WORLD PERSPECTIVES ON CHILD ABUSE

Eighth Edition

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

Sponsored by:

UNICEF
Public Health Agency Canada
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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 75 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, Public Health Agency Canada, and the American Humane Association. In addition, we are particularly grateful for the in-kind support we received from Dr. David Wolfe, Director of the CAMH Centre for Prevention Science and Professor of Psychology and Psychiatry at the University of Toronto, Canada, and his research assistant, Debbie Chiodo, for the questionnaire 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 2007-08, 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 Christin Glodek for her development of the Annotated Bibliography included in Section IV; Kimberly Svevo, MA, ISPCAN Executive Director, for her tireless fund raising to support this project and her overall leadership; and also Alexander Poleshchuk and Chuck Wilson for their overall coordination of the World Perspectives project. We also wish to thank ISPCAN staff members, Molly Hubbard and Lauren Haney for their project support through its development and publication. We also appreciate the important efforts by volunteer translators, Georges Abanda Ngon, Maria Makayonok and Carolina Gomez, who made it possible to offer the survey and Executive Summary in 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 Eighth *Edition* continues this tradition of contributing to the field's body of knowledge.

Deborah Daro
Editor

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World Perspectives on Child Abuse:
An International Resource Book
Eighth 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, seven editions of this publication have been produced and released at subsequent bi-annual Congresses sponsored by ISPCAN. This document is the *Eighth Edition* in the series and is being released in conjunction with the 17th International Congress being held in Hong Kong.

A central component of each *World Perspectives* is a mail survey of key informants identified by the ISPCAN leadership as being knowledgeable about child maltreatment issues within their respective countries. For the past 16 years, these surveys have provided consistent information on how these key informants perceive the child abuse problem and public policy response. In the first survey (1992), there were 80 respondents representing 30 countries. In the second edition (1996) there were 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 countries bring represented in that edition. Over time, the number of countries represented in the survey has expanded, growing to 58 countries in the fourth edition (2000), 67 countries in the fifth edition (2002), 64 countries in the sixth edition (2004) and 72 countries represented in the seventh study (2006). The current edition includes representation from 75 countries, of which 52 (or 69%) are classified as developing countries. Although our sample of countries, or respondents within countries, is not consistent across all reporting periods, we believe this method does afford 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 addition to reporting the survey results, this edition includes a special section describing the surveillance and administrative data systems maintained by six industrialized countries (e.g., Australia, Canada, France, Italy, United States and United Kingdom). In addition to describing the definitions and data collection methods used in each case, the chapter presents trend data from four of these countries with respect to the number of cases investigated and substantiated at varying points between 1990 and 2005. This addition provides readers with more precise information on the challenges presented by the implementation and use of these systems to provide accurate estimates of the maltreatment problem both within and across jurisdictions.

As we have in the past, two other components are included in this issue. First, the report includes a series of commentaries and briefs we obtained from ISPCAN members and other professionals working in the area of child maltreatment, regarding research and practice innovations in their respective countries. Second, the report includes an annotated bibliography summarizing over 85 articles and policy papers that have been published over the past two years on child abuse, organized in terms of the country in which the research has been conducted.

KEY SURVEY FINDINGS

Scope of the problem

The most common behaviors considered child abuse and neglect across all countries are physical abuse by parents or caretakers and sexual abuse as defined as incest, sexual touching or pornography; these two behavioral categories were labeled as child abuse by all but three respondents. Other behaviors mentioned by more than 80% of all respondents as abusive include: failure to provide adequate food, clothing or shelter; abandonment by a parent or caretaker; child prostitution; children living on the street; physical beating of a child by any adult; forcing a child to beg; female or child infanticide; and abuse or neglect occurring within foster care or educational settings.

Only three items demonstrated significant regional differences in the definition of abuse or neglect – failure to secure medical care for a child based on specific religious beliefs, parental substance abuse and physical discipline. In the case of physical discipline, this behavior was notably less likely to be listed by respondents from Africa and Asia than elsewhere in the world. In the case of parental substance abuse, respondents from the Americas and Asia were least likely to report such behavior as being commonly considered a form of child maltreatment.

