1186.

This study attempts to learn more about child sexual abuse (CSA) in Chinese societies by studying CSA experiences among 2,300 senior high school students in four provinces in China. The response rate for the questionnaire was 70.5%. The study found that more females than males reported unwanted sexual experience before the age of 16, and that both males and females who experienced CSA were more likely to be depressed, suicidal, drink more alcohol and report sexual intercourse than unaffected students. Female CSA students were also more likely to have an eating disorder, and males were more violent. The authors conclude that despite differences between Eastern and Western societies in attitudes towards consensual sexual experiences and CSA, the psychological and behavioral effects of CSA are similar across cultures.

Tang, C. & Yan, E. (2004). Intention to participate in child sexual abuse prevention programs: a study of Chinese adults in Hong Kong. *Child Abuse & Neglect, 28(11),* 1187-1197.

This study examined the intention to participate in child sexual abuse prevention programs and the attitudes towards child sexual abuse among prospective participants. In the study, 1,606 Chinese adults (497 male and 1,109 female) were interviewed individually about their attitudes towards CSA prevention programs, commonly held CSA myths and attitudes towards it, knowledge of CSA victims, and perceived prevalence of CSA. The researchers found that adults with firm intentions to participate in the program had fewer myths about child sexual abuse and were more likely to be female, while those whose commitment was not as strong reported holding many more myths (e.g., skeptical of child reports of abuse, believe that boys are unlikely victims, etc.) The Authors conclude that more attention should be paid to the myths adults carry with them.

Croatia

Brajsa-Zganec, A. (2005). The long-term effects of war experiences on children's depression in the Republic of Croatia. *Child Abuse & Neglect, 29(1),* 31-43.

This study examined the effect war experiences had on children's depression and whether other factors such as social support, intensity of war experiences, and extroversion played any role in the extent of the depression. The

sample contained 583 children, ages 12 to 15; 283 of whom were displaced from different parts of Croatia for approximately 3 1/2 years. The author used the following instruments with the children: Questionnaire on Children's Stressful and Traumatic War Experiences, Reynolds Adolescent Depression Scale, Junior Eysenck Personality Questionnaire, and Interpersonal Support Evaluation List. The study found a difference based on gender - boys who experienced more war experiences were more depressed. Social support did help relieve depressive symptoms for both boys and girls. For girls, instrumental support and self-esteem were mediating factors in depressive symptoms. The author concludes that "boys suffer more from the long-term effects of war" than girls.

Denmark

Helweg-Larsen, K. & Laresen, H.B. (2005). A critical review of available data on sexual abuse of children in Denmark. *Child Abuse & Neglect, 29(6),* 715-724.

This study reported on the data available in Demark regarding the incidence of child sexual abuse. These data bases include the Danish National Patient Register, the Danish National Criminal Register, and all police files concerning reported CSA from 1998. The researchers concluded that criminal statistics contain the most comprehensive data, based upon the average annual incidence of CSA in each register: .06 /1,000 for the Danish National Patient Register, .5/1,000 for the Criminal Register, and 1/1,000 for the police files (.6/1000 with indecent exposure eliminated). Further, the authors note that the police reports have the most thorough information about the victims and nature of the offense. The authors do discuss that, due to the way the data is collected (through parents and close adults), this information needs to be supplemented with data obtained for population-based self-reported surveys.

Germany

Nickel, R. & Egle, U.T. Psychological defense styles, childhood adversities and psychopathology in adulthood. *Child Abuse & Neglect, 30(2),* 157-170.

This study examines the link between childhood maltreatment, psychological defense styles and adult psychopathology, including the presence of psychosomatic disorders. Using two inpatient populations, this study involved a sample of 266 inpatients from the psychosomatic-psychotherapeutic department and 109 participants being treated for lower back pain from the orthopedic department. Participation was voluntary. A variety of information was collected, including socio-demographic data, medical and psychosocial history. Assessments used included the Defense Mechanism Inventory, the Symptom Checklist 90, and the SOMS—Screening for Somatoform Disorders. The study found that reported sexual and/or physical abuse was associated with more somatization, but not immature defense styles, while the more immature the psychological defense, the more somatization and psychological distress exhibited by the study participant.

Israel

Boehm, A. & Itzhaky, H. (2004). The social marketing approach: a way to increase reporting and treatment of sexual assault. *Child Abuse & Neglect, 28(3),* 253-265.

This case study examines whether a social marketing approach to reporting incidents of sexual assault can overcome the traditional silencing of victims that often happens within communities. The authors used a variety of methods to examine the existing norms within the community, including how silencing was occurring, via interviews with community leaders and residents, and then cross-checking the information derived from different sources to ensure accurate interpretation. A marketing strategy was then devised to address sources of silencing within the community. The marketing strategy identified three main groups in the community - the undecided, the opponents of disclosure, and the passive participants who went along with the prevailing opinion and remained silent. Each group was then targeted with specific messages to help combat the silencing. At the same time, the team blanketed the community with information advocating reporting and treatment, and the promotion of an effective alternative to the silencing. The authors found that, as a result of the social marketing campaign, the community was more willing to recognize the reality of assaults, encourage reporting by victims and those aware of others that have been victimized, more readily engage leaders concerned about bringing the issue to the public and insure that victims and their families seek out and receive treatment.

Hershkowitz, I., Horowitz, D. & Lamb, M. (2005). Trends in children's disclosure of abuse in Israel: A national study. *Child Abuse & Neglect, 29(11),* 1203-1214.

This study looked at all suspected cases of physical and sexual abuse in Israel between 1998 and 2002 in order to identify characteristics of victims that are associated with disclosure/nondisclosure during formal investigations. They found that rates of disclosure were greater in sexual abuse than physical abuse, and that children were less likely to identify/disclose if the suspected perpetrator was a parent. Disclosure increased as children became older. The authors conclude that their study confirmed previous, smaller-scale studies from the United States.

Hershkowitz, I., Horowitz, D., Lamb, M., Orbach, Y. & Sternberg, K. (2004). Interviewing youthful suspects in alleged sex crimes: a descriptive analysis. *Child Abuse & Neglect, 28(4),* 423-438.

This study, one of the first of its kind, examines the various techniques used by investigators to obtain accurate and complete information from young perpetrators regarding their alleged offenses. The researchers found that interviewers used similar questioning techniques on older and younger children. These techniques were classified, using four categories introduced by Lamb and his colleagues. The categories consisted of invitations, the least focused of the interview techniques, e.g., “tell me what happened” or “tell me what happened when you were touched”), directive utterances (more focused, asking for more specific details, e.g., when did it happen?, what color was his shirt?), option-posing utterances (focusing a child’s attention on something not mentioned, but does not communicate the “expected” response), and suggestive utterances (the interviewer implies what the response should be, e.g., “you forced him, didn’t you?”). The authors found that certain strategies (such as invitations as opposed to directive questions and option-posing prompts) increased the likelihood that youth will provide the most complete information and admit to the offence. Furthermore, the group found that invitations produced the most information.

Schiff, M. & Zeira, A. (2005). Dating violence and sexual risk behaviors in a sample of at-risk Israeli youth. *Child Abuse & Neglect, 29(11)*, 1249-1263.

This exploratory study looked at Israeli youth who are at-risk for dropping out of school. Within this group, the study examined reported incidents of dating violence and its association with sexual risk. The sample size was 105 at-risk youth (51 male, 54 female) who completed self-administered anonymous questionnaires (Hebrew versions of the Conflict in Adolescent Dating Relationships Inventory, the Conflict Tactics Scale and the Self-Efficacy to Refuse Sexual Behavior Scales) in small, same-gender groups. The researchers found high rates of dating violence among these at-risk adolescents, in particular with perpetration of verbal-emotional abuse (both genders). Reported victimization of physical abuse was higher among boys, while sexual abuse victimization was higher among girls. The authors conclude their study with a discussion of the need to design and implement specific prevention interventions, at least among at-risk adolescents in Israel, as well as the need to further study the high rates of reported victimization among boys.

Italy

Crisma, M, Bascelli, E., Paci, D. & Romito, P. (2004). Adolescents who experienced sexual abuse: fears, needs and impediments to disclosure. *Child Abuse & Neglect, 28(10*), 1035-1048.

Part of a larger research project funded by the European Union through Daphne funds, this study looked at impediments to disclosure of sexual abuse among 36 adolescent victims of sexual abuse in Italy, using anonymous interviews. The authors used qualitative analysis to identify the teens’ feelings, fears, needs, and received help. The researchers found that factors impeding disclosure included fear of not being believed, and shame and fear of causing trouble to the family. Factors impeding seeking professional help included ignorance of existing protective services, desire for continued secrecy, not understanding abuse occurred, mistrust of adults and professionals, and fear of consequences. The authors also found that those adolescents who did disclose to professionals received very limited support. The authors conclude with a discussion about the need for adolescents to receive better information about the problem of sexual abuse, and where and how to seek help if they are abused. The authors also called for professionals to receive better training on the scope of the problem and how to respond.

New Zealand

Fergusson, D., Boden, J. & Horwood, L.J. (2006). Examining the intergenerational transmission of violence in a New Zealand birth cohort. *Child Abuse & Neglect, 30(2),* 89-108.

This study aimed to determine whether exposure to inter-parental violence is a predictor of: later (adult) inter-partner violence, and general adult aggressive behavior, and whether these two later behaviors remain after controlling for family, social and demographic factors. This study used data from the Christchurch Health and

Development Study, which is a longitudinal study of an unselected birth cohort of 1,265 children who were born in 1977. The study used data from the sample at ages 25, 21 and 18. The following assessments were used in the study: the Conflict Tactics Scale, the Revised Conflict Tactics Scale, and the Self-Report Delinquency Inventory. The confounding factors were identified through the literature review and included measures of family socio-economic background, measures of family functioning, measures of child abuse, and measures of individual characteristics. The authors found that the association between exposure to domestic violence in childhood and later violent behaviors was weak. Some evidence suggested a link between exposure to inter-parental violence in childhood and increased rates of inter-partner violence perpetration and victimization. The regression analysis indicated that there may be no association between exposure to inter-parental violence in childhood and later violent behaviors in the absence of confounding factors. The authors conclude the study with a discussion of its limitations.

Norway

Kvam, M. H. (2004). Sexual abuse of deaf children. A retrospective analysis of the prevalence and characteristics of childhood sexual abuse among deaf adults in Norway. *Child Abuse & Neglect, 28(3),* 241-251.

This study was designed to determine the prevalence and characteristics of childhood sexual abuse among deaf adults. In 1999, the author distributed a self-administered questionnaire (also available as a videotape in sign language) to 1150 adult deaf members of the Norwegian Deaf Register. This survey was based on an earlier survey of the general Norwegian population in 1993. The results of the 1993 survey were compared to findings from a 1999 survey of the deaf Norwegian group. The study found that deaf children are at greater risk of sexual abuse than hearing children, and that when deaf children were victimized, the abuse was more serious and not often reported. In particular, the study showed that children who attend special schools for the deaf (either boarding or day students) experienced an elevated risk for abuse.

Ronning, J., Handegaard, B. & Sourander, A. (2004). Self-perceived peer harassment in a community sample of Norwegian school children. *Child Abuse & Neglect, 28(10),* 1067-1079.

This study examines the prevalence of harassment in schools and looks at whether it is associated with emotional and behavioral problems. The authors sampled 4,130 youth, grades 6 through 10, in 66 Norwegian schools. The children completed questionnaires on harassment and emotional/behavioral problems. Upon analysis, the authors report that boys experience more harassment than girls; that there is a strong association between self-perceived harassment and emotional/behavioral problems, particularly peer problems, and conduct disorders. The authors conclude that their study highlights the need for more regular screening in school in order to improve children's relationships.

Ystgaard, M., Hestetun, I., Loeb, M. & Mehlum, L. (2004). Is there a specific relationship between childhood sexual and physical abuse and repeated suicidal behavior? *Child Abuse & Neglect, 28(8),* 863-875.

This study examined 74 subjects who were admitted to a hospital after making a suicide attempt in order to determine whether childhood sexual and physical abuse can predict repeated suicide attempts and self-mutilation, as opposed to other severe childhood adversities. The researchers found a significant and independent link between childhood sexual and physical abuse and repeated suicidal behavior.

Palestine

Khamis, V. (2005). Post-traumatic stress disorder among school age Palestinian children. *Child Abuse & Neglect, 29(1),* 81-95.

The study attempted to determine the extent of post traumatic stress disorder (PTSD) among Palestinian school-age children, and whether variables such as child's characteristics, socioeconomic status, family environment, and/or parental style of influence played any role in the development of PTSD. The sample size was 1,000 children ages 12 to 16, who attended public and private schools in Palestine. Using an interview format, the children completed questionnaires at school, while the parents did so at home. The author found that a majority of Palestinian children (54%) experienced at least one lifetime trauma, while 34% developed PTSD. Most of the children diagnosed with PTSD were refugees, males and working. The author found associations between the variables (family environment, parenting style, etc.) and the development of PTSD, but identified that family

ambiance (i.e., experience of anxiety in the home) was the only predictor of PTSD. The author concludes with a discussion of the importance of assessing students for PTSD in the schools.

Punamaki, R.-L., Komproe, I., Qouta, S., El-Masri, M. & deJong, J.T. (2005). The deterioration and mobilization effects of trauma on social support: Childhood maltreatment and adulthood military violence in a Palestinian community sample. *Child Abuse & Neglect, 29(4),* 351-373.

This study examined the differences between social support offered to those who had experienced childhood maltreatment as opposed to those who experienced military violence in adulthood. In all, 585 Palestinians between the ages of 16 and 60 were included in the survey. Childhood maltreatment was measured by a questionnaire developed for the study, while exposure to military violence was measured by the Harvard Trauma Questionnaire. The Social Network Schedule was used to assess satisfaction with the social support received and the Revised SCL90-R Symptoms Checklist was used to assess the mental health of participants. The authors found that social support for victims of childhood maltreatment was low compared with the support experienced by individuals with an exposure to military violence. Both types of experiences led to high levels of mental health symptoms, but the abundant social support experienced by the military violence victims somewhat mediated the mental health symptoms.

Portugal

Figueiredo, B., Bifulco, A., Paiva, C., Maia, A., Fernandes, E. & Matos, R. (2004). History of childhood abuse in Portuguese parents. *Child Abuse & Neglect, 28(6),* 671-684.

Relying on self-report, the researchers examined the extent of childhood physical and sexual abuse of nearly 1,000 Portuguese parents. The parents were selected through public primary schools in Portugal. Each participant completed the Childhood History Questionnaire (in Portuguese). With a response rate of 69%, the study found rates of abuse that were consistently lower than those reported in US and Spanish studies which used the same questionnaire (the Childhood History Questionnaire). The authors discuss possible explanations for the lower rates, including the fact that they sampled parents associated with schools - which precluded childless adults and parents who had custody revoked - and that the parents in the study were relatively stable, two-parent households. The authors also note that the lower rates may be due to the 10-year lag between the first (US) study and this one, and the Spanish study served as a mid-way point, although authors do not feel that these factors account for all the differences in patterns seen between the studies.

Russia

Dalenberg, C. & Palesh, O. (2004). Relationship between child abuse history, trauma, and dissociation in Russian college students. *Child Abuse & Neglect, 28(4),* 461-474.

This study examines the relationship between child abuse history, trauma and dissociation among Russian undergraduate college students, as well as, to test the Russian Dissociative Continuum Scale. Three hundred and one undergraduate students participated in the survey by completing the following measures: the Dissociation Continuum Scale, the Violence History Questionnaire, the Traumatic Events Survey (TES) and a demographic measure. An American comparison group was drawn from 500 American university students at the Alliant International University. The authors note that lack of literature on dissociation (and child abuse) in Russia makes this an interesting study. The study found the scores on dissociation significantly higher in the Russian sample compared to the US group. Prior child abuse, violent trauma, and/or childhood experience of a fearful event were the best predictors for experiencing dissociation. The authors end with a discussion of why the American and Russian findings are so different, including the fact that the Russian sample may be underreporting child trauma, and the American-designed physical abuse assessment tool may omit particular Russian methods of discipline.

South Africa

King, G., Flisher, A., Noubary, F., Reece, R., Marais, A. & Lombard, C. (2004). Substance abuse and behavioral correlates of sexual assault among South African adolescents. *Child Abuse & Neglect, 28(6),* 685-698.

This study looked at the prevalence of sexual assault among Cape Town high school students and potential outcomes, including alcohol/substance use, behavioral problems and suicidal behaviors. The authors used the 1997 South African Community Epidemiology Network on Drug Use (SACENDU) school survey, with a stratified

sample of 2,946 grade 8 and 11 students in public high schools. The study found that students from single family homes or those who lived with one biological parent and one step parent were more likely to be victims of rape. Predictors of victimization included alcohol use, anti-social behavior, suicidal dialogue and attempts, though racially classified social groups, age, drug use and cigarette smoking were not found to be significant predictors. The study concludes with a discussion of the importance of multiple factors in the sexual assault of adolescents and the importance of strengthening the programs interfacing with these students.

Petersen, I., Bhana, A. & McKay, M. (2005). Sexual violence and youth in South Africa: The need for community-based prevention interventions. *Child Abuse & Neglect, 29(11*), 1233-1248.

This study explored multiple levels of risk influences that can lead to adolescent girls becoming victims, and boys perpetrators of sexual violence. The study used a volunteer sample of adolescents from 13 to 16 living in a semi-rural Zulu tribal area. All participants participated in focus groups, as well as, individual interviews, covering the following topics: identification of personal characteristics, key social-environmental and socio-cultural factors which may encourage sexual violence, and general factors within the broad social environment. The authors identified a number of significant factors at three different levels. The first level, that of the general environment, the authors found that the normalization of violence, poverty, notions of masculinity, and the rights of males to sexually dominate females contribute to attitudes that are supportive of rape. At the social level, the identified high-risk social norms and weak adult and community protection of children or management of adolescents, increase the likelihood of rape. At the intra-personal level, they found that low self-esteem, efficacy and inter-personal affective anger contributed to negative outcomes. The authors concluded that prevention programs must address factors at all three levels in order to be effective.

Pierce, L. & Bozalet, V. (2004). Child abuse in South Africa: an examination of how child abuse and neglect are defined. *Child Abuse & Neglect, 28(8),* 817-832.

This study examined which types of child abuse and neglect lay people and human service workers in Cape Town thought were the most serious. The questionnaire contained 17 categories of child maltreatment, including societal abuse, revised from the original Giovannoni and Becerra version. In all, 181 Cape Town residents completed this revised questionnaire. The researchers found that respondents ranked sexual abuse and child prostitution as most serious, while child labor and housing were ranked as the least serious. Lay people, in general, ranked all types of abuse as more serious than did human service workers.

Spain

Cerezo, M.A. & Pons-Salvador, G. (2004). Improving child maltreatment detection systems: a large-scale case study involving health, social services, and school professionals. *Child Abuse & Neglect, 28(11),* 1153—1169.

This study took five years and had two phases. It was designed to improve the gap between the number of identified cases of child maltreatment versus the actual prevalence, and to expand the ability to detect child maltreatment among professionals working in the community. Phase one of the study trained health and social service agency personnel in the detection of child abuse and neglect. In phase two, school professionals from all schools in the area studies were trained in detection. The authors conclude that training health and social service professionals improved the detection system, but since they work in limited numbers with young children, training school professionals would yield further improvement in the detection system because these are the professionals who see all the children, not just those already in the health and social service system.

Perez-Albeniz, A. & de Paul, J. (2004). Gender differences in empathy in parents at high- and low-risk of child physical abuse. *Child Abuse & Neglect, 28(3),* 289-300.

This study examines whether high-risk parents have less perspective, empathy, and more personal distress than low-risk parents and whether there are gender differences. From a sample of 331 parents, 19 high-risk and 26 low-risk parents were selected to participate in the study. Using several indexes and inventories, including the CAP Inventory, Interpersonal Reactivity Index, and the Parent/Partner Empathy Scale, the researchers found that high-risk parents do show an empathy deficit - in particular toward their family members. They also found that high-risk mothers and fathers exhibit a different pattern, with the mothers exhibiting more “personal distress” and the fathers less “perspective-taking” than their low-risk counterparts.

Sweden

Jonzon, E. & Lindblad, F. (2006). Risk factors and protective factors in relation to subjective health among adult female victims of child sexual abuse. *Child Abuse & Neglect, 30(2),* 127-143.

This study examines the risk and protective factors in relation to subjective health among adult female victims of child sexual abuse (csa) using both a variable and person-oriented approach to the data. The sample of 152 women was derived from advertisements placed in a magazine published by a national organization for sexually abused women. A combination of interviews and questionnaires were used with the women. Six main factors were analyzed in the study: child sexual abuse, child physical abuse and negative life events (all three risk factors), social support, coping, and self-esteem (all three protective factors). The authors found that the presence of resources, especially social support, is more important for health than the quantity of risk factors or severity of abuse. They also note that the concept of self-esteem, and its relationship to social support and health outcome, is complex and should be studied further. The authors discuss some of the study's limitations, including the fact that confounding factors not included in the study such as intelligence, parenting quality and genetics render the study incomplete. They also note that the way they derived the sample, from a group of more educated women and members of a women's group, means that it was not representative of all women who have been sexually abused.

Leander, L., Granhag, P., Christianson, S., (2005), Children exposed to obscene phone calls: What they remember and tell. *Child Abuse & Neglect, 29(8)*, 871-888.

This study examined what children recalled and told about obscene phone calls (defined as verbal sexual abuse). The data for the study came from the Criminal Investigation Department in Malmo, Sweden, and included police reports and investigations and interviews with the victims. Sixty-four cases of child victims between the ages of 8 and 16 were identified for inclusion in the study. They found that, while the children remembered the call, they omitted most of the sexual content, and the perpetrators questions and statements. The researchers conclude that it is probable that the children do remember the sexual content, but chose not to report it, possible due to shame, embarrassment or interviewer discomfort with the topic. The authors note that it is important that those who interview children regarding these matters are aware of the high degree of omission errors that can occur and, therefore, devote sufficient resources to insuring a successful and complete interview.

Steel, J. & Herlitz, C. (2005). The association between childhood and adolescent sexual abuse and proxies for sexual risk behavior: A random sample of the general population of Sweden. *Child Abuse & Neglect, 29(10)*, 1141-1153.

This large scale, random sample study examined the relationship between childhood or adolescent sexual abuse (CASA) and subsequent sexual risk behaviors (SRB). A random sample of 4,781 persons were identified from the Swedish Post Address Register (which contained 6,119,000 people); 2,810 participants ultimately agreed to participate in the study. This is the first study in Sweden conducted with such a large sample. The researchers found that a history of CASA was associated with early first intercourse, younger diagnosis of sexually transmitted diseases, and higher risk of: unintended pregnancy, engagement in group sex, exchanging sex for money, substance abuse, and adult sexual and physical assault. This study confirmed previous, smaller scale studies on this subject.

Sundell, K. & Vinnerljung, B. (2004). Outcomes of family group conferencing in Sweden: a 3-year follow-up. *Child Abuse & Neglect, 28(3),* 267-287.

This study examines long-term outcomes to children and families of family group conferencing (FGC) as compared to traditional child protection investigations. The researchers used a concurrent prospective study with nonequivalent comparison groups. In all, 97 children participating in family group conferencing were compared with 142 children in the traditional CPS system. Each child was followed for three years. While cautioning that their study is not a randomized control study and thus the results should be viewed with caution, the researchers found that the family group conferencing method generally yielded better process results (more information from extended family members, more family involvement, etc.), but long-term expectations of this method were not met. They found that the FGCs slightly increased the proportion of reports coming from extended families, and the care within the extended family. However, they found more FGC children re-referred to CPS, re-reported for abuse, and no variance on either case closure or service provision. The authors end the study with a wide-ranging examination of factors that may have been in play, given the unexpectedly weak results, as well as, a discussion on the need to rigorously evaluate new interventions before implementing them in a wide-spread manner.

Taiwan

Feng, J.-Y. & Levine, M. (2005). Factors associated with nurses' intention to report child abuse: A national survey of Taiwanese nurses. *Child Abuse & Neglect, 29(7),* 783-795.

This study looked at how Taiwanese nurses were interpreting a new mandatory child maltreatment reporting law and attitudes which would prompt (or prevent) a nurse from reporting suspected maltreatment. The researchers identified 1,617 nurses (1400 nurses returned the survey) working in pediatric, psychiatric and emergency care in Taiwan for inclusion in the survey. The questionnaire included demographic information, attitudes towards and knowledge of child abuse, knowledge of reporting laws, and eight vignettes of child abuse. The authors found that nurses do accept responsibility for reporting, but believe they need better training in order to do so. The authors conclude with a discussion of the need for in-service education about child abuse for the nurses.

Turkey

Kepenekci, Y. & Cinkir, S. (2006). Bullying among Turkish high school students. *Child Abuse & Neglect, 30(2),* 193-204.

This study investigated the extent of bullying in public high schools in Turkey and aimed to increase awareness of bullying within the school community. In all, 692 students from five high schools in Ankara were asked to complete a questionnaire to determine their perceptions of bullying in schools. All students reported experiencing bullying at least once during the academic year. While there were no significant gender differences in bullying, a high percentage of the boys reported experiencing bullying, and more boys that girls engaged in bullying behavior. The authors concluded with a discussion of the need, due to the universal nature of the experience, to implement effective bullying prevention and intervention programs.

United Kingdom

Evans, E., Hawton, K. & Rodham, K. (2004). Suicidal phenomena and abuse in adolescents: a review of epidemiological studies. *Child Abuse & Neglect, 29(1),* 45-58.

This literature review examined the international literature on the link between childhood abuse and later suicidal thoughts/behaviors, and identifies areas for further study. The authors examined ten studies and found that those who were abused (physical or sexual) were more likely to experience suicidal thoughts/behaviors than other children. Greater detail is provided in the article regarding the various types of abuse and the likelihood of suicidal thoughts/behavior. The authors conclude with a discussion of the implications for clinicians when working with attempted suicide patients, and the need for more school-based strategies given the prevalence of suicidal thoughts/behaviors among children.

May-Chahal, C. & Cawson, P. (2005). Measuring child maltreatment in the United Kingdom: A study of the prevalence of child abuse and neglect. *Child Abuse & Neglect, 29(9),* 969-984.

This study aimed to develop a reliable measure of child maltreatment in the UK. The researchers interviewed over 2,869 young adults from throughout the UK. Highlights of the findings include: over 90% of responses report coming from a loving family; 16% of respondents reported experiencing some form of maltreatment; physical and emotional abuse/neglect took place most often inside the home; sexual abuse most often occurred outside the home in dating relationships. The authors conclude that child maltreatment in the UK remains an "extensive social problem."

Roberts, R., O'Connor, T., Dunn, J., Golding, J., et al. (2004). The effects of child sexual abuse in later family life; mental health, parenting and adjustment of offspring. *Child Abuse & Neglect, 28(5)*, 525-545.

The researchers examined the long-term outcomes of child sexual abuse (occurred before age 13), including later mental health, family organization, parenting behaviors and adjustment in offspring. They used a sub-sample of 8,292 families from the Avon Longitudinal Study of Parents and Children. They found that child sexual abuse was associated with a variety of outcomes, including single mother status, step-fathers, poorer mental health, teen pregnancy, and behavior problems among their offspring. The researchers found that prior child sexual abuse has long-term consequences for the victims. The authors conclude their study with a discussion of why they may have found independent verification of the long-term effects of CSA when others have not been able to establish the link, and identify some of the study's limitations.

REFERENCES

Bross, D.C., Miyoshi, T.J., Miyoshi, P.K. & Krugman, R.D. (2000). *World perspectives on child abuse: The fourth international resource book*. Prepared for ISPCAN by the Kempe Children's Center, Denver, CO. Oxford, UK: Elsevier Science, Ltd.

Bross, D.C., Miyoshi, T.J., Miyoshi, P.K. & Krugman, R.D. (2002). *World perspectives on child abuse: The fifth international resource book*. Prepared for ISPCAN by the Kempe Children's Center, Denver, CO. Oxford, UK: Elsevier Science, Ltd.

Daro, D., & Donnelly, A.C. (2002). Child abuse prevention: Accomplishments and challenges. In J.E.B. Myers, L. Berliner, J. Briere, C.T. Hendrix, C. Jenny, & T.A. Reid (Eds.), *The APSAC handbook on child maltreatment*. 2nd ed. Thousand Oaks, CA: Sage.

Lewis, O., Sargent, J., Chaffin, M. et al. (2003). Progress report on the development of child abuse prevention, identification, and treatment systems in Eastern Europe. *Child Abuse & Neglect, 28,* 93-111.

Sedlek, A. and Broadhurst, D. (1996). Third National Incidence Study of Child Abuse and Neglect (NIS-3): Executive Summary. Washington D.C.: U.S. Department of Health and Human Services, ACYF, NCCAN.

Trocmé, N., MacLaurin, B., Fallon, B., Daciuk, J., Billingsley, D., Tourigny, M., et al. (2001). *Canadian incidence study of reported child abuse and neglect: Final report.* (Scientific Report.) Ottawa, ON: Minister of Public Works and Government Services Canada. Available from http://www.hc-sc.gc.ca/pphb-dgspsp/publicat/cisfr-ecirf/

UNICEF (2006). *The State of the World's Children 2006*. New York: Author. Available at http://www.unicef.org/publications/index_30398.html

Zellman, G.L., & Fair, C.C. (2002). Preventing and reporting abuse. In J.E.B. Myers, L. Berliner, J. Briere, C.T. Hendrix, C. Jenny, & T.A. Reid (Eds.), *The APSAC handbook on child maltreatment*. 2nd ed. Thousand Oaks, CA: Sage.

Appendix A

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Appendix B

ISPCAN Survey

ISPCAN WORLD PERSPECTIVES ON CHILD ABUSE
SEVENTH EDITION

Name: _____
Title/Position: _____
Organization: _____
Address: _____

_____
(City) (State) (Postal Code)
Country: _____
Telephone Number: _____
E-Mail Address: _____
Have you responded to a prior
World Perspective Survey? YES NO

Please indicate your **primary** discipline (CHECK ONLY ONE)

____ Social Work/Social Welfare
____ Psychology
____ Education/Teacher
____ Legal (Lawyer/Judge)
____ Law Enforcement
____ Physician (Pediatrics)
____ Physician (Psychiatry)
____ Physician (Other)
____ Other Health Care (e.g., nursing)
____ Other discipline: _____

Section I: Scope and Awareness of the Child Abuse Problem

1. Which of the following behaviors are generally viewed as "child abuse or neglect" in your country? (CHECK ALL THAT APPLY).

Relationship by a parent or caregiver toward a child
____ Physical abuse (e.g., beatings, burning)
____ Physical discipline (e.g., spanking, hitting to correct child's behavior)
____ Failure to provide adequate food, clothing or shelter (neglect)
____ Failure to secure medical care for child based on religious beliefs
____ Sexual abuse (e.g., incest, sexual touching, pornography)
____ Abandonment by parents or caretakers
____ Emotional abuse (e.g., repeated belittling or insulting of a child)
____ Psychological neglect (e.g., failure to provide emotional support/attention)
____ Non-organic failure to thrive (FTT) with no medical basis
____ Parental substance abuse affecting the child
____ Parental mental illness affecting the child
____ Domestic violence between the parents
Social conditions and other behaviors affecting child safety
____ Physical beating of a child by any adult
____ Children living on the street
____ Prostituting a child
____ Female/child infanticide
____ Female Circumcision/Female Genital Mutilation
____ Forcing a child to beg
____ Abuse by another child
____ Children serving as soldiers
____ Child labor
Abuse or neglect of a child within a
____ foster care, group home or orphanage
____ day care center
____ school or educational training center
____ psychiatric institution
____ detention facility
Other conditions viewed as abuse or neglect (Please specify)

_____
_____

2. What form of child abuse takes the greatest amount of time for you and your colleagues? (CHECK ONLY ONE RESPONSE)

___ Physical abuse
___ Sexual abuse
___ Neglect
___ Psychological maltreatment
___ Street Children
___ Abandoned Children
___ Other: _____

3. Have there been any general population surveys or studies on the number of child abuse or neglect cases occurring in your country in the past ten years?

____ YES (Date of most recent study: _____)
____ NO
____ Do not know

IF YES

a. Based on this type of survey and other information you have, would you say the number of child abuse cases in your country over the past ten years has increased, decreased, or is about the same?

___ Child abuse cases have increased compared to ten years ago.
___ Child abuse cases have decreased compared to ten years ago.
___ The number of child abuse cases is about the same.
___ Do not know

b. IF THERE HAS BEEN A CHANGE in the number of cases compared to ten years ago, how important do you think the following factors have been in contributing to this change?

	Please circle the correct response.			
Factors	**No Impact**	**Moderate Impact**	**Major Impact**	**Do not Know**
An actual increase or decrease in the incidence of abuse.	1	2	3	9
A change in the laws or law enforcement efforts.	1	2	3	9
A change in public awareness about child abuse.	1	2	3	9
A change in people's willingness to report child abuse.	1	2	3	9
A change in government documentation of reported cases.	1	2	3	9
Other (specify):	1	2	3	9

4. Have you or any organization in your country conducted a systematic public opinion poll in the PAST TEN YEARS to determine the public's general awareness of child abuse or how to prevent it?

____YES (Year of most recent study:_____)
____ NO

IF YES, PLEASE COMPLETE THE FOLLOWING QUESTIONS.

IF NO, PLEASE CONTINUE TO **SECTION II**.

5. Based on these polls and other information you have, how aware is the **general public** in your country about the following issues?

Issue	Please circle the appropriate response.			
	Minimally Aware	**Moderately Aware**	**Highly Aware**	**Do not Know**
The number of abused children	1	2	3	9
The multiple causes of child abuse	1	2	3	9
How a society or culture can prevent child abuse	1	2	3	9
How individuals can act on their own to protect children	1	2	3	9

6. Over the **past ten years**, do you think public awareness of child abuse has decreased, remained the same, or increased for these issues?

Issue	Please circle the appropriate response			
	Decreased Awareness	**No Change in Awareness**	**Increase in Awareness**	**Do not Know**
The number of abused children	1	2	3	9
The multiple causes of child abuse	1	2	3	9
How a society or culture can prevent child abuse	1	2	3	9
How individuals can act on their own to protect children	1	2	3	9

7. How important do you think each of the following factors has been in changing awareness levels?

Factors	Please circle the correct response			
	No Impact	**Moderate Impact**	**Major Impact**	**Do not Know**
Use of public awareness campaigns (i.e., print, radio, TV)	1	2	3	9
Professional education	1	2	3	9
Government policies	1	2	3	9
Advocacy efforts to change public policies and behaviors	1	2	3	9
Other (specify):	1	2	3	9
Other (specify):	1	2	3	9

Section II: Official Documentation of Child Abuse

8. Does any government agency maintain an "official" record or count of all suspected child abuse cases reported in your country each year (e.g., does your country maintain a child abuse central registry or compile statistical summaries)?

____ YES
____ NO

IF YES:

a. How long has this system been in place?
_____ Less than five years
_____ 5 to 10 years
_____ More than 10 years
_____ Do not know

b. For each type of maltreatment listed below, please indicate if this label or type is used in your official system to classify child abuse reports?

Types of Cases	**Please circle the correct response**	
Physical abuse	YES	NO
Sexual abuse	YES	NO
Neglect	YES	NO
Psychological maltreatment	YES	NO

c. For each type of abuse that is included in your system, please indicate if the official records show any change over the past ten years in the number of cases with this problem.

	Please check the correct box		
Types of Cases	**More Cases**	**Fewer Cases**	**No Change**
Physical abuse			
Sexual abuse			
Neglect			
Psychological maltreatment			

d. Are there any subgroups of children (e.g., migrants, Roma children, aboriginals, immigrants) who are systematically excluded from this reporting system?

____ YES
____ NO
____ Do not know

IF YES: Please describe these populations:
_____
_____

9. Does any government agency in your country maintain an "official" annual count of **deaths** that occur as a result of child abuse or neglect?

____ YES
____ NO

IF YES:

a. How long has this system been established in your country?
   ___ Less than five years
   ___ 5 to 10 years
   ___ More than 10 years
   ___ Do not know

b. Based on this system and other information you have, over the past ten years has the number of reported child abuse related fatalities increased, decreased or remained the same?
   ___ The number of reported fatalities has increased.
   ___ The number of reported fatalities has decreased.
   ___ The number of reported fatalities is about the same.
   ___ Do not know

Section III: Intervention Systems

10. Does your country have an official government agency (or agencies) that is responsible for responding to cases of child abuse and neglect?

    ___ YES
    ___ NO

11. Does your country have official national laws or policies regarding child abuse and neglect (e.g., a child protection plan or a formal set of expectations about how to respond to the problem of child abuse)?

    ___ YES
    ___ NO

    IF YES

    a. When was the law or policy first established?

       ___ Before 1980
       ___ Between 1980 and 1989
       ___ Between 1990 and 2000
       ___ After 2000
       ___ Do not know

    b. Since the law or policy was originally adopted, how many times has it been revised (e.g., had new components added or altered the reporting mechanism, provided substantial new funding, etc.)?

       ___ Law/policy is regularly updated on an annual basis
       ___ Law/policy has had some revisions but not annually
       ___ Law/policy has remained essentially unchanged
       ___ Do not know

c. In the table below, please indicate which, if any, of the following elements are included in this law or policy.

Law/Policy	Please circle the correct response	
Mandated reporting of suspected child abuse for specific groups of professionals or individuals	YES	NO
Provisions that allow for voluntary reporting of suspected abuse by any professional or individual	YES	NO
Requirement that reports be investigated within a specific time period (e.g., 24 hours, one week, etc.).	YES	NO
Provisions for removing child from his or her parents/caretakers to insure the child's safety	YES	NO
Specific criminal penalties for abusing a child	YES	NO
Requirements that all victims receive some form of service or intervention	YES	NO
Requirements that all abusers receive some form of service or intervention	YES	NO
Requires the development and support for specific prevention services	YES	NO
Requires that a separate attorney or advocate be assigned to represent the child's interests	YES	NO
Other key provisions: (please specify) _____	YES	NO
Other key provisions: (please specify) _____	YES	NO

d. Is your official law or policy currently being enforced?
   ____ Law or policy is widely enforced.
   ____ Law or policy is inconsistently enforced.
   ____ Law or policy is never or almost never enforced.
   ____ Do not know

e. Are government resources provided to support your official law or policy?
   ____ Law or policy is widely supported by government resources.
   ____ Law or policy is inconsistently supported by government resources.
   ____ Law or policy is never or almost never supported by government resources.
   ____ Do not know

f. In responding to a report of child abuse, how often is the report investigated in the manner outlined in your official law or policy?
   ____ Investigations are generally investigated according to the law or policies.
   ____ Some investigations are conducted according to the law or policy.
   ____ Few investigations are conducted according to the law or policy.
   ____ No investigations are conducted according to the law or policy.
   ____ Do not know

12. How different is the capacity of local agencies to respond to child abuse between the urban or more populated areas of your country and the rural or isolated regions?
   ____ Response resources and capacity are very similar between urban and rural areas.
   ____ Urban areas have more resources and capacity to respond.
   ____ Rural areas have more resources and capacity to respond.
   ____ Do not know

13. For those families identified as needing child protection, mental health services or family support services as a result of having abused or neglected their children, please indicate which of the following services are available. **For those services that are available**, please indicate the capacity of these services to reach all families involved or at risk of abuse.

Service	**Please circle the correct response**				
	Is service available?		**If YES, is the capacity**		
			Adequate in less than 1/3 of the country	**Adequate in 1/3 to 2/3 of the country**	**Adequate in more than 2/3 of the country**
Therapy programs for those who physically abuse a child	YES	NO	1	2	3
Therapy programs for child victims of physical abuse	YES	NO	1	2	3
Therapy programs for those who sexually abuse a child	YES	NO	1	2	3
Therapy programs for child victims of sexual abuse	YES	NO	1	2	3
Case management services/ meeting families' basic needs	YES	NO	1	2	3
Home-based services to assist parents in changing their behaviors	YES	NO	1	2	3
Foster care with official foster parents	YES	NO	1	2	3
Group homes for abused children	YES	NO	1	2	3
Institutional care for abused children	YES	NO	1	2	3
Financial and other material support	YES	NO	1	2	3
Short-term hospitalization for mental illness	YES	NO	1	2	3
Substance abuse related treatments for parents	YES	NO	1	2	3
Substance abuse related treatments for children	YES	NO	1	2	3
Family Resource Centers for parents to share experiences/concerns	YES	NO	1	2	3
Universal home visits for all new parents	YES	NO	1	2	3
Targeted home visits for new parents at-risk	YES	NO	1	2	3
Free child care	YES	NO	1	2	3
Universal health screening for child	YES	NO	1	2	3
Universal access to free medical care for child	YES	NO	1	2	3
Universal access to free medical care for all citizens	YES	NO	1	2	3

14. Please indicate how involved each of the following community sectors is in providing support for child abuse treatment and prevention services.

Agency Type	Please circle correct response				
	Not Involved	**Minimally Involved**	**Moderately Involved**	**Very Involved**	**Do not know**
Hospitals/Medical Centers	1	2	3	4	9
Mental Health Agencies	1	2	3	4	9
Businesses/Factories	1	2	3	4	9
Schools	1	2	3	4	9
Public social service agencies	1	2	3	4	9
Community-based NGOs	1	2	3	4	9
Religious institutions	1	2	3	4	9
Voluntary civic organizations	1	2	3	4	9
Courts/law enforcement	1	2	3	4	9
Universities	1	2	3	4	9
Other (specify):	1	2	3	4	9
Other (specify):	1	2	3	4	9

15. A wide range of agencies can be involved in the treatment and prevention of child abuse in any country. How much funding does each of the following types of organizations in your country provide for child abuse treatment or prevention services?

Funding Source	Please circle the correct response			
	No Funding	**Moderate Funding**	**Major Funding**	**Do Not Know**
International NGOs (e.g., UNICEF, WHO, UN, World Bank, etc.)	1	2	3	9
International Relief Organizations (World Vision, Red Cross, etc.)	1	2	3	9
National Government	1	2	3	9
State/Provincial Government	1	2	3	9
Local Government	1	2	3	9
Private foundations	1	2	3	9
Individuals	1	2	3	9
Corporations/local businesses	1	2	2	9
Other:	1	2	3	9
Other:	1	2	3	9

Section IV: Summary Questions

16. How important are the following issues in limiting efforts to prevent child abuse in your country?

Issue	Please circle appropriate response		
	Not Important	Moderately Important	Very Significant
Limited resources for improving the government's response to child abuse	1	2	3
Lack of system to investigate reports of child abuse	1	2	3
Public resistance to supporting major change or program expansion in this area	1	2	3
Extreme poverty in the country	1	2	3
Decline in family life and informal support systems available for parents	1	2	3
Country's dependency on foreign investment to sustain its local economy	1	2	3
Strong sense of family privacy and parental rights to raise children as they choose	1	2	3
General support for the use of corporal punishment/physical discipline of children	1	2	3
Lack of commitment or support for children's rights	1	2	3
Overwhelming number of children living on their own	1	2	3
Generally inadequate and poorly developed systems of basic health care or social services	1	2	3
Other:	1	2	3
Other:	1	2	3

17. How effective have each of the following strategies been in preventing child abuse in your country?

Strategy	Please circle correct response		
	Strategy NOT used in country	Strategy used BUT not effective	Strategy used AND seems effective
Home-based services and support for parents at risk	1	2	3
Media campaigns to raise public awareness	1	2	3
Risk assessment methods	1	2	3
Increasing individual responsibility for child protection	1	2	3
Prosecution of child abuse offenders	1	2	3
Universal home visitation for new parents	1	2	3
Improving/increasing local services	1	2	3
A system of universal health care and access to preventive medical care	1	2	3
Professional training	1	2	3
Advocacy for children's rights	1	2	3
Improving the living conditions of families (e.g., housing, access to clean water, etc.).	1	2	3

18. How useful have the following ISPCAN programs/resources been in assisting you and your colleagues in addressing the problem of child abuse in your country?

ISPCAN Program	Please circle appropriate response			
	Are you aware of this service?	IF YES, do you find the service		
		Not Useful	Moderately Useful	Very Useful
Child Abuse and Neglect: The International Journal	YES NO	1	2	3
ISPCAN Bi-Annual Congresses	YES NO	1	2	3
ISPCAN-sponsored Regional Conferences	YES NO			
The LINK: ISPCAN Newsletter	YES NO	1	2	3
ITPI training project	YES NO	1	2	3
Other ISPCAN training efforts	YES NO	1	2	3
Developing Countries Scholarships	YES NO	1	2	3
ISPCAN List serv	YES NO	1	2	3
Web page and Internet services (e.g., virtual discussions, links to other resources, etc.)	YES NO	1	2	3
National Partners Program	YES NO	1	2	3
Informal networking/ links to other professionals	YES NO	1	2	3

19. Every country has addressed the child abuse issue in different and unique ways. In your country, what have been the four or five MAJOR milestones, or events, which have shaped your efforts to address child abuse (e.g., the formation of a specific organization, passage of specific policies or legislation, significant involvement of the media, etc.)

Event	Year
1.	
2.	
3.	
4.	
5.	

ADDENDUM

A. (Continued from Question 3 in Survey)
Have there been any general population surveys or studies on the number of child abuse or neglect cases occurring in your country in the past ten years?

____ YES (Date of most recent study: _____)
____ NO
____ Do not know

IF AVAILABLE, based on these incidence studies and other information you have, please provide information on the incidence of child abuse in your country for the most recent year available, and the level of confidence you have in these statistics.

i. Please Indicate the Incidence of **Physical Abuse** in your country (e.g. number of cases/1000 children): _____

In what year were these numbers reported? _____

Your degree of confidence in these numbers:
___ Highly Confident
___ Moderately Confident
___ Somewhat Confident
___ Not At All Confident

ii. Please Indicate the Incidence of **Sexual Abuse** in your country (e.g. number of cases/1000 children): _____

In what year were these numbers reported? _____

Your degree of confidence in these numbers:
___ Highly Confident
___ Moderately Confident
___ Somewhat Confident
___ Not At All Confident

B. (Continued from Question 9 in Survey)
Does any government agency in your country maintain an "official" annual count of **deaths** that occur as a result of child abuse or neglect?

____ YES
____ NO

IF AVAILABLE, please provide information on the incidence of reported child abuse related child fatalities in your country for the most recent year available, and the level of confidence you have in these statistics.

a.) Please Indicate the Incidence of **Abuse Related Child Fatalities** in your country (e.g. number of cases/1000 children):_____

In what year were these numbers reported? _____

Your degree of confidence in these numbers:
___ Highly Confident
___ Moderately Confident
___ Somewhat Confident
___ Not At All Confident

Thank you for your efforts in completing this form.
If you have any questions, please contact: ispcan@ispcan.org

Please return all responses by December 10, 2005.
If you cannot complete the questionnaire, please let us know as soon as possible.

Please return survey responses by e-mail to: ispcan@ispcan.org
By fax to: 1.630.876.6917

Or by regular mail to: ISPCAN
Attn: World Perspectives
245 W. Roosevelt Rd, Building 6, Suite 39
West Chicago, IL 60185
USA

Appendix C

Country Specific Profiles

ALBANIA

Region: Europe

Previous World Perspectives surveys completed: 1998

OFFICIAL RECORDS

Country maintains official count of CAN cases: NO

If yes, classifications included:

- ☐ Physical abuse
- ☐ Sexual abuse
- ☐ Psychological maltreatment
- ☐ Neglect

SERVICES

Services available, and capacity of these services to reach all families involved or at risk of abuse.

Adequate in ***Less Than*** *1/3* of Country:

- Financial and material support

Unavailable:

- Therapy programs for physical abusers and sexual abusers
- Therapy programs for child victims of physical abuse
- Therapy programs for child victims of sexual abuse
- Case management services/meeting basic needs
- Home-based services to assist parents in changing their behaviors
- Foster care with official foster parents
- Group homes for abused children
- Short-term hospitalization for mental illness
- Substance abuse treatments for children
- Substance abuse treatments for parents
- Institutional care for abused children
- Family Resource Centers for parents to share experiences/concerns
- Universal health screening for child
- Universal access to free medical care for child
- Universal access to free medical care for all citizens
- Universal home visits for all new parents
- Targeted home visits for new parents at-risk
- Free child care

FUNDING

Activity level of sectors in funding child abuse treatment or prevention services.

	Major	Limited	None	Unknown
Int'l NGOs		◆		
Int'l Relief Organizations				◆
National Government			◆	
State/Local Government			◆	
Private foundations			◆	
Individuals			◆	
Businesses			◆	

POLICY

Official government law or policy regarding child abuse and neglect? YES*

* National Plan of Action against Child Trafficking

If yes, date established: 2005

Core Elements

- Specific criminal penalties for trafficking a child
- Requirements that all victims receive some form of service/intervention

Enforcement Level: NA

Level of Government Support: NA

RESEARCH (in past 10 years)

- Population-based surveys conducted to assess scope of problem: NO
- Public opinion polls to assess awareness: NO

SERVICE PROVIDERS

Relative involvement in child abuse treatment and prevention services.

Not Involved:

- Schools
- Businesses/Factories

Minimally Involved:

- Hospitals/Medical Centers
- Mental Health Agencies
- Public social service agencies
- Courts/law enforcement

Moderately Involved:

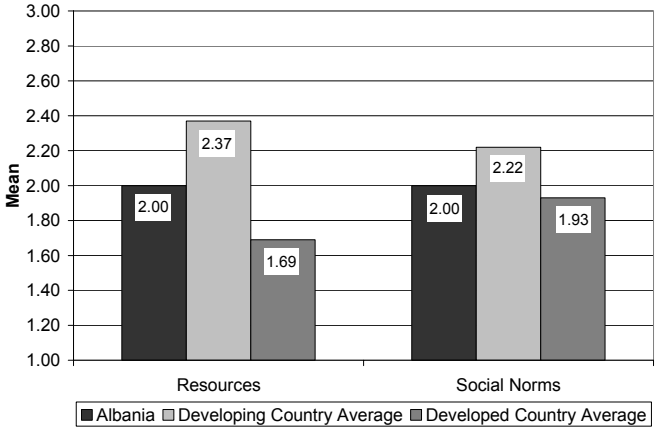
- Voluntary civic organizations
- Religious institutions

Very Involved:

- NA

BARRIERS

Average rating of limiting factors to CAN prevention, (E.g. poverty, support for use of corporal punishment, etc) (Scale: 1="Not important" to 3="Very significant")



ARGENTINA

Region: Americas

Previous World Perspectives surveys completed: 1996, 1998, 2000, 2002, 2004

OFFICIAL RECORDS

Country maintains official count of CAN cases: NO

If yes, classifications included:

- ☐ Physical abuse
- ☐ Sexual abuse
- ☐ Psychological maltreatment
- ☐ Neglect

SERVICES

Services available, and capacity of these services to reach all families involved or at risk of abuse.

Adequate in ***Less Than*** *1/3* of Country:

- Therapy programs for child victims of physical abuse and sexual abuse
- Financial and material support

Adequate in ***1/3 to 2/3*** of Country:

- Case management services/meeting basic needs
- Substance abuse treatments for children

Adequate in ***More Than*** *2/3* of Country:

- Foster care with official foster parents
- Institutional care for abused children
- Short-term hospitalization for mental illness
- Free child care
- Universal health screening for child
- Universal access to free medical care for child
- Universal access to free medical care for all citizens

Unavailable:

- Therapy programs for physical abusers and sexual abusers
- Home-based services to assist parents in changing their behaviors
- Group homes for abused children
- Substance abuse treatments for parents
- Family Resource Centers for parents to share experiences/concerns
- Universal home visits for all new parents
- Targeted home visits for new parents at-risk

FUNDING

Activity level of sectors in funding child abuse treatment or prevention services.

	Major	Limited	None	Unknown
Int'l NGOs			◆	
Int'l Relief Organizations			◆	
National Government		◆		
State/Local Government		◆		
Private foundations			◆	
Individuals			◆	
Businesses			◆	

POLICY

Official government law or policy regarding child abuse and neglect? YES

If yes, date established: Between 1990-2000

Core Elements

- Mandated reporting of suspected child abuse for specific groups of professionals
- Victims receive some form of service/intervention
- Attorney assigned to represent the child's interests

Enforcement Level: Inconsistently enforced

Level of Government Support: Inconsistently supported

RESEARCH (in past 10 years)

- Population-based surveys conducted to assess scope of problem: NO
- Public opinion polls to assess awareness: NO

SERVICE PROVIDERS

Relative involvement in child abuse treatment and prevention services.

Not Involved:

- Universities
- Businesses/Factories

Minimally Involved:

- Community-based NGOs
- Religious institutions
- Voluntary civic organizations

Moderately Involved:

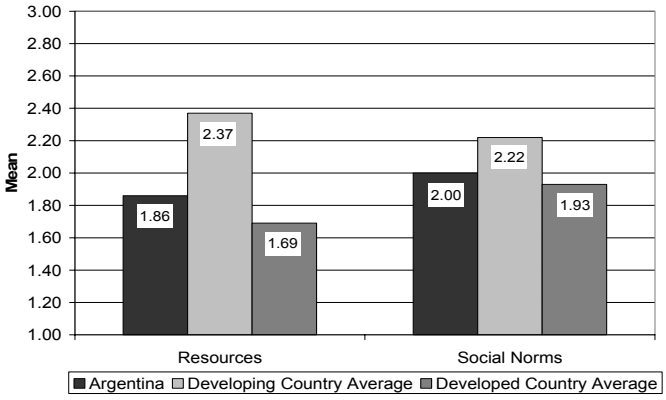
- Hospitals/Medical Centers
- Mental Health Agencies
- Schools
- Public social service agencies
- Courts/law enforcement

Very Involved:

- NA

BARRIERS

Average rating of limiting factors to CAN prevention, (E.g. poverty, support for use of corporal punishment, etc) (Scale: 1="Not important" to 3="Very significant")



ARMENIA

Region: Western Asia

Previous World Perspectives surveys completed: 2004

OFFICIAL RECORDS

Country maintains official count of CAN cases: YES

If yes, classifications included:

- ☑ Physical abuse
- ☑ Sexual abuse
- ☑ Psychological maltreatment
- ☑ Neglect

SERVICES

Services available, and capacity of these services to reach all families involved or at risk of abuse.

Adequate in ***Less Than*** *1/3* of Country:

- Therapy programs for physical abusers
- Therapy programs for child victims of physical abuse and sexual abuse
- Case management services/meeting basic needs
- Home-based services to assist parents in changing their behaviors
- Foster care with official foster parents
- Group homes for abused children
- Short-term hospitalization for mental illness
- Substance abuse treatments for children
- Substance abuse treatments for parents
- Family Resource Centers for parents to share experiences/concerns

Adequate in ***More Than*** *2/3* of Country:

- Institutional care for abused children
- Universal home visits for all new parents
- Universal health screening for child

Unavailable:

- Therapy programs for sexual abusers
- Targeted home visits for new parents at-risk
- Free child care
- Universal access to free medical care for child
- Universal access to free medical care for all citizens

FUNDING

Activity level of sectors in funding child abuse treatment or prevention services.

	Major	Limited	None	Unknown
Int'l NGOs		◆		
Int'l Relief Organizations		◆		
National Government		◆		
State/Local Government		◆		
Private foundations			◆	
Individuals			◆	
Businesses			◆	

POLICY

Official government law or policy regarding child abuse and neglect? YES

If yes, date established: After 2000

Core Elements

- Mandated reporting of suspected child abuse for specific groups of professionals
- Victims receive some form of service/intervention
- Criminal penalties for abusing a child
- Development/support for prevention services

Enforcement Level: Inconsistently enforced

Level of Government Support: Widely supported

RESEARCH (in past 10 years)

- Population-based surveys conducted to assess scope of problem: YES
- Public opinion polls to assess awareness: YES

SERVICE PROVIDERS

Relative involvement in child abuse treatment and prevention services.

Not Involved:

- Businesses/Factories
- Voluntary civic organizations
- Universities

Minimally Involved:

- Schools
- Public social service agencies
- Religious institutions

Moderately Involved:

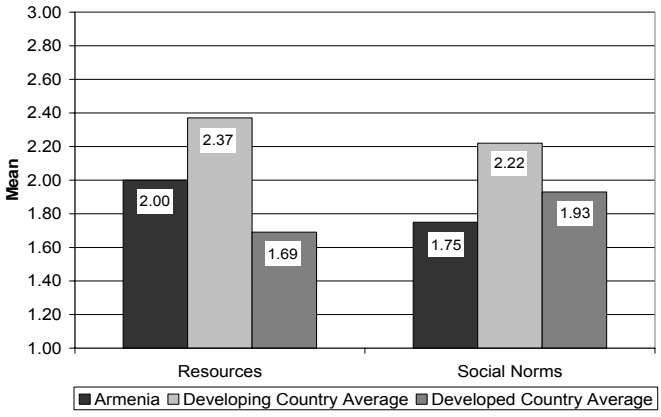
- Hospitals/Medical Centers
- Mental Health Agencies
- Community-based NGOs

Very Involved:

- Courts/law enforcement

BARRIERS

Average rating of limiting factors to CAN prevention, (E.g. poverty, support for use of corporal punishment, etc) (Scale: 1="Not important" to 3="Very significant")



AUSTRALIA

Region: Oceania

Previous World Perspectives surveys completed:
1992, 1996, 1998, 2000, 2002, 2004

OFFICIAL RECORDS

Country maintains official count of CAN cases: YES

If yes, classifications included:

- ☑ Physical abuse
- ☑ Sexual abuse
- ☑ Psychological maltreatment
- ☑ Neglect

SERVICES

Services available, and capacity of these services to reach all families involved or at risk of abuse.

Adequate in ***Less Than*** *1/3* of Country:

- Therapy programs for physical abusers and sexual abusers
- Therapy programs for child victims of physical abuse and sexual abuse
- Foster care with official foster parents
- Group homes for abused children
- Short-term hospitalization for mental illness
- Substance abuse treatments for children
- Targeted home visits for new parents at-risk
- Free child care

Adequate in ***1/3 to 2/3*** of Country:

- Case management services/meeting basic needs
- Home-based services to assist parents in changing their behaviors
- Financial and material support
- Substance abuse treatments for parents
- Family Resource Centers for parents to share experiences/concerns
- Universal home visits for all new parents

Adequate in ***More Than*** *2/3* of Country:

- Universal health screening for child
- Universal access to free medical care for child
- Universal access to free medical care for all citizens

Unavailable:

- Institutional care for abused children

FUNDING

Activity level of sectors in funding child abuse treatment or prevention services.

	Major	Limited	None	Unknown
Int'l NGOs			◆	
Int'l Relief Organizations			◆	
National Government		◆		
State/Local Government	◆			
Private foundations		◆		
Individuals		◆		
Businesses		◆		

POLICY

Official government law or policy regarding child abuse and neglect? YES*

If yes, date established: Before 1980

Core Elements

- Mandated reporting of suspected child abuse for specific groups of professionals
- Removing the child from caretakers to insure safety
- Attorney assigned to represent the child's interests

Enforcement Level: Widely enforced

Level of Government Support: Widely supported

RESEARCH (in past 10 years)

- Population-based surveys conducted to assess scope of problem: YES
- Public opinion polls to assess awareness: YES

SERVICE PROVIDERS

Relative involvement in child abuse treatment and prevention services.

Not Involved:

- Businesses/Factories

Minimally Involved:

- Mental Health Agencies
- Voluntary civic org.
- Universities

Moderately Involved:

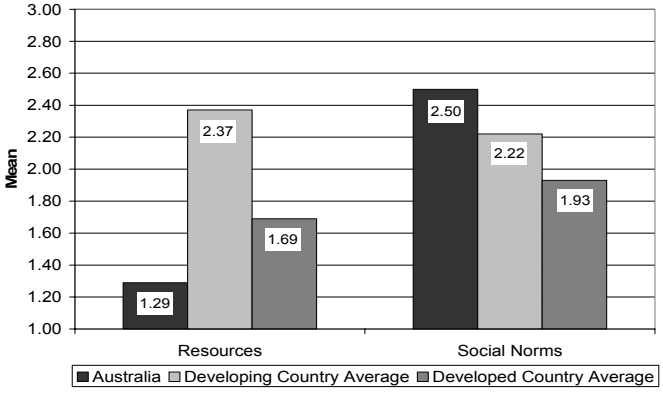
- Schools
- Religious institutions
- Professional associations

Very Involved:

- Hospitals/Medical Centers
- Public social services
- Community-based NGOs
- Courts/law enforcement

BARRIERS

Average rating of limiting factors to CAN prevention,
(E.g. poverty, support for use of corporal punishment, etc)
(Scale: 1="Not important" to 3="Very significant")



* While there is no national standard governing child welfare practice in Australia, each state and territory government has established an official policy covering the identification and reporting of child abuse.

BAHRAIN

Region: Western Asia

Previous World Perspectives surveys completed: 2002, 2004

OFFICIAL RECORDS

Country maintains official count of CAN cases: YES

If yes, classifications included:

- ☑ Physical abuse
- ☑ Sexual abuse
- ☑ Psychological maltreatment
- ☑ Neglect

SERVICES

Services available, and capacity of these services to reach all families involved or at risk of abuse.

Adequate in ***Less Than*** *1/3* of Country:

- Therapy programs for child victims of physical abuse
- Therapy programs for child victims of sexual abuse
- Case management services/meeting basic needs
- Financial and material support
- Short-term hospitalization for mental illness
- Substance abuse treatments for children
- Substance abuse treatments for parents

Adequate in ***More Than*** *2/3* of Country:

- Universal health screening for child
- Universal access to free medical care for child
- Universal access to free medical care for all citizens

Available (Adequacy Unknown):

- Home-based services to assist parents in changing their behaviors

Unavailable:

- Therapy programs for physical abusers and sexual abusers
- Foster care with official foster parents
- Group homes for abused children
- Institutional care for abused children
- Family Resource Centers for parents to share experiences/concerns
- Universal home visits for all new parents
- Targeted home visits for new parents at-risk
- Free child care

FUNDING

Activity level of sectors in funding child abuse treatment or prevention services.

	Major	Limited	None	Unknown
Int'l NGOs			◆	
Int'l Relief Organizations			◆	
National Government		◆		
State/Local Government			◆	
Private foundations			◆	
Individuals		◆		
Businesses		◆		

POLICY

Official government law or policy regarding child abuse and neglect? NO

If yes, date established: NA

Core Elements: NA

Enforcement Level: NA

Level of Government Support: NA

RESEARCH (in past 10 years)

- Population-based surveys conducted to assess scope of problem: YES
- Public opinion polls to assess awareness: NO

SERVICE PROVIDERS

Relative involvement in child abuse treatment and prevention services.

Not Involved:

- NA

Minimally Involved:

- Schools
- Public social service agencies
- Religious institutions
- Courts/law enforcement
- Universities
- Businesses/Factories

Moderately Involved:

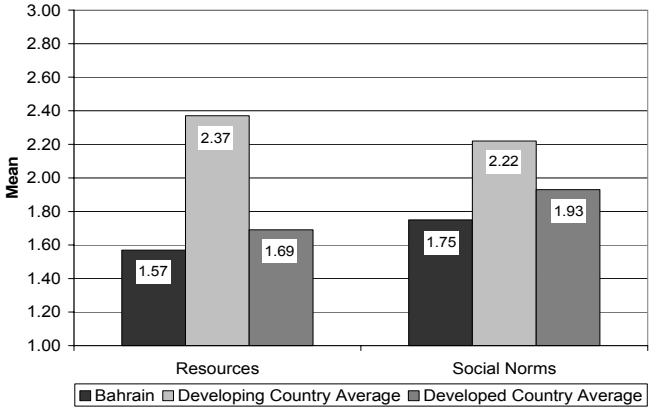
- Community-based NGOs
- Voluntary civic organizations

Very Involved:

- Hospitals/Medical Centers
- Mental Health Agencies

BARRIERS

Average rating of limiting factors to CAN prevention, (E.g. poverty, support for use of corporal punishment, etc) (Scale: 1="Not important" to 3="Very significant")



BANGLADESH

Region: Southern Asia

Previous World Perspectives surveys completed: 1996, 1998

OFFICIAL RECORDS

Country maintains official count of CAN cases: YES

If yes, classifications included:

- ☐ Physical abuse
- ☑ Sexual abuse
- ☐ Psychological maltreatment
- ☐ Neglect

SERVICES

Services available, and capacity of these services to reach all families involved or at risk of abuse.

Adequate in ***Less Than*** *1/3* of Country:

- Therapy programs for physical abusers and sexual abusers
- Therapy programs for child victims of physical abuse and sexual abuse
- Case management services/meeting basic needs
- Institutional care for abused children
- Short-term hospitalization for mental illness
- Substance abuse treatments for children
- Free child care
- Universal health screening for child
- Universal access to free medical care for child
- Universal access to free medical care for all citizens

Unavailable:

- Home-based services to assist parents in changing their behaviors
- Foster care with official foster parents
- Group homes for abused children
- Financial and material support
- Substance abuse treatments for parents
- Family Resource Centers for parents to share experiences/concerns
- Universal home visits for all new parents
- Targeted home visits for new parents at-risk

FUNDING

Activity level of sectors in funding child abuse treatment or prevention services.

	Major	Limited	None	Unknown
Int'l NGOs		◆		
Int'l Relief Organizations		◆		
National Government	◆			
State/Local Government		◆		
Private foundations				◆
Individuals		◆		
Businesses		◆		

POLICY

Official government law or policy regarding child abuse and neglect? YES

If yes, date established: Before 1980

Core Elements

- Mandated reporting of suspected child abuse for specific groups of professionals
- Voluntary reporting of suspected abuse
- Victims receive some form of service/intervention
- Attorney assigned to represent the child's interests

Enforcement Level: Widely enforced

Level of Government Support: Widely supported

RESEARCH (in past 10 years)

- Population-based surveys conducted to assess scope of problem: NO
- Public opinion polls to assess awareness: YES

SERVICE PROVIDERS

Relative involvement in child abuse treatment and prevention services.

Not Involved:

- NA

Moderately Involved:

- Community-based NGOs

Minimally Involved:

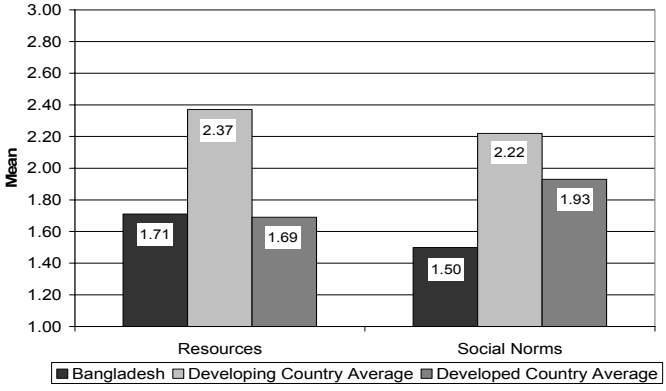
- Religious institutions

Very Involved:

- Hospitals/Medical Centers
- Mental Health Agencies
- Public social service agencies
- Courts/law enforcement

BARRIERS

Average rating of limiting factors to CAN prevention, (E.g. poverty, support for use of corporal punishment, etc) (Scale: 1="Not important" to 3="Very significant")



BELARUS

Region: Europe

Previous World Perspectives surveys completed: None

OFFICIAL RECORDS

Country maintains official count of CAN cases: NO

If yes, classifications included:

- ☐ Physical abuse
- ☐ Sexual abuse
- ☐ Psychological maltreatment
- ☐ Neglect

SERVICES

Services available, and capacity of these services to reach all families involved or at risk of abuse.

Adequate in ***Less Than*** *1/3* of Country:

- Therapy programs for child victims of physical abuse and sexual abuse
- Case management services/meeting basic needs
- Home-based services to assist parents in changing their behaviors
- Institutional care for abused children
- Short-term hospitalization for mental illness
- Substance abuse treatments for children

Adequate in ***1/3 to 2/3*** of Country:

- Family Resource Centers for parents to share experiences/concerns
- Universal home visits for all new parents
- Targeted home visits for new parents at-risk

Adequate in ***More Than*** *2/3* of Country:

- Foster care with official foster parents
- Free child care
- Universal health screening for child
- Universal access to free medical care for child
- Universal access to free medical care for all citizens

Unavailable:

- Therapy programs for physical abusers and sexual abusers
- Group homes for abused children
- Financial and material support
- Substance abuse treatments for parents

FUNDING

Activity level of sectors in funding child abuse treatment or prevention services.

	Major	Limited	None	Unknown
Int'l NGOs		◆		
Int'l Relief Organizations			◆	
National Government	◆			
State/Local Government	◆			
Private foundations			◆	
Individuals			◆	
Businesses			◆	

POLICY

Official government law or policy regarding child abuse and neglect? YES

If yes, date established: After 2000

Core Elements

- Mandated reporting of suspected child abuse for specific groups of professionals
- Victims receive some form of service/intervention
- Criminal penalties for sexual abuse
- Attorney assigned to represent the child's interests

Enforcement Level: Widely enforced

Level of Government Support: Widely supported

RESEARCH (in past 10 years)

- Population-based surveys conducted to assess scope of problem: NO
- Public opinion polls to assess awareness: YES

SERVICE PROVIDERS

Relative involvement in child abuse treatment and prevention services.

Not Involved:

- Businesses/Factories

Moderately Involved:

- Community-based NGOs

Very Involved:

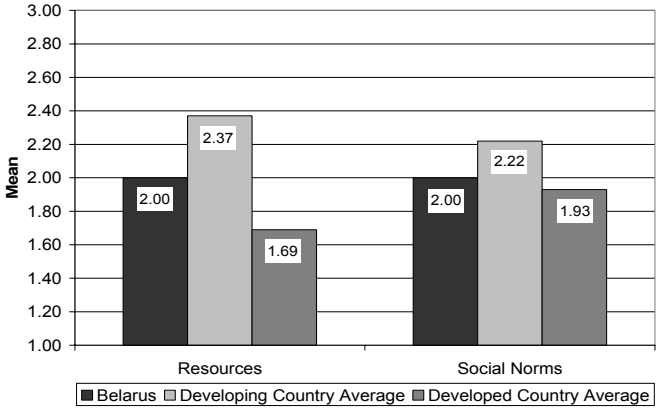
- Courts/law enforcement
- Family support centers

Minimally Involved:

- Hospitals/Medical Centers
- Mental Health Agencies
- Public social service agencies
- Schools/Universities
- Religious institutions
- Voluntary civic organizations

BARRIERS

Average rating of limiting factors to CAN prevention, (E.g. poverty, support for use of corporal punishment, etc) (Scale: 1="Not important" to 3="Very significant")



BENIN

Region: Africa

Previous World Perspectives surveys completed: 1998, 2000, 2002

OFFICIAL RECORDS

Country maintains official count of CAN cases: YES

If yes, classifications included:

- ☑ Physical abuse
- ☑ Sexual abuse
- ☑ Psychological maltreatment
- ☑ Neglect

SERVICES

Services available, and capacity of these services to reach all families involved or at risk of abuse.

Adequate in ***Less Than*** *1/3* of Country:

- Home-based services to assist parents in changing their behaviors
- Financial and material support

Unavailable:

- Therapy programs for physical abusers and sexual abusers
- Group homes for abused children
- Substance abuse treatments for parents
- Therapy programs for child victims of physical abuse and sexual abuse
- Case management services/meeting basic needs
- Institutional care for abused children
- Short-term hospitalization for mental illness
- Substance abuse treatments for children
- Family Resource Centers for parents to share experiences/concerns
- Universal home visits for all new parents
- Targeted home visits for new parents at-risk
- Foster care with official foster parents
- Free child care
- Universal health screening for child
- Universal access to free medical care for child
- Universal access to free medical care for all citizens

FUNDING

Activity level of sectors in funding child abuse treatment or prevention services.

	Major	Limited	None	Unknown
Int'l NGOs	◆			
Int'l Relief Organizations	◆			
National Government		◆		
State/Local Government		◆		
Private foundations		◆		
Individuals		◆		
Businesses		◆		

POLICY

Official government law or policy regarding child abuse and neglect? YES

If yes, date established: Between 1990-2000

Core Elements

- Mandated reporting of suspected child abuse for specific groups of professionals
- Victims receive some form of service/intervention
- Attorney assigned to represent the child's interests

Enforcement Level: Almost never enforced

Level of Government Support: Inconsistently supported

RESEARCH (in past 10 years)

- Population-based surveys conducted to assess scope of problem: NO
- Public opinion polls to assess awareness: YES

SERVICE PROVIDERS

Relative involvement in child abuse treatment and prevention services.

Not Involved:

- Hospitals/Medical Centers
- Mental Health Agencies
- Businesses/Factories

Very Involved:

- Public social services
- Community-based NGOs
- Religious institutions
- Voluntary civic organizations
- Courts/law enforcement

Moderately Involved:

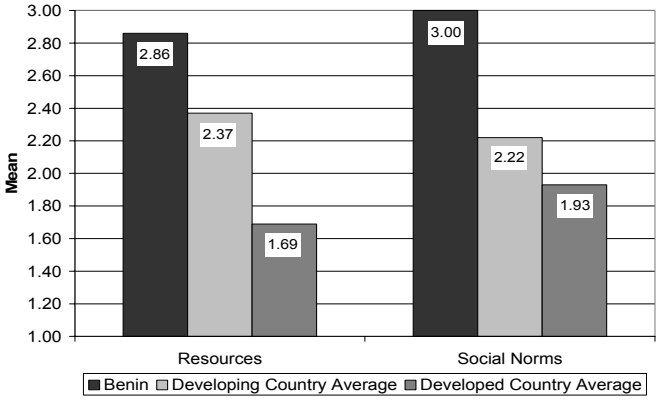
- Universities

Minimally Involved:

- Schools

BARRIERS

Average rating of limiting factors to CAN prevention, (E.g. poverty, support for use of corporal punishment, etc) (Scale: 1="Not important" to 3="Very significant")



BOSNIA AND HERZEGOVINA

Region: Europe

Previous World Perspectives surveys completed: None

OFFICIAL RECORDS

Country maintains official count of CAN cases: NO

If yes, classifications included:

- ☐ Physical abuse
- ☐ Sexual abuse
- ☐ Psychological maltreatment
- ☐ Neglect

SERVICES

Services available, and capacity of these services to reach all families involved or at risk of abuse.

Adequate in ***Less Than*** *1/3* of Country:

- Therapy programs for physical abusers and sexual abusers
- Therapy programs for child victims of physical abuse and sexual abuse
- Foster care with official foster parents
- Short-term hospitalization for mental illness
- Family Resource Centers for parents to share experiences/concerns

Adequate in ***1/3 to 2/3*** of Country:

- Case management services/meeting basic needs
- Universal home visits for all new parents
- Universal health screening for child
- Universal access to free medical care for child

Unavailable:

- Home-based services to assist parents in changing their behaviors
- Institutional care for abused children
- Group homes for abused children
- Financial and material support
- Targeted home visits for new parents at-risk
- Free child care

FUNDING

Activity level of sectors in funding child abuse treatment or prevention services.

	Major	Limited	None	Unknown
Int'l NGOs	◆			
Int'l Relief Organizations			◆	
National Government		◆		
State/Local Government		◆		
Private foundations			◆	
Individuals			◆	
Businesses			◆	

POLICY

Official government law or policy regarding child abuse and neglect? YES

If yes, date established: Before 1980

Core Elements

- Mandated reporting of suspected child abuse for specific groups of professionals
- Victims receive some form of service/intervention
- Abusers receive some form of service/intervention
- Attorney assigned to represent the child's interests

Enforcement Level: Inconsistently enforced

Level of Government Support: Inconsistently supported

RESEARCH (in past 10 years)

- Population-based surveys conducted to assess scope of problem: YES
- Public opinion polls to assess awareness: YES

SERVICE PROVIDERS

Relative involvement in child abuse treatment and prevention services.

Not Involved:

- Hospitals/Medical Centers
- Businesses/Factories

Moderately Involved:

- Schools/Universities
- Public social service agencies
- Voluntary civic organizations

Minimally Involved:

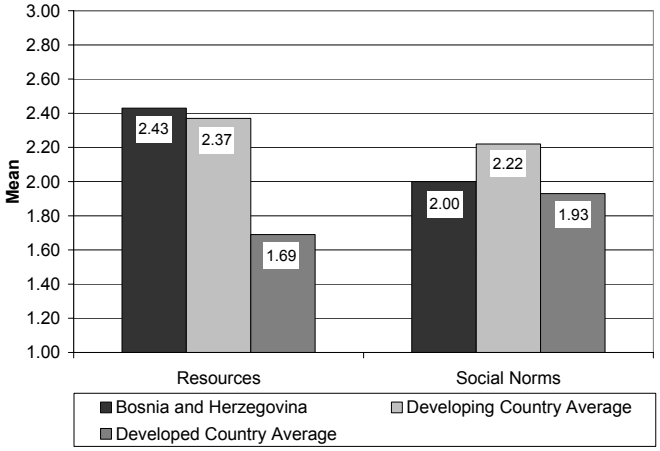
- Mental Health Agencies
- Religious institutions
- Courts/law enforcement

Very Involved:

- Community-based NGOs

BARRIERS

Average rating of limiting factors to CAN prevention, (E.g. poverty, support for use of corporal punishment, etc) (Scale: 1="Not important" to 3="Very significant")



BRAZIL

Region: Americas

Previous World Perspectives surveys completed:
1992, 1996, 1998, 2000, 2002, 2004

OFFICIAL RECORDS

Country maintains official count of CAN cases: YES

If yes, classifications included:

- ☑ Physical abuse
- ☑ Sexual abuse
- ☑ Psychological maltreatment
- ☑ Neglect

SERVICES

Services available, and capacity of these services to reach all families involved or at risk of abuse.