Maltreatment Trends

The survey's data collection methods do not provide an accurate method for determining changes in the incidence of maltreatment. Not only do countries and cultures differ in what is viewed as child maltreatment, countries also differ in their capacity to establish formal surveillance systems and provide ongoing accurate analysis of the data generated by these systems. As in *Section II* of the report notes, even countries with comparable resources and relatively sophisticated administrative data systems may produce estimates of the problem that are not consistent within or across countries.

As a crude indicator of change over time, however, survey respondents were asked two sets of questions regarding changes in the incidence of maltreatment. First, all respondents were asked for their professional assessment of changes in maltreatment rates over the past 10 years. Sixty-three respondents (84% of the full sample) responded to this question. Of those responding, two-thirds indicated that they believe the number of child abuse cases have increased, about 10% reported no change, and 22% indicated the number of cases have declined. Second, respondents from countries that maintain and publish official counts of child abuse cases were also asked to record recent trends with respect to the number of cases involving physical abuse, sexual abuse, neglect and psychological maltreatment. Forty-six respondents (61% of the sample) answered this set of questions. Of those responding, 61% reported increases in physical abuse cases, 71% reported increases in sexual abuse cases, 75% reported increases in neglect cases, and 64% reported increases in psychological maltreatment cases. In most cases, professionals in our sample observed both an increase in the reported incidences of child maltreatment and an increase in the public's perception of the problem.

National child abuse policy characteristics

Ninety percent of respondents reported that their country has an official policy regarding child maltreatment. With respect to implementation, however, policies within the sample's developing countries were significantly more likely than those within the sample's developed countries to have been recently established (e.g., post-2000, less likely to be widely enforced, less likely to receive adequate annual government support, and more likely to be largely limited to the country's urban areas). Although no statistically significant differences were observed across regions, respondents from Central and South America were the most likely to report the lack of adequate government support and the absence of sufficient policy implementation in the rural parts of their countries.

In terms of key similarities across countries, most policies include 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 report that their policies include 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 and law enforcement), many jurisdictions accept reports from any individual who voluntarily comes forward to report a case.

It is noteworthy that almost three-quarters of respondents reported that the policies in their respective countries contain a requirement that all victims receive some form of service or intervention, and over half of countries' policies included provisions for the development and support of prevention services. In contrast, only 28% of the sample reported that their policies included a provision to provide services to perpetrators.

Common treatment strategies

Of the 20 specific service strategies included in the survey, all but three were reported as being available in at least half of the countries. Service availability was most restricted among those efforts targeting parents or perpetrators, while a richer array of service options were identified for child victims or general family support. Among the services least likely to be offered within the countries represented in this sample, were therapy programs for sexual or physical abuse offenders, home-based services to help abusive families alter their behaviors, family resource centers, and targeted home-visitation services for parents at-risk of maltreatment. In addition to these services, universal home-visitation programs for new parents were not generally available, with only about one-third of the respondents indicating that this option existed within their country.

Respondents from developed countries were often twice as likely to report the availability of key service models targeting parents or offenders (e.g., therapy programs of physical abuse or sexual abuse offenders, home-based services to assist family reunification or maintenance, family resource centers and targeted home-visits for high risk new parents). The magnitude of differences in service availability was significant between the two groups of countries in all but seven cases. Regional differences in the availability of services surfaced for all types of service

models with respondents from African countries generally reporting a less diverse pool of parent, child and general services.

The only services judged by at least half of the respondents as being adequate in at-least two-thirds of their country, was universal access to free medical care and universal home-visits for new parents, for those few countries offering this option. In all other cases, less than one-third of the respondents reported that a given service strategy was generally available and had adequate capacity to meet the needs of the majority of families or victims.

Common prevention strategies

Respondents were asked to identify whether various CAN prevention strategies were used in their country or not, and if so, whether the strategy was effective or not. The four most common prevention strategies utilized by this sample of countries are advocacy, professional training, media campaigns and the prosecution of child abuse offenders. Over 90% of respondents indicated that these four strategies are available in their country. However, only about one-third of respondents who reported the use of prosecution of child abuse offenders as a strategy for preventing maltreatment rated this approach as effective. In contrast, professional education was viewed as effective by about two-thirds of the sample, while advocacy and media campaigns were viewed as effective in about half of the cases in which they were used.

The majority of respondents also reported the availability of four additional strategies -- improving or increasing local services; universal health care and access to preventive medical care; improving living conditions; and increasing individual responsibility for child protection. Although not as common as the prior set of strategies, these efforts appear to be widely used, but only within certain regions. As might be expected, respondents from developed countries reported efforts to improve or increase local services as significantly more common and effective than did respondents from developing countries.

Less than half the respondents reported the use of home-based services and supports for at-risk parents, risk assessment methods to better target support to those at high risk for maltreatment, and universal home-visitation programs for new parents. Respondents from developed countries were significantly more likely to report using, and finding effective, both home-based supports for parents at-risk and risk assessment methods, than were their colleagues from developing countries.

Barriers to expanding prevention efforts

The most commonly cited barriers to preventing child abuse across the full sample were limited resources, strong sense of family privacy and parental rights, and a lack of effective systems to investigate abuse reports. There was a substantial variation in the relative significance of the economic and social resource items across region. Respondents from Europe and Oceania perceived these conditions as less significant barriers to developing a process for preventing child abuse than did respondents from Africa and to a lesser extent the Americas and Asia. In almost all cases, these patterns reflect a higher level of concern regarding the negative impacts of these conditions on prevention efforts voiced by respondents from African countries. Although none of the variations in the level of concern respondents expressed with respect to social norms were statistically significant, the patterns were similar, with higher levels of concern regarding these factors voiced among African respondents and lower levels of concern voiced among respondents from Europe and Oceania.

Differences by a country's developmental status were found for nine of the 11 factors examined. Developing countries reported each barrier to be more significant than developed countries. The only two factors for which a significant difference was not observed between respondents from developing and developed countries was the barrier posed by a society's strong sense of family privacy and parental rights to raise children as they choose and public resistance to supporting major change or program expansion. Examining the trends in the relative rankings that respondents have provided on these two issues over the past six years, we found stable or slight reductions in the importance of these issues among respondents from developing countries and a corresponding increased the level of concern regarding these issues among respondents from developed countries.

Predictors of child well-being

While not all early deaths of young children reflect abusive and neglectful situations, many are results 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 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. On this point, the data is encouraging. A comparison of the under-five mortality rate (U5MR) in 2006 to the levels reported in 1990 found a decline of over 30% within our sample countries. It is particularly encouraging that declines were observed in all five of the World Bank's economic categories. Of the 72 countries in our sample for which this data was available, only four countries (Cameroon, Zambia, the Congo and South Africa) reported increases during this period. Reductions in this indicator were 60% or greater in several countries from our sample (Brazil, Egypt, Greece, Peru, Poland Portugal, Singapore, Syria, Thailand and Turkey). Despite notable gains among some developing countries, the differential performance on this measure between countries in the highest and lowest economic categories has increased, with child mortality levels being 23 times higher among countries in the lowest strata as compared to the highest income countries in our sample. Although child mortality rates remain unacceptably high in many of the poorest countries, the progress being made among middle income countries suggests the policy and service contexts in these regions may be better received for combating child maltreatment than in the past.

In addition to developmental status, we identified a number of contextual and policy variables that might be related to reductions in child mortality including both contextual issues (e.g., birth rate and perception of CAN funding levels and barriers to change), as well as public policy and service availability as documented in our survey. As we have observed in the past, mortality rates for young children are significantly higher within countries with fewer economic resources, as measured by the World Bank's ranking, as well as among countries where respondents reported more severe resource and social norms barriers to prevention. In addition, lower mortality rates were associated with a greater number of parent services, child services and general services; more mature CAN policies (e.g., implemented prior to 2000); and more consistent government support for policy implementation. In testing these relationships through multivariate analysis, however, the only significant predictors of child mortality were changes in a country's birth rate, the severity of a country's social and economic barriers to prevention and the number of available services for child victims. None of the other policy elements tested in these models remained significant after accounting for these factors.