Adequate in ***Less Than*** *1/3* of Country:

- Foster care with official foster parents
- Group homes for abused children
- Financial and material support
- Short-term hospitalization for mental illness
- Substance abuse treatments for children
- Substance abuse treatments for parents
- Free child care

Adequate in ***1/3 to 2/3*** of Country:

- Therapy programs for physical abusers
- Therapy programs for child victims of physical abuse and sexual abuse
- Case management services/meeting basic needs
- Institutional care for abused children
- Family Resource Centers for parents to share experiences/concerns
- Universal health screening for child
- Universal access to free medical care for child
- Universal access to free medical care for all citizens

Unavailable:

- Therapy programs for sexual abusers
- Home-based services to assist parents in changing their behaviors
- Universal home visits for all new parents
- Targeted home visits for new parents at-risk

FUNDING

Activity level of sectors in funding child abuse treatment or prevention services.

	Major	Limited	None	Unknown
Int'l NGOs		◆		
Int'l Relief Organizations		◆		
National Government		◆		
State/Local Government	◆			
Private foundations	◆			
Individuals		◆		
Businesses		◆		

POLICY

Official government law or policy regarding child abuse and neglect? YES

If yes, date established: Between 1990-2000

Core Elements

- Mandated reporting of suspected child abuse for specific groups of professionals
- Victims receive some form of service/intervention
- Attorney assigned to represent the child's interests

Enforcement Level: Inconsistently enforced

Level of Government Support: Inconsistently supported

RESEARCH (in past 10 years)

- Population-based surveys conducted to assess scope of problem: NO
- Public opinion polls to assess awareness: NO

SERVICE PROVIDERS

Relative involvement in child abuse treatment and prevention services.

Not Involved:

- NA

Minimally Involved:

- Businesses/Factories

Moderately Involved:

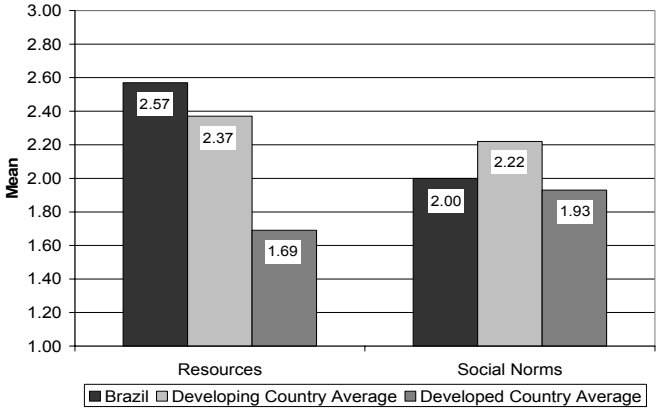
- Mental Health Agencies
- Schools/Universities
- Religious institutions
- Voluntary civic organizations

Very Involved:

- Hospitals/Medical Centers
- Public social service agencies
- Community-based NGOs
- Courts/law enforcement

BARRIERS

Average rating of limiting factors to CAN prevention,
(E.g. poverty, support for use of corporal punishment, etc)
(Scale: 1="Not important" to 3="Very significant")



BULGARIA

Region: Europe

Previous World Perspectives surveys completed: 2002, 2004

OFFICIAL RECORDS

Country maintains official count of CAN cases: YES

If yes, classifications included:

- ☑ Physical abuse
- ☑ Sexual abuse
- ☑ Psychological maltreatment
- ☑ Neglect

SERVICES

Services available, and capacity of these services to reach all families involved or at risk of abuse.

Adequate in ***Less Than*** *1/3* of Country:

- Therapy programs for child victims of physical abuse and sexual abuse
- Case management services/meeting basic needs
- Institutional care for abused children
- Substance abuse treatments for parents
- Substance abuse treatments for children

Adequate in ***1/3 to 2/3*** of Country:

- Foster care with official foster parents
- Short-term hospitalization for mental illness
- Targeted home visits for new parents at-risk

Adequate in ***More Than*** *2/3* of Country:

- Universal home visits for all new parents
- Free child care
- Universal health screening for child
- Universal access to free medical care for child
- Universal access to free medical care for all citizens

Unavailable:

- Therapy programs for physical abusers and sexual abusers
- Home-based services to assist parents in changing their behaviors
- Group homes for abused children
- Family Resource Centers for parents to share experiences/concerns

FUNDING

Activity level of sectors in funding child abuse treatment or prevention services.

	Major	Limited	None	Unknown
Int'l NGOs		◆		
Int'l Relief Organizations		◆		
National Government	◆			
State/Local Government		◆		
Private foundations	◆			
Individuals			◆	
Businesses			◆	

POLICY

Official government law or policy regarding child abuse and neglect? YES

If yes, date established: After 2000

Core Elements

- Mandated reporting of suspected child abuse for specific groups of professionals
- Victims receive some form of service/intervention
- Social Worker assigned to represent the child's interests

Enforcement Level: Widely enforced

Level of Government Support: Inconsistently supported

RESEARCH (in past 10 years)

- Population-based surveys conducted to assess scope of problem: NO
- Public opinion polls to assess awareness: NO

SERVICE PROVIDERS

Relative involvement in child abuse treatment and prevention services.

Not Involved:

- Community-based NGOs
- Businesses/Factories

Minimally Involved:

- Hospitals/Medical Centers
- Religious institutions
- Courts/law enforcement
- Schools

Moderately Involved:

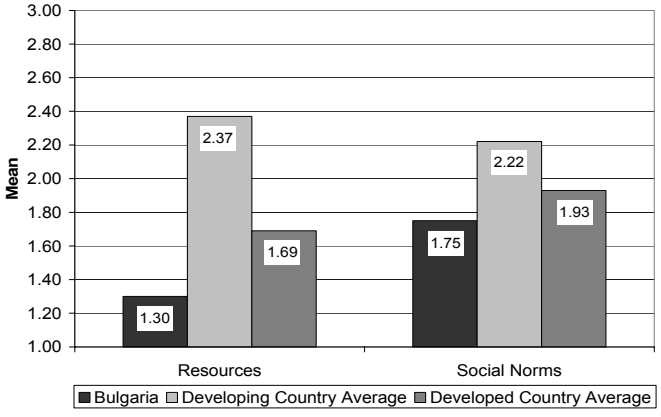
- Mental Health Agencies
- Voluntary civic organizations

Very Involved:

- Public social service agencies

BARRIERS

Average rating of limiting factors to CAN prevention,
(E.g. poverty, support for use of corporal punishment, etc)
(Scale: 1="Not important" to 3="Very significant")



CAMEROON

Region: Africa

Previous World Perspectives surveys completed: 1998, 2000, 2004

OFFICIAL RECORDS

Country maintains official count of CAN cases: YES

If yes, classifications included:

- ☑ Physical abuse
- ☑ Sexual abuse
- ☐ Psychological maltreatment
- ☑ Neglect

SERVICES

Services available, and capacity of these services to reach all families involved or at risk of abuse.

Adequate in ***Less Than*** *1/3* of Country:

- Therapy programs for child victims of sexual abuse
- Short-term hospitalization for mental illness

Unavailable:

- Therapy programs for physical abusers and sexual abusers
- Therapy programs for child victims of physical abuse
- Case management services/meeting basic needs
- Home-based services to assist parents in changing their behaviors
- Foster care with official foster parents
- Group homes for abused children
- Institutional care for abused children
- Financial and material support
- Substance abuse treatments for parents
- Substance abuse treatments for children
- Universal home visits for all new parents
- Targeted home visits for new parents at-risk
- Family Resource Centers for parents to share experiences/concerns
- Free child care
- Universal health screening for child
- Universal access to free medical care for child
- Universal access to free medical care for all citizens

FUNDING

Activity level of sectors in funding child abuse treatment or prevention services.

	Major	Limited	None	Unknown
Int'l NGOs				◆
Int'l Relief Organizations				◆
National Government			◆	
State/Local Government			◆	
Private foundations				◆
Individuals			◆	
Businesses			◆	

POLICY

Official government law or policy regarding child abuse and neglect? YES

If yes, date established: Before 1980

Core Elements

- Voluntary reporting of suspected abuse
- Victims receive some form of service/intervention
- Criminal penalties for abusing a child

Enforcement Level: Inconsistently enforced

Level of Government Support: Inconsistently supported

RESEARCH (in past 10 years)

- Population-based surveys conducted to assess scope of problem: YES
- Public opinion polls to assess awareness: NO

SERVICE PROVIDERS

Relative involvement in child abuse treatment and prevention services.

Not Involved:

- Businesses/Factories
- Universities

Moderately Involved:

- Mental Health Agencies
- Courts/law enforcement
- Schools

Minimally Involved:

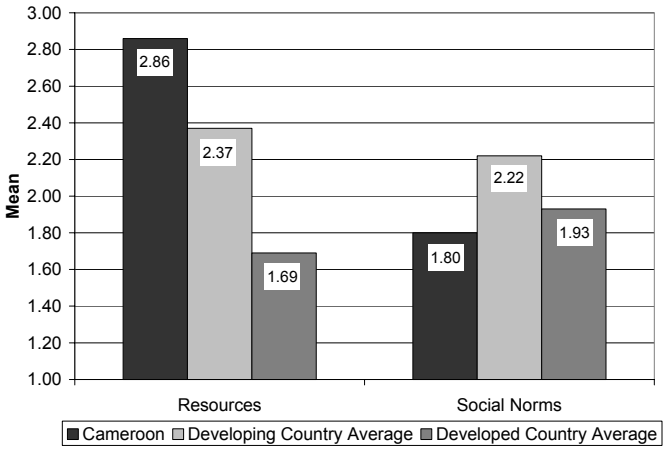
- Public social service agencies

Very Involved:

- Hospitals/Medical Centers
- Religious institutions
- Community-based NGOs
- Voluntary civic organizations

BARRIERS

Average rating of limiting factors to CAN prevention, (E.g. poverty, support for use of corporal punishment, etc) (Scale: 1="Not important" to 3="Very significant")



CANADA

Region: Americas

Previous World Perspectives surveys completed:
1992, 1996, 1998, 2000, 2002, 2004

OFFICIAL RECORDS

Country maintains official count of CAN cases: YES

If yes, classifications included:

- ☑ Physical abuse
- ☑ Sexual abuse
- ☑ Psychological maltreatment
- ☑ Neglect

SERVICES

Services available, and capacity of these services to reach all families involved or at risk of abuse.

Adequate in ***Less Than*** *1/3* of Country:

- Therapy programs for physical abusers and sexual abusers
- Universal home visits for all new parents
- Targeted home visits for new parents at-risk

Adequate in ***1/3 to 2/3*** of Country:

- Therapy programs for child victims of physical abuse and sexual abuse
- Institutional care for abused children
- Short-term hospitalization for mental illness

Adequate in ***More Than*** *2/3* of Country:

- Case management services/meeting basic needs
- Home-based services to assist parents in changing their behaviors
- Foster care with official foster parents
- Group homes for abused children
- Substance abuse treatments for parents
- Substance abuse treatments for children
- Financial and material support
- Family Resource Centers for parents to share experiences/concerns
- Universal health screening for child
- Universal access to free medical care for child
- Universal access to free medical care for all citizens

Unavailable:

- Free child care

FUNDING

Activity level of sectors in funding child abuse treatment or prevention services.

	Major	Limited	None	Unknown
Int'l NGOs			◆	
Int'l Relief Organizations			◆	
National Government		◆		
State/Local Government	◆			
Private foundations		◆		
Individuals		◆		
Businesses		◆		

POLICY

Official government law or policy regarding child abuse and neglect? YES

If yes, date established: Before 1980

Core Elements

- Mandated reporting of suspected child abuse for specific groups of professionals
- Victims receive some form of service/intervention
- Attorney assigned to represent the child's interests
- Abusers receive some form of service/intervention

Enforcement Level: Widely enforced

Level of Government Support: Widely supported

RESEARCH (in past 10 years)

- Population-based surveys conducted to assess scope of problem: YES
- Public opinion polls to assess awareness: NO

SERVICE PROVIDERS

Relative involvement in child abuse treatment and prevention services.

Not Involved:

- NA

Minimally Involved:

- Religious institutions
- Voluntary civic organizations
- Businesses/Factories
- Universities

Moderately Involved:

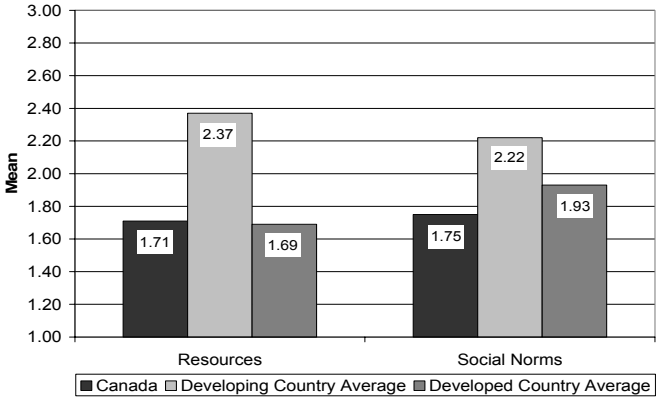
- Schools
- Community-based NGOs
- Courts/law enforcement

Very Involved:

- Hospitals/Medical Centers
- Mental Health Agencies
- Public social service agencies

BARRIERS

Average rating of limiting factors to CAN prevention,
(E.g. poverty, support for use of corporal punishment, etc)
(Scale: 1="Not important" to 3="Very significant")



CHILE

Region: Americas

Previous World Perspectives surveys completed: 1992, 2002

OFFICIAL RECORDS

Country maintains official count of CAN cases: YES

If yes, classifications included:

- ☑ Physical abuse
- ☑ Sexual abuse
- ☑ Psychological maltreatment
- ☑ Neglect

SERVICES

Services available, and capacity of these services to reach all families involved or at risk of abuse.

Adequate in ***Less Than*** *1/3* of Country:

- Therapy programs for physical abusers and sexual abusers

Adequate in ***1/3 to 2/3*** of Country:

- Therapy programs for child victims of physical abuse and sexual abuse
- Substance abuse treatments for parents

Adequate in ***More Than*** *2/3* of Country:

- Case management services/meeting basic needs
- Universal home visits for all new parents
- Targeted home visits for new parents at-risk
- Free child care
- Universal health screening for child
- Universal access to free medical care for child

Available (Adequacy Unknown):

- Foster care with official foster parents
- Institutional care for abused children
- Substance abuse treatments for children

Unavailable:

- Home-based services to assist parents in changing their behaviors
- Group homes for abused children
- Financial and material support
- Short-term hospitalization for mental illness
- Family Resource Centers for parents to share experiences/concerns
- Universal access to free medical care for all citizens

FUNDING

Activity level of sectors in funding child abuse treatment or prevention services.

	Major	Limited	None	Unknown
Int'l NGOs		◆		
Int'l Relief Organizations		◆		
National Government	◆			
State/Local Government		◆		
Private foundations		◆		
Individuals			◆	
Businesses				◆

POLICY

Official government law or policy regarding child abuse and neglect? YES

If yes, date established: Between 1990-2000

Core Elements

- Mandated reporting of suspected child abuse for specific groups of professionals
- Victims receive some form of service/intervention
- Attorney assigned to represent the child's interests
- Abusers receive some form of service/intervention

Enforcement Level: Inconsistently enforced

Level of Government Support: Inconsistently supported

RESEARCH (in past 10 years)

- Population-based surveys conducted to assess scope of problem: YES
- Public opinion polls to assess awareness: NO

SERVICE PROVIDERS

Relative involvement in child abuse treatment and prevention services.

Not Involved:

- NA

Minimally Involved:

- Religious institutions
- Voluntary civic organizations
- Businesses/Factories

Moderately Involved:

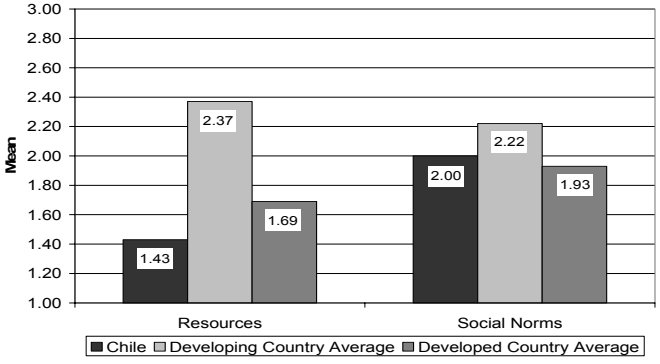
- Hospitals/Medical Centers
- Mental Health Agencies
- Schools/Universities
- Community-based NGOs

Very Involved:

- Public social service agencies
- Courts/law enforcement

BARRIERS

Average rating of limiting factors to CAN prevention, (E.g. poverty, support for use of corporal punishment, etc) (Scale: 1="Not important" to 3="Very significant")



CHINA

Region: Eastern Asia

Previous World Perspectives surveys completed: 1998, 2002, 2004

OFFICIAL RECORDS

Country maintains official count of CAN cases: YES

If yes, classifications included:

- ☑ Physical abuse
- ☑ Sexual abuse
- ☐ Psychological maltreatment
- ☐ Neglect

SERVICES

Services available, and capacity of these services to reach all families involved or at risk of abuse.

Available (Adequacy Unknown):

- Therapy programs for physical abusers
- Therapy programs for child victims of physical abuse and sexual abuse
- Financial and material support
- Short-term hospitalization for mental illness

Unavailable:

- Therapy programs for sexual abusers
- Case management services/meeting basic needs
- Home-based services to assist parents in changing their behaviors
- Foster care with official foster parents
- Group homes for abused children
- Institutional care for abused children
- Substance abuse treatments for children
- Substance abuse treatments for parents
- Family Resource Centers for parents to share experiences/concerns
- Universal home visits for all new parents
- Targeted home visits for new parents at-risk
- Free child care
- Universal health screening for child
- Universal access to free medical care for child
- Universal access to free medical care for all citizens

FUNDING

Activity level of sectors in funding child abuse treatment or prevention services.

	Major	Limited	None	Unknown
Int'l NGOs		◆		
Int'l Relief Organizations		◆		
National Government		◆		
State/Local Government		◆		
Private foundations		◆		
Individuals				◆
Businesses				◆

POLICY

Official government law or policy regarding child abuse and neglect? YES

If yes, date established: Before 1980

Core Elements

- Voluntary reporting of suspected abuse
- Victims receive some form of service/intervention
- Attorney assigned to represent the child's interests
- Abusers receive some form of service/intervention

Enforcement Level: Inconsistently enforced

Level of Government Support: Widely supported

RESEARCH (in past 10 years)

- Population-based surveys conducted to assess scope of problem: YES
- Public opinion polls to assess awareness: YES

SERVICE PROVIDERS

Relative involvement in child abuse treatment and prevention services.

Not Involved:

- NA

Minimally Involved:

- Voluntary civic organizations
- Businesses/Factories
- Universities

Moderately Involved:

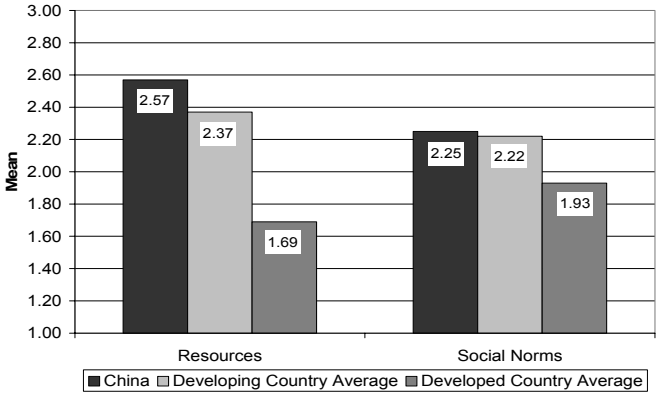
- Hospitals/Medical Centers
- Mental Health Agencies
- Public social service agencies
- Community-based NGOs
- Courts/law enforcement

Very Involved:

- NA

BARRIERS

Average rating of limiting factors to CAN prevention,
(E.g. poverty, support for use of corporal punishment, etc)
(Scale: 1="Not important" to 3="Very significant")



COLOMBIA

Region: Americas

Previous World Perspectives surveys completed: 1998, 2002, 2004

OFFICIAL RECORDS

Country maintains official count of CAN cases: YES

If yes, classifications included:

- ☑ Physical abuse
- ☑ Sexual abuse
- ☑ Psychological maltreatment
- ☑ Neglect

SERVICES

Services available, and capacity of these services to reach all families involved or at risk of abuse.

Adequate in ***Less Than** 1/3* of Country:

- Therapy programs for child victims of physical abuse and sexual abuse
- Therapy programs for sexual abusers
- Foster care with official foster parents
- Institutional care for abused children
- Group homes for abused children
- Financial and material support
- Short-term hospitalization for mental illness
- Substance abuse treatments for children

Adequate in ***1/3 to 2/3*** of Country:

- Universal health screening for child

Unavailable:

- Therapy programs for physical abusers
- Case management services/meeting basic needs
- Home-based services to assist parents in changing their behaviors
- Substance abuse treatments for parents
- Universal home visits for all new parents
- Targeted home visits for new parents at-risk
- Free child care
- Universal access to free medical care for child
- Universal access to free medical care for all citizens

FUNDING

Activity level of sectors in funding child abuse treatment or prevention services.

	Major	Limited	None	Unknown
Int'l NGOs		◆		
Int'l Relief Organizations		◆		
National Government	◆			
State/Local Government		◆		
Private foundations		◆		
Individuals			◆	
Businesses				◆

POLICY

Official government law or policy regarding child abuse and neglect? YES

If yes, date established: Between 1980-1989

Core Elements

- Mandated reporting of suspected child abuse for specific groups of professionals
- Victims receive some form of service/intervention
- Attorney assigned to represent the child's interests
- Criminal penalties for abusing a child

Enforcement Level: Inconsistently enforced

Level of Government Support: Inconsistently supported

RESEARCH (in past 10 years)

- Population-based surveys conducted to assess scope of problem: YES
- Public opinion polls to assess awareness: YES

SERVICE PROVIDERS

Relative involvement in child abuse treatment and prevention services.

Not Involved:

- Public social service agencies

Minimally Involved:

- Hospitals/Medical Centers
- Mental Health Agencies
- Religious institutions
- Community-based NGOs
- Schools
- Courts/law enforcement

Moderately Involved:

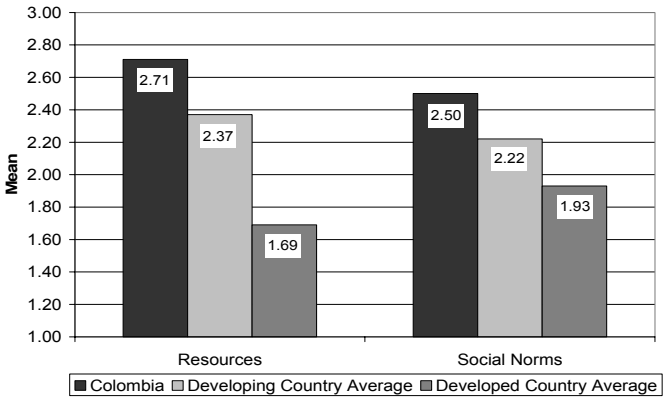
- Universities
- Voluntary civic organizations

Very Involved:

- Businesses/Factories

BARRIERS

Average rating of limiting factors to CAN prevention, (E.g. poverty, support for use of corporal punishment, etc) (Scale: 1="Not important" to 3="Very significant")



CONGO, DEM. REP OF

Region: Africa

Previous World Perspectives surveys completed: 2002, 2004

OFFICIAL RECORDS

Country maintains official count of CAN cases: YES

If yes, classifications included:

- ☑ Physical abuse
- ☑ Sexual abuse
- ☑ Psychological maltreatment
- ☑ Neglect

SERVICES

Services available, and capacity of these services to reach all families involved or at risk of abuse.

Adequate in ***Less Than*** *1/3* of Country:

- Therapy programs for physical abusers and sexual abusers
- Therapy programs for child victims of physical abuse and sexual abuse
- Financial and material support

Available (Adequacy Unknown):

- Institutional care for abused children
- Group homes for abused children

Unavailable:

- Home-based services to assist parents in changing their behaviors
- Case management services/meeting basic needs
- Foster care with official foster parents
- Short-term hospitalization for mental illness
- Substance abuse treatments for children
- Substance abuse treatments for parents
- Family Resource Centers for parents to share experiences/concerns
- Universal home visits for all new parents
- Universal access to free medical care for all citizens
- Universal health screening for child
- Universal access to free medical care for child
- Targeted home visits for new parents at-risk

FUNDING

Activity level of sectors in funding child abuse treatment or prevention services.

	Major	Limited	None	Unknown
Int'l NGOs	◆			
Int'l Relief Organizations	◆			
National Government		◆		
State/Local Government			◆	
Private foundations		◆		
Individuals			◆	
Businesses		◆		

POLICY

Official government law or policy regarding child abuse and neglect? YES

If yes, date established: Between 1990-2000

Core Elements

- Mandated reporting of suspected child abuse for specific groups of professionals
- Victims receive some form of service/intervention
- Attorney assigned to represent the child's interests
- Criminal penalties for abusing a child

Enforcement Level: Inconsistently enforced

Level of Government Support: Inconsistently supported

RESEARCH (in past 10 years)

- Population-based surveys conducted to assess scope of problem: YES
- Public opinion polls to assess awareness: YES

SERVICE PROVIDERS

Relative involvement in child abuse treatment and prevention services.

Not Involved:

- NA

Minimally Involved:

- Public social service agencies
- Community-based NGOs

Moderately Involved:

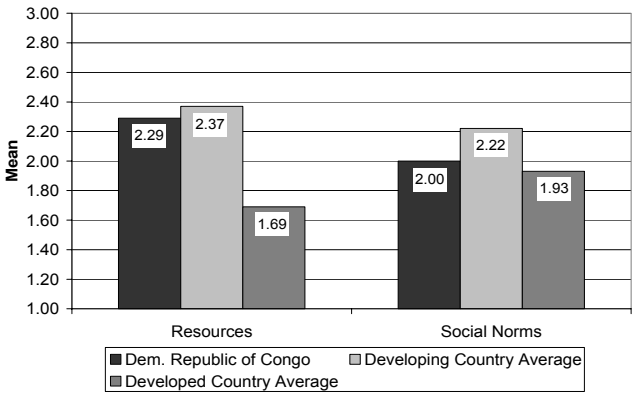
- Hospitals/Medical Centers
- Religious institutions
- Voluntary civic organizations
- Courts/law enforcement
- Universities

Very Involved:

- Mental Health Agencies

BARRIERS

Average rating of limiting factors to CAN prevention, (E.g. poverty, support for use of corporal punishment, etc) (Scale: 1="Not important" to 3="Very significant")



COTE D'IVOIRE

Region: Africa

Previous World Perspectives surveys completed: 2002, 2004

OFFICIAL RECORDS

Country maintains official count of CAN cases: NO

If yes, classifications included:

- ☐ Physical abuse
- ☐ Sexual abuse
- ☐ Psychological maltreatment
- ☐ Neglect

SERVICES

Services available, and capacity of these services to reach all families involved or at risk of abuse.

Adequate in ***Less Than*** *1/3* of Country:

- Therapy programs for child victims of physical abuse and sexual abuse
- Financial and material support
- Institutional care for abused children
- Group homes for abused children
- Short-term hospitalization for mental illness
- Substance abuse treatments for children
- Universal access to free medical care for all citizens
- Universal health screening for child
- Universal access to free medical care for child

Adequate in ***1/3 to 2/3*** of Country:

- Substance abuse treatments for parents

Available (Adequacy Unknown):

Unavailable:

- Therapy programs for physical abusers and sexual abusers
- Home-based services to assist parents in changing their behaviors
- Case management services/meeting basic needs
- Foster care with official foster parents
- Targeted home visits for new parents at-risk
- Family Resource Centers for parents to share experiences/concerns
- Universal home visits for all new parents

FUNDING

Activity level of sectors in funding child abuse treatment or prevention services.

	Major	Limited	None	Unknown
Int'l NGOs	◆			
Int'l Relief Organizations	◆			
National Government				◆
State/Local Government		◆		
Private foundations		◆		
Individuals			◆	
Businesses		◆		

POLICY

Official government law or policy regarding child abuse and neglect? YES

If yes, date established: Between 1990-2000

Core Elements

- Victims receive some form of service/intervention
- Attorney assigned to represent the child's interests
- Criminal penalties for abusing a child

Enforcement Level: Inconsistently enforced

Level of Government Support: Inconsistently supported

RESEARCH (in past 10 years)

- Population-based surveys conducted to assess scope of problem: YES
- Public opinion polls to assess awareness: YES

SERVICE PROVIDERS

Relative involvement in child abuse treatment and prevention services.

Not Involved:

- Hospitals/Medical Centers

Minimally Involved:

- Schools/Universities

Moderately Involved:

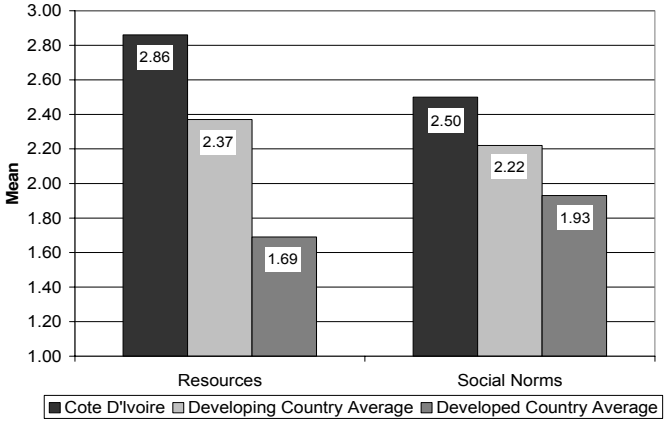
- Public social service agencies
- Religious institutions
- Voluntary civic organizations

Very Involved:

- Mental Health Agencies
- Courts/law enforcement
- Community-based NGOs

BARRIERS

Average rating of limiting factors to CAN prevention, (E.g. poverty, support for use of corporal punishment, etc) (Scale: 1="Not important" to 3="Very significant")



DENMARK

Region: Europe

Previous World Perspectives surveys completed: 1996, 1998, 2000, 2002, 2004

OFFICIAL RECORDS

Country maintains official count of CAN cases: NO

If yes, classifications included:

- ☐ Physical abuse
- ☐ Sexual abuse
- ☐ Psychological maltreatment
- ☐ Neglect

SERVICES

Services available, and capacity of these services to reach all families involved or at risk of abuse.

Adequate in ***Less Than*** *1/3* of Country:

- Therapy programs for sexual abusers

Adequate in ***1/3 to 2/3*** of Country:

- Therapy programs for child victims of physical abuse

Adequate in ***More Than*** *2/3* of Country:

- Therapy programs for physical abusers
- Therapy programs for child victims of sexual abuse
- Case management services/meeting basic needs
- Home-based services to assist parents in changing their behaviors
- Foster care with official foster parents
- Group homes for abused children
- Institutional care for abused children
- Universal home visits for all new parents
- Targeted home visits for new parents at-risk
- Free child care
- Universal health screening for child
- Universal access to free medical care for child
- Substance abuse treatments for children
- Financial and material support
- Short-term hospitalization for mental illness
- Family Resource Centers for parents to share experiences/concerns
- Universal access to free medical care for all citizens
- Substance abuse treatments for parents

FUNDING

Activity level of sectors in funding child abuse treatment or prevention services.

	Major	Limited	None	Unknown
Int'l NGOs		◆		
Int'l Relief Organizations		◆		
National Government	◆			
State/Local Government	◆			
Private foundations		◆		
Individuals		◆		
Businesses			◆	

POLICY

Official government law or policy regarding child abuse and neglect? YES

If yes, date established: Before 1980

Core Elements

- Mandated reporting of suspected child abuse for specific groups of professionals
- Victims receive some form of service/intervention
- Attorney assigned to represent the child's interests
- Abusers receive some form of service/intervention

Enforcement Level: Widely enforced

Level of Government Support: Widely supported

RESEARCH (in past 10 years)

- Population-based surveys conducted to assess scope of problem: YES
- Public opinion polls to assess awareness: NO

SERVICE PROVIDERS

Relative involvement in child abuse treatment and prevention services.

Not Involved:

- Businesses/Factories

Moderately Involved:

- Universities/Schools
- Voluntary civic organizations

Minimally Involved:

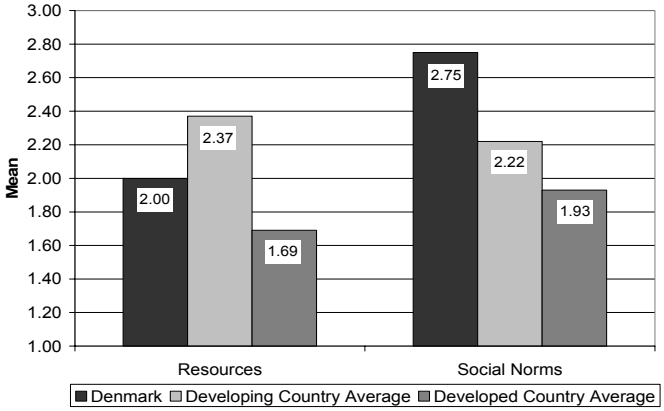
- Community-based NGOs

Very Involved:

- Hospitals/Medical Centers
- Mental Health Agencies
- Public social service agencies
- Courts/law enforcement

BARRIERS

Average rating of limiting factors to CAN prevention, (E.g. poverty, support for use of corporal punishment, etc) (Scale: 1="Not important" to 3="Very significant")



EGYPT

Region: Africa

Previous World Perspectives surveys completed: 2002, 2004

OFFICIAL RECORDS

Country maintains official count of CAN cases: YES

If yes, classifications included: NA

- ☐ Physical abuse
- ☐ Sexual abuse
- ☐ Psychological maltreatment
- ☐ Neglect

SERVICES

Services available, and capacity of these services to reach all families involved or at risk of abuse.

Adequate in ***Less Than*** *1/3* of Country:

- Short-term hospitalization for mental illness
- Substance abuse treatments for parents
- Substance abuse treatments for children

Adequate in ***1/3 to 2/3*** of Country:

- Foster care with official foster parents
- Group homes for abused children
- Institutional care for abused children

Adequate in ***More Than*** *2/3* of Country:

- Therapy programs for child victims of physical abuse
- Therapy programs for physical abusers
- Universal health screening for child
- Universal access to free medical care for child
- Universal access to free medical care for all citizens

Unavailable:

- Therapy programs for sexual abusers
- Therapy programs for child victims of sexual abuse

FUNDING

Activity level of sectors in funding child abuse treatment or prevention services.

	Major	Limited	None	Unknown
Int'l NGOs	◆			
Int'l Relief Organizations			◆	
National Government		◆		
State/Local Government		◆		
Private foundations			◆	
Individuals			◆	
Businesses				◆

POLICY

Official government law or policy regarding child abuse and neglect? YES

If yes, date established: Between 1990-2000

Core Elements

- Mandated reporting of suspected child abuse for specific groups of professionals
- Victims receive some form of service/intervention
- Attorney assigned to represent the child's interests
- Abusers receive some form of service/intervention

Enforcement Level: Inconsistently enforced

Level of Government Support: Inconsistently supported

RESEARCH (in past 10 years)

- Population-based surveys conducted to assess scope of problem: YES
- Public opinion polls to assess awareness: YES

SERVICE PROVIDERS

Relative involvement in child abuse treatment and prevention services.

Not Involved:

- Businesses/Factories
- Universities

Minimally Involved:

- Mental Health Agencies
- Schools
- Public social service agencies
- Religious institutions
- Courts/law enforcement

Moderately Involved:

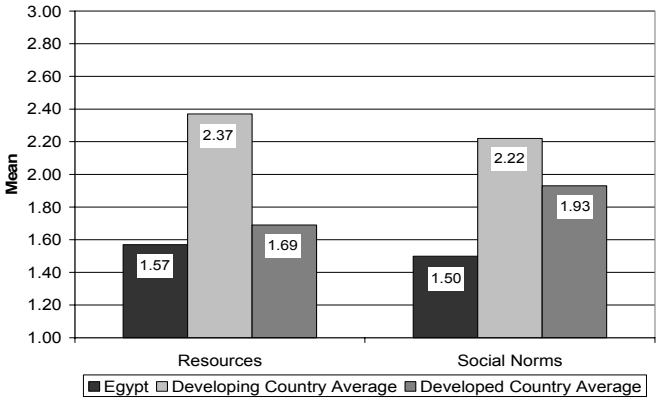
- Hospitals/Medical Centers
- Community-based NGOs
- Voluntary civic organizations

Very Involved:

- NA

BARRIERS

Average rating of limiting factors to CAN prevention, (E.g. poverty, support for use of corporal punishment, etc) (Scale: 1="Not important" to 3="Very significant")



ENGLAND

Region: Europe

Previous World Perspectives surveys completed:
1992, 1996, 1998, 2000, 2002, 2004

OFFICIAL RECORDS

Country maintains official count of CAN cases: YES

If yes, classifications included:

- ☑ Physical abuse
- ☑ Sexual abuse
- ☑ Psychological maltreatment
- ☑ Neglect

SERVICES

Services available, and capacity of these services to reach all families involved or at risk of abuse.

Adequate in ***Less Than*** *1/3* of Country:

- Therapy programs for physical abusers and sexual abusers
- Therapy programs for child victims of physical abuse and sexual abuse
- Home-based services to assist parents in changing their behaviors
- Foster care with official foster parents
- Institutional care for abused children
- Group homes for abused children
- Family Resource Centers for parents to share experiences/concerns

Adequate in ***1/3 to 2/3*** of Country:

- Substance abuse treatments for children
- Targeted home visits for new parents at-risk

Adequate in ***More Than*** *2/3* of Country:

- Case management services/meeting basic needs
- Financial and material support
- Short-term hospitalization for mental illness
- Substance abuse treatments for parents
- Universal home visits for all new parents
- Universal health screening for child
- Universal access to free medical care for child
- Universal access to free medical care for all citizens

FUNDING

Activity level of sectors in funding child abuse treatment or prevention services.