SUMMARY

As we have observed in past surveys, there is an emerging global agreement regarding the major behaviors that constitute child abuse and neglect (e.g., sexual abuse, physical abuse, children living on the street and 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 that 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 is inextricably linked to funding. Although the proportion of developing countries that are 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 its dissemination of best practices.

World Perspectives on Child Abuse
Eighth 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, seven editions of this publication have been produced and released at subsequent bi-annual Congresses sponsored by ISPCAN. This document is the *Eighth Edition* in the series and is being released in conjunction with the 17th International Congress, which is being held in Hong Kong. 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.

A central component of each *World Perspectives* is a mail survey of key informants who have been identified by the ISPCAN leadership as being knowledgeable about child maltreatment issues within their respective countries. For the past 16 years, these surveys have provided consistent information on how these key informants perceive the child abuse problem and public policy response in the following areas:

- the key behaviors and conditions defined as constituting child maltreatment;
- the current professional response to maltreatment (e.g., reporting systems, case investigative systems, legal prosecution of 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
- the particular strengths or strategies that have been found effective in preventing child abuse.

In the first survey (1992), there were 80 respondents representing 30 countries. In the second edition (1996) there were 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 countries being represented in that edition. Over time, the number of countries represented in the survey has expanded, growing to 58 countries in the fourth edition (2000), 67 countries in the fifth edition (2002), 64 countries in the sixth edition (2004) and 72 countries represented in the seventh study (2006). The current edition includes representation from 75 countries, of which 52 (or 69%) are classified as developing countries. As described in this document, this sample includes 11 countries that have been represented in all eight editions, and six countries participating for the first time. Although our sample of countries or respondents within countries is not consistent across all reporting periods, we believe this method does afford 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 addition to reporting the survey findings, the *Eighth Edition* also incorporates administrative draws maintained by public child welfare agencies in selected industrialized countries. Developed in partnership with ISPCAN and researchers from the U.S.A., Canada, England, Australia, Italy and France, this chapter provides a more detailed analysis of child maltreatment trends as reflected in the official reports maintained by four countries and establishes an analytic framework for fostering international comparisons.

As in the past, this edition includes commentaries developed by ISPCAN colleagues from a diverse set of countries which summarize various policy and research efforts underway in their country and a detailed annotated bibliography summarizing the content of key journal articles and government reports issued over the past two years that address various aspects of the maltreatment problem. Both of these features are included in order to expand the flow of information for those professionals who do not have easy access to peer-reviewed journals or research reports.

STRUCTURE OF THE REPORT

The *Eighth Edition* of *World Perspectives* is divided into four 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; level of public awareness; 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. This section also addresses the major barriers identified by respondents that limit their ability to address child maltreatment, as well as the role these barriers and other conditions play in predicting a country's under-five mortality rate.

As noted above, *Section II* describes the surveillance and administrative data systems maintained by six industrialized countries (Australia, Canada, France, Italy, United States and United Kingdom). In addition to describing the definitions and data collection methods used in each case, the chapter presents trend data from four of these countries with respect to the number of cases investigated and substantiated at various points between 1990 and 2005. This addition provides readers with more precise information on the challenges presented by the implementation and how to use these systems for accurate estimates of the maltreatment problem both within and across jurisdictions.

Section III 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 the public and business communities in child protection.

Section IV includes an annotated bibliography which summarizes over 85 articles and policy papers that have been published over the past two years on child abuse, organized by the country 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; 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, as well as a list of international and national resources are presented in *Appendices A, B, C* and *D* respectively.

SECTION I: SURVEY OF KEY INFORMANTS

METHODOLOGY

Study Procedure

The *Eighth 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 complete the *World Perspectives* survey. 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 societies in Argentina, Australia, Belarus, Cameroon, Columbia, Congo, Germany, Hong Kong, Italy, Nigeria, Romania, Singapore, Turkey, Uganda and the United States contributed information to the database. In addition to these sources, the current pool of potential respondents included representatives from three UNICEF regional offices.

The 2008 initial respondent sample included 140 informants representing 121 countries. Each respondent was sent a questionnaire by electronic mail to obtain their assessments on a range of issues as described below. If more than one representative from a country was surveyed, respondents were asked to collaborate and complete a single survey for their country. Although the 2008 initial sample was smaller than in past years, the proportion of completed surveys was notably higher, producing completed profiles for 75 countries (62% of all countries targeted). The absolute number of countries represented in the survey is slightly higher this year than in 2006 and 17% higher than the number reporting in 2004 (75 versus 64). *Table 1* summarizes response rates for each of the world's five major regions – Africa, Americas, Asia, Europe and Oceania. Our response rate this year exceeded 60% in all but one region, Africa.

This data may not be representative of all ISPCAN members or all countries, 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*. Those who wish for additional information on a given country, are encouraged to contact the relevant respondent.

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	26	13	50%
Americas	51	18	11	61%
Asia	50	38	24	63%
Europe	49	36	24	67%
Oceania	25	3	3	100%
Total	**233**	**121**	**75**	**62%**

Measures

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

- the key behaviors and conditions defined as constituting child maltreatment;

- the current professional response to maltreatment (e.g., reporting systems, case investigative systems, legal prosecution of 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
- the particular strengths or strategies that have been found effective in preventing child abuse.

Respondents were also 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 in addressing 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 will be 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 2008*. These indicators are meant to reflect a country's level of national health and its children's 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, as well as 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 reflects, in part, a country's capacity and success in providing for a child's basic health care, educational, economic and safety needs, and also offers an overall picture of the climate in which respondents in the current sample work to reduce the prevalence and impacts of child abuse.

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 other 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 who completed 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. Respondents were also asked to provide explicit approval to have their name included among the list of respondents. Only those individuals who provided this consent are listed in *Appendix A*.

Data Analyses

Survey data is 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 "developing" or "developed" 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). GNP, a broad measure, was considered to be the best single indicator of economic capacity and progress; at the same time, it was recognized that GNP does not, by itself, constitute an accurate measure of a country's welfare nor its success in terms of economic 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 incomes are classified as developed.

Our initial analysis involved computing simple frequencies or means for all variables to determine general variability across countries. We then conducted appropriate statistical tests to determine if this variation was significant between developed and developing countries (e.g., chi-squares or t-tests) or among the five regions (i.e., chi-square or ANOVAs). In cases where regional variations appear large and noteworthy, but could not be formally tested due to sample size limitations, we highlighted trends and discussed them as potential rather than statistically significant differences. Finally, we conducted a set of multiple regression analyses to identify the most relevant policy and contextual predictors of various child well-being indicators.

SAMPLE DESCRIPTION

Figure 1 summarizes the participation rate for the 125 countries that have ever responded to any of the eight *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 2008 sample includes 11 countries that have been represented in all eight editions and six countries participating for the first time. Nearly 50% of all countries in the current sample have been represented in four or more of the surveys and over two-thirds have been represented in more than half of the surveys. Furthermore, over 60% of those completing the survey on their country have completed prior surveys, a trend that contributes to the increased reliability of the information provided across time.

Collectively, the 2008 sample represents all regions of the world, with 23 countries classified as developed countries and 52 classified as developing countries (69% of the total sample). This year is the first time in the history of our data collection efforts that developing countries represent more than 55% of the total sample. This distribution reflects, in part, ISPCAN's success in extending its membership and services to developing regions of the world, particularly Africa, Asia and Eastern Europe. Because these regions have fewer resources to invest in specific policies or service alternatives, one might expect to see an overall decline in the proportion of respondents indicating active child abuse policies and robust service systems. In fact, the current sample included a higher proportion of countries with formal child abuse policies and a greater array of services than we have seen in the past. These trends would suggest that public policy and service efforts in developing countries, while more modest than those observed in developed regions, are expanding.

Although not an exhaustive sample, the responding countries cover almost 82**%** of the world's total population and 79**%** of the world's children. This represents a notable increase in the coverage of this report from our earliest 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 recent coverage increase reflects the inclusion of India, that began 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 12**%** 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. Also reflective of ISPCAN's membership, are the professional disciplines represented among survey respondents. Over one-third of those completing the survey are medical professionals, including pediatricians (25%), general practitioners or psychiatrists (12%) or other medical professionals such as nurses (1%). One-quarter of the respondents are psychologists and 16% are social workers. The balance of the sample included professionals working in education, law or other unspecified fields.