	Major	Limited	None	Unknown
Int'l NGOs				◆
Int'l Relief Organizations				◆
National Government	◆			
State/Local Government	◆			
Private foundations		◆		
Individuals				◆
Businesses			◆	

POLICY

Official government law or policy regarding child abuse and neglect? YES

If yes, date established: Before 1980

Core Elements

- Mandated reporting of suspected child abuse for specific groups of professionals
- Attorney assigned to represent the child's interests
- Criminal penalsties for abusing a child

Enforcement Level: Widely enforced

Level of Government Support: Widely supported

RESEARCH (in past 10 years)

- Population-based surveys conducted to assess scope of problem: YES
- Public opinion polls to assess awareness: YES

SERVICE PROVIDERS

Relative involvement in child abuse treatment and prevention services.

Not Involved:

- Businesses/Factories
- Universities

Minimally Involved:

- Religious institutions
- Voluntary civic organizations
- Community-based NGOs

Moderately Involved:

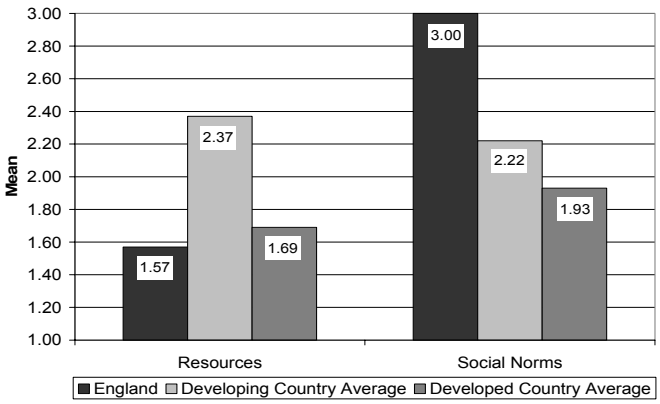
- Courts/law enforcement
- Mental Health Agencies

Very Involved:

- Hospitals/Medical Centers
- Public social service agencies
- Schools

BARRIERS

Average rating of limiting factors to CAN prevention,
(E.g. poverty, support for use of corporal punishment, etc)
(Scale: 1="Not important" to 3="Very significant")



ESTONIA

Region: Europe

Previous World Perspectives surveys completed: 1996, 2000, 2002, 2004

OFFICIAL RECORDS

Country maintains official count of CAN cases: NO

If yes, classifications included:

- ☐ Physical abuse
- ☐ Sexual abuse
- ☐ Psychological maltreatment
- ☐ Neglect

SERVICES

Services available, and capacity of these services to reach all families involved or at risk of abuse.

Adequate in ***Less Than*** *1/3* of Country:

- Home-based services to assist parents in changing their behaviors
- Foster care with official foster parents
- Institutional care for abused children
- Financial and material support
- Short-term hospitalization for mental illness
- Substance abuse treatments for children
- Targeted home visits for new parents at-risk

Adequate in ***1/3 to 2/3*** of Country:

- Universal health screening for child
- Universal access to free medical care for all citizens

Adequate in ***More Than*** *2/3* of Country:

- Universal home visits for all new parents
- Universal access to free medical care for child

Unavailable:

- Therapy programs for physical abusers and sexual abusers
- Therapy programs for child victims of physical abuse and sexual abuse
- Case management services/meeting basic needs
- Group homes for abused children
- Substance abuse treatments for parents
- Free child care
- Family Resource Centers for parents to share experiences/concerns

FUNDING

Activity level of sectors in funding child abuse treatment or prevention services.

	Major	Limited	None	Unknown
Int'l NGOs		◆		
Int'l Relief Organizations		◆		
National Government		◆		
State/Local Government		◆		
Private foundations			◆	
Individuals			◆	
Businesses			◆	

POLICY

Official government law or policy regarding child abuse and neglect? YES

If yes, date established: After 2000

Core Elements

- Mandated reporting of suspected child abuse for specific groups of professionals
- Attorney assigned to represent the child's interests
- Criminal penalties for abusing a child

Enforcement Level: Widely enforced

Level of Government Support: Inconsistently supported

RESEARCH (in past 10 years)

- Population-based surveys conducted to assess scope of problem: YES
- Public opinion polls to assess awareness: NO

SERVICE PROVIDERS

Relative involvement in child abuse treatment and prevention services.

Not Involved:

- Courts/law enforcement

Minimally Involved:

- Religious institutions
- Voluntary civic organizations
- Businesses/Factories

Moderately Involved:

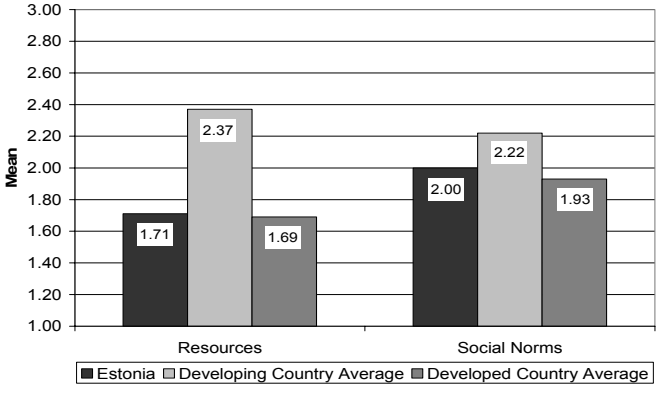
- Hospitals/Medical Centers
- Mental Health Agencies
- Schools/Universities

Very Involved:

- Public social service agencies
- Community-based NGOs

BARRIERS

Average rating of limiting factors to CAN prevention, (E.g. poverty, support for use of corporal punishment, etc) (Scale: 1="Not important" to 3="Very significant")



ETHIOPIA

Region: Africa

Previous World Perspectives surveys completed: None

OFFICIAL RECORDS

Country maintains official count of CAN cases: NO

If yes, classifications included:

- ☐ Physical abuse
- ☐ Sexual abuse
- ☐ Psychological maltreatment
- ☐ Neglect

SERVICES

Services available, and capacity of these services to reach all families involved or at risk of abuse.

Adequate in ***Less Than*** *1/3* of Country:

- Therapy programs for child victims of physical abuse and sexual abuse
- Financial and material support

FUNDING

Activity level of sectors in funding child abuse treatment or prevention services.

	Major	Limited	None	Unknown
Int'l NGOs	◆			
Int'l Relief Organizations		◆		
National Government				◆
State/Local Government				◆
Private foundations				◆
Individuals				◆
Businesses				◆

POLICY

Official government law or policy regarding child abuse and neglect? YES

If yes, date established: Before 1980

Core Elements

- Mandated reporting of suspected child abuse for specific groups of professionals
- Attorney assigned to represent the child's interests
- Criminal penalties for abusing a child

Enforcement Level: Inconsistently enforced

Level of Government Support: NA

RESEARCH (in past 10 years)

- Population-based surveys conducted to assess scope of problem: NO
- Public opinion polls to assess awareness: NO

SERVICE PROVIDERS

Relative involvement in child abuse treatment and prevention services.

Not Involved:

- NA

Minimally Involved:

- NA

Moderately Involved:

- Hospitals/Medical Centers
- Courts/law enforcement
- Community-based NGOs
- Voluntary civic organizations
- Businesses/Factories

Very Involved:

- NA

BARRIERS

Average rating of limiting factors to CAN prevention, (E.g. poverty, support for use of corporal punishment, etc) (Scale: 1="Not important" to 3="Very significant")

- NA

FINLAND

Region: Europe

Previous World Perspectives surveys completed: 1992, 1996, 2000

OFFICIAL RECORDS

Country maintains official count of CAN cases: NO

If yes, classifications included:

- ☐ Physical abuse
- ☐ Sexual abuse
- ☐ Psychological maltreatment
- ☐ Neglect

SERVICES

Services available, and capacity of these services to reach all families involved or at risk of abuse.

Adequate in ***Less Than*** *1/3* of Country:

- Therapy programs for physical abusers and sexual abusers
- Institutional care for abused children

Adequate in ***1/3 to 2/3*** of Country:

- Therapy programs for child victims of sexual abuse
- Case management services/meeting basic needs
- Group homes for abused children
- Substance abuse treatments for parents
- Substance abuse treatments for children
- Family Resource Centers for parents to share experiences/concerns

Adequate in ***More Than*** *2/3* of Country:

- Therapy programs for child victims of physical abuse
- Home-based services to assist parents in changing their behaviors
- Foster care with official foster parents
- Financial and material support
- Short-term hospitalization for mental illness
- Universal home visits for all new parents
- Targeted home visits for new parents at-risk
- Universal access to free medical care for child

Available (Adequacy Unknown):

- Free child care
- Universal health screening for child

Unavailable

- Universal access to free medical care for all citizens

FUNDING

Activity level of sectors in funding child abuse treatment or prevention services.

	Major	Limited	None	Unknown
Int'l NGOs			◆	
Int'l Relief Organizations			◆	
National Government	◆			
State/Local Government	◆			
Private foundations		◆		
Individuals		◆		
Businesses			◆	

POLICY

Official government law or policy regarding child abuse and neglect? YES

If yes, date established: Before 1980

Core Elements

- Mandated reporting of suspected child abuse for specific groups of professionals
- All victims receive some form of service/intervention

Enforcement Level: Widely enforced

Level of Government Support: Widely supported

RESEARCH (in past 10 years)

- Population-based surveys conducted to assess scope of problem: NO
- Public opinion polls to assess awareness: NO

SERVICE PROVIDERS

Relative involvement in child abuse treatment and prevention services.

Not Involved:

- NA

Minimally Involved:

- Voluntary civic organizations
- Businesses/Factories
- Universities

Moderately Involved:

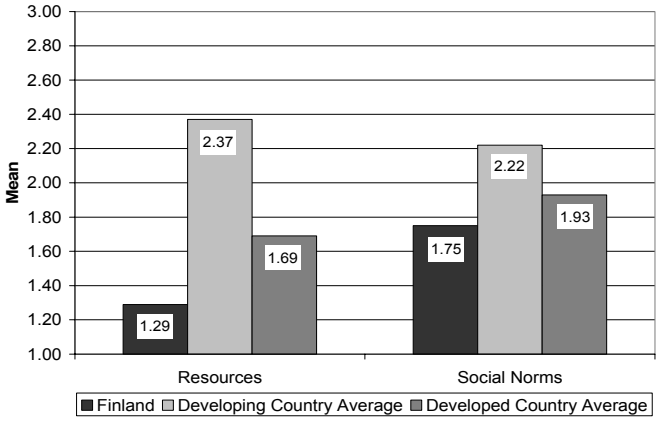
- Community-based NGOs
- Religious institutions
- Schools

Very Involved:

- Hospitals/Medical Centers
- Mental Health Agencies
- Public social service agencies
- Courts/law enforcement

BARRIERS

Average rating of limiting factors to CAN prevention,
(E.g. poverty, support for use of corporal punishment, etc)
(Scale: 1="Not important" to 3="Very significant")



FRANCE

Region: Europe

Previous World Perspectives surveys completed:
1992, 1996, 1998, 2000, 2002, 2004

OFFICIAL RECORDS

Country maintains official count of CAN cases: YES

If yes, classifications included:

- ☑ Physical abuse
- ☑ Sexual abuse
- ☑ Psychological maltreatment
- ☑ Neglect

SERVICES

Services available, and capacity of these services to reach all families involved or at risk of abuse.

Adequate in ***Less Than** 1/3* of Country:

- Therapy programs for physical abusers
- Substance abuse treatments for children

Adequate in ***1/3 to 2/3*** of Country:

- Therapy programs for child victims of physical abuse and sexual abuse
- Family Resource Centers for parents to share experiences/concerns
- Universal home visits for all new parents
- Targeted home visits for new parents at-risk

Adequate in ***More Than** 2/3* of Country:

- Case management services/meeting basic needs
- Home-based services to assist parents in changing their behaviors
- Foster care with official foster parents
- Group homes for abused children
- Institutional care for abused children
- Financial and material support
- Short-term hospitalization for mental illness
- Substance abuse treatments for parents
- Free child care
- Universal health screening for child
- Universal access to free medical care for child
- Universal access to free medical care for all citizens

Unavailable:

- Therapy programs for sexual abusers

FUNDING

Activity level of sectors in funding child abuse treatment or prevention services.

	Major	Limited	None	Unknown
Int'l NGOs			◆	
Int'l Relief Organizations			◆	
National Government	◆			
State/Local Government	◆			
Private foundations		◆		
Individuals		◆		
Businesses			◆	

POLICY

Official government law or policy regarding child abuse and neglect? YES

If yes, date established: Before 1980

Core Elements

- Mandated reporting of suspected child abuse for specific groups of professionals
- All victims receive some form of service/intervention
- Criminal penalties for abusing a child

Enforcement Level: Widely enforced

Level of Government Support: Widely supported

RESEARCH (in past 10 years)

- Population-based surveys conducted to assess scope of problem: YES
- Public opinion polls to assess awareness: NO

SERVICE PROVIDERS

Relative involvement in child abuse treatment and prevention services.

Not Involved:

- Businesses/Factories

Minimally Involved:

- Voluntary civic organizations

Moderately Involved:

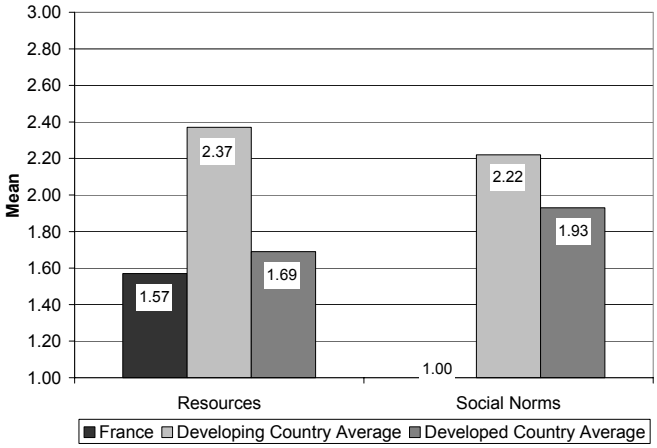
- Mental Health Agencies
- Community-based NGOs
- Religious institutions
- Universities

Very Involved:

- Hospitals/Medical Centers
- Courts/law enforcement
- Public social service agencies
- Schools

BARRIERS

Average rating of limiting factors to CAN prevention,
(E.g. poverty, support for use of corporal punishment, etc)
(Scale: 1="Not important" to 3="Very significant")



GEORGIA

Region: Western Asia

Previous World Perspectives surveys completed: 2004

OFFICIAL RECORDS

Country maintains official count of CAN cases: NO

If yes, classifications included:

- ☐ Physical abuse
- ☐ Sexual abuse
- ☐ Psychological maltreatment
- ☐ Neglect

SERVICES

Services available, and capacity of these services to reach all families involved or at risk of abuse.

Adequate in ***Less Than*** *1/3* of Country:

- Therapy programs for child victims of physical abuse and sexual abuse
- Case management services/meeting basic needs
- Home-based services to assist parents in changing their behaviors
- Short-term hospitalization for mental illness
- Substance abuse treatments for parents

Adequate in ***1/3 to 2/3*** of Country:

- Foster care with official foster parents
- Universal health screening for child

Unavailable:

- Therapy programs for sexual abusers and physical abusers
- Group homes for abused children
- Institutional care for abused children
- Financial and material support
- Substance abuse treatments for children
- Family Resource Centers for parents to share experiences/concerns
- Universal home visits for all new parents
- Targeted home visits for new parents at-risk
- Free child care
- Universal access to free medical care for child
- Universal access to free medical care for all citizens

FUNDING

Activity level of sectors in funding child abuse treatment or prevention services.

	Major	Limited	None	Unknown
Int'l NGOs	◆			
Int'l Relief Organizations			◆	
National Government			◆	
State/Local Government			◆	
Private foundations			◆	
Individuals			◆	
Businesses			◆	

POLICY

Official government law or policy regarding child abuse and neglect? NO

If yes, date established: NA

Core Elements

- NA

Enforcement Level: NA

Level of Government Support: NA

RESEARCH (in past 10 years)

- Population-based surveys conducted to assess scope of problem: NO
- Public opinion polls to assess awareness: NO

SERVICE PROVIDERS

Relative involvement in child abuse treatment and prevention services.

Not Involved:

- Public social service agencies
- Schools/Universities
- Religious institutions
- Voluntary civic organizations
- Businesses/Factories

Minimally Involved:

- Hospitals/Medical Centers
- Mental Health Agencies
- Courts/law enforcement

Moderately Involved:

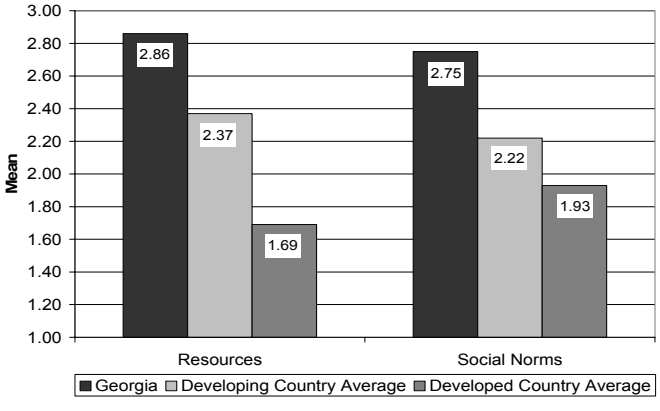
- Community-based NGOs

Very Involved:

- NA

BARRIERS

Average rating of limiting factors to CAN prevention, (E.g. poverty, support for use of corporal punishment, etc) (Scale: 1="Not important" to 3="Very significant")



GERMANY

Region: Europe

Previous World Perspectives surveys completed:
1992, 1996, 1998, 2000, 2002, 2004

OFFICIAL RECORDS

Country maintains official count of CAN cases: YES

If yes, classifications included:

- ☑ Physical abuse
- ☑ Sexual abuse
- ☐ Psychological maltreatment
- ☐ Neglect

SERVICES

Services available, and capacity of these services to reach all families involved or at risk of abuse.

Adequate in ***More Than** 2/3* of Country:

- Therapy programs for child victims of physical abuse and sexual abuse
- Therapy programs for physical abusers and sexual abusers
- Case management services/meeting basic needs
- Home-based services to assist parents in changing their behaviors
- Foster care with official foster parents
- Group homes for abused children
- Institutional care for abused children
- Financial and material support
- Short-term hospitalization for mental illness
- Substance abuse treatments for parents
- Substance abuse treatments for children
- Family Resource Centers for parents to share experiences/concerns
- Universal home visits for all new parents
- Targeted home visits for new parents at-risk
- Free child care
- Universal health screening for child
- Universal access to free medical care for child
- Universal access to free medical care for all citizens

FUNDING

Activity level of sectors in funding child abuse treatment or prevention services.

	Major	Limited	None	Unknown
Int'l NGOs		◆		
Int'l Relief Organizations		◆		
National Government		◆		
State/Local Government				◆
Private foundations		◆		
Individuals		◆		
Businesses		◆		

POLICY

Official government law or policy regarding child abuse and neglect? YES

If yes, date established: Before 1980

Core Elements

- Voluntary reporting of suspected child abuse by any professional or individual
- All abusers receive some form of service/intervention
- Criminal penalties for abusing a child

Enforcement Level: Widely enforced

Level of Government Support: Widely supported

RESEARCH (in past 10 years)

- Population-based surveys conducted to assess scope of problem: YES
- Public opinion polls to assess awareness: NO

SERVICE PROVIDERS

Relative involvement in child abuse treatment and prevention services.

Not Involved:
- NA

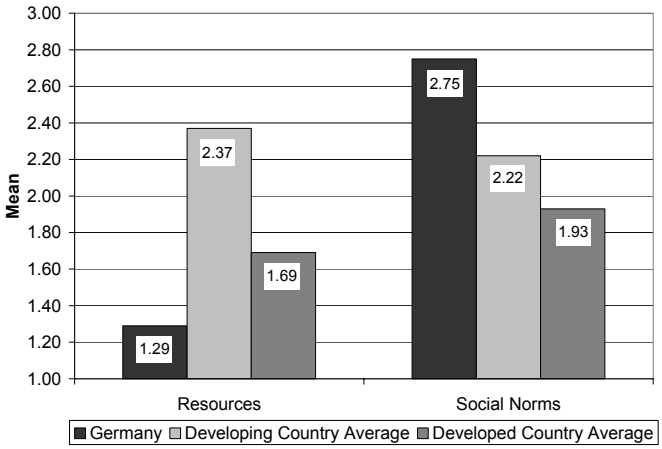
Minimally Involved:
- NA

Moderately Involved:
- NA

Very Involved:
- NA

BARRIERS

Average rating of limiting factors to CAN prevention,
(E.g. poverty, support for use of corporal punishment, etc)
(Scale: 1="Not important" to 3="Very significant")



GREECE

Region: Europe

Previous World Perspectives surveys completed:
1992, 1996, 1998, 2000, 2002

OFFICIAL RECORDS

Country maintains official count of CAN cases: NO

If yes, classifications included:

- ☐ Physical abuse
- ☐ Sexual abuse
- ☐ Psychological maltreatment
- ☐ Neglect

SERVICES

Services available, and capacity of these services to reach all families involved or at risk of abuse.

Adequate in ***Less Than*** *1/3* of Country:

- Therapy programs for child victims of physical abuse and sexual abuse
- Home-based services to assist parents in changing their behaviors
- Foster care with official foster parents
- Financial and material support
- Substance abuse treatments for children
- Substance abuse treatments for parents
- Free child care

Adequate in ***1/3 to 2/3*** of Country:

- Short-term hospitalization for mental illness
- Universal health screening for child
- Universal access to free medical care for child
- Universal access to free medical care for all citizens

Unavailable:

- Therapy programs for sexual abusers and physical abusers
- Case management services/meeting basic needs
- Group homes for abused children
- Institutional care for abused children
- Family Resource Centers for parents to share experiences/concerns
- Universal home visits for all new parents
- Targeted home visits for new parents at-risk

FUNDING

Activity level of sectors in funding child abuse treatment or prevention services.

	Major	Limited	None	Unknown
Int'l NGOs		◆		
Int'l Relief Organizations		◆		
National Government		◆		
State/Local Government		◆		
Private foundations			◆	
Individuals			◆	
Businesses			◆	

POLICY

Official government law or policy regarding child abuse and neglect? NO*

If yes, date established: NA

Core Elements

- NA

Enforcement Level: NA

Level of Government Support: NA

RESEARCH (in past 10 years)

- Population-based surveys conducted to assess scope of problem: NO
- Public opinion polls to assess awareness: NO

SERVICE PROVIDERS

Relative involvement in child abuse treatment and prevention services.

Not Involved:

- Businesses/Factories

Minimally Involved:

- Religious institutions
- Courts/law enforcement

Moderately Involved:

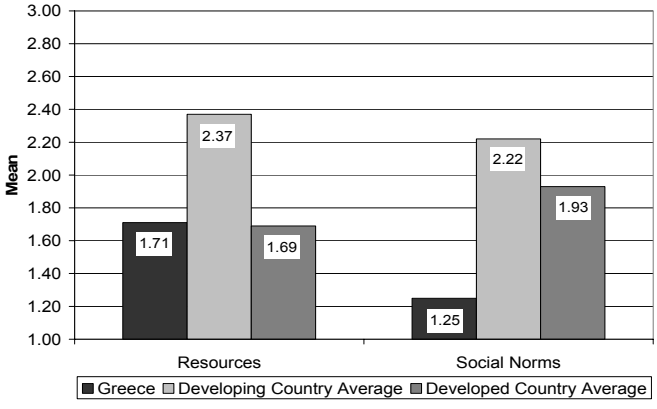
- Voluntary civic organizations
- Community-based NGOs
- Universities

Very Involved:

- Hospitals/Medical Centers
- Mental Health Agencies
- Public social service agencies
- Schools

BARRIERS

Average rating of limiting factors to CAN prevention,
(E.g. poverty, support for use of corporal punishment, etc)
(Scale: 1="Not important" to 3="Very significant")



* While there is no National Child Protection Plan in Greece, cases of child abuse are addressed within the framework of criminal, civil and family legislation.

HONDURAS

Region: Americas

Previous World Perspectives surveys completed: None

OFFICIAL RECORDS

Country maintains official count of CAN cases: YES

If yes, classifications included:

- ☑ Physical abuse
- ☑ Sexual abuse
- ☐ Psychological maltreatment
- ☑ Neglect

SERVICES

Services available, and capacity of these services to reach all families involved or at risk of abuse.

Adequate in ***Less Than*** *1/3* of Country:

- Foster care with official foster parents

Adequate in ***More Than*** *2/3* of Country:

- Short-term hospitalization for mental illness
- Universal access to free medical care for child
- Universal access to free medical care for all citizens

Unavailable:

- Therapy programs for sexual abusers and physical abusers
- Therapy programs for child victims of physical abuse and sexual abuse
- Home-based services to assist parents in changing their behaviors
- Financial and material support
- Substance abuse treatments for children
- Substance abuse treatments for parents
- Free child care
- Case management services/meeting basic needs
- Group homes for abused children
- Institutional care for abused children
- Family Resource Centers for parents to share experiences/concerns
- Universal health screening for child
- Universal home visits for all new parents
- Targeted home visits for new parents at-risk

FUNDING

Activity level of sectors in funding child abuse treatment or prevention services.

	Major	Limited	None	Unknown
Int'l NGOs		◆		
Int'l Relief Organizations				◆
National Government		◆		
State/Local Government			◆	
Private foundations				◆
Individuals				◆
Businesses				◆

POLICY

Official government law or policy regarding child abuse and neglect? YES

If yes, date established: Between 1990-2000

Core Elements

- Mandated reporting of suspected child abuse for specific groups of professionals
- Victims receive some form of service/intervention
- Attorney assigned to represent the child's interests
- Criminal penalties for abusing a child

Enforcement Level: Inconsistently enforced

Level of Government Support: Inconsistently supported

RESEARCH (in past 10 years)

- Population-based surveys conducted to assess scope of problem: YES
- Public opinion polls to assess awareness: NO

SERVICE PROVIDERS

Relative involvement in child abuse treatment and prevention services.

Not Involved:

- NA

Minimally Involved:

- Universities

Moderately Involved:

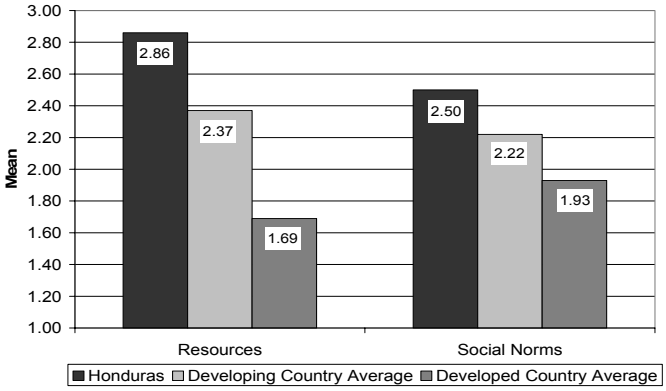
- Hospitals/Medical Centers
- Mental Health Agencies
- Public social service agencies
- Community-based NGOs
- Religious institutions
- Courts/law enforcement

Very Involved:

- Voluntary civic organizations

BARRIERS

Average rating of limiting factors to CAN prevention,
(E.g. poverty, support for use of corporal punishment, etc)
(Scale: 1="Not important" to 3="Very significant")



HONG KONG, SARC*

Region: Eastern Asia

Previous World Perspectives surveys completed: 1996, 1998, 2000, 2002, 2004

OFFICIAL RECORDS

Country maintains official count of CAN cases: YES

If yes, classifications included:

- ☑ Physical abuse
- ☑ Sexual abuse
- ☑ Psychological maltreatment
- ☑ Neglect

SERVICES

Services available, and capacity of these services to reach all families involved or at risk of abuse.

Adequate in ***Less Than*** *1/3* of Country:

- Therapy programs for child victims of physical abuse and sexual abuse
- Therapy programs for physical abusers and sexual abusers
- Case management services/meeting basic needs
- Substance abuse treatments for children
- Substance abuse treatments for parents

Adequate in ***1/3 to 2/3*** of Country:

- Foster care with official foster parents
- Group homes for abused children
- Institutional care for abused children
- Financial and material support

Adequate in ***More Than*** *2/3* of Country:

- Short-term hospitalization for mental illness
- Universal health screening for child

Available (Adequacy Unknown):

- Universal access to free medical care for child

Unavailable:

- Home-based services to assist parents in changing their behaviors
- Family Resource Centers for parents to share experiences/concerns
- Universal home visits for all new parents
- Targeted home visits for new parents at-risk
- Free child care
- Universal access to free medical care for all citizens

FUNDING

Activity level of sectors in funding child abuse treatment or prevention services.

	Major	Limited	None	Unknown
Int'l NGOs			◆	
Int'l Relief Organizations			◆	
National Government	◆			
State/Local Government	◆			
Private foundations	◆			
Individuals		◆		
Businesses		◆		

POLICY

Official government law or policy regarding child abuse and neglect? NO**

If yes, date established: NA

Core Elements: NA

Enforcement Level: NA

Level of Government Support: NA

RESEARCH (in past 10 years)

- Population-based surveys conducted to assess scope of problem: YES
- Public opinion polls to assess awareness: YES

SERVICE PROVIDERS

Relative involvement in child abuse treatment and prevention services.

Not Involved:

- NA

Moderately Involved:

- Mental Health Agencies
- Public social service agencies
- Voluntary civic organizations
- Religious institutions
- Universities
- Courts/law enforcement

Minimally Involved:

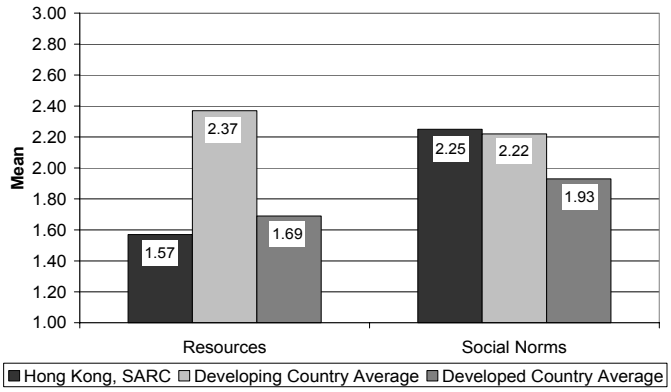
- Businesses/Factories

Very Involved:

- Hospitals/Medical Centers
- Schools
- Community-based NGOs

BARRIERS

Average rating of limiting factors to CAN prevention, (E.g. poverty, support for use of corporal punishment, etc) (Scale: 1="Not important" to 3="Very significant")



*Special Administrative Region of China

HUNGARY

Region: Europe

Previous World Perspectives surveys completed: 2000, 2002, 2004

OFFICIAL RECORDS

Country maintains official count of CAN cases: YES

If yes, classifications included:

- ☑ Physical abuse
- ☑ Sexual abuse
- ☑ Psychological maltreatment
- ☑ Neglect

SERVICES

Services available, and capacity of these services to reach all families involved or at risk of abuse.

Adequate in ***Less Than*** *1/3* of Country:

- Therapy programs for child victims of physical abuse and sexual abuse

Adequate in ***1/3 to 2/3*** of Country:

- Case management services/meeting basic needs
- Home-based services to assist parents in changing their behaviors
- Short-term hospitalization for mental illness

Adequate in ***More Than*** *2/3* of Country:

- Foster care with official foster parents
- Institutional care for abused children
- Financial and material support
- Substance abuse treatments for parents
- Universal home visits for all new parents
- Free child care
- Universal health screening for child
- Universal access to free medical care for child

Available (Adequacy Unknown):

- Substance abuse treatments for children

Unavailable:

- Therapy programs for sexual abusers and physical abusers
- Group homes for abused children
- Family Resource Centers for parents to share experiences/concerns
- Targeted home visits for new parents at-risk
- Universal access to free medical care for all citizens

FUNDING

Activity level of sectors in funding child abuse treatment or prevention services.

	Major	Limited	None	Unknown
Int'l NGOs		◆		
Int'l Relief Organizations		◆		
National Government	◆			
State/Local Government	◆			
Private foundations		◆		
Individuals			◆	
Businesses			◆	

POLICY

Official government law or policy regarding child abuse and neglect? YES

If yes, date established: Between 1990-2000

Core Elements

- Mandated reporting of suspected child abuse for specific groups of professionals
- Attorney assigned to represent the child's interests
- Criminal penalties for abusing a child

Enforcement Level: Inconsistently enforced

Level of Government Support: Inconsistently supported

RESEARCH (in past 10 years)

- Population-based surveys conducted to assess scope of problem: NO
- Public opinion polls to assess awareness: YES

SERVICE PROVIDERS

Relative involvement in child abuse treatment and prevention services.

Not Involved:

- Businesses/Factories
- Schools/Universities

Minimally Involved:

- Hospitals/Medical Centers
- Mental Health Agencies
- Voluntary civic organizations
- Courts

Moderately Involved:

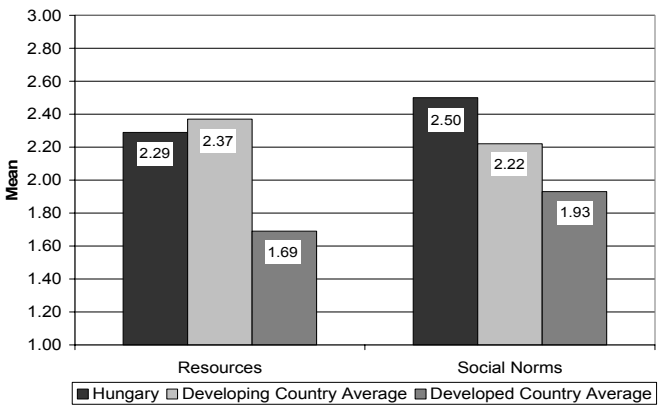
- Community-based NGOs
- Public social service agencies

Very Involved:

- Law enforcement

BARRIERS

Average rating of limiting factors to CAN prevention, (E.g. poverty, support for use of corporal punishment, etc) (Scale: 1="Not important" to 3="Very significant")



ICELAND

Region: Europe

Previous World Perspectives surveys completed: 2002

OFFICIAL RECORDS

Country maintains official count of CAN cases: YES

If yes, classifications included:

- ☑ Physical abuse
- ☑ Sexual abuse
- ☑ Psychological maltreatment
- ☑ Neglect

SERVICES

Services available, and capacity of these services to reach all families involved or at risk of abuse.

Adequate in ***More Than** 2/3* of Country:

- Therapy programs for child victims of physical abuse and sexual abuse
- Case management services/meeting basic needs
- Home-based services to assist parents in changing their behaviors
- Short-term hospitalization for mental illness
- Foster care with official foster parents
- Institutional care for abused children
- Financial and material support
- Substance abuse treatments for parents
- Substance abuse treatments for children
- Group homes for abused children
- Family Resource Centers for parents to share experiences/concerns
- Targeted home visits for new parents at-risk
- Universal access to free medical care for all citizens
- Universal home visits for all new parents
- Universal health screening for child
- Universal access to free medical care for child

Unavailable:

- Therapy programs for sexual abusers and physical abusers
- Free child care

FUNDING

Activity level of sectors in funding child abuse treatment or prevention services.

	Major	Limited	None	Unknown
Int'l NGOs			◆	
Int'l Relief Organizations		◆		
National Government	◆			
State/Local Government	◆			
Private foundations		◆		
Individuals			◆	
Businesses			◆	

POLICY

Official government law or policy regarding child abuse and neglect? YES

If yes, date established: Before 1980

Core Elements

- Mandated reporting of suspected child abuse for specific groups of professionals
- All victims receive some form of service/intervention
- Attorney assigned to represent the child's interests
- Criminal penalties for abusing a child

Enforcement Level: Widely enforced

Level of Government Support: Widely supported

RESEARCH (in past 10 years)

- Population-based surveys conducted to assess scope of problem: YES
- Public opinion polls to assess awareness: NO

SERVICE PROVIDERS

Relative involvement in child abuse treatment and prevention services.

Not Involved:

- Voluntary civic organizations
- Religious institutions
- Businesses/Factories
- Universities

Minimally Involved:

- Community-based NGOs

Moderately Involved:

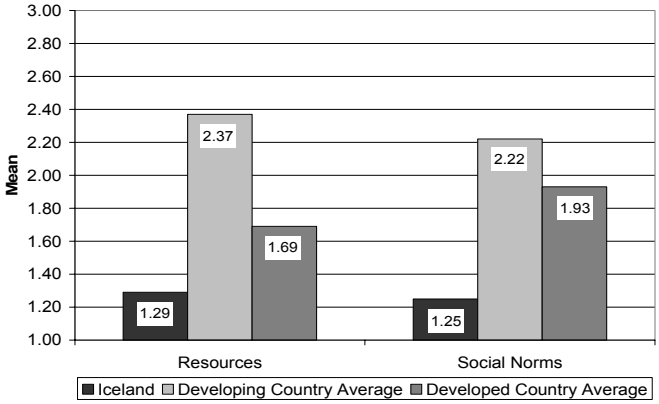
- Hospitals/Medical Centers
- Mental Health Agencies
- Schools
- Courts/law enforcement

Very Involved:

- Public social service agencies

BARRIERS

Average rating of limiting factors to CAN prevention, (E.g. poverty, support for use of corporal punishment, etc) (Scale: 1="Not important" to 3="Very significant")



INDIA

Region: South-Central Asia

Previous World Perspectives surveys completed: 1992, 2004

OFFICIAL RECORDS

Country maintains official count of CAN cases: NO

If yes, classifications included:

- ☐ Physical abuse
- ☐ Sexual abuse
- ☐ Psychological maltreatment
- ☐ Neglect

SERVICES

Services available, and capacity of these services to reach all families involved or at risk of abuse.

Adequate in ***Less Than*** *1/3* of Country:

- Therapy programs for child victims of physical abuse and sexual abuse
- Case management services/meeting basic needs
- Group homes for abused children
- Institutional care for abused children
- Financial and material support
- Short-term hospitalization for mental illness
- Substance abuse treatments for parents
- Substance abuse treatments for children
- Free child care

Unavailable:

- Therapy programs for sexual abusers and physical abusers
- Home-based services to assist parents in changing their behaviors
- Foster care with official foster parents
- Family Resource Centers for parents to share experiences/concerns
- Universal home visits for all new parents
- Targeted home visits for new parents at-risk
- Universal access to free medical care for all citizens
- Universal health screening for child
- Universal access to free medical care for child

FUNDING

Activity level of sectors in funding child abuse treatment or prevention services.