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. This data is summarized in *Table 3*. As expected, significant differences exist across regions and developmental status. For example, regional differences showed the African region to have the highest under-five mortality rate (129/1,000) compared to Asia (45/1,000), the Americas (25/1,000), Europe (9/1,000) and Oceania (10/1,000). Several additional indicators show similar patterns by region and developmental status, with developing countries in general and the African region in particular, reporting higher rates than developed countries of HIV/AIDS, higher rates of 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 676 for African countries, 234 for those in Asia, 105 for those in the Americas, and 13 for those in Europe. 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	2008
Africa								
Benin			✓	✓	✓		✓	
Cameroon			✓	✓		✓	✓	✓
Congo, Dem. Rep of					✓	✓	✓	✓
Côte d'Ivoire					✓	✓	✓	
Egypt					✓	✓	✓	✓
Ethiopia							✓	✓
Ghana			✓	✓	✓	✓		
Kenya	✓	✓	✓		✓	✓		
Liberia						✓		
Mauritius						✓	✓	✓
Morocco								✓
Namibia					✓			
Nigeria	✓				✓	✓		✓
Rwanda				✓	✓	✓	✓	✓
Senegal			✓	✓				
Sierra Leone								✓
Somalia							✓	
South Africa	✓	✓	✓	✓	✓	✓	✓	✓
Tanzania			✓	✓				
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						✓		
Guatemala								✓
Honduras							✓	✓
Mexico			✓	✓	✓	✓	✓	✓
Panama			✓	✓				
Peru	✓				✓	✓	✓	✓
St. Lucia							✓	
Trinidad & Tobago				✓				
United States of America	✓	✓	✓	✓	✓	✓	✓	✓
Uruguay	✓							

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

Country	1992	1996	1998	2000	2002	2004	2006	2008
Asia								
Eastern Asia								
China			✓		✓	✓	✓	✓
Hong Kong Sp Adm. Reg. China		✓	✓	✓	✓	✓	✓	✓
Japan		✓	✓	✓	✓		✓	✓
Korea, Rep of				✓	✓	✓	✓	✓
Mongolia						✓	✓	
Taiwan			✓	✓	✓		✓	✓
South-Central Asia								
Afghanistan								✓
Bangladesh		✓	✓				✓	✓
India	✓					✓	✓	✓
Iran					✓			
Iraq								✓
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	✓	✓		✓			✓	✓

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

Country	1992	1996	1998	2000	2002	2004	2006	2008
France	✓	✓	✓	✓	✓	✓		✓
Germany	✓	✓	✓	✓	✓	✓	✓	✓
Greece	✓	✓	✓	✓	✓		✓	✓
Hungary				✓	✓	✓	✓	✓
Iceland					✓		✓	✓
Ireland	✓	✓	✓					
Italy	✓	✓	✓	✓	✓	✓	✓	✓
Latvia				✓		✓		
Luxembourg				✓				
Macedonia			✓					
Montenegro								✓
Netherlands	✓	✓	✓	✓	✓	✓	✓	✓
Northern Ireland			✓	✓				
Norway	✓	✓	✓		✓			
Poland			✓		✓	✓	✓	✓
Portugal			✓		✓	✓	✓	✓
Romania				✓		✓	✓	✓
Russian Federation			✓	✓	✓	✓	✓	✓
Scotland		✓	✓	✓	✓	✓	✓	
Serbia & Montenegro				✓	✓	✓	✓	
Serbia								✓
Slovak Republic			✓	✓	✓	✓		
Spain	✓	✓	✓	✓	✓	✓	✓	✓
Sweden	✓	✓			✓	✓	✓	✓
Switzerland			✓	✓	✓	✓		✓
Turkey					✓		✓	✓
Ukraine						✓		✓
Wales			✓	✓				
Oceania								
Australia	✓	✓	✓	✓	✓	✓	✓	✓
Fiji								✓
New Zealand		✓	✓	✓	✓	✓	✓	✓