	Major	Limited	None	Unknown
Int'l NGOs		◆		
Int'l Relief Organizations		◆		
National Government		◆		
State/Local Government		◆		
Private foundations		◆		
Individuals		◆		
Businesses			◆	

POLICY

Official government law or policy regarding child abuse and neglect? YES

If yes, date established: Before 1980

Core Elements

- Voluntary reporting of suspected child abuse by any pofessional or individual
- All victims receive some form of service/intervention
- Attorney assigned to represent the child's interests
- Criminal penalties for abusing a child

Enforcement Level: Widely enforced

Level of Government Support: Inconsistently supported

RESEARCH (in past 10 years)

- Population-based surveys conducted to assess scope of problem: NO
- Public opinion polls to assess awareness: YES

SERVICE PROVIDERS

Relative involvement in child abuse treatment and prevention services.

Not Involved:

- Businesses/Factories

Minimally Involved:

- Hospitals/Medical Centers
- Mental Health Agencies
- Schools/Universities
- Public social service agencies
- Religious institutions

Moderately Involved:

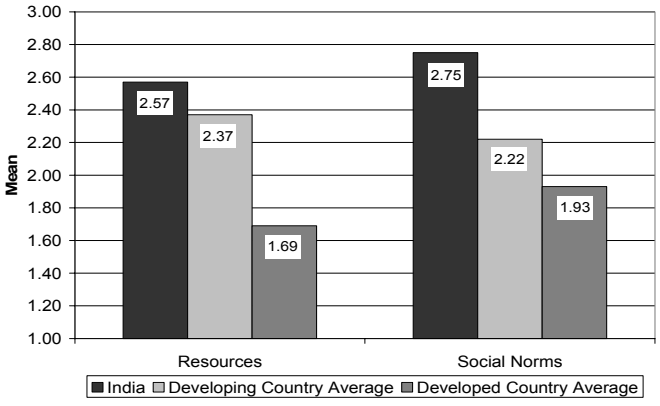
- Voluntary civic organizations
- Courts/law enforcement

Very Involved:

- Community-based NGOs

BARRIERS

Average rating of limiting factors to CAN prevention, (E.g. poverty, support for use of corporal punishment, etc) (Scale: 1="Not important" to 3="Very significant")



ISRAEL

Region: Western Asia

Previous World Perspectives surveys completed:
1992, 1996, 1998, 2000, 2002, 2004

OFFICIAL RECORDS

Country maintains official count of CAN cases: YES

If yes, classifications included:

- ☑ Physical abuse
- ☑ Sexual abuse
- ☑ Psychological maltreatment
- ☑ Neglect

SERVICES

Services available, and capacity of these services to reach all families involved or at risk of abuse.

Adequate in ***Less Than*** *1/3* of Country:

- Therapy programs for child victims of physical abuse and sexual abuse
- Therapy programs for sexual abusers and physical abusers
- Home-based services to assist parents in changing their behaviors
- Substance abuse treatments for parents
- Universal home visits for all new parents

Adequate in ***1/3 to 2/3*** of Country:

- Case management services/meeting basic needs
- Foster care with official foster parents
- Institutional care for abused children
- Group homes for abused children
- Targeted home visits for new parents at-risk

Adequate in ***More Than*** *2/3* of Country:

- Short-term hospitalization for mental illness
- Substance abuse treatments for children
- Universal health screening for child
- Universal access to free medical care for child
- Universal access to free medical care for all citizens

Unavailable:

- Free child care
- Financial and material support
- Family Resource Centers for parents to share experiences/concerns

FUNDING

Activity level of sectors in funding child abuse treatment or prevention services.

	Major	Limited	None	Unknown
Int'l NGOs			◆	
Int'l Relief Organizations			◆	
National Government		◆		
State/Local Government		◆		
Private foundations	◆			
Individuals		◆		
Businesses	◆			

POLICY

Official government law or policy regarding child abuse and neglect? YES

If yes, date established: Between 1980-1989

Core Elements

- Mandated reporting of suspected child abuse for specific groups of professionals
- Provisions for removing child from his/her parents/caretaker to insure the child's safety
- Criminal penalties for abusing a child

Enforcement Level: Inconsistently enforced

Level of Government Support: Inconsistently supported

RESEARCH (in past 10 years)

- Population-based surveys conducted to assess scope of problem: YES
- Public opinion polls to assess awareness: NO

SERVICE PROVIDERS

Relative involvement in child abuse treatment and prevention services.

Not Involved:

- NA

Minimally Involved:

- Hospitals/Medical Centers
- Mental Health Agencies
- Religious institutions

Moderately Involved:

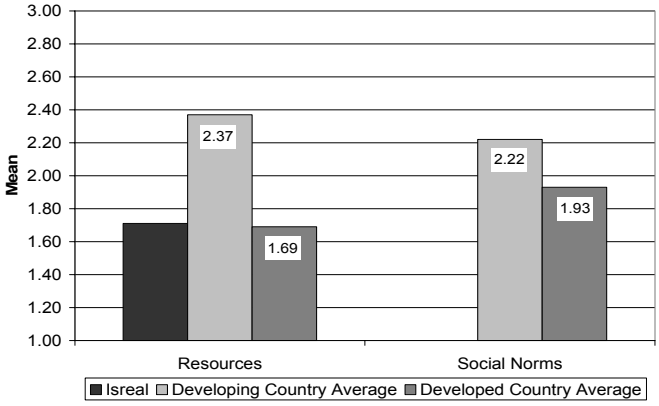
- Schools/Universities
- Businesses/Factories
- Voluntary civic organizations
- Private therapists

Very Involved:

- Courts/law enforcement
- Community-based NGOs
- Public social service agencies

BARRIERS

Average rating of limiting factors to CAN prevention,
(E.g. poverty, support for use of corporal punishment, etc)
(Scale: 1="Not important" to 3="Very significant")



ITALY

Region: Europe

Previous World Perspectives surveys completed:
1992, 1996, 1998, 2000, 2002, 2004

OFFICIAL RECORDS

Country maintains official count of CAN cases: YES

If yes, classifications included:

- ☑ Physical abuse
- ☑ Sexual abuse
- ☑ Psychological maltreatment
- ☑ Neglect

SERVICES

Services available, and capacity of these services to reach all families involved or at risk of abuse.

Adequate in ***Less Than*** *1/3* of Country:

- Therapy programs for child victims of physical abuse and sexual abuse
- Therapy programs for physical abusers
- Case management services/meeting basic needs
- Home-based services to assist parents in changing their behaviors
- Foster care with official foster parents
- Group homes for abused children
- Institutional care for abused children
- Financial and material support
- Short-term hospitalization for mental illness
- Targeted home visits for new parents at-risk
- Universal home visits for all new parents

Adequate in ***1/3 to 2/3*** of Country:

- Substance abuse treatments for parents
- Substance abuse treatments for children
- Family Resource Centers for parents to share experiences/concerns
- Free child care

Adequate in ***More Than*** *2/3* of Country:

- Universal health screening for child
- Universal access to free medical care for child
- Universal access to free medical care for all citizens

Unavailable:

- Therapy programs for sexual abusers

FUNDING

Activity level of sectors in funding child abuse treatment or prevention services.

	Major	Limited	None	Unknown
Int'l NGOs			◆	
Int'l Relief Organizations			◆	
National Government		◆		
State/Local Government	◆			
Private foundations		◆		
Individuals			◆	
Businesses			◆	

POLICY

Official government law or policy regarding child abuse and neglect? YES

If yes, date established: Between 1990-2000

Core Elements

- Mandated reporting of suspected child abuse for specific groups of professionals
- Provisions for removing child from his/her parents/caretaker to insure the child's safety
- Criminal penalties for abusing a child
- All victims receive some form of service/intervention

Enforcement Level: Inconsistently enforced

Level of Government Support: Inconsistently supported

RESEARCH (in past 10 years)

- Population-based surveys conducted to assess scope of problem: YES
- Public opinion polls to assess awareness: NO

SERVICE PROVIDERS

Relative involvement in child abuse treatment and prevention services.

Not Involved:

- Businesses/Factories

Minimally Involved:

- Religious institutions
- Universities

Moderately Involved:

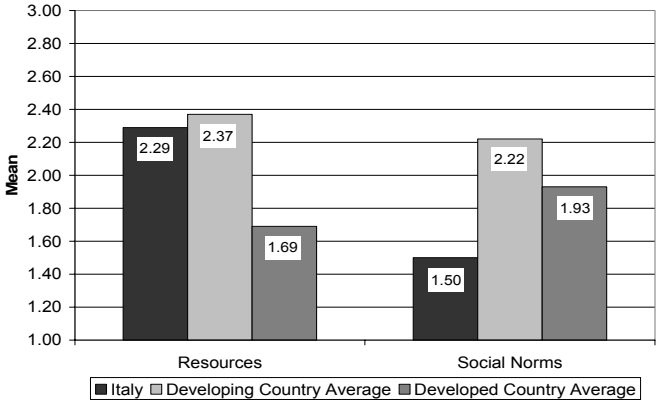
- Hospitals/Medical Centers
- Mental Health Agencies
- Schools
- Voluntary civic organizations

Very Involved:

- Courts/law enforcement
- Community-based NGOs
- Public social service agencies

BARRIERS

Average rating of limiting factors to CAN prevention,
(E.g. poverty, support for use of corporal punishment, etc)
(Scale: 1="Not important" to 3="Very significant")



JAPAN

Region: Eastern Asia

Previous World Perspectives surveys completed: 1996, 1998, 2000, 2002

OFFICIAL RECORDS

Country maintains official count of CAN cases: YES

If yes, classifications included:

- ☑ Physical abuse
- ☑ Sexual abuse
- ☑ Psychological maltreatment
- ☑ Neglect

SERVICES

Services available, and capacity of these services to reach all families involved or at risk of abuse.

Adequate in ***Less Than*** *1/3* of Country:

- Therapy programs for physical abusers
- Therapy programs for child victims of physical abuse and sexual abuse
- Home-based services to assist parents in changing their behaviors
- Foster care with official foster parents
- Institutional care for abused children
- Targeted home visits for new parents at-risk

Adequate in ***1/3 to 2/3*** of Country:

- Universal access to free medical care for child

Adequate in ***More Than*** *2/3* of Country:

- Universal health screening for child
- Universal access to free medical care for all citizens

Unavailable:

- Therapy programs for sexual abusers
- Case management services/meeting basic needs
- Group homes for abused children
- Financial and material support
- Short-term hospitalization for mental illness
- Substance abuse treatments for parents
- Substance abuse treatments for children
- Family Resource Centers for parents to share experiences/concerns
- Universal home visits for all new parents
- Free child care

FUNDING

Activity level of sectors in funding child abuse treatment or prevention services.

	Major	Limited	None	Unknown
Int'l NGOs			◆	
Int'l Relief Organizations			◆	
National Government				◆
State/Local Government	◆			
Private foundations			◆	
Individuals			◆	
Businesses			◆	

POLICY

Official government law or policy regarding child abuse and neglect? YES

If yes, date established: Between 1990-2000

Core Elements

- Mandated reporting of suspected child abuse for specific groups of professionals
- Provisions for removing child from his/her parents/caretaker to insure the child's safety
- Requires development and support of prevention services

Enforcement Level: Widely enforced

Level of Government Support: Widely supported

RESEARCH (in past 10 years)

- Population-based surveys conducted to assess scope of problem: YES
- Public opinion polls to assess awareness: NO

SERVICE PROVIDERS

Relative involvement in child abuse treatment and prevention services.

Not Involved:

- Religious institutions
- Businesses/Factories
- Universities

Minimally Involved:

- Mental Health Agencies
- Schools
- Voluntary civic organizations
- Courts/law enforcement

Moderately Involved:

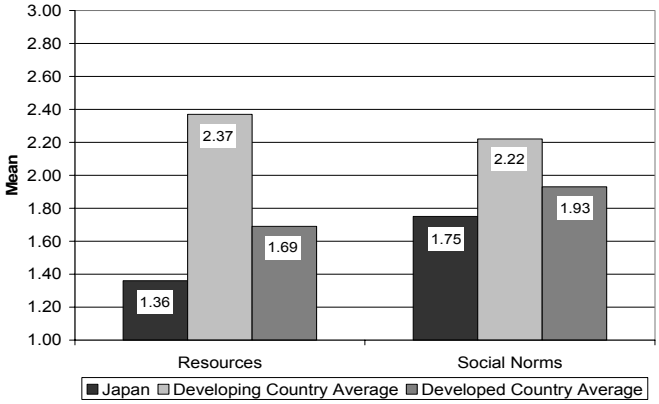
- Hospitals/Medical Centers
- Community-based NGOs

Very Involved:

- Public social service agencies

BARRIERS

Average rating of limiting factors to CAN prevention, (E.g. poverty, support for use of corporal punishment, etc) (Scale: 1="Not important" to 3="Very significant")



KOREA, REP. OF

Region: Eastern Asia

Previous World Perspectives surveys completed: 2000, 2002, 2004

OFFICIAL RECORDS

Country maintains official count of CAN cases: YES

If yes, classifications included:

- ☑ Physical abuse
- ☑ Sexual abuse
- ☑ Psychological maltreatment
- ☑ Neglect

SERVICES

Services available, and capacity of these services to reach all families involved or at risk of abuse.

Adequate in ***Less Than*** *1/3* of Country:

- Therapy programs for child victims of physical abuse and sexual abuse
- Therapy programs for physical abusers and sexual abusers
- Home-based services to assist parents in changing their behaviors
- Case management services/meeting basic needs
- Foster care with official foster parents
- Short-term hospitalization for mental illness
- Substance abuse treatments for parents
- Substance abuse treatments for children
- Group homes for abused children

Adequate in ***1/3 to 2/3*** of Country:

- Institutional care for abused children
- Financial and material support
- Universal health screening for child
- Free child care

Adequate in ***More Than*** *2/3* of Country:

Unavailable:

- Universal access to free medical care for child
- Universal access to free medical care for all citizens
- Family Resource Centers for parents to share experiences/concerns
- Universal home visits for all new parents
- Targeted home visits for new parents at-risk

FUNDING

Activity level of sectors in funding child abuse treatment or prevention services.

	Major	Limited	None	Unknown
Int'l NGOs		◆		
Int'l Relief Organizations		◆		
National Government	◆			
State/Local Government	◆			
Private foundations		◆		
Individuals		◆		
Businesses		◆		

POLICY

Official government law or policy regarding child abuse and neglect? YES

If yes, date established: After 2000

Core Elements

- Mandated reporting of suspected child abuse for specific groups of professionals
- All victims receive some form of service/intervention
- All abusers receive some form of service intervention
- Requires development and support of prevention services

Enforcement Level: Inconsistently enforced

Level of Government Support: Inconsistently supported

RESEARCH (in past 10 years)

- Population-based surveys conducted to assess scope of problem: NO
- Public opinion polls to assess awareness: NO

SERVICE PROVIDERS

Relative involvement in child abuse treatment and prevention services.

Not Involved:

- NA

Minimally Involved:

- Mental Health Agencies
- Schools/Universities
- Businesses/Factories
- Courts/law enforcement

Moderately Involved:

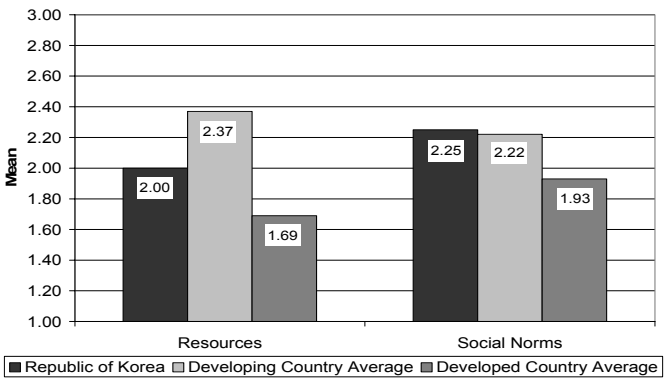
- Hospitals/Medical Centers
- Voluntary civic organizations
- Religious institutions

Very Involved:

- Public social service agencies
- Community-based NGOs

BARRIERS

Average rating of limiting factors to CAN prevention, (E.g. poverty, support for use of corporal punishment, etc) (Scale: 1="Not important" to 3="Very significant")



LEBANON

Region: Western Asia

Previous World Perspectives surveys completed: 2004

OFFICIAL RECORDS

Country maintains official count of CAN cases: YES

If yes, classifications included:

- ☑ Physical abuse
- ☑ Sexual abuse
- ☑ Psychological maltreatment
- ☑ Neglect

SERVICES

Services available, and capacity of these services to reach all families involved or at risk of abuse.

Adequate in ***Less Than*** *1/3* of Country:

- Therapy programs for child victims of physical abuse and sexual abuse
- Home-based services to assist parents in changing their behaviors
- Foster care with official foster parents
- Substance abuse treatments for parents
- Substance abuse treatments for children

Adequate in ***1/3 to 2/3*** of Country:

- Financial and material support
- Short-term hospitalization for mental illness
- Family Resource Centers for parents to share experiences/concerns
- Free child care

Adequate in ***More Than*** *2/3* of Country:

- Case management services/meeting basic needs
- Institutional care for abused children

Unavailable:

- Therapy programs for physical abusers and sexual abusers
- Group homes for abused children
- Universal home visits for all new parents
- Targeted home visits for new parents at-risk
- Universal health screening for child
- Universal access to free medical care for child
- Universal access to free medical care for all citizens

FUNDING

Activity level of sectors in funding child abuse treatment or prevention services.

	Major	Limited	None	Unknown
Int'l NGOs		◆		
Int'l Relief Organizations		◆		
National Government		◆		
State/Local Government		◆		
Private foundations		◆		
Individuals				◆
Businesses			◆	

POLICY

Official government law or policy regarding child abuse and neglect? YES

If yes, date established: Between 1980-1989

Core Elements

- Mandated reporting of suspected child abuse for specific groups of professionals
- All victims receive some form of service/intervention
- Requires development and support of prevention services
- Criminal penalties for abusing a child

Enforcement Level: Inconsistently enforced

Level of Government Support: Inconsistently supported

RESEARCH (in past 10 years)

- Population-based surveys conducted to assess scope of problem: YES
- Public opinion polls to assess awareness: YES

SERVICE PROVIDERS

Relative involvement in child abuse treatment and prevention services.

Not Involved:

- Businesses/Factories

Minimally Involved:

- Hospitals/Medical Centers
- Mental Health Agencies

Moderately Involved:

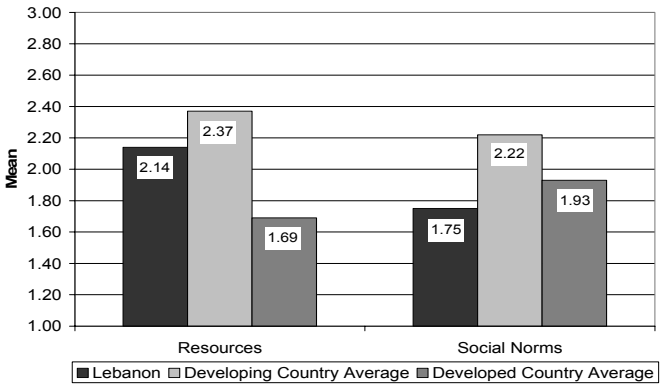
- Schools/Universities
- Public social service agencies
- Voluntary civic organizations
- Religious institutions
- International NGOs

Very Involved:

- Community-based NGOs
- Courts/law enforcement

BARRIERS

Average rating of limiting factors to CAN prevention, (E.g. poverty, support for use of corporal punishment, etc) (Scale: 1="Not important" to 3="Very significant")



MALAYSIA

Region: South-Eastern Asia

Previous World Perspectives surveys completed:
1992, 1996, 1998, 2000, 2002, 2004

OFFICIAL RECORDS

Country maintains official count of CAN cases: YES

If yes, classifications included:

- ☑ Physical abuse
- ☑ Sexual abuse
- ☑ Psychological maltreatment
- ☑ Neglect

SERVICES

Services available, and capacity of these services to reach all families involved or at risk of abuse.

Adequate in ***Less Than*** *1/3* of Country:

- Therapy programs for child victims of physical abuse and sexual abuse
- Therapy programs for physical abusers
- Case management services/meeting basic needs
- Foster care with official foster parents
- Group homes for abused children
- Substance abuse treatments for parents

Adequate in ***1/3 to 2/3*** of Country:

- Institutional care for abused children
- Financial and material support
- Universal home visits for all new parents
- Universal access to free medical care for all citizens

Adequate in ***More Than*** *2/3* of Country:

- Short-term hospitalization for mental illness
- Universal health screening for child
- Universal access to free medical care for child

Unavailable:

- Therapy programs for sexual abusers
- Home-based services to assist parents in changing their behaviors
- Substance abuse treatments for children
- Family Resource Centers for parents to share experiences/concerns
- Targeted home visits for new parents at-risk
- Free child care

FUNDING

Activity level of sectors in funding child abuse treatment or prevention services.

	Major	Limited	None	Unknown
Int'l NGOs		◆		
Int'l Relief Organizations		◆		
National Government	◆			
State/Local Government	◆			
Private foundations		◆		
Individuals				◆
Businesses				◆

POLICY

Official government law or policy regarding child abuse and neglect? YES

If yes, date established: Between 1990-2000

Core Elements

- Mandated reporting of suspected child abuse for specific groups of professionals
- All victims receive some form of service/intervention
- All abusers receive some form of service/intervention
- Criminal penalties for abusing a child

Enforcement Level: Inconsistently enforced

Level of Government Support: Widely supported

RESEARCH (in past 10 years)

- Population-based surveys conducted to assess scope of problem: NO
- Public opinion polls to assess awareness: NO

SERVICE PROVIDERS

Relative involvement in child abuse treatment and prevention services.

Not Involved:

- Businesses/Factories

Minimally Involved:

- Voluntary civic organizations
- Universities

Moderately Involved:

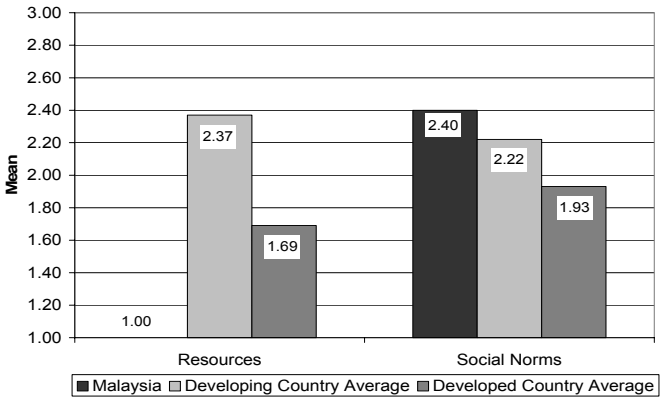
- Schools
- Community-based NGOs
- Religious institutions

Very Involved:

- Hospitals/Medical Centers
- Mental Health Agencies
- Courts/law enforcement
- Public social service agencies

BARRIERS

Average rating of limiting factors to CAN prevention,
(E.g. poverty, support for use of corporal punishment, etc)
(Scale: 1="Not important" to 3="Very significant")



MAURITIUS

Region: Africa

Previous World Perspectives surveys completed: 2004

OFFICIAL RECORDS

Country maintains official count of CAN cases: YES

If yes, classifications included:

- ☑ Physical abuse
- ☑ Sexual abuse
- ☑ Psychological maltreatment
- ☑ Neglect

SERVICES

Services available, and capacity of these services to reach all families involved or at risk of abuse.

Adequate in ***Less Than*** *1/3* of Country:

- Therapy programs for child victims of physical abuse and sexual abuse
- Foster care with official foster parents
- Group homes for abused children
- Institutional care for abused children
- Short-term hospitalization for mental illness
- Substance abuse treatments for parents

Adequate in ***More Than*** *2/3* of Country:

- Free child care
- Universal health screening for child
- Universal access to free medical care for child
- Universal access to free medical care for all citizens

Unavailable:

- Therapy programs for physical and sexual abusers
- Home-based services to assist parents in changing their behaviors
- Case management services/meeting basic needs
- Financial and material support
- Substance abuse treatments for children
- Family Resource Centers for parents to share experiences/concerns
- Targeted home visits for new parents at-risk
- Universal home visits for all new parents

FUNDING

Activity level of sectors in funding child abuse treatment or prevention services.

	Major	Limited	None	Unknown
Int'l NGOs		◆		
Int'l Relief Organizations		◆		
National Government	◆			
State/Local Government	◆			
Private foundations	◆			
Individuals		◆		
Businesses		◆		

POLICY

Official government law or policy regarding child abuse and neglect? YES

If yes, date established: Between 1990-2000

Core Elements

- Mandated reporting of suspected child abuse for specific groups of professionals
- All victims receive some form of service/intervention
- All abusers receive some form of service/intervention
- Criminal penalties for abusing a child
- Attorney assigned to represent the child's interests

Enforcement Level: Widely enforced

Level of Government Support: Widely supported

RESEARCH (in past 10 years)

- Population-based surveys conducted to assess scope of problem: YES
- Public opinion polls to assess awareness: YES

SERVICE PROVIDERS

Relative involvement in child abuse treatment and prevention services.

Moderately Involved:

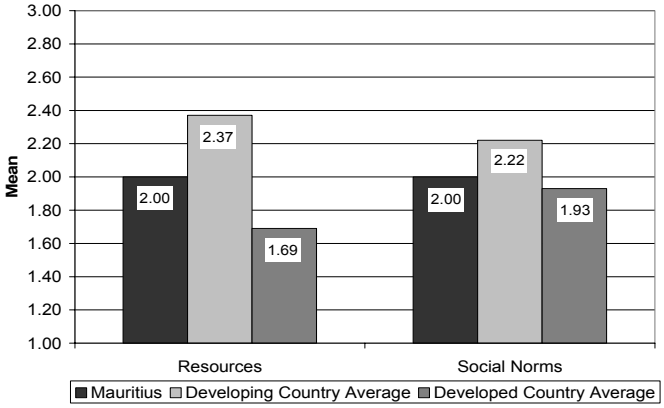
- Mental Health Agencies
- Businesses/Factories

Very Involved:

- Hospitals/Medical Centers
- Courts/law enforcement
- Public social service agencies
- Community-based NGOs
- Religious institutions
- Voluntary civic organizations
- Schools/Universities

BARRIERS

Average rating of limiting factors to CAN prevention, (E.g. poverty, support for use of corporal punishment, etc) (Scale: 1="Not important" to 3="Very significant")



MEXICO

Region: Americas

Previous World Perspectives surveys completed: 1998, 2000, 2002, 2004

OFFICIAL RECORDS

Country maintains official count of CAN cases: YES

If yes, classifications included:

- ☑ Physical abuse
- ☐ Sexual abuse
- ☐ Psychological maltreatment
- ☐ Neglect

SERVICES

Services available, and capacity of these services to reach all families involved or at risk of abuse.

Adequate in ***Less Than** 1/3* of Country:

- Therapy programs for child victims of physical abuse and sexual abuse
- Therapy programs for physical and sexual abusers
- Case management services/meeting basic needs
- Foster care with official foster parents
- Group homes for abused children
- Substance abuse treatments for parents
- Home-based services to assist parents in changing their behaviors
- Substance abuse treatments for children
- Family Resource Centers for parents to share experiences/concerns
- Free child care
- Institutional care for abused children
- Financial and material support
- Short-term hospitalization for mental illness

Adequate in ***1/3 to 2/3*** of Country:

- Universal health screening for child
- Universal access to free medical care for child
- Universal access to free medical care for all citizens

Unavailable:

- Targeted home visits for new parents at-risk
- Universal home visits for all new parents

FUNDING

Activity level of sectors in funding child abuse treatment or prevention services.

	Major	Limited	None	Unknown
Int'l NGOs		◆		
Int'l Relief Organizations			◆	
National Government		◆		
State/Local Government		◆		
Private foundations		◆		
Individuals		◆		
Businesses			◆	

POLICY

Official government law or policy regarding child abuse and neglect? YES

If yes, date established: Before 1980

Core Elements

- Mandated reporting of suspected child abuse for specific groups of professionals
- All victims receive some form of service/intervention
- Criminal penalties for abusing a child
- Attorney assigned to represent the child's interests

Enforcement Level: Inconsistently enforced

Level of Government Support: Widely supported

RESEARCH (in past 10 years)

- Population-based surveys conducted to assess scope of problem: YES
- Public opinion polls to assess awareness: YES

SERVICE PROVIDERS

Relative involvement in child abuse treatment and prevention services.

Moderately Involved:

- Mental Health Agencies
- Religious institutions
- Voluntary civic organizations
- Courts/law enforcement
- Universities

Minimally Involved:

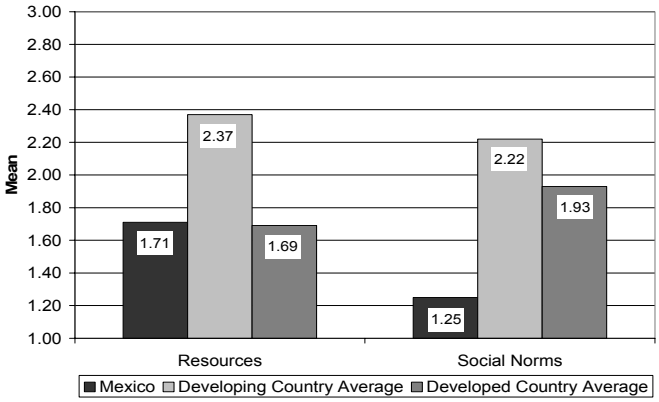
- Hospitals/Medical Centers
- Schools
- Public social service agencies
- Community-based NGOs

Very Involved:

- Businesses/Factories

BARRIERS

Average rating of limiting factors to CAN prevention,
(E.g. poverty, support for use of corporal punishment, etc)
(Scale: 1="Not important" to 3="Very significant")



MONGOLIA

Region: Eastern Asia

Previous World Perspectives surveys completed: 2004

OFFICIAL RECORDS

Country maintains official count of CAN cases: YES

If yes, classifications included:

- ☑ Physical abuse
- ☑ Sexual abuse
- ☑ Psychological maltreatment
- ☑ Neglect

SERVICES

Services available, and capacity of these services to reach all families involved or at risk of abuse.

Adequate in ***Less Than*** *1/3* of Country:

- Therapy programs for child victims of physical abuse and sexual abuse
- Therapy programs for physical and sexual abusers
- Short-term hospitalization for mental illness
- Institutional care for abused children
- Financial and material support
- Substance abuse treatments for children
- Family Resource Centers for parents to share experiences/concerns
- Targeted home visits for new parents at-risk
- Case management services/meeting basic needs

Adequate in ***1/3 to 2/3*** of Country:

- Free child care
- Universal health screening for child
- Universal access to free medical care for child

Unavailable:

- Foster care with official foster parents
- Group homes for abused children
- Substance abuse treatments for parents
- Universal home visits for all new parents
- Universal access to free medical care for all citizens

FUNDING

Activity level of sectors in funding child abuse treatment or prevention services.

	Major	Limited	None	Unknown
Int'l NGOs		◆		
Int'l Relief Organizations				◆
National Government				◆
State/Local Government				◆
Private foundations				◆
Individuals				◆
Businesses				◆

POLICY

Official government law or policy regarding child abuse and neglect? YES

If yes, date established: After 2000

Core Elements

- Mandated reporting of suspected child abuse for specific groups of professionals
- All victims receive some form of service/intervention
- All abusers receive some form of service/intervention
- Attorney assigned to represent the child's interests

Enforcement Level: NA

Level of Government Support: Inconsistently supported

RESEARCH (in past 10 years)

- Population-based surveys conducted to assess scope of problem: YES
- Public opinion polls to assess awareness: NO

SERVICE PROVIDERS

Relative involvement in child abuse treatment and prevention services.

Not Involved:

- NA

Minimally Involved:

- Businesses/Factories

Moderately Involved:

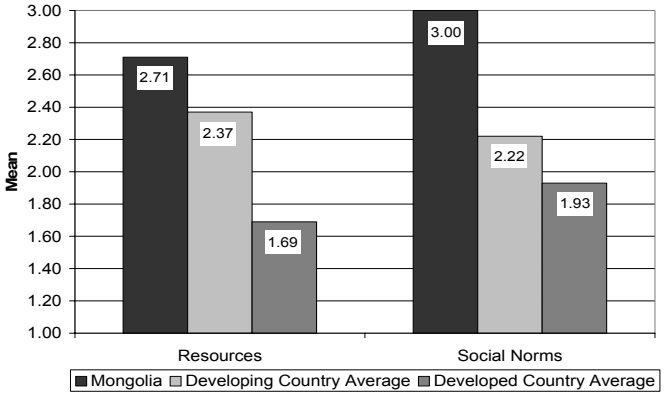
- Mental Health Agencies
- Public social service agencies
- Religious institutions
- Courts/law enforcement
- Universities

Very Involved:

- Hospitals/Medical Centers
- Schools
- Community-based NGOs
- Voluntary civic organizations

BARRIERS

Average rating of limiting factors to CAN prevention, (E.g. poverty, support for use of corporal punishment, etc) (Scale: 1="Not important" to 3="Very significant")



MONTENEGRO

Region: Europe

Previous World Perspectives surveys completed: None

OFFICIAL RECORDS

Country maintains official count of CAN cases: YES

If yes, classifications included:

- ☑ Physical abuse
- ☑ Sexual abuse
- ☑ Psychological maltreatment
- ☑ Neglect

SERVICES

Services available, and capacity of these services to reach all families involved or at risk of abuse.

Adequate in ***Less Than*** *1/3* of Country:

- Case management services/meeting basic needs
- Group homes for abused children
- Substance abuse treatments for children
- Substance abuse treatments for parents

Adequate in ***1/3 to 2/3*** of Country:

- Short-term hospitalization for mental illness

Adequate in ***More Than*** *2/3* of Country:

- Universal health screening for child
- Universal access to free medical care for child
- Universal access to free medical care for all citizens

Unavailable:

- Therapy programs for child victims of physical abuse and sexual abuse
- Therapy programs for physical and sexual abusers
- Foster care with official foster parents
- Home-based services to assist parents in changing their behaviors
- Institutional care for abused children
- Financial and material support
- Family Resource Centers for parents to share experiences/concerns
- Universal home visits for all new parents
- Targeted home visits for new parents at-risk
- Free child care

FUNDING

Activity level of sectors in funding child abuse treatment or prevention services.

	Major	Limited	None	Unknown
Int'l NGOs		◆		
Int'l Relief Organizations			◆	
National Government		◆		
State/Local Government				◆
Private foundations			◆	
Individuals			◆	
Businesses			◆	

POLICY

Official government law or policy regarding child abuse and neglect? YES

If yes, date established: After 2000

Core Elements

- Mandated reporting of suspected child abuse for specific groups of professionals
- All victims receive some form of service/intervention
- Criminal penalties for abusing a child

Enforcement Level: Inconsistently enforced

Level of Government Support: Inconsistently supported

RESEARCH (in past 10 years)

- Population-based surveys conducted to assess scope of problem: NO
- Public opinion polls to assess awareness: NO

SERVICE PROVIDERS

Relative involvement in child abuse treatment and prevention services.

Not Involved:

- Businesses/Factories
- Religious institutions
- Universities

Minimally Involved:

- Hospitals/Medical Centers
- Mental Health Agencies
- Schools
- Community-based NGOs
- Voluntary civic organizations

Moderately Involved:

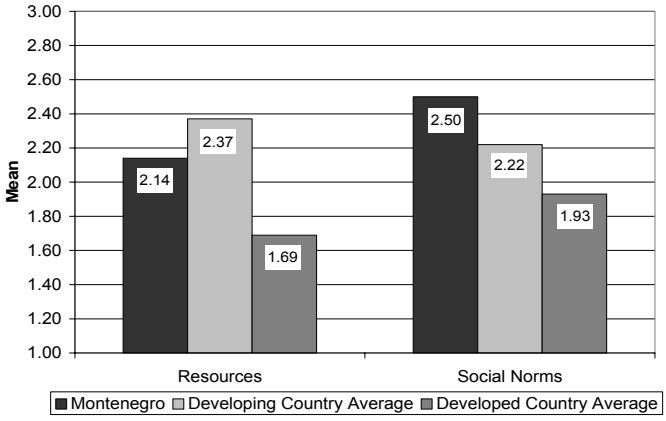
- Courts/law enforcement

Very Involved:

- Public social service agencies

BARRIERS

Average rating of limiting factors to CAN prevention, (E.g. poverty, support for use of corporal punishment, etc) (Scale: 1="Not important" to 3="Very significant")



NEPAL

Region: South-Central Asia

Previous World Perspectives surveys completed: 2004

OFFICIAL RECORDS

Country maintains official count of CAN cases: NO

If yes, classifications included:

- ☐ Physical abuse
- ☐ Sexual abuse
- ☐ Psychological maltreatment
- ☐ Neglect

SERVICES

Services available, and capacity of these services to reach all families involved or at risk of abuse.

Adequate in ***Less Than*** *1/3* of Country:

- Therapy programs for child victims of physical abuse and sexual abuse
- Therapy programs for physical and sexual abusers
- Foster care with official foster parents
- Home-based services to assist parents in changing their behaviors
- Institutional care for abused children
- Financial and material support
- Family Resource Centers for parents to share experiences/concerns
- Targeted home visits for new parents at-risk
- Free child care
- Case management services/meeting basic needs
- Group homes for abused children
- Short-term hospitalization for mental illness
- Substance abuse treatments for children
- Substance abuse treatments for parents

Unavailable:

- Universal home visits for all new parents
- Universal health screening for child
- Universal access to free medical care for child
- Universal access to free medical care for all citizens

FUNDING

Activity level of sectors in funding child abuse treatment or prevention services.

	Major	Limited	None	Unknown
Int'l NGOs	◆			
Int'l Relief Organizations		◆		
National Government		◆		
State/Local Government		◆		
Private foundations			◆	
Individuals			◆	
Businesses			◆	

POLICY

Official government law or policy regarding child abuse and neglect? YES

If yes, date established: Between 1990-2000

Core Elements

- Mandated reporting of suspected child abuse for specific groups of professionals
- All victims receive some form of service/intervention
- All abusers receive some form of service/intervention
- Criminal penalties for abusing a child
- Attorney assigned to represent the child's interests

Enforcement Level: Inconsistently enforced

Level of Government Support: Almost never supported

RESEARCH (in past 10 years)

- Population-based surveys conducted to assess scope of problem: YES
- Public opinion polls to assess awareness: YES

SERVICE PROVIDERS

Relative involvement in child abuse treatment and prevention services.

Moderately Involved:

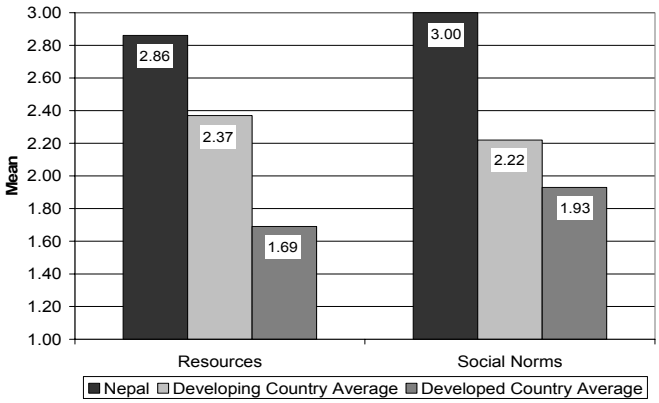
- Hospitals/Medical Centers
- Mental Health Agencies
- Schools/Universities
- Community-based NGOs
- Public social service agencies
- Religious institutions
- Voluntary civic organizations

Minimally Involved:

- Courts/law enforcement
- Businesses/Factories

BARRIERS

Average rating of limiting factors to CAN prevention, (E.g. poverty, support for use of corporal punishment, etc) (Scale: 1="Not important" to 3="Very significant")



NETHERLANDS

Region: Europe

Previous World Perspectives surveys completed:
1992, 1996, 1998, 2000, 2002, 2004

OFFICIAL RECORDS

Country maintains official count of CAN cases: YES

If yes, classifications included:

- ☑ Physical abuse
- ☑ Sexual abuse
- ☑ Psychological maltreatment
- ☑ Neglect

SERVICES

Services available, and capacity of these services to reach all families involved or at risk of abuse.

Adequate in ***Less Than*** *1/3* of Country:

- Therapy programs for child victims of physical abuse and sexual abuse
- Therapy programs for sexual abusers
- Targeted home visits for new parents at-risk

Adequate in ***1/3 to 2/3*** of Country:

- Case management services/meeting basic needs
- Home-based services to assist parents in changing their behaviors

Adequate in ***More Than*** *2/3* of Country:

- Therapy programs for physical abusers
- Foster care with official foster parents

Available (Adequacy Unknown):

- Institutional care for abused children
- Short-term hospitalization for mental illness
- Substance abuse treatments for children
- Substance abuse treatments for parents
- Universal health screening for child

Unavailable:

- Group homes for abused children
- Financial and material support
- Family Resource Centers for parents to share experiences/concerns
- Universal home visits for all new parents
- Free child care
- Universal access to free medical care for child
- Universal access to free medical care for all citizens

FUNDING

Activity level of sectors in funding child abuse treatment or prevention services.

	Major	Limited	None	Unknown
Int'l NGOs				◆
Int'l Relief Organizations				◆
National Government	◆			
State/Local Government	◆			
Private foundations				◆
Individuals				◆
Businesses			◆	

POLICY

Official government law or policy regarding child abuse and neglect? YES

If yes, date established: After 2000

Core Elements

- Voluntary reporting of suspected child abuse by any professional or individual
- All victims receive some form of service/intervention
- All abusers receive some form of service/intervention

Enforcement Level: Inconsistently enforced

Level of Government Support: Inconsistently supported

RESEARCH (in past 10 years)

- Population-based surveys conducted to assess scope of problem: NO
- Public opinion polls to assess awareness: NO

SERVICE PROVIDERS

Relative involvement in child abuse treatment and prevention services.

Not Involved:

- Businesses/Factories

Moderately Involved:

- Schools
- Courts/law enforcement
- Public social service agencies

Minimally Involved:

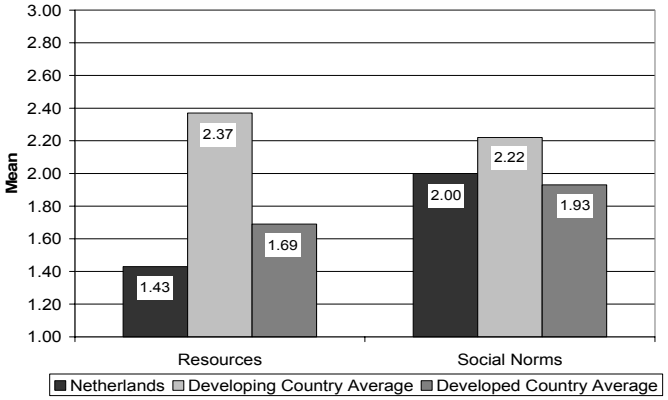
- Hospitals/Medical Centers
- Community-based NGOs
- Religious institutions
- Voluntary civic organizations
- Universities

Very Involved:

- Mental Health Agencies

BARRIERS

Average rating of limiting factors to CAN prevention,
(E.g. poverty, support for use of corporal punishment, etc)
(Scale: 1="Not important" to 3="Very significant")



NEW ZEALAND

Region: Oceania

Previous World Perspectives surveys completed:
1996, 1998, 2000, 2002, 2004

OFFICIAL RECORDS

Country maintains official count of CAN cases: YES

If yes, classifications included:

- ☑ Physical abuse
- ☑ Sexual abuse
- ☑ Psychological maltreatment
- ☑ Neglect

SERVICES

Services available, and capacity of these services to reach all families involved or at risk of abuse.

Adequate in ***More Than** 2/3* of Country:

- Therapy programs for child victims of physical abuse and sexual abuse
- Therapy programs for physical and sexual abusers
- Targeted home visits for new parents at-risk
- Foster care with official foster parents
- Case management services/meeting basic needs
- Home-based services to assist parents in changing their behaviors
- Group homes for abused children
- Financial and material support
- Family Resource Centers for parents to share experiences/concerns
- Universal home visits for all new parents
- Universal access to free medical care for child
- Short-term hospitalization for mental illness
- Substance abuse treatments for children
- Substance abuse treatments for parents
- Universal health screening for child

Unavailable:

- Institutional care for abused children
- Free child care
- Universal access to free medical care for all citizens

FUNDING

Activity level of sectors in funding child abuse treatment or prevention services.

	Major	Limited	None	Unknown
Int'l NGOs			◆	
Int'l Relief Organizations			◆	
National Government	◆			
State/Local Government		◆		
Private foundations		◆		
Individuals			◆	
Businesses		◆		

POLICY

Official government law or policy regarding child abuse and neglect? YES

If yes, date established: Before 1980

Core Elements

- Voluntary reporting of suspected child abuse by any professional or individual
- All victims receive some form of service/intervention
- Criminal penalties for abusing a child
- Attorney assigned to represent the child's interests

Enforcement Level: Widely enforced

Level of Government Support: Widely supported

RESEARCH (in past 10 years)

- Population-based surveys conducted to assess scope of problem: YES
- Public opinion polls to assess awareness: YES

SERVICE PROVIDERS

Relative involvement in child abuse treatment and prevention services.

Not Involved:

- Businesses/Factories

Minimally Involved:

- NA

Moderately Involved:

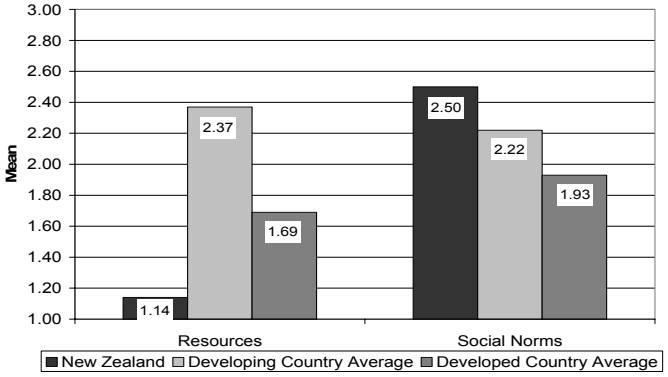
- Schools/Universities

Very Involved:

- Hospitals/Medical Centers
- Mental Health Agencies
- Public social service agencies
- Community-based NGOs
- Religious institutions
- Voluntary civic organizations
- Courts/law enforcement

BARRIERS

Average rating of limiting factors to CAN prevention,
(E.g. poverty, support for use of corporal punishment, etc)
(Scale: 1="Not important" to 3="Very significant")



PAKISTAN

Region: South-Central Asia

Previous World Perspectives surveys completed: 1992, 1996, 1998, 2002, 2004

OFFICIAL RECORDS

Country maintains official count of CAN cases: NO

If yes, classifications included:

- ☐ Physical abuse
- ☐ Sexual abuse
- ☐ Psychological maltreatment
- ☐ Neglect

SERVICES

Services available, and capacity of these services to reach all families involved or at risk of abuse.

Adequate in ***Less Than*** *1/3* of Country:

- Therapy programs for child victims of physical abuse and sexual abuse
- Institutional care for abused children
- Short-term hospitalization for mental illness
- Substance abuse treatments for parents
- Substance abuse treatments for children

Adequate in ***1/3 to 2/3*** of Country:

- Free child care
- Universal access to free medical care for child
- Universal access to free medical care for all citizens

Unavailable:

- Therapy programs for physical and sexual abusers
- Case management services/meeting basic needs
- Foster care with official foster parents
- Home-based services to assist parents in changing their behaviors
- Group homes for abused children
- Financial and material support

FUNDING

Activity level of sectors in funding child abuse treatment or prevention services.

	Major	Limited	None	Unknown
Int'l NGOs		◆		
Int'l Relief Organizations		◆		
National Government		◆		
State/Local Government		◆		
Private foundations			◆	
Individuals			◆	
Businesses			◆	

POLICY

Official government law or policy regarding child abuse and neglect? YES

If yes, date established: After 2000

Core Elements

- Voluntary reporting of suspected child abuse by any professional or individual
- All victims receive some form of service/intervention
- Criminal penalties for abusing a child
- Attorney assigned to represent the child's interests
- Criminal penalties for abusing a child

Enforcement Level: Inconsistently enforced

Level of Government Support: Inconsistently supported

RESEARCH (in past 10 years)

- Population-based surveys conducted to assess scope of problem: YES
- Public opinion polls to assess awareness: NO

SERVICE PROVIDERS

Relative involvement in child abuse treatment and prevention services.

Not Involved:

- Businesses/Factories
- Schools/Universities
- Religious institutions
- Courts

Minimally Involved:

- Hospitals/Medical Centers
- Public social service agencies

Moderately Involved:

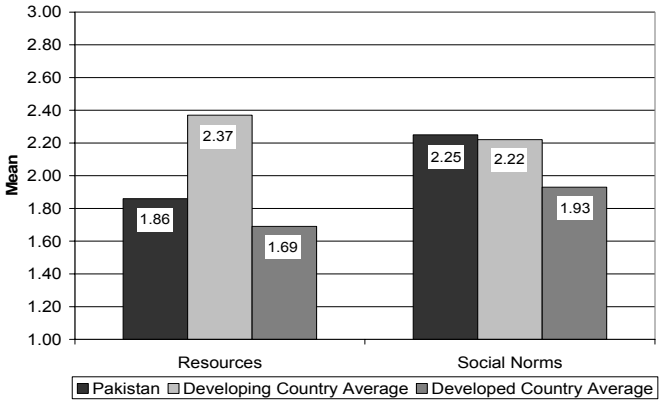
- Law enforcement

Very Involved:

- NA

BARRIERS

Average rating of limiting factors to CAN prevention, (E.g. poverty, support for use of corporal punishment, etc) (Scale: 1="Not important" to 3="Very significant")



PERU

Region: Americas

Previous World Perspectives surveys completed: 1992, 2002, 2004

OFFICIAL RECORDS

Country maintains official count of CAN cases: NO

If yes, classifications included:

- ☐ Physical abuse
- ☐ Sexual abuse
- ☐ Psychological maltreatment
- ☐ Neglect

SERVICES

Services available, and capacity of these services to reach all families involved or at risk of abuse.

Adequate in ***Less Than** 1/3* of Country:

- Therapy programs for child victims of physical abuse and sexual abuse
- Therapy programs for physical abusers
- Institutional care for abused children
- Short-term hospitalization for mental illness
- Substance abuse treatments for parents
- Substance abuse treatments for children
- Universal health screening for child

Unavailable:

- Therapy programs for sexual abusers
- Home-based services to assist parents in changing their behaviors
- Case management services/meeting basic needs
- Foster care with official foster parents
- Group homes for abused children
- Financial and material support
- Family Resource Centers for parents to share experiences/concerns
- Universal home visits for all new parents
- Targeted home visits for new parents at-risk
- Free child care
- Universal access to free medical care for all citizens
- Universal access to free medical care for child

FUNDING

Activity level of sectors in funding child abuse treatment or prevention services.

	Major	Limited	None	Unknown
Int'l NGOs	◆			
Int'l Relief Organizations				◆
National Government		◆		
State/Local Government		◆		
Private foundations			◆	
Individuals				◆
Businesses		◆		

POLICY

Official government law or policy regarding child abuse and neglect? YES

If yes, date established: After 2000

Core Elements

- Mandated reporting of suspected child abuse for specific groups of professionals
- All victims receive some form of service/intervention
- Criminal penalties for abusing a child
- Attorney assigned to represent the child's interests

Enforcement Level: Almost never enforced

Level of Government Support: Almost never supported

RESEARCH (in past 10 years)

- Population-based surveys conducted to assess scope of problem: YES
- Public opinion polls to assess awareness: YES

SERVICE PROVIDERS

Relative involvement in child abuse treatment and prevention services.

Not Involved:

- Mental Health Agencies
- Community-based NGOs
- Religious institutions

Minimally Involved:

- Hospitals/Medical Centers
- Voluntary civic organizations
- Schools
- Courts/law enforcement

Moderately Involved:

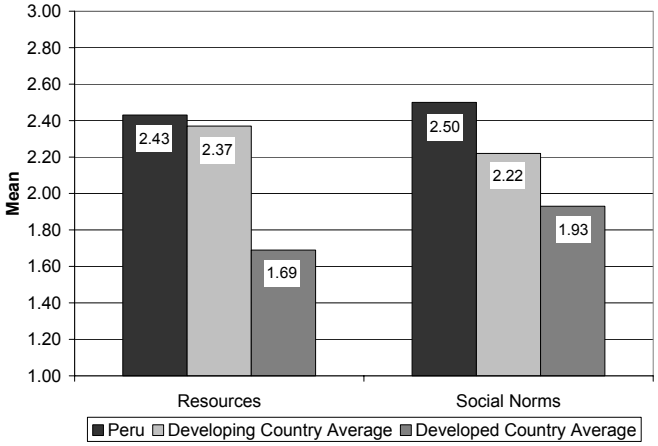
- Universities

Very Involved:

- Businesses/Factories

BARRIERS

Average rating of limiting factors to CAN prevention, (E.g. poverty, support for use of corporal punishment, etc) (Scale: 1="Not important" to 3="Very significant")



PHILIPPINES

Region: South-Eastern Asia

Previous World Perspectives surveys completed: 1996, 2000, 2002, 2004

OFFICIAL RECORDS

Country maintains official count of CAN cases: YES

If yes, classifications included:

- ☑ Physical abuse
- ☑ Sexual abuse
- ☑ Psychological maltreatment
- ☑ Neglect

SERVICES

Services available, and capacity of these services to reach all families involved or at risk of abuse.

Adequate in ***Less Than*** *1/3* of Country:

- Therapy programs for child victims of physical abuse and sexual abuse
- Therapy programs for physical and sexual abusers
- Case management services/meeting basic needs
- Institutional care for abused children
- Financial and material support
- Universal access to free medical care for all citizens
- Foster care with official foster parents
- Group homes for abused children
- Substance abuse treatments for parents
- Substance abuse treatments for children
- Short-term hospitalization for mental illness
- Universal health screening for child
- Universal access to free medical care for child

Unavailable:

- Home-based services to assist parents in changing their behaviors
- Family Resource Centers for parents to share experiences/concerns
- Universal home visits for all new parents
- Targeted home visits for new parents at-risk
- Free child care

FUNDING

Activity level of sectors in funding child abuse treatment or prevention services.

	Major	Limited	None	Unknown
Int'l NGOs	◆			
Int'l Relief Organizations		◆		
National Government			◆	
State/Local Government			◆	
Private foundations		◆		
Individuals		◆		
Businesses		◆		

POLICY

Official government law or policy regarding child abuse and neglect? YES

If yes, date established: Before 1980

Core Elements

- Mandated reporting of suspected child abuse for specific groups of professionals
- All victims receive some form of service/intervention
- Criminal penalties for abusing a child
- Attorney assigned to represent the child's interests

Enforcement Level: Inconsistently enforced

Level of Government Support: Inconsistently supported

RESEARCH (in past 10 years)

- Population-based surveys conducted to assess scope of problem: NO
- Public opinion polls to assess awareness: NO

SERVICE PROVIDERS

Relative involvement in child abuse treatment and prevention services.

Not Involved:

- Businesses/Factories
- Courts/law enforcement

Moderately Involved:

- Hospitals/Medical Centers
- Schools
- Religious institutions
- Voluntary civic organizations

Minimally Involved:

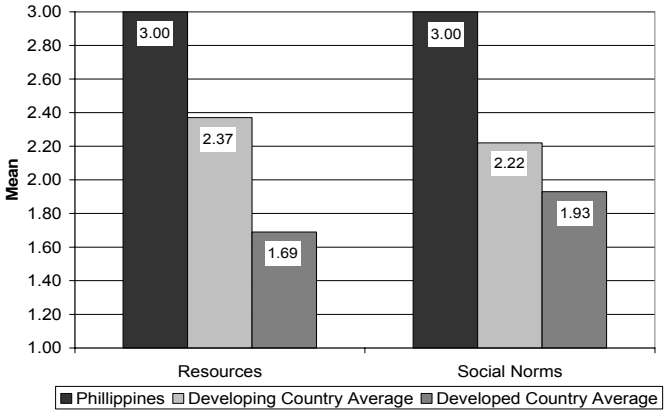
- Universities

Very Involved:

- Public social service agencies
- Community-based NGOs

BARRIERS

Average rating of limiting factors to CAN prevention, (E.g. poverty, support for use of corporal punishment, etc) (Scale: 1="Not important" to 3="Very significant")



POLAND

Region: Europe

Previous World Perspectives surveys completed: 1998, 2002, 2004

OFFICIAL RECORDS

Country maintains official count of CAN cases: NO

If yes, classifications included:

- ☐ Physical abuse
- ☐ Sexual abuse
- ☐ Psychological maltreatment
- ☐ Neglect

SERVICES

Services available, and capacity of these services to reach all families involved or at risk of abuse.

Adequate in ***Less Than*** *1/3* of Country:

- Therapy programs for child victims of physical abuse and sexual abuse
- Foster care with official foster parents
- Group homes for abused children
- Free child care

Adequate in ***1/3 to 2/3*** of Country:

- Financial and material support
- Universal health screening for child

Adequate in ***More Than*** *2/3* of Country:

- Institutional care for abused children
- Short-term hospitalization for mental illness
- Substance abuse treatments for parents
- Substance abuse treatments for children
- Universal access to free medical care for all citizens
- Universal access to free medical care for child

Unavailable:

- Therapy programs for physical and sexual abusers
- Home-based services to assist parents in changing their behaviors
- Case management services/meeting basic needs
- Family Resource Centers for parents to share experiences/concerns
- Universal home visits for all new parents
- Targeted home visits for new parents at-risk

FUNDING

Activity level of sectors in funding child abuse treatment or prevention services.

	Major	Limited	None	Unknown
Int'l NGOs			◆	
Int'l Relief Organizations			◆	
National Government			◆	
State/Local Government		◆		
Private foundations		◆		
Individuals		◆		
Businesses			◆	

POLICY

Official government law or policy regarding child abuse and neglect? NO

If yes, date established: NA

Core Elements

- NA

Enforcement Level: NA

Level of Government Support: NA

RESEARCH (in past 10 years)

- Population-based surveys conducted to assess scope of problem: YES
- Public opinion polls to assess awareness: NO

SERVICE PROVIDERS

Relative involvement in child abuse treatment and prevention services.

Not Involved:

- Businesses/Factories
- Universities

Moderately Involved:

- Mental Health Agencies
- Schools
- Public social service agencies
- Courts/law enforcement
- Voluntary civic organizations

Minimally Involved:

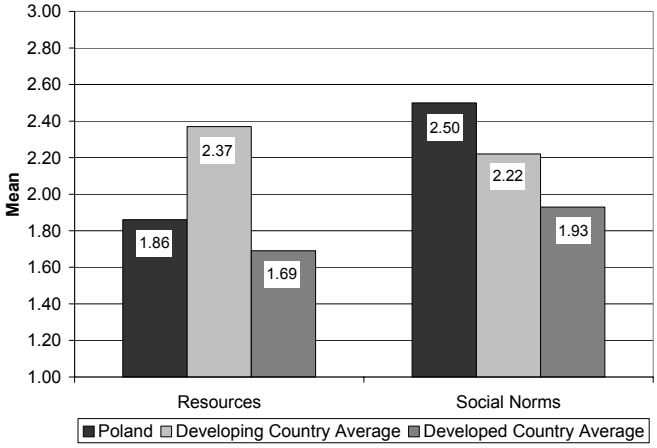
- Hospitals/Medical Centers
- Religious institutions

Very Involved:

- Community-based NGOs

BARRIERS

Average rating of limiting factors to CAN prevention, (E.g. poverty, support for use of corporal punishment, etc) (Scale: 1="Not important" to 3="Very significant")



PORTUGAL

Region: Europe

Previous World Perspectives surveys completed: 1998, 2002, 2004

OFFICIAL RECORDS

Country maintains official count of CAN cases: NO

If yes, classifications included:

- ☐ Physical abuse
- ☐ Sexual abuse
- ☐ Psychological maltreatment
- ☐ Neglect

SERVICES

Services available, and capacity of these services to reach all families involved or at risk of abuse.

Adequate in ***Less Than*** *1/3* of Country:

- Therapy programs for child victims of physical abuse
- Foster care with official foster parents

Adequate in ***1/3 to 2/3*** of Country:

- Therapy programs for child victims of sexual abuse
- Therapy programs for sexual abusers
- Case management services/meeting basic needs
- Institutional care for abused children
- Short-term hospitalization for mental illness
- Substance abuse treatments for parents

Adequate in ***More Than*** *2/3* of Country:

- Free child care
- Universal health screening for child
- Universal access to free medical care for all citizens
- Universal access to free medical care for child

Unavailable:

- Therapy programs for physical abusers
- Home-based services to assist parents in changing their behaviors
- Group homes for abused children
- Financial and material support
- Substance abuse treatments for children
- Family Resource Centers for parents to share experiences/concerns
- Universal home visits for all new parents
- Targeted home visits for new parents at-risk

FUNDING

Activity level of sectors in funding child abuse treatment or prevention services.

	Major	Limited	None	Unknown
Int'l NGOs				◆
Int'l Relief Organizations			◆	
National Government			◆	
State/Local Government			◆	
Private foundations			◆	
Individuals			◆	
Businesses			◆	

POLICY

Official government law or policy regarding child abuse and neglect? YES

If yes, date established: Between 1990-2000

Core Elements

- Mandated reporting of suspected child abuse for specific groups of professionals
- Provisions for removing child from his/her parents or caretakers to ensure the child's safety
- Criminal penalties for abusing a child
- Attorney assigned to represent the child's interests

Enforcement Level: Inconsistently enforced

Level of Government Support: Widely supported

RESEARCH (in past 10 years)

- Population-based surveys conducted to assess scope of problem: NO
- Public opinion polls to assess awareness: NO

SERVICE PROVIDERS

Relative involvement in child abuse treatment and prevention services.

Not Involved:

- NA

Minimally Involved:

- NA

Moderately Involved:

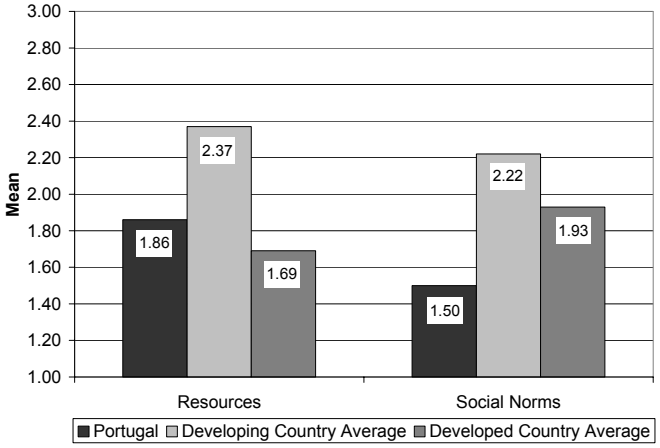
- Hospitals/Medical Centers
- Mental Health Agencies
- Schools/Universities
- Public social service agencies
- Courts/law enforcement

Very Involved:

- Community-based NGOs
- Voluntary civic organizations

BARRIERS

Average rating of limiting factors to CAN prevention, (E.g. poverty, support for use of corporal punishment, etc) (Scale: 1="Not important" to 3="Very significant")



ROMANIA

Region: Europe

Previous World Perspectives surveys completed: 2000, 2004

OFFICIAL RECORDS

Country maintains official count of CAN cases: NO

If yes, classifications included:

- ☐ Physical abuse
- ☐ Sexual abuse
- ☐ Psychological maltreatment
- ☐ Neglect

SERVICES

Services available, and capacity of these services to reach all families involved or at risk of abuse.

Adequate in ***Less Than*** *1/3* of Country:

- Therapy programs for child victims of sexual abuse
- Therapy programs for sexual abusers
- Case management services/meeting basic needs
- Home-based services to assist parents in changing their behaviors
- Group homes for abused children
- Substance abuse treatments for parents
- Family Resource Centers for parents to share experiences/concerns

Adequate in ***1/3 to 2/3*** of Country:

- Foster care with official foster parents
- Universal home visits for all new parents
- Universal access to free medical care for child
- Short-term hospitalization for mental illness

Adequate in ***More Than*** *2/3* of Country:

- Universal health screening for child

Unavailable:

- Therapy programs for child victims of physical abuse
- Therapy programs for physical abusers
- Institutional care for abused children
- Financial and material support
- Substance abuse treatments for children
- Free child care
- Targeted home visits for new parents at-risk
- Universal access to free medical care for all citizens

FUNDING

Activity level of sectors in funding child abuse treatment or prevention services.

	Major	Limited	None	Unknown
Int'l NGOs		◆		
Int'l Relief Organizations		◆		
National Government		◆		
State/Local Government		◆		
Private foundations		◆		
Individuals			◆	
Businesses			◆	

POLICY

Official government law or policy regarding child abuse and neglect? YES

If yes, date established: After 2000

Core Elements

- Mandated reporting of suspected child abuse for specific groups of professionals
- All victims receive some form of service/intervention
- Provisions for removing child from his/her parents or caretakers to ensure the child's safety
- Criminal penalties for abusing a child

Enforcement Level: Inconsistently enforced

Level of Government Support: Inconsistently supported

RESEARCH (in past 10 years)

- Population-based surveys conducted to assess scope of problem: YES
- Public opinion polls to assess awareness: NO

SERVICE PROVIDERS

Relative involvement in child abuse treatment and prevention services.

Not Involved:

- Courts/law enforcement
- Religious institutions
- Universities
- Businesses/Factories

Minimally Involved:

- Hospitals/Medical Centers
- Mental Health Agencies
- Schools

Moderately Involved:

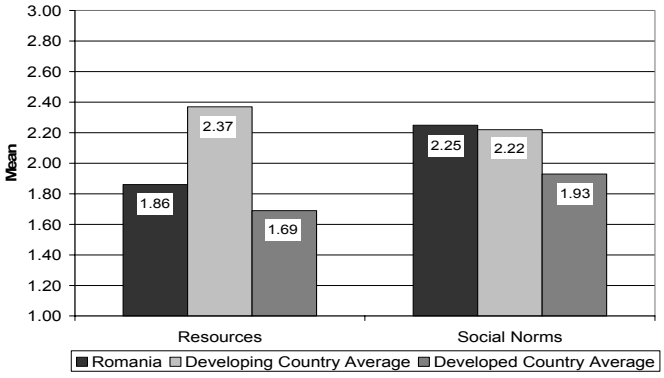
- Public social service agencies
- Community-based NGOs
- Voluntary civic organizations

Very Involved:

- NA

BARRIERS

Average rating of limiting factors to CAN prevention, (E.g. poverty, support for use of corporal punishment, etc) (Scale: 1="Not important" to 3="Very significant")



RUSSIA

Region: Europe

Previous World Perspectives surveys completed: 1998, 2000, 2002, 2004

OFFICIAL RECORDS

Country maintains official count of CAN cases: YES

If yes, classifications included:

- ☑ Physical abuse
- ☐ Sexual abuse
- ☐ Psychological maltreatment
- ☑ Neglect

SERVICES

Services available, and capacity of these services to reach all families involved or at risk of abuse.

Adequate in ***Less Than*** *1/3* of Country:

- Therapy programs for child victims of physical and sexual abuse
- Case management services/meeting basic needs
- Home-based services to assist parents in changing their behaviors
- Foster care with official foster parents
- Group homes for abused children
- Family Resource Centers for parents to share experiences/concerns
- Universal access to free medical care for all citizens
- Substance abuse treatments for parents

Adequate in ***1/3 to 2/3*** of Country:

- Institutional care for abused children
- Financial and material support
- Short-term hospitalization for mental illness
- Substance abuse treatments for children
- Targeted home visits for new parents at-risk
- Free child care
- Universal access to free medical care for child

Adequate in ***More Than*** *2/3* of Country:

- Universal health screening for child
- Universal home visits for all new parents

Unavailable:

- Therapy programs for physical and sexual abusers

FUNDING

Activity level of sectors in funding child abuse treatment or prevention services.

	Major	Limited	None	Unknown
Int'l NGOs	◆			
Int'l Relief Organizations		◆		
National Government		◆		
State/Local Government		◆		
Private foundations		◆		
Individuals		◆		
Businesses		◆		

POLICY

Official government law or policy regarding child abuse and neglect? YES

If yes, date established: Between 1990-2000

Core Elements

- Mandated reporting of suspected child abuse for specific groups of professionals
- All victims receive some form of service/intervention
- Provisions for removing child from his/her parents or caretakers to ensure the child's safety
- Criminal penalties for abusing a child
- Attorney assigned to represent the child's interests

Enforcement Level: Inconsistently enforced

Level of Government Support: Inconsistently supported

RESEARCH (in past 10 years)

- Population-based surveys conducted to assess scope of problem: YES
- Public opinion polls to assess awareness: YES

SERVICE PROVIDERS

Relative involvement in child abuse treatment and prevention services.

Very Involved:

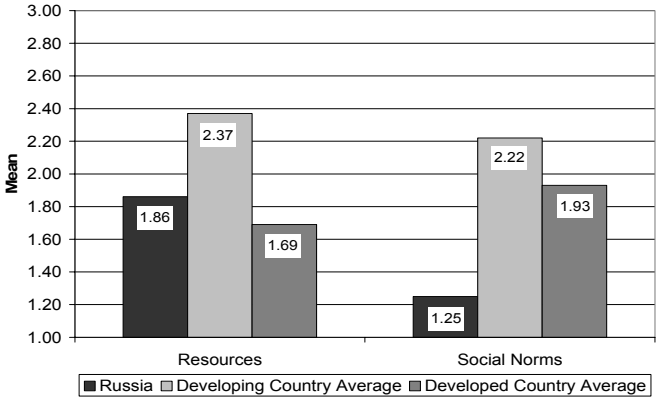
- Hospitals/Medical Centers
- Mental Health Agencies
- Public social service agencies
- Schools

Minimally Involved:

- Courts/law enforcement
- Businesses/Factories
- Community-based NGOs
- Religious institutions
- Voluntary civic organizations

BARRIERS

Average rating of limiting factors to CAN prevention,
(E.g. poverty, support for use of corporal punishment, etc)
(Scale: 1="Not important" to 3="Very significant")



RWANDA

Region: Africa

Previous World Perspectives surveys completed: 2000, 2002, 2004

OFFICIAL RECORDS

Country maintains official count of CAN cases: YES

If yes, classifications included:

- ☑ Physical abuse
- ☑ Sexual abuse
- ☐ Psychological maltreatment
- ☑ Neglect

SERVICES

Services available, and capacity of these services to reach all families involved or at risk of abuse.

Available (Adequacy unknown):

- Therapy programs for child victims of sexual abuse
- Foster care with official foster parents
- Institutional care for abused children
- Short-term hospitalization for mental illness
- Universal health screening for child

Unavailable:

- Therapy programs for child victims of physical abuse
- Therapy programs for physical and sexual abusers
- Case management services/meeting basic needs
- Home-based services to assist parents in changing their behaviors
- Financial and material support
- Group homes for abused children
- Substance abuse treatments for children
- Substance abuse treatments for parents
- Family Resource Centers for parents to share experiences/concerns
- Universal home visits for all new parents
- Targeted home visits for new parents at-risk
- Free child care
- Universal access to free medical care for all citizens
- Universal access to free medical care for child

FUNDING

Activity level of sectors in funding child abuse treatment or prevention services.

	Major	Limited	None	Unknown
Int'l NGOs	◆			
Int'l Relief Organizations	◆			
National Government	◆			
State/Local Government	◆			
Private foundations			◆	
Individuals			◆	
Businesses			◆	

POLICY

Official government law or policy regarding child abuse and neglect? YES

If yes, date established: After 2000

Core Elements

- Mandated reporting of suspected child abuse for specific groups of professionals
- All victims receive some form of service/intervention
- All abusers receive some form of service/intervention
- Criminal penalties for abusing a child
- Attorney assigned to represent the child's interests

Enforcement Level: Widely enforced

Level of Government Support: Widely supported

RESEARCH (in past 10 years)

- Population-based surveys conducted to assess scope of problem: YES
- Public opinion polls to assess awareness: NO

SERVICE PROVIDERS

Relative involvement in child abuse treatment and prevention services.

Moderately Involved:

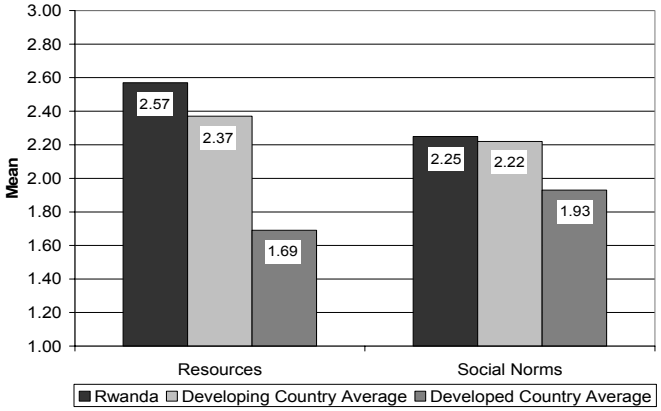
- Schools/universities

Very Involved:

- Hospitals/Medical Centers
- Mental Health Agencies
- Public social service agencies
- Community-based and International NGOs
- Religious institutions
- Courts/law enforcement
- Voluntary civic organizations

BARRIERS

Average rating of limiting factors to CAN prevention, (E.g. poverty, support for use of corporal punishment, etc) (Scale: 1="Not important" to 3="Very significant")



SAINT LUCIA

Region: Americas

OFFICIAL RECORDS

Country maintains official count of CAN cases: YES

If yes, classifications included:

- ☑ Physical abuse
- ☑ Sexual abuse
- ☑ Psychological maltreatment
- ☑ Neglect

SERVICES

Services available, and capacity of these services to reach all families involved or at risk of abuse.

Adequate in ***Less Than*** *1/3* of Country:

- Therapy programs for physical and sexual abusers
- Institutional care for abused children
- Financial and material support
- Substance abuse treatments for children
- Universal home visits for all new parents
- Targeted home visits for new parents at-risk

Adequate in ***1/3 to 2/3*** of Country:

- Therapy programs for child victims of physical and sexual abuse
- Case management services/meeting basic needs
- Foster care with official foster parents
- Substance abuse treatments for parents
- Family Resource Centers for parents to share experiences/concerns

Adequate in ***More Than*** *2/3* of Country:

- Short-term hospitalization for mental illness
- Universal health screening for child

Unavailable:

- Home-based services to assist parents in changing their behaviors
- Group homes for abused children
- Free child care
- Universal access to free medical care for child
- Universal access to free medical care for all citizens

FUNDING

Activity level of sectors in funding child abuse treatment or prevention services.

	Major	Limited	None	Unknown
Int'l NGOs		◆		
Int'l Relief Organizations			◆	
National Government		◆		
State/Local Government				◆
Private foundations				◆
Individuals		◆		
Businesses				◆

POLICY

Official government law or policy regarding child abuse and neglect? YES

If yes, date established: Before 1980

Core Elements

- Voluntary reporting of suspected child abuse by any professional or individual
- Criminal penalties for abusing a child
- Provisions for removing child from his/her parents or caretakers to ensure the child's safety

Enforcement Level: Widely enforced

Level of Government Support: Widely supported

RESEARCH (in past 10 years)

- Population-based surveys conducted to assess scope of problem: NO
- Public opinion polls to assess awareness: NO

SERVICE PROVIDERS

Relative involvement in child abuse treatment and prevention services.

Not Involved:

- Businesses/Factories

Minimally Involved:

- Schools
- Community-based NGOs
- Religious institutions
- Voluntary civic organizations

Moderately Involved:

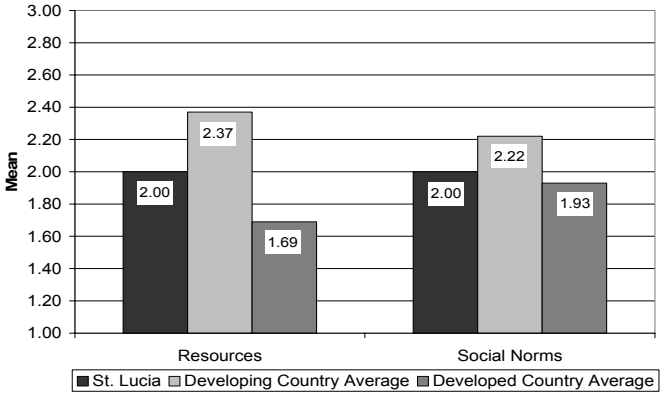
- Hospitals/Medical Centers
- Mental Health Agencies

Very Involved:

- Courts/law enforcement
- Public social service agencies

BARRIERS

Average rating of limiting factors to CAN prevention,
(E.g. poverty, support for use of corporal punishment, etc)
(Scale: 1="Not important" to 3="Very significant")



SCOTLAND

Region: Europe

Previous World Perspectives surveys completed:
1996, 1998, 2000, 2002, 2004

OFFICIAL RECORDS

Country maintains official count of CAN cases: YES

If yes, classifications included:

- ☑ Physical abuse
- ☑ Sexual abuse
- ☑ Psychological maltreatment
- ☑ Neglect

SERVICES

Services available, and capacity of these services to reach all families involved or at risk of abuse.

Adequate in ***Less Than*** *1/3* of Country:

- Therapy programs for child victims of physical abuse
- Financial and material support

Adequate in ***1/3 to 2/3*** of Country:

- Therapy programs for physical and sexual abusers
- Therapy programs for child victims of sexual abuse
- Short-term hospitalization for mental illness
- Substance abuse treatments for children
- Family Resource Centers for parents to share experiences/concerns

Adequate in ***More Than*** *2/3* of Country:

- Case management services/meeting basic needs
- Home-based services to assist parents in changing their behaviors
- Foster care with official foster parents
- Institutional care for abused children
- Substance abuse treatments for parents
- Targeted home visits for new parents at-risk
- Universal health screening for child
- Universal access to free medical care for child
- Universal access to free medical care for all citizens

Unavailable:

- Group homes for abused children

FUNDING

Activity level of sectors in funding child abuse treatment or prevention services.

	Major	Limited	None	Unknown
Int'l NGOs			◆	
Int'l Relief Organizations			◆	
National Government	◆			
State/Local Government	◆			
Private foundations		◆		
Individuals			◆	
Businesses			◆	

POLICY

Official government law or policy regarding child abuse and neglect? YES

If yes, date established: Before 1980

Core Elements

- Voluntary reporting of suspected child abuse for any professional or individual
- All victims receive some form of service/intervention
- Provisions for removing child from his/her parents or caretakers to ensure the child's safety
- Criminal penalties for abusing a child

Enforcement Level: Widely enforced

Level of Government Support: Widely supported

RESEARCH (in past 10 years)

- Population-based surveys conducted to assess scope of problem: YES
- Public opinion polls to assess awareness: NO

SERVICE PROVIDERS

Relative involvement in child abuse treatment and prevention services.

Not Involved:

- Businesses/Factories

Minimally Involved:

- Voluntary civic organizations

Moderately Involved:

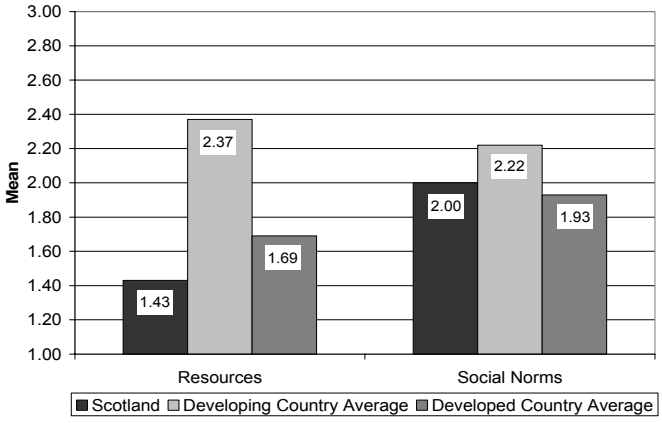
- Mental Health Agencies
- Religious institutions

Very Involved:

- Hospitals/Medical Centers
- Public social service agencies
- Courts/law enforcement
- Community-based NGOs
- Schools/Universities

BARRIERS

Average rating of limiting factors to CAN prevention,
(E.g. poverty, support for use of corporal punishment, etc)
(Scale: 1="Not important" to 3="Very significant")



SERBIA

Region: Europe

Previous World Perspectives surveys completed: 2000, 2002, 2004

OFFICIAL RECORDS

Country maintains official count of CAN cases: NO

If yes, classifications included:

- ☐ Physical abuse
- ☐ Sexual abuse
- ☐ Psychological maltreatment
- ☐ Neglect

SERVICES

Services available, and capacity of these services to reach all families involved or at risk of abuse.

Adequate in ***Less Than*** *1/3* of Country:

- Therapy programs for child victims of physical abuse and sexual abuse
- Therapy programs for physical abusers
- Home-based services to assist parents in changing their behaviors
- Institutional care for abused children
- Substance abuse treatments for children
- Targeted home visits for new parents at-risk

Adequate in ***1/3 to 2/3*** of Country:

- Case management services/meeting basic needs
- Foster care with official foster parents
- Financial and material support
- Short-term hospitalization for mental illness
- Substance abuse treatments for parents

Adequate in ***More Than*** *2/3* of Country:

- Universal home visits for all new parents
- Free child care
- Universal health screening for child
- Universal access to free medical care for child
- Universal access to free medical care for all citizens

Unavailable:

- Therapy programs for sexual abusers
- Group homes for abused children
- Family Resource Centers for parents to share experiences/concerns

FUNDING

Activity level of sectors in funding child abuse treatment or prevention services.

	Major	Limited	None	Unknown
Int'l NGOs	◆			
Int'l Relief Organizations		◆		
National Government	◆			
State/Local Government		◆		
Private foundations				◆
Individuals				◆
Businesses				◆

POLICY

Official government law or policy regarding child abuse and neglect? YES

If yes, date established: After 2000

Core Elements

- Mandated reporting of suspected child abuse for specific groups of professionals
- All victims receive some form of service/intervention
- Criminal penalties for abusing a child
- Provisions for removing child from his/her parents or caretakers to ensure the child's safety

Enforcement Level: Inconsistently enforced

Level of Government Support: Inconsistently supported

RESEARCH (in past 10 years)

- Population-based surveys conducted to assess scope of problem: NO
- Public opinion polls to assess awareness: YES

SERVICE PROVIDERS

Relative involvement in child abuse treatment and prevention services.

Not Involved:

- Businesses/Factories

Minimally Involved:

- Religious institutions
- Voluntary civic organizations

Moderately Involved:

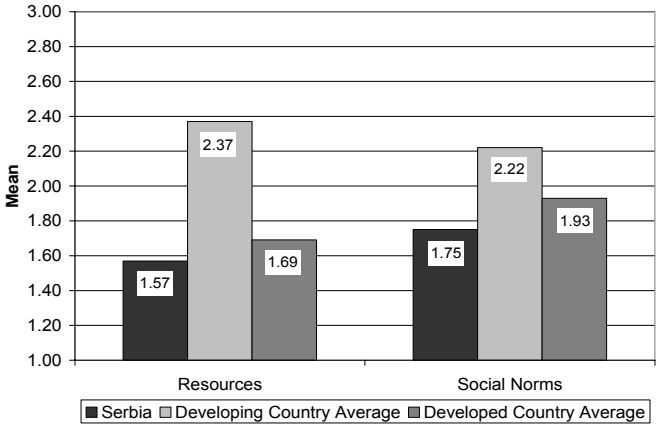
- Hospitals/Medical Centers
- Mental Health Agencies
- Schools
- Courts/law enforcement

Very Involved:

- Community-based NGOs
- Public social service agencies

BARRIERS

Average rating of limiting factors to CAN prevention, (E.g. poverty, support for use of corporal punishment, etc) (Scale: 1="Not important" to 3="Very significant")



SINGAPORE

Region: South-Eastern Asia

Previous World Perspectives surveys completed: 1996, 1998, 2000, 2004

OFFICIAL RECORDS

Country maintains official count of CAN cases: YES

If yes, classifications included:

- ☑ Physical abuse
- ☑ Sexual abuse
- ☑ Psychological maltreatment
- ☑ Neglect

SERVICES

Services available, and capacity of these services to reach all families involved or at risk of abuse.

Adequate in ***1/3 to 2/3*** of Country:

- Home-based services to assist parents in changing their behaviors
- Family Resource Centers for parents to share experiences/concerns
- Universal home visits for all new parents
- Free child care
- Universal access to free medical care for child
- Universal access to free medical care for all citizens

Adequate in ***More Than*** *2/3* of Country:

- Therapy programs for child victims of physical abuse and sexual abuse
- Therapy programs for physical and sexual abusers
- Case management services/meeting basic needs
- Foster care with official foster parents
- Group homes for abused children
- Institutional care for abused children
- Financial and material support
- Short-term hospitalization for mental illness
- Substance abuse treatments for parents
- Substance abuse treatments for children
- Targeted home visits for new parents at-risk
- Universal health screening for child

FUNDING

Activity level of sectors in funding child abuse treatment or prevention services.

	Major	Limited	None	Unknown
Int'l NGOs			◆	
Int'l Relief Organizations			◆	
National Government	◆			
State/Local Government	◆			
Private foundations		◆		
Individuals		◆		
Businesses		◆		

POLICY

Official government law or policy regarding child abuse and neglect? YES

If yes, date established: Before 1980

Core Elements

- Voluntary reporting of suspected child abuse for any professional or individual
- All victims receive some form of service/intervention
- All abusers receive some form of service/intervention
- Criminal penalties for abusing a child
- Attorney assigned to represent the child's interests

Enforcement Level: Widely enforced

Level of Government Support: Widely supported

RESEARCH (in past 10 years)

- Population-based surveys conducted to assess scope of problem: YES
- Public opinion polls to assess awareness: YES

SERVICE PROVIDERS

Relative involvement in child abuse treatment and prevention services.

Minimally Involved:

- Mental Health Agencies
- Schools/Universities
- Religious institutions

Moderately Involved:

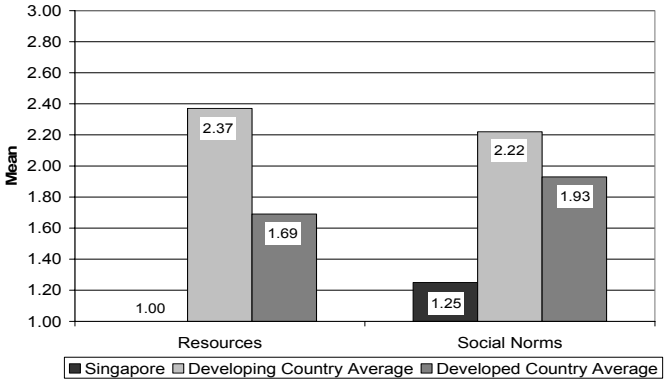
- Hospitals/Medical Centers
- Public social service agencies
- Community-based NGOs
- Voluntary civic organizations

Very Involved:

- Courts/law enforcement

BARRIERS

Average rating of limiting factors to CAN prevention, (E.g. poverty, support for use of corporal punishment, etc) (Scale: 1="Not important" to 3="Very significant")



SOMALIA

Region: Africa

Previous World Perspectives surveys completed: None

OFFICIAL RECORDS

Country maintains official count of CAN cases: NO

If yes, classifications included:

- ☐ Physical abuse
- ☐ Sexual abuse
- ☐ Psychological maltreatment
- ☐ Neglect

SERVICES

Services available, and capacity of these services to reach all families involved or at risk of abuse.

Adequate in ***Less Than*** *1/3* of Country:

- Therapy programs for child victims of physical abuse
- Home-based services to assist parents in changing their behaviors
- Financial and material support
- Family Resource Centers for parents to share experiences/concerns

Unavailable:

- Therapy programs for child victims of physical abuse
- Therapy programs for physical and sexual abusers
- Case management services/meeting basic needs
- Foster care with official foster parents
- Institutional care for abused children
- Group homes for abused children
- Short-term hospitalization for mental illness
- Substance abuse treatments for children
- Substance abuse treatments for parents
- Targeted home visits for new parents at-risk
- Universal home visits for all new parents
- Free child care
- Universal health screening for child
- Universal access to free medical care for child
- Universal access to free medical care for all citizens

FUNDING

Activity level of sectors in funding child abuse treatment or prevention services.

	Major	Limited	None	Unknown
Int'l NGOs		◆		
Int'l Relief Organizations		◆		
National Government			◆	
State/Local Government			◆	
Private foundations			◆	
Individuals		◆		
Businesses			◆	

POLICY

Official government law or policy regarding child abuse and neglect? NO

If yes, date established: NA

Core Elements

- NA

Enforcement Level: NA

Level of Government Support: NA

RESEARCH (in past 10 years)

- Population-based surveys conducted to assess scope of problem: YES
- Public opinion polls to assess awareness: NO

SERVICE PROVIDERS

Relative involvement in child abuse treatment and prevention services.

Not Involved:

- Hospitals/Medical Centers
- Mental Health Agencies
- Public social service agencies
- Voluntary civic organizations
- Courts/law enforcement
- Businesses/Factories
- Universities

Minimally Involved:

- Schools

Very Involved:

- Community-based NGOs
- Religious institutions

BARRIERS

Average rating of limiting factors to CAN prevention, NA

SOUTH AFRICA

Region: Africa

Previous World Perspectives surveys completed: 1992, 1996, 1998, 2000, 2002, 2004

OFFICIAL RECORDS

Country maintains official count of CAN cases: YES

If yes, classifications included:

- ☑ Physical abuse
- ☑ Sexual abuse
- ☐ Psychological maltreatment
- ☑ Neglect

SERVICES

Services available, and capacity of these services to reach all families involved or at risk of abuse.

Adequate in ***Less Than*** *1/3* of Country:

- Therapy programs for child victims of physical and sexual abuse
- Therapy programs for physical and sexual abusers
- Group homes for abused children
- Financial and material support
- Short-term hospitalization for mental illness
- Substance abuse treatments for children
- Family Resource Centers for parents to share experiences/concerns
- Foster care with official foster parents
- Institutional care for abused children
- Substance abuse treatments for parents
- Universal health screening for child
- Universal access to free medical care for child

Unavailable:

- Case management services/meeting basic needs
- Home-based services to assist parents in changing their behaviors
- Targeted home visits for new parents at-risk
- Universal home visits for all new parents
- Free child care
- Universal access to free medical care for all citizens

FUNDING

Activity level of sectors in funding child abuse treatment or prevention services.

	Major	Limited	None	Unknown
Int'l NGOs	◆			
Int'l Relief Organizations		◆		
National Government		◆		
State/Local Government		◆		
Private foundations	◆			
Individuals		◆		
Businesses		◆		

POLICY

Official government law or policy regarding child abuse and neglect? YES

If yes, date established: Before 1980

Core Elements

- Mandated reporting of suspected child abuse for specific groups of professionals
- Criminal penalties for abusing a child
- Provisions for removing child from his/her parents or caretakers to ensure the child's safety

Enforcement Level: Inconsistently enforced

Level of Government Support: Inconsistently supported

RESEARCH (in past 10 years)

- Population-based surveys conducted to assess scope of problem: YES
- Public opinion polls to assess awareness: NO

SERVICE PROVIDERS

Relative involvement in child abuse treatment and prevention services.

Not Involved:

- Businesses/Factories

Minimally Involved:

- Mental Health Agencies

Moderately Involved:

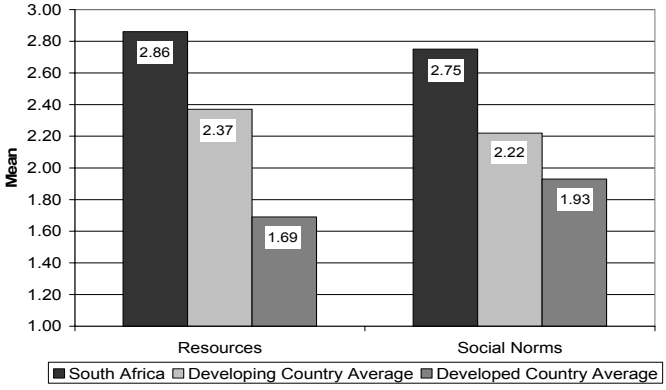
- Hospitals/Medical Centers
- Religious institutions
- Courts/law enforcement
- Universities

Very Involved:

- Public social service agencies
- Community-based NGOs
- Voluntary civic organizations

BARRIERS

Average rating of limiting factors to CAN prevention, (E.g. poverty, support for use of corporal punishment, etc) (Scale: 1="Not important" to 3="Very significant")



SPAIN

Region: Europe

Previous World Perspectives surveys completed:
1992, 1996, 1998, 2000, 2002, 2004

OFFICIAL RECORDS

Country maintains official count of CAN cases: YES

If yes, classifications included:

- ☑ Physical abuse
- ☑ Sexual abuse
- ☑ Psychological maltreatment
- ☑ Neglect

SERVICES

Services available, and capacity of these services to reach all families involved or at risk of abuse.

Adequate in ***Less Than*** *1/3* of Country:

- Short-term hospitalization for mental illness

Adequate in ***1/3 to 2/3*** of Country:

- Therapy programs for child victims of physical abuse and sexual abuse
- Case management services/meeting basic needs
- Home-based services to assist parents in changing their behaviors
- Group homes for abused children
- Universal home visits for all new parents
- Targeted home visits for new parents at-risk

Adequate in ***More Than*** *2/3* of Country:

- Foster care with official foster parents
- Institutional care for abused children
- Financial and material support
- Substance abuse treatments for parents
- Substance abuse treatments for children
- Universal health screening for child
- Universal access to free medical care for child
- Universal access to free medical care for all citizens

Unavailable:

- Family Resource Centers for parents to share experiences/concerns

FUNDING

Activity level of sectors in funding child abuse treatment or prevention services.

	Major	Limited	None	Unknown
Int'l NGOs		◆		
Int'l Relief Organizations		◆		
National Government	◆			
State/Local Government	◆			
Private foundations		◆		
Individuals		◆		
Businesses			◆	

POLICY

Official government law or policy regarding child abuse and neglect? YES

If yes, date established: Before 1980

Core Elements

- Mandated reporting of suspected child abuse for specific groups of professionals
- All victims receive some form of service/intervention
- All abusers receive some form of service/intervention
- Attorney assigned to represent the child's interests

Enforcement Level: Widely enforced

Level of Government Support: Widely supported

RESEARCH (in past 10 years)

- Population-based surveys conducted to assess scope of problem: YES
- Public opinion polls to assess awareness: YES

SERVICE PROVIDERS

Relative involvement in child abuse treatment and prevention services.

Not Involved:

- NA

Minimally Involved:

- Businesses/Factories

Moderately Involved:

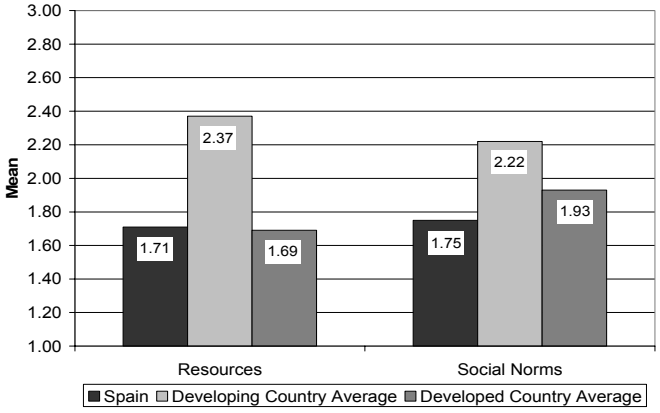
- Mental Health Agencies
- Schools/Universities
- Community-based NGOs
- Religious institutions
- Voluntary civic organizations

Very Involved:

- Hospitals/Medical Centers
- Courts/law enforcement
- Public social service agencies

BARRIERS

Average rating of limiting factors to CAN prevention,
(E.g. poverty, support for use of corporal punishment, etc)
(Scale: 1="Not important" to 3="Very significant")



SRI LANKA

Region: South-Central Asia

Previous World Perspectives surveys completed: 1998, 2000, 2002, 2004

OFFICIAL RECORDS

Country maintains official count of CAN cases: YES

If yes, classifications included:

- ☑ Physical abuse
- ☑ Sexual abuse
- ☑ Psychological maltreatment
- ☑ Neglect

SERVICES

Services available, and capacity of these services to reach all families involved or at risk of abuse.

Adequate in ***Less Than*** *1/3* of Country:

- Therapy programs for child victims of physical abuse
- Therapy programs for physical and sexual abusers
- Substance abuse treatments for parents
- Targeted home visits for new parents at-risk

Adequate in ***1/3 to 2/3*** of Country:

- Therapy programs for child victims of sexual abuse
- Case management services/meeting basic needs
- Foster care with official foster parents
- Group homes for abused children
- Financial and material support
- Substance abuse treatments for children

Adequate in ***More Than*** *2/3* of Country:

- Institutional care for abused children
- Short-term hospitalization for mental illness
- Free child care
- Universal health screening for child
- Universal access to free medical care for child
- Universal access to free medical care for all citizens

Unavailable:

- Home-based services to assist parents in changing their behaviors
- Family Resource Centers for parents to share experiences/concerns
- Universal home visits for all new parents

FUNDING

Activity level of sectors in funding child abuse treatment or prevention services.

	Major	Limited	None	Unknown
Int'l NGOs	◆			
Int'l Relief Organizations		◆		
National Government		◆		
State/Local Government		◆		
Private foundations			◆	
Individuals			◆	
Businesses		◆		

POLICY

Official government law or policy regarding child abuse and neglect? YES

If yes, date established: Between 1990-2000

Core Elements

- Voluntary reporting of suspected child abuse by any professional or individual
- All victims receive some form of service/intervention
- All abusers receive some form of service/intervention
- Attorney assigned to represent the child's interests

Enforcement Level: Widely enforced

Level of Government Support: Widely supported

RESEARCH (in past 10 years)

- Population-based surveys conducted to assess scope of problem: YES
- Public opinion polls to assess awareness: YES

SERVICE PROVIDERS

Relative involvement in child abuse treatment and prevention services.

Moderately Involved:

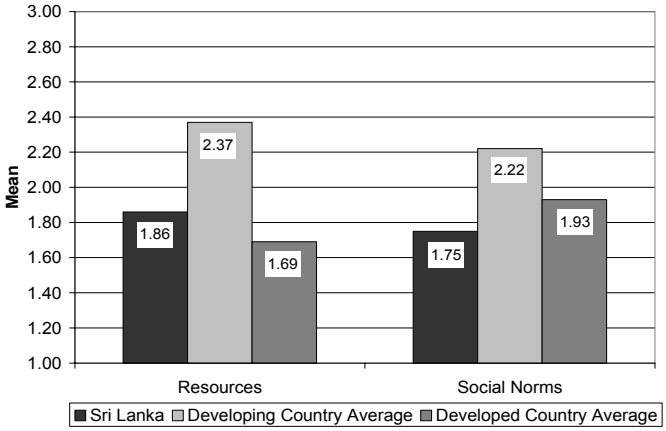
- Hospitals/Medical Centers
- Mental Health Agencies
- Schools/Universities
- Community-based NGOs
- Public social service agencies
- Religious institutions
- Voluntary civic organizations Courts/law enforcement

Minimally Involved:

- Businesses/Factories

BARRIERS

Average rating of limiting factors to CAN prevention, (E.g. poverty, support for use of corporal punishment, etc) (Scale: 1="Not important" to 3="Very significant")



SWEDEN

Region: Europe

Previous World Perspectives surveys completed: 1992, 1996, 2002, 2004

OFFICIAL RECORDS

Country maintains official count of CAN cases: NO

If yes, classifications included:

- ☐ Physical abuse
- ☐ Sexual abuse
- ☐ Psychological maltreatment
- ☐ Neglect

SERVICES

Services available, and capacity of these services to reach all families involved or at risk of abuse.

Adequate in ***Less Than*** *1/3* of Country:

- Therapy programs for child victims of physical abuse
- Therapy programs for sexual abusers

Adequate in ***1/3 to 2/3*** of Country:

- Therapy programs for child victims of sexual abuse
- Group homes for abused children
- Family Resource Centers for parents to share experiences/concerns

Adequate in ***More Than*** *2/3* of Country:

- Case management services/meeting basic needs
- Home-based services to assist parents in changing their behaviors
- Foster care with official foster parents
- Institutional care for abused children
- Financial and material support
- Short-term hospitalization for mental illness
- Substance abuse treatments for children
- Substance abuse treatments for parents
- Universal home visits for all new parents
- Targeted home visits for new parents at-risk
- Universal health screening for child
- Universal access to free medical care for child

Unavailable:

- Therapy programs for physical abusers
- Free child care
- Universal access to free medical care for all citizens

FUNDING

Activity level of sectors in funding child abuse treatment or prevention services.

	Major	Limited	None	Unknown
Int'l NGOs			◆	
Int'l Relief Organizations			◆	
National Government		◆		
State/Local Government	◆			
Private foundations		◆		
Individuals			◆	
Businesses			◆	

POLICY

Official government law or policy regarding child abuse and neglect? YES

If yes, date established: Before 1980

Core Elements

- Mandated reporting of suspected child abuse for specific groups of professionals
- All victims receive some form of service/intervention
- Attorney assigned to represent the child's interests
- Criminal penalties for abusing a child

Enforcement Level: Widely enforced

Level of Government Support: Widely supported

RESEARCH (in past 10 years)

- Population-based surveys conducted to assess scope of problem: YES
- Public opinion polls to assess awareness: NO

SERVICE PROVIDERS

Relative involvement in child abuse treatment and prevention services.

Not Involved:

- Businesses/Factories
- Voluntary civic organizations
- Courts/law enforcement
- Universities

Moderately Involved:

- Schools

Minimally Involved:

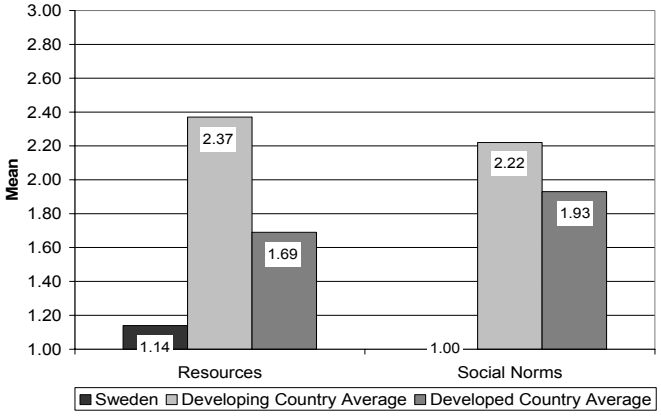
- Hospitals/Medical Centers
- Community-based NGOs
- Religious institutions

Very Involved:

- Public social service agencies
- Mental Health Agencies

BARRIERS

Average rating of limiting factors to CAN prevention, (E.g. poverty, support for use of corporal punishment, etc) (Scale: 1="Not important" to 3="Very significant")



SYRIA

Region: Western Asia

Previous World Perspectives surveys completed: 2004

OFFICIAL RECORDS

Country maintains official count of CAN cases: NO

If yes, classifications included:

- ☐ Physical abuse
- ☐ Sexual abuse
- ☐ Psychological maltreatment
- ☐ Neglect

SERVICES

Services available, and capacity of these services to reach all families involved or at risk of abuse.

Adequate in ***Less Than*** *1/3* of Country:

- Institutional care for abused children
- Short-term hospitalization for mental illness
- Substance abuse treatments for children
- Substance abuse treatments for parents
- Universal health screening for child
- Universal access to free medical care for child
- Universal access to free medical care for all citizens

Unavailable:

- Therapy programs for child victims of physical and sexual abuse
- Therapy programs for physical and sexual abusers
- Therapy programs for physical abusers
- Case management services/meeting basic needs
- Home-based services to assist parents in changing their behaviors
- Foster care with official foster parents
- Financial and material support
- Universal home visits for all new parents
- Targeted home visits for new parents at-risk
- Group homes for abused children
- Family Resource Centers for parents to share experiences/concerns
- Free child care

FUNDING

Activity level of sectors in funding child abuse treatment or prevention services.

	Major	Limited	None	Unknown
Int'l NGOs			◆	
Int'l Relief Organizations			◆	
National Government		◆		
State/Local Government				
Private foundations			◆	
Individuals		◆		
Businesses			◆	

POLICY

Official government law or policy regarding child abuse and neglect? NO

If yes, date established: NA

Core Elements

- NA

Enforcement Level: NA

Level of Government Support: NA

RESEARCH (in past 10 years)

- Population-based surveys conducted to assess scope of problem: YES
- Public opinion polls to assess awareness: NO

SERVICE PROVIDERS

Relative involvement in child abuse treatment and prevention services.

Not Involved:

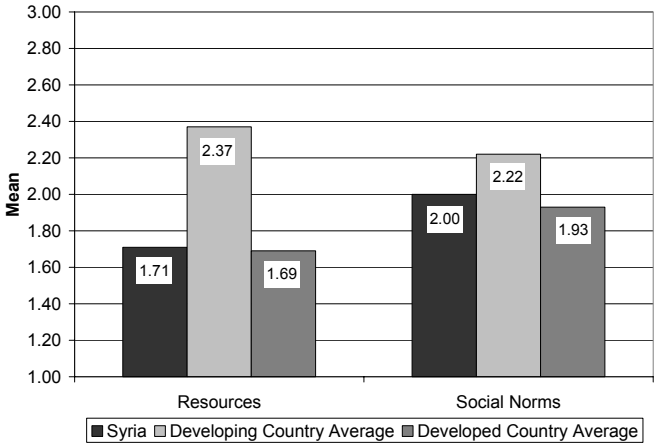
- Businesses/Factories
- Public social service agencies
- Voluntary civic organizations
- Religious institutions
- Universities

Minimally Involved:

- Hospitals/Medical Centers
- Mental Health Agencies
- Community-based NGOs
- Courts/law enforcement
- Schools

BARRIERS

Average rating of limiting factors to CAN prevention, (E.g. poverty, support for use of corporal punishment, etc) (Scale: 1="Not important" to 3="Very significant")



TAIWAN, REPUBLIC OF CHINA

Region: Eastern Asia

Previous World Perspectives surveys completed: 1998, 2000, 2002

OFFICIAL RECORDS

Country maintains official count of CAN cases: YES

If yes, classifications included:

- ☑ Physical abuse
- ☑ Sexual abuse
- ☑ Psychological maltreatment
- ☑ Neglect

SERVICES

Services available, and capacity of these services to reach all families involved or at risk of abuse.

Adequate in ***Less Than** 1/3* of Country:

- Therapy programs for child victims of physical and sexual abuse
- Therapy programs for physical and sexual abusers
- Case management services/meeting basic needs
- Home-based services to assist parents in changing their behaviors
- Group homes for abused children
- Institutional care for abused children
- Financial and material support
- Short-term hospitalization for mental illness
- Substance abuse treatments for children
- Substance abuse treatments for parents
- Free child care
- Universal health screening for child

Adequate in ***1/3 to 2/3*** of Country:

- Foster care with official foster parents
- Universal access to free medical care for child

Unavailable:

- Family Resource Centers for parents to share experiences/concerns
- Universal home visits for all new parents
- Targeted home visits for new parents at-risk
- Universal access to free medical care for all citizens

FUNDING

Activity level of sectors in funding child abuse treatment or prevention services.

	Major	Limited	None	Unknown
Int'l NGOs			◆	
Int'l Relief Organizations		◆		
National Government		◆		
State/Local Government		◆		
Private foundations	◆			
Individuals			◆	
Businesses			◆	

POLICY

Official government law or policy regarding child abuse and neglect? YES

If yes, date established: Between 1990-2000

Core Elements

- Mandated reporting of suspected child abuse for specific groups of professionals
- All victims receive some form of service/intervention
- Attorney assigned to represent the child's interests
- Criminal penalties for abusing a child

Enforcement Level: Widely enforced

Level of Government Support: Inconsistently supported

RESEARCH (in past 10 years)

- Population-based surveys conducted to assess scope of problem: YES
- Public opinion polls to assess awareness: NO

SERVICE PROVIDERS

Relative involvement in child abuse treatment and prevention services.

Not Involved:

- Hospitals/Medical Centers
- Mental Health Agencies
- Businesses/Factories

Minimally Involved:

- Schools/Universities
- Religious institutions

Moderately Involved:

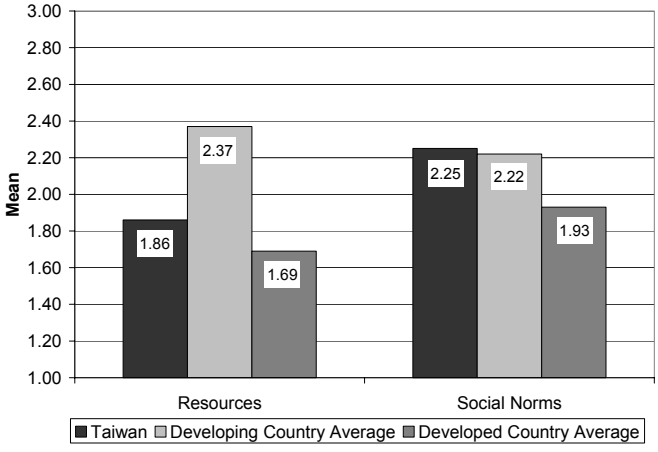
- Public social service agencies
- Community-based NGOs
- Courts/law enforcement

Very Involved:

- Voluntary civic organizations

BARRIERS

Average rating of limiting factors to CAN prevention, (E.g. poverty, support for use of corporal punishment, etc) (Scale: 1="Not important" to 3="Very significant")



TAJIKISTAN

Region: South-Central Asia

Previous World Perspectives surveys completed: None

OFFICIAL RECORDS

Country maintains official count of CAN cases: YES

If yes, classifications included:

- ☑ Physical abuse
- ☑ Sexual abuse
- ☐ Psychological maltreatment
- ☐ Neglect

SERVICES

Services available, and capacity of these services to reach all families involved or at risk of abuse.

Adequate in ***Less Than*** *1/3* of Country:

- Therapy programs for child victims of sexual abuse
- Group homes for abused children
- Short-term hospitalization for mental illness
- Substance abuse treatments for children
- Substance abuse treatments for parents
- Family Resource Centers for parents to share experiences/concerns
- Universal health screening for child

Unavailable:

- Therapy programs for physical and sexual abusers
- Therapy programs for child victims of physical abuse
- Case management services/meeting basic needs
- Home-based services to assist parents in changing their behaviors
- Foster care with official foster parents
- Institutional care for abused children
- Financial and material support
- Universal home visits for all new parents
- Targeted home visits for new parents at-risk
- Free child care
- Universal access to free medical care for child
- Universal access to free medical care for all citizens

FUNDING

Activity level of sectors in funding child abuse treatment or prevention services.

	Major	Limited	None	Unknown
Int'l NGOs	◆			
Int'l Relief Organizations		◆		
National Government		◆		
State/Local Government		◆		
Private foundations	◆			
Individuals			◆	
Businesses			◆	

POLICY

Official government law or policy regarding child abuse and neglect? NO

If yes, date established: NA

Core Elements

- NA

Enforcement Level: NA

Level of Government Support: NA

RESEARCH (in past 10 years)

- Population-based surveys conducted to assess scope of problem: YES
- Public opinion polls to assess awareness: YES

SERVICE PROVIDERS

Relative involvement in child abuse treatment and prevention services.

Moderately Involved:

- Hospitals/Medical Centers
- Community-based NGOs
- Courts/law enforcement

Minimally Involved:

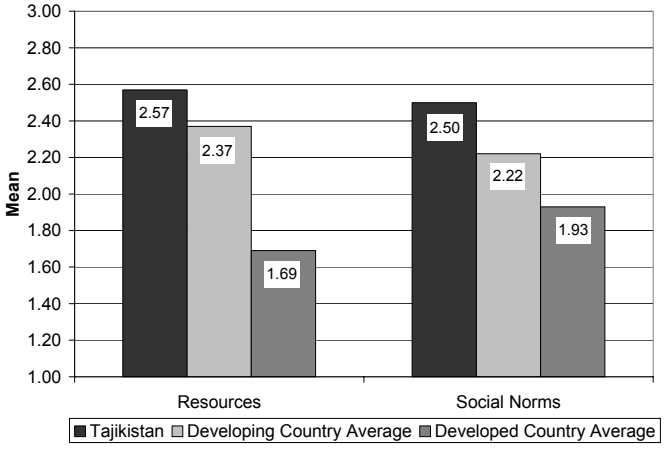
- Mental Health Agencies
- Schools/Universities
- Public social service agencies
- Religious institutions
- Voluntary civic organizations

Not Involved:

- Businesses/Factories

BARRIERS

Average rating of limiting factors to CAN prevention, (E.g. poverty, support for use of corporal punishment, etc) (Scale: 1="Not important" to 3="Very significant")



THAILAND

Region: South-Eastern Asia

Previous World Perspectives surveys completed: 1998, 2002, 2004

OFFICIAL RECORDS

Country maintains official count of CAN cases: NO

If yes, classifications included:

- ☐ Physical abuse
- ☐ Sexual abuse
- ☐ Psychological maltreatment
- ☐ Neglect

SERVICES

Services available, and capacity of these services to reach all families involved or at risk of abuse.

Adequate in ***Less Than*** *1/3* of Country:

- Therapy programs for physical and sexual abusers
- Foster care with official foster parents
- Group homes for abused children
- Short-term hospitalization for mental illness
- Family Resource Centers for parents to share experiences/concerns
- Targeted home visits for new parents at-risk
- Free child care

Adequate in ***1/3 to 2/3*** of Country:

- Therapy programs for child victims of physical and sexual abuse
- Case management services/meeting basic needs
- Home-based services to assist parents in changing their behaviors
- Financial and material support
- Substance abuse treatments for parents

Adequate in ***More Than*** *2/3* of Country:

- Institutional care for abused children
- Substance abuse treatments for children
- Universal health screening for child
- Universal access to free medical care for child
- Universal access to free medical care for all citizens

Unavailable:

- Universal home visits for all new parents

FUNDING

Activity level of sectors in funding child abuse treatment or prevention services.

	Major	Limited	None	Unknown
Int'l NGOs	◆			
Int'l Relief Organizations		◆		
National Government		◆		
State/Local Government		◆		
Private foundations	◆			
Individuals		◆		
Businesses			◆	

POLICY

Official government law or policy regarding child abuse and neglect? YES

If yes, date established: After 2000

Core Elements

- Mandated reporting of suspected child abuse for specific groups of professionals
- All victims receive some form of service/intervention
- Attorney assigned to represent the child's interests
- Criminal penalties for abusing a child

Enforcement Level: Inconsistently enforced

Level of Government Support: Inconsistently supported

RESEARCH (in past 10 years)

- Population-based surveys conducted to assess scope of problem: NO
- Public opinion polls to assess awareness: YES

SERVICE PROVIDERS

Relative involvement in child abuse treatment and prevention services.

Not Involved:

- Businesses/Factories
- Religious institutions

Minimally Involved:

- Mental Health Agencies
- Universities
- Community-based NGOs

Moderately Involved:

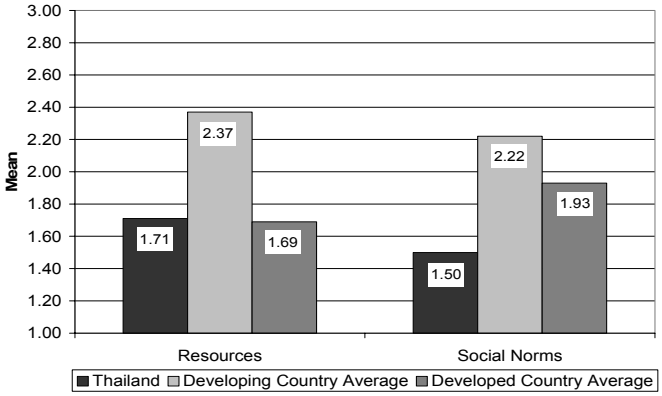
- Hospitals/Medical Centers
- Voluntary civic organizations

Very Involved:

- Public social service agencies
- Schools

BARRIERS

Average rating of limiting factors to CAN prevention,
(E.g. poverty, support for use of corporal punishment, etc)
(Scale: 1="Not important" to 3="Very significant")



TOGO

Region: Africa

Previous World Perspectives surveys completed: 2000, 2002

OFFICIAL RECORDS

Country maintains official count of CAN cases: NO

If yes, classifications included:

- ☐ Physical abuse
- ☐ Sexual abuse
- ☐ Psychological maltreatment
- ☐ Neglect

SERVICES

Services available, and capacity of these services to reach all families involved or at risk of abuse.

Unavailable:

- Therapy programs for child victims of physical and sexual abuse
- Therapy programs for physical and sexual abusers
- Case management services/meeting basic needs
- Home-based services to assist parents in changing their behaviors
- Foster care with official foster parents
- Institutional care for abused children
- Financial and material support
- Short-term hospitalization for mental illness
- Substance abuse treatments for children
- Substance abuse treatments for parents
- Group homes for abused children
- Family Resource Centers for parents to share experiences/concerns
- Universal home visits for all new parents
- Targeted home visits for new parents at-risk
- Universal health screening for child
- Universal access to free medical care for child
- Free child care
- Universal access to free medical care for all citizens

FUNDING

Activity level of sectors in funding child abuse treatment or prevention services.

	Major	Limited	None	Unknown
Int'l NGOs		◆		
Int'l Relief Organizations			◆	
National Government			◆	
State/Local Government			◆	
Private foundations			◆	
Individuals			◆	
Businesses			◆	

POLICY

Official government law or policy regarding child abuse and neglect? YES

If yes, date established: After 2000

Core Elements

- Voluntary reporting of suspected child abuse by any professional or individual
- Criminal penalties for abusing a child
- All victims receive some form of service/intervention
- Attorney assigned to represent the child's interests

Enforcement Level: Inconsistently enforced

Level of Government Support: Inconsistently supported

RESEARCH (in past 10 years)

- Population-based surveys conducted to assess scope of problem: NA
- Public opinion polls to assess awareness: NA

SERVICE PROVIDERS

Relative involvement in child abuse treatment and prevention services.

Not Involved:

- Businesses/ Factories
- Voluntary civic organizations
- Universities

Minimally Involved:

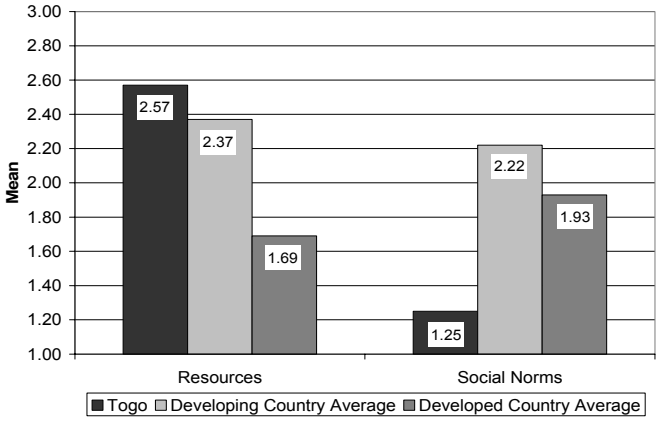
- Hospitals/Medical Centers
- Mental Health Agencies
- Public social service agencies
- Courts/law enforcement
- Schools
- Religious institutions

Moderately Involved:

- Community-based NGOs

BARRIERS

Average rating of limiting factors to CAN prevention,
(E.g. poverty, support for use of corporal punishment, etc)
(Scale: 1="Not important" to 3="Very significant")



TURKEY

Region: Europe

Previous World Perspectives surveys completed: 2002

OFFICIAL RECORDS

Country maintains official count of CAN cases: YES

If yes, classifications included:

- ☑ Physical abuse
- ☑ Sexual abuse
- ☐ Psychological maltreatment
- ☑ Neglect

SERVICES

Services available, and capacity of these services to reach all families involved or at risk of abuse.

Adequate in ***Less Than*** *1/3* of Country:

- Therapy programs for child victims of physical and sexual abuse
- Case management services/meeting basic needs
- Foster care with official foster parents
- Financial and material support
- Substance abuse treatments for children
- Substance abuse treatments for parents

Adequate in ***1/3 to 2/3*** of Country:

- Institutional care for abused children
- Short-term hospitalization for mental illness
- Universal home visits for all new parents

Unavailable:

- Therapy programs for physical and sexual abusers
- Home-based services to assist parents in changing their behaviors
- Group homes for abused children
- Family Resource Centers for parents to share experiences/concerns
- Targeted home visits for new parents at-risk
- Free child care
- Universal health screening for child
- Universal access to free medical care for child
- Universal access to free medical care for all citizens

FUNDING

Activity level of sectors in funding child abuse treatment or prevention services.

	Major	Limited	None	Unknown
Int'l NGOs		◆		
Int'l Relief Organizations				◆
National Government		◆		
State/Local Government		◆		
Private foundations		◆		
Individuals				◆
Businesses		◆		

POLICY

Official government law or policy regarding child abuse and neglect? YES

If yes, date established: Before 1980

Core Elements

- Mandated reporting of suspected child abuse for specific groups of professionals
- All victims receive some form of service/intervention
- Attorney assigned to represent the child's interests
- Criminal penalties for abusing a child

Enforcement Level: Inconsistently enforced

Level of Government Support: Inconsistently supported

RESEARCH (in past 10 years)

- Population-based surveys conducted to assess scope of problem: YES
- Public opinion polls to assess awareness: NO

SERVICE PROVIDERS

Relative involvement in child abuse treatment and prevention services.

Moderately Involved:

- Hospitals/Medical Centers
- Mental Health Agencies
- Public social service agencies
- Community-based NGOs
- Voluntary civic organizations

Not Involved:

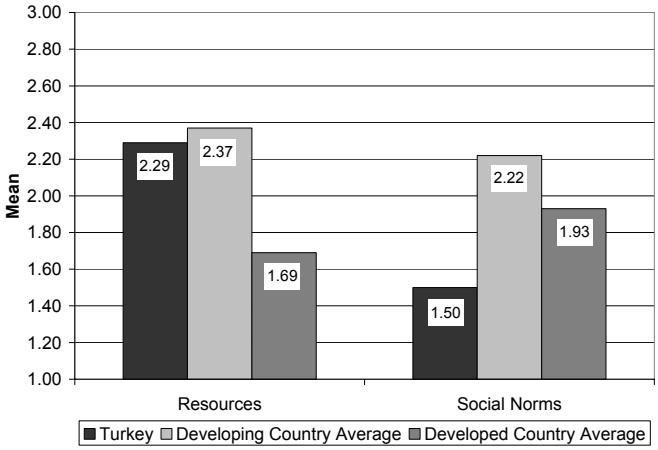
- Businesses/Factories
- Religious institutions

Minimally Involved:

- Schools
- Universities

BARRIERS

Average rating of limiting factors to CAN prevention, (E.g. poverty, support for use of corporal punishment, etc) (Scale: 1="Not important" to 3="Very significant")



TURKMENISTAN

Region: South-Central Asia

Previous World Perspectives surveys completed: 2002

OFFICIAL RECORDS

Country maintains official count of CAN cases: NO

If yes, classifications included:

- ☐ Physical abuse
- ☐ Sexual abuse
- ☐ Psychological maltreatment
- ☐ Neglect

SERVICES

Services available, and capacity of these services to reach all families involved or at risk of abuse.

Available (Adequacy unknown):

- Institutional care for abused children
- Short-term hospitalization for mental illness
- Substance abuse treatments for parents
- Substance abuse treatments for children
- Family Resource Centers for parents to share experiences/concerns
- Free child care
- Universal health screening for child
- Universal access to free medical care for child
- Universal access to free medical care for all citizens

Unavailable:

- Therapy programs for child victims of physical and sexual abuse
- Therapy programs for physical and sexual abusers
- Foster care with official foster parents
- Group homes for abused children
- Targeted home visits for new parents at-risk
- Case management services/meeting basic needs
- Home-based services to assist parents in changing their behaviors
- Financial and material support
- Universal home visits for all new parents

FUNDING

Activity level of sectors in funding child abuse treatment or prevention services.

	Major	Limited	None	Unknown
Int'l NGOs		◆		
Int'l Relief Organizations			◆	
National Government		◆		
State/Local Government		◆		
Private foundations			◆	
Individuals		◆		
Businesses			◆	

POLICY

Official government law or policy regarding child abuse and neglect? YES

If yes, date established: After 2000

Core Elements

- Mandated reporting of suspected child abuse for specific groups of professionals
- All victims receive some form of service/intervention
- All abusers receive some form of service/intervention
- Criminal penalties for abusing a child

Enforcement Level: Inconsistently enforced

Level of Government Support: Inconsistently supported

RESEARCH (in past 10 years)

- Population-based surveys conducted to assess scope of problem: NO
- Public opinion polls to assess awareness: NO

SERVICE PROVIDERS

Relative involvement in child abuse treatment and prevention services.

Not Involved:

- Businesses/Factories
- Schools/Universities
- Public social service agencies
- Religious institutions

Moderately Involved:

- NA

Minimally Involved:

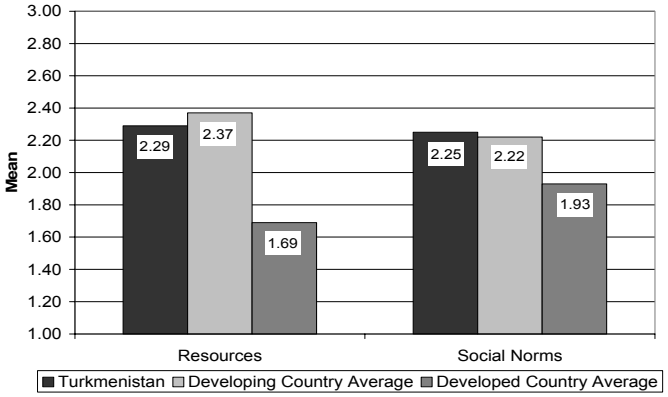
- Mental Health Agencies
- Community-based NGOs
- Voluntary civic organizations

Very Involved:

- Hospitals/Medical Centers
- Courts/law enforcement

BARRIERS

Average rating of limiting factors to CAN prevention, (E.g. poverty, support for use of corporal punishment, etc) (Scale: 1="Not important" to 3="Very significant")



UNITED STATES OF AMERICA

Region: Americas

Previous World Perspectives surveys completed: 1992, 1996, 1998, 2000, 2002, 2004

OFFICIAL RECORDS

Country maintains official count of CAN cases: YES

If yes, classifications included:

- ☑ Physical abuse
- ☑ Sexual abuse
- ☑ Psychological maltreatment
- ☑ Neglect

SERVICES

Services available, and capacity of these services to reach all families involved or at risk of abuse.

Adequate in ***Less Than*** *1/3* of Country:

- Universal home visits for all new parents
- Free child care

Adequate in ***1/3 to 2/3*** of Country:

- Substance abuse treatments for parents
- Substance abuse treatments for children
- Targeted home visits for new parents at-risk

Adequate in ***More Than*** *2/3* of Country:

- Therapy programs for child victims of physical and sexual abuse
- Therapy programs for physical and sexual abusers
- Foster care with official foster parents
- Case management services/meeting basic needs
- Home-based services to assist parents in changing their behaviors
- Financial and material support
- Short-term hospitalization for mental illness
- Family Resource Centers for parents to share experiences/concerns
- Group homes for abused children
- Institutional care for abused children

Unavailable:

- Universal health screening for child
- Universal access to free medical care for child
- Universal access to free medical care for all citizens

FUNDING

Activity level of sectors in funding child abuse treatment or prevention services.

	Major	Limited	None	Unknown
Int'l NGOs			◆	
Int'l Relief Organizations			◆	
National Government	◆			
State/Local Government	◆			
Private foundations		◆		
Individuals		◆		
Businesses		◆		

POLICY

Official government law or policy regarding child abuse and neglect? YES

If yes, date established: Before 1980

Core Elements

- Mandated reporting of suspected child abuse for specific groups of professionals
- All victims receive some form of service/intervention
- Attorney assigned to represent the child's interests
- All abusers receive some form of service/intervention

Enforcement Level: Widely enforced

Level of Government Support: Widely supported

RESEARCH (in past 10 years)

- Population-based surveys conducted to assess scope of problem: YES
- Public opinion polls to assess awareness: YES

SERVICE PROVIDERS

Relative involvement in child abuse treatment and prevention services.

Moderately Involved:

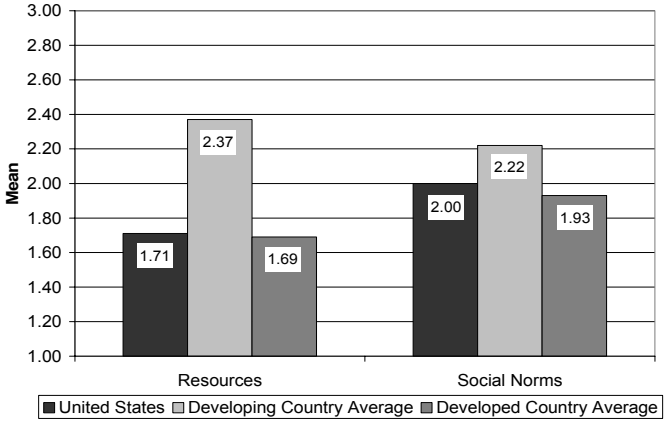
- Hospitals/Medical Centers
- Mental Health Agencies
- Community-based NGOs
- Courts/law enforcement

Minimally Involved:

- Schools/Universities
- Businesses/Factories
- Public social service agencies
- Religious institutions
- Voluntary civic organizations

BARRIERS

Average rating of limiting factors to CAN prevention, (E.g. poverty, support for use of corporal punishment, etc) (Scale: 1="Not important" to 3="Very significant")



YEMEN

Region: Western Asia

Previous World Perspectives surveys completed: None

OFFICIAL RECORDS

Country maintains official count of CAN cases: NO

If yes, classifications included:

- ☐ Physical abuse
- ☐ Sexual abuse
- ☐ Psychological maltreatment
- ☐ Neglect

SERVICES

Services available, and capacity of these services to reach all families involved or at risk of abuse.

Unavailable:

- Therapy programs for child victims of physical and sexual abuse
- Therapy programs for physical and sexual abusers
- Foster care with official foster parents
- Group homes for abused children
- Targeted home visits for new parents at-risk
- Case management services/meeting basic needs
- Home-based services to assist parents in changing their behaviors
- Financial and material support
- Institutional care for abused children
- Short-term hospitalization for mental illness
- Substance abuse treatments for parents
- Substance abuse treatments for children
- Family Resource Centers for parents to share experiences/concerns
- Free child care
- Universal health screening for child
- Universal access to free medical care for child
- Universal access to free medical care for all citizens
- Universal home visits for all new parents

FUNDING

Activity level of sectors in funding child abuse treatment or prevention services.

	Major	Limited	None	Unknown
Int'l NGOs		◆		
Int'l Relief Organizations				◆
National Government		◆		
State/Local Government				◆
Private foundations				
Individuals				◆
Businesses				◆

POLICY

Official government law or policy regarding child abuse and neglect? NO

If yes, date established: NA

Core Elements

- NA

Enforcement Level: NA

Level of Government Support: NA

RESEARCH (in past 10 years)

- Population-based surveys conducted to assess scope of problem: YES
- Public opinion polls to assess awareness: NO

SERVICE PROVIDERS

Relative involvement in child abuse treatment and prevention services.

Not Involved:

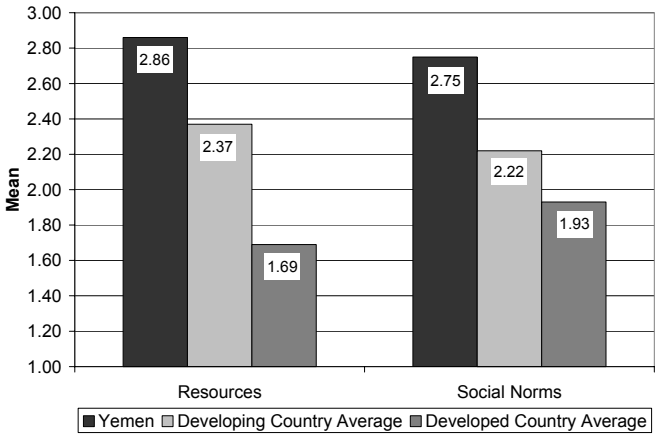
- Mental Health Agencies
- Hospitals/Medical Centers
- Courts/law enforcement
- Voluntary civic organizations
- Businesses/Factories
- Schools/Universities
- Public social service agencies
- Religious institutions

Minimally Involved:

- Community-based NGOs
- Universities

BARRIERS

Average rating of limiting factors to CAN prevention, (E.g. poverty, support for use of corporal punishment, etc) (Scale: 1="Not important" to 3="Very significant")



ZAMBIA

Region: Africa

OFFICIAL RECORDS

Country maintains official count of CAN cases: NO

If yes, classifications included:

- ☐ Physical abuse
- ☐ Sexual abuse
- ☐ Psychological maltreatment
- ☐ Neglect

SERVICES

Services available, and capacity of these services to reach all families involved or at risk of abuse.

Adequate in ***Less Than*** *1/3* of Country:

- Substance abuse treatments for parents
- Substance abuse treatments for children

Adequate in ***1/3 to 2/3*** of Country:

- Short-term hospitalization for mental illness

Adequate in ***More Than*** *2/3* of Country:

- Universal health screening for child
- Universal access to free medical care for child
- Universal access to free medical care for all citizens

Unavailable:

- Therapy programs for child victims of physical and sexual abuse
- Therapy programs for physical and sexual abusers
- Foster care with official foster parents
- Group homes for abused children
- Targeted home visits for new parents at-risk
- Case management services/meeting basic needs
- Home-based services to assist parents in changing their behaviors
- Financial and material support
- Institutional care for abused children
- Family Resource Centers for parents to share experiences/concerns
- Free child care
- Universal home visits for all new parents

FUNDING

Activity level of sectors in funding child abuse treatment or prevention services.

	Major	Limited	None	Unknown
Int'l NGOs			◆	
Int'l Relief Organizations		◆		
National Government			◆	
State/Local Government		◆		
Private foundations			◆	
Individuals		◆		
Businesses			◆	

POLICY

Official government law or policy regarding child abuse and neglect? YES

If yes, date established: Before 1980

Core Elements

- Mandated reporting of suspected child abuse for specific groups of professionals
- Criminal penalties for abusing a child
- Provisions for removing child from his/her parents or caretakers to ensure the child's safety

Enforcement Level: Inconsistently enforced

Level of Government Support: Inconsistently supported

RESEARCH (in past 10 years)

- Population-based surveys conducted to assess scope of problem: NO
- Public opinion polls to assess awareness: NO

SERVICE PROVIDERS

Relative involvement in child abuse treatment and prevention services.

Not Involved:

- Courts/law enforcement
- Businesses/Factories

Minimally Involved:

- Mental Health Agencies
- Community-based NGOs
- Schools

Moderately Involved:

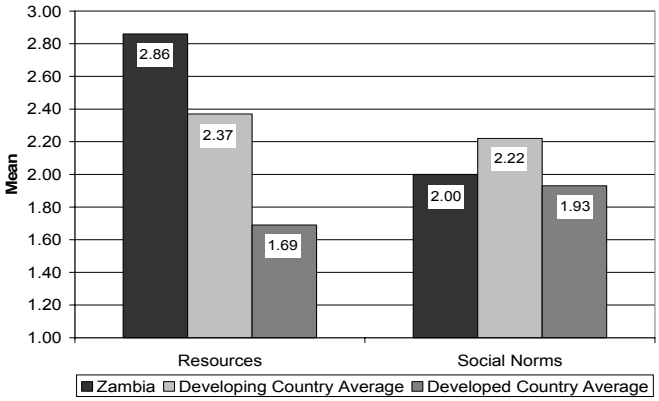
- Hospitals/Medical Centers
- Public social service agencies
- Voluntary civic organizations
- Religious institutions

Very Involved:

- NA

BARRIERS

Average rating of limiting factors to CAN prevention, (E.g. poverty, support for use of corporal punishment, etc) (Scale: 1="Not important" to 3="Very significant")



Appendix D

International and National Resources

International Resources

Canadian International Development Agency (CIDA)

www.acdi-cida.gc.ca/index.htm
Canadian International Development Agency
200 Promenade du Portage
Gatineau, Quebec K1A 0G4
CANADA
Telephone: 819 997 5006 Toll free: 1 800 230 6349
Facsimile: 819 953 6088
E-mail: info@acdi-cida.gc.ca

CIDA supports sustainable development in developing countries in order to reduce poverty and to contribute to a more secure, equitable and prosperous world. Priorities include: Human rights, democracy, & good governance; increasing respect for human rights, including children's rights; and to strengthen both civil society and the security of the individual.

Casa Alianza

www.casa-alianza.org/EN/
Casa Aliana Internacional
1734-2050 San Pedro
San José
COSTA RICA
Telephone: 506 253 54393 Facsimile: 506 224 5689
E-mail: info@casa-alianza.org

Casa Alianza is an independent, non profit organisation dedicated to the rehabilitation and defense of street children in Guatemala, Honduras, Mexico and Nicaragua.

Centers for Disease Control and Prevention (CDC) U.S.A.

www.cdc.gov
Centers for Disease Control and Prevention
Public Inquiries/MASO, Mailstop F07
1600 Clifton Road
Atlanta, GA 30333
USA
Telephone: 1 800 311 3435

The CDC works with partners throughout the nation and world to monitor health, detect and investigate health problems, conduct research to enhance prevention, develop and advocate sound public health policies, implement prevention strategies, promote healthy behaviors, foster safe and healthful environments, and provide leadership and training.

Coalition to Stop the Use of Child Soldiers

www.child-soldiers.org
Coalition to Stop the Use of Child Soldiers
International Secretariat
2nd floor, 2-12 Pentonville Road
London N1 9HF
UNITED KINGDOM
Telephone: 44 20 7713 2761 Facsimile: 44 20 7713 2794
E-mail: info@child-soldiers.org

The Coalition to Stop the Use of Child Soldiers (CSC) unites national, regional and international organisations and networks in Africa, Asia, Europe, Latin America and the Middle East. It is the leading network for monitoring and reporting on the use of child soldiers world-wide.

Child Rights Information Network (CRIN)

www.crin.org
Child Rights Information Network
c/o Save the Children
1 St John's Lane
London EC1M 4AR
UNITED KINGDOM
Telephone: 44 20 7012 6865 Facsimile: 44 20 7012 6952
E-mail: info@crin.org

CRIN is a global network that disseminates information about the Convention on the Rights of the Child and child rights amongst non-governmental organisations (NGOs), United Nations agencies, inter-governmental organisation (IGOs), educational institutions, and other child rights experts.

Defence for Children International

www.defence-for-children.org
Defence for Children International
1 rue de Varembe PO Box 88
1221 Geneva 20
SWITZERLAND
E-mail: dci-hq@pingnet.ch

To foster awareness about, and solidarity around, children's rights situations, issues and initiatives throughout the world. To seek, promote and implement the most effective means of securing the protection of children's rights in concrete situations, from both a preventative and curative standpoint.

End Child Prostitution, Child Pornography and Trafficking of Children for Sexual Purposes (ECPAT)

www.ecpat.net
ECPAT International Secretariat
328 Phaya Thai Road
Bangkok 10400
THAILAND
Telephone: 66 2 215 3388 Facsimile: 66 2 215 8272
E-mail: info@ecpat.net

ECAPAT represents a network of organisations and individuals working together to eliminate the commercial sexual exploitation of children. It seeks to encourage the world community to ensure that children everywhere enjoy their fundamental rights free from all forms of commercial sexual exploitation.

End all Corporal Punishment of Children (EPOCH)

www.endcorporalpunishment.org
E-mail: info@endcorporalpunishment.org

The Global Initiative to End All Corporal Punishment of Children aims to ensure that the recommendations of the Committee on the Rights of the Child and other human rights bodies are accepted and that governments move speedily to implement legal reform and public education programmes.

Human Rights Watch - Children's Rights
http://www.hrw.org/children/
Human Rights Watch
350 Fifth Avenue, 34th floor
New York, NY 10118-3299
USA
Telephone: 1212 290 4700 Facsimile: 1212 736 1300
E-mail: hrwnyc@hrw.org

Human Rights Watch established the Children's Rights Division in 1994 to monitor human rights abuses against children around the world and to campaign to end them. They challenge abuses carried out or tolerated by governments and, when appropriate, by armed opposition groups.

International Labour Organization (ILO) International Programme on the Elimination of Child Labour (IPEC)
www.ilo.org/public/english/standards/ipec
International Labour Office
4, route des Morillons
CH-1211 Geneva 22
SWITZERLAND
Telephone: 41.22.799.8181 Facsimile: 41.22.799.877
E-mail: ipec@ilo.org

A UN specialized agency which seeks the promotion of social justice and internationally recognized human and labour rights. IPEC's aim is to work towards the progressive elimination of child labour by strengthening national capacities to address child labour problems, and by creating a worldwide movement to combat it.

International Save the Children Alliance
www.savethechildren.net/alliance
International Save the Children Alliance
Second Floor, Cambridge House
100 Cambridge Grove
London, W6 0LE
UNITED KINGDOM
Telephone: 44 (0) 20 8748 2554
Facsimile: 44 (0) 20 8237 8000

Twenty-seven Save the Children organizations make up the International Save the Children Alliance, the world's largest independent movement for children, making improvements for children in over 115 countries.

International Society for Prevention of Child Abuse and Neglect (ISPCAN)
www.ispcan.org
ISPCAN Secretariat
25 W. 560 Geneva Rd. Suite L2C
Carol Stream, IL 60188
USA
Telephone: 1 630 221 1311 Facsimile: 1 630 221 1313
E-mail: ispcan@ispcan.org

ISPCAN is a multidisciplinary professional society whose mission is to support professionals and individuals around the world working to prevent child abuse and neglect. It brings together a worldwide cross-section of committed professionals to work towards the prevention and treatment of child abuse, neglect and exploitation globally.

Terre des Hommes
www.terredeshommes.org
International Federation terre des hommes
31, ch. Frank-Thomas
1208 Geneva
SWITZERLAND
Telephone: 41 22 736 33 72 Facsimile: 41 22 736 15 10
E-mail: info@terredeshommes.org

The mission of the Terre des Hommes organisations is to work for the rights of the child and to promote equitable development without racial, religious, cultural or gender-based discrimination. To this end, they support development projects designed to improve the living conditions of disadvantaged children, their families and their communities.

The United Nations Children's Fund (UNICEF)
www.unicef.org
UNICEF House
3 United Nations Plaza
New York, New York 10017
USA
Telephone 1.212.326.7000 Facsimile: 1.212.887.7465
E-mail: information@unicefusa.org

UNICEF works for children's rights, their survival, development and protection. Guided by the Convention on the Rights of the Child, UNICEF strives to establish children's rights as enduring ethical principles and international standards of behaviour towards children.

World Health Organization (WHO)
www.who.int
World Health Organization
Avenue Appia 20
1211 Geneva 27
SWITZERLAND
Telephone: 41 22 791 21 11 Facsimile: 41 22 791 3111
Telex: 415 416
Telegraph: UNISANTE GENEVA
E-mail: inf@who.int

The World Health Organization, is the United Nations specialized agency for health. WHO's objective is the attainment by all peoples of the highest possible level of health.

World Vision International (WVI)
www.wvi.org
World Vision International
Partnership Offices
800 West Chestnut Avenue
Monrovia, CA 91016-3198
USA
Telephone: 1 626 3018811
Facsimile: 1 626 301 7786

World Vision International is a Christian relief and development organisation working for the well being of all people, especially children. Through emergency relief, education, health care, economic development and promotion of justice, World Vision helps communities help themselves.

ISPCAN National Partners

African Network for the Prevention and Protection Against Child Abuse and Neglect - Ethiopia

www.anppcan.org
ANPPCAN - ETHIOPIA
P. O. Box 34359
Addis Ababa
ETHIOPIA
Telephone: 251 1 535 48/ 251 1 505 202
Facsimile: 251 1 539 757
E-mail: anppcan-eth@telecom.net.et

ANPPCAN - Ethiopia strives towards the prevention of child maltreatment and protection of children against abuse, neglect and exploitation through advocacy, development of information system on child rights, increasing public awareness, encouraging child participation, providing psycho-social and related services for child victims of maltreatment and other supports for children in especially difficult circumstances.

African Network for the Prevention and Protection Against Child Abuse and Neglect - Nigeria

www.anppcan.org
ANPPCAN National Secretariat
43 Lumumba Street
New Haven, Enugu
NIGERIA
Telephone: 234 42 257923/450112
Facsimile: 234 42 450112/557566
E-mail: childabuse@infoweb.abs.net

ANPPCAN - Nigeria works to reduce child abuse and neglect drastically in the African Continent, and Nigeria in particular by raising awareness and change attitudes of policy makers and the public on child welfare issues, foster an environment in which the creative potential of the child is maximized, and to protect and promote the rights of the child.

African Network for the Prevention and Protection Against Child Abuse and Neglect - Uganda

www.anppcan.org
ANPPCAN – UGANDA
PO BOX 24640, Kampala
UGANDA
Telephone: 256 41254550 Facsimile: 256 41344648
E-mail: anppcan@infocom.co.ug

ANPPCAN - Uganda Chapter is committed to the prevention of and protection against child abuse and neglect through research and advocacy, networking with other organisations as well as service delivery, working with children and communities for sustained impact. It is also committed to addressing the problem of child abuse and neglect and promoting the rights of children in Africa.

Against Child Abuse - Hong Kong

www.aca.org.hk
ACA
107-108, G/F, Wai Yuen House, Chuk Yuen (North) Estate
Wong Tai Sin, Kowloon
HONG KONG
Telephone: 852 2351 1177 Facsimile: 852 2752 8483
E-mail: aca@aca.org.hk

ACA strives for the removal of all forms of child abuse and/or child neglect in Hong Kong, to establish, maintain and support a professional service for the assistance of abused or neglected children or parents having problems with their children and to promote the awareness of the general public in Hong Kong towards prevention of child abuse.

American Professional Society on the Abuse of Children - USA

www.apsac.org
APSAC
PO Box 30669
Charleston, SC 29417
USA
Telephone: 1-877-402-7722
E-mail: john-madden@ouhsc.edu

APSAC is focused on meeting the needs of professionals engaged in all aspects of services for maltreated children and their families. It is committed to preventing child maltreatment, promoting research and guidelines to inform professional practice, connecting professionals from the many disciplines to promote the best response to child maltreatment, and educating the public about child abuse and neglect.

Asociación Afecto - Contra El Maltrato Infantil

www.afecto.org
Asociación Afecto contra el maltrato infantil
Transversal 4 No. 51 A – 01
Bogotá D.C., Colombia
Telephone: 57 1 2459387
E-mail: afecto@afecto.org.co

AFECTO carries out projects of care, prevention of child maltreatment and sexual abuse, and promotion of good treatment by providing training to groups, mobilizing public opinion, generating and starting campaigns and studies with the purpose of reducing maltreatment and violence against boys and girls.

Association Française d'Information et de Recherche sur l'Efance Maltraitée – (AFIREM)

Hôpital des Enfants Malades,
149, rue de Sevres
75730 Paris Cedex 15
FRANCE
Telephone: 33 1 44 49 47 24 Facsimile: 33 1 42 73 13 14
E-mail: afirem@libertysurf.fr

AFIREM is an association of doctors, social workers, psychologists, teachers, lawyers, judges, teachers, and others - working together to prevent, detect, and treat child abuse. AFIREM seeks to facilitate the detection of child abuse and neglect, promote the on-going evaluation of current practices and innovative practices, and promote a multidisciplinary approach to the prevention of child abuse.

British Association for the Study and Prevention of Child Abuse and Neglect - UK
www.baspcan.org.uk
BASPCAN
10 Priory Street
York YO1 6EZ
UNITED KINGDOM
Telephone: 0904 621133 Facsimile: 0904 642239
E-mail: baspcan@baspcan.org.uk

BASPCAN aims to prevent physical, emotional and sexual abuse and neglect of children by promoting the physical, emotional, and social well-being of children. We aim to promote rights of children as citizens, through multi-disciplinary collaboration, education, campaigning and other appropriate activities, within our powers and resources.

Cameroon Society for the Prevention of Child Abuse and Neglect
CASPCAN
P. O. Box 25254
Messa Yaoundé
REPUBLIC OF CAMEROON
Telephone: 237 230 33 28
E-mail: caspcan@yahoo.fr

CASPCAN works to protect victims of child maltreatment, to denounce such acts, to encourage listening and dialouge between parents and child victims and to organize and promote educational training programs for professionals working in the field of child abuse and neglect.

Danish Society for Prevention of Child Abuse and Neglect
www.daspcan.dk
DASPCAN
c/o Department of Pediatrics,
County Hospital, DK-4700
DENMARK
Telephone: 45 4373 1020 Facsimile: 45 5572 1481
E-mail: too@cn.stam.dk

DASPCAN works to increase and facilitate knowledge on children exposed to physical violence, sexual and psychological abuse and neglect, and to enhance cooperation among professionals in the field of child abuse and neglect.

German Society for Prevention of Child Abuse and Neglect
www.dggkv.de
GESPCAN
Andreaskloster 14
50667 Koln
GERMANY
Telephone: 49 221 136 42 7 Facsimile: 49 221 130 00 10
E-mail: dggkv@t-online.de

GESPCAN is a multidisciplinary organization established as a forum where the exchange and discussion of various concepts and ideas of different professions is possible in order to enhance the ability to understand each other and to improve interdisciplinary cooperation and communication.

Italian Network of Agencies Against Child Abuse
www.cismai.org
CISMAI
via del Mezzegtta, 1int
Florence, 50135
ITALY

CISMAI, formed in 1993, resulted from collaboration between five child protection centers. The organization aims to develop the knowledge and competences of a diverse range of professionals involved in prevention and treatment of all forms of abuse and neglect. The mission of CISMAI is to establish the well-being of children by improving the public awareness of the problem and the effectiveness of professional system involved in prevention and treatment of child abuse.

IUS et VITA - Democratic Republic of Congo
IUS et VITA
Boulevard du 30 juin n 100/D
Kinshasa, Gombe 5745
Dem. Rep. of Congo
Telephone: 00243 99 22646 Facsimile: 1.320.204.4593
E-mail: maditshibangu@yahoo.fr

IUS et VITA seeks the promotion of Human Rights (especially those of children), to create a new social culture of justice and humanism, by fighting against child labour, child sexual abuse, and the protection of human life.

Japanese Society for Prevention of Child Abuse and Neglect
www.jaspcan.org
JaSPCAN
c/o Osakafu, Shakai-fukushi Kaikan,
7-4-15, Tanimachi, Chuo-ku, 542-0012
JAPAN
Telephone: 81 6 764 5027 Facsimile: 81 6 764 5027
E-mail: jaspcanic@k4.dion.ne.jp

JaSPCAN is a national multidisciplinary association of physicians, nurses, legal experts, social workers and other professionals dedicated to the prevention and treatment of child abuse and neglect by developing basic, practical and systematic research, promoting cooperation among public and private agencies, and raising public awareness.

Malaysian Association for the Protection of Children
MPA 3rd Floor (Annexe Block), National Cancer Society Building, 66
Jalan Raja Muda Abdul Aziz
50300 Kuala Lumpur
MALAYSIA
Telephone: 603 2694 2362 Facsimile: 603 2691 3446
E-mail: mapcorg@po.jaring.my

MAPC maintains and promotes knowledge on the protection of children in Malaysia by conducting talks, seminars, conferences and exhibition for the advancement of knowledge and continuity of education for the protection of children.

National Association for Prevention of Child Abuse and Neglect
www.napcan.org.au
NAPCAN
PO BOX K241
Haymarket, 1240
AUSTRALIA
Telephone: 61 2 9211 0224 Facsimile: 61 2 9211 5676
E-mail: napcanaus@aol.com

NAPCAN is committed to stopping child abuse by producing national campaigns and distributing free resources that promote positive and practical actions to stop child abuse. They work with federal, state government and non-government organisations to develop child protection legislation, policies & practices that are in the best interests of children.

Nordic Association for Prevention of Child Abuse and Neglect
www.nfbo.com
NASPCAN
Socialforvaltningen, Box 104
SE 291 22 Kristianstad
SWEDEN
Telephone: 46 44 13 57 99
Facsimile: 46 44 21 22 99
E-mail: Rskimo@ra.dk

Representing all Nordic countries, NASPCAN's mission is to improve the work being done to protect children from abuse and neglect by affording members the opportunity to share experiences, to update knowledge as well as stimulate the exchange of knowledge. The group organizes conferences, national training events and publishes a newsletter 2 - 3 times per year.

Singapore Children's Society
www.childrensociety.org.sg
Singapore Children's Society
Peritoneal Dialysis Centre
9 Hospital Drive #02-01
Singapore 169612
SINGAPORE
Telephone: 6326 6709
Facsimile: 6326 6700
E-mail: info@childrensociety.org.sg

SCS is committed to protect the physical, emotional and mental well-being of children, particularly the disadvantaged and those at risk, through child abuse and neglect prevention efforts, social services and a children's home.

South African Society for Prevention of Child Abuse and Neglect
www.saspcan.org.za
SASPCAN
Postnet Suite 205,
Private Bag X30500
Houghton 2041
SOUTH AFRICA
Telephone: 033 34248971
Facsimile: 033 3942080
E-mail: saspcan@absamail.co.za

SASPCAN provides support for anyone who wishes to assist in combating child abuse in our country. It is also a networking organisation which provides information and training in this field and promotes inter-disciplinary co-operation in and co-ordination of services to abused children and their families.

Societti Nationale Pentru Prevenirea Abuzurilor Si Neglejarii Coppilului
SN-CAN
Str. Milcov nr. 4, bl10, ap 6
Timisoara, 3000553
ROMANIA
Telephone: 40 56 293176
E-mail: cepcopil@rdslink.ro

SN-CAN mission is to develop child abuse and neglect prevention in Romania by supporting the development of services for CAN, by developing trainings for professionals, as well as networking with different structures involved in CAN, and by obtaining partnerships with other national and international organizations

Turkish Society for Prevention of Child Abuse and Neglect
www.tspcan.org
TSPCAN
Oyak sitesi 7. blok No. 7
Cankaya, Ankara 6610
TURKEY
Telephone: 90 312 4398947
Facsimile: 90 312 4413352

TSPCAN is a voluntary, independent, multidisciplinary, non-governmental organization. It is committed to the prevention of child abuse and neglect. It’s mission is to raise awareness and build capacities of professionals and volunteers working in relevant sectors and/or organizations for the prevention and protection of children.