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

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 $) 2006
Africa													
Cameroon	18175	8791	87	149	11	7	670	66	50	-	-	5.4	1080
Congo, Dem	60644	32671	129	205	12	13	1300	46	46	-	-	3.2	130
Egypt	74166	29263	29	35	14	4	84	98	71	96	91	<0.1	1350
Ethiopia	81021	41299	77	123	20	11	670	22	52	71	66	-	180
Mauritius	1252	360	13	14	14	4x	22	100	73	94	96	0.6	5450
Morocco	30853	11135	34	37	15	9	230	81	71	89	83	0.1	1900
Nigeria	144720	73703	99	191	14	9	-	48	47	72	64	3.9	640
Rwanda	9464	4844	98	160	6	4	750	74	46	72	75	3.1	250
Sierra Leone	5743	2827	159	270	24	9	1800	57	42	-	-	1.6	240
South Africa	48282	18349	56	69	15	3x	150x	88	50	87	87	18.8	5390
Togo	6410	3192	69	108	12	14	480x	52	58	84	72	3.2	350
Uganda	29899	16828	78	134	12	5	510	60	50	-	-	6.7	300
Zambia	11696	6164	102	182	12	6	730	58	41	89	89	17	630
Americas													
Argentina	39134	12277	14	16	7	1	39	96	75	99	98	0.6	5150
Bolivia	9354	4131	50	61	7	1	230	85	65	94	96	0.1	1100
Brazil	189323	62408	19	20	8	2x	76	90	72	95	95	0.5	4730
Canada	32577	6948	5	6	6	-	-	100	80	99	100	0.3	36170
Chile	16465	4897	8	9	6	0	17	95	78	91	89	0.3	6980
Colombia	45558	16233	17	21	9	1	78	93	73	87	87	0.6	2740
Guatemala	13029	6463	31	41	12	2	150	95	70	96	92	0.9	2640
Honduras	6969	3235	23	27	10	1	110x	87	70	90	92	1.5	1200
Mexico	105342	37911	29	35	8	2	62	97	76	98	98	0.3	7870
Peru	27589	10318	21	25	11	1	190	83	71	96	97	0.6	2920
USA	302841	75757	6	8	8	0	8x	100	78	92	93	0.6	44970
Asia													
Afghanistan	26088	13982	165	257	-	7	1600	39	43	-	-	<0.1	250x
Armenia	3010	789	21	24	8	5	27	92	72	77	81	0.1	1930
Bahrain	739	226	9	10	8	5x	46x	-	75	97	97	-	14370x
Bangladesh	155991	64194	52	69	22	13	320	74	63	93	96	<0.1	480
China	1320864	348276	20	24	2		48	77	73	99	99	0.1	2010
Georgia	4433	1043	28	31	7	2x	23	82	71	93	93	0.2	1560
Hong Kong*	-	-	-	-	-	-	-	-	-	-	-	-	-
India	1151751	445361	57	76	30	20	300	86	64	92	86	0.9	820
Iraq	28506	13691	37	46	15	5	290x	81	58	94	81	-	2170x
Japan	127953	21393	3	4	8	-	8x	100	82	100	100	<0.1	38410
Korea, Rep. of	48050	10616	5	5	4	-	20x	92	78	100	99	<0.1	17690

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 $) 2006
Kyrgyzstan	5259	1959	36	41	5	4	100	77	66	87	86	0.1	490
Lebanon	4055	1367	26	30	6	5	100x	100	72	93	92	0.1	5490
Malaysia	26114	9623	10	12	9	-	28	99	74	96	95	0.5	5490
Pakistan	160943	70673	78	97	19	13	530x	91	65	77	59	0.1	720
Philippines	86264	36430	24	32	20	6	170x	85	71	93	95	<0.1	1420
Saudi Arabia	24175	9671	21	25	11	11x	-	-	72	77	79	-	12510x
Singapore	4382	1010	2	3	8	2	6x	100	80	-	-	0.3	29320
Sri Lanka	19207	5576	11	13	22	16	43	79	72	99	98	<0.1	1300
Syria	19408	8342	12	14	9	9	65	93	74	97	92	-	570
Taiwan *	-	-	-	-	-	-	-	-	-	-	-	-	-
Tajikistan	6640	3090	56	68	10	7	97	59	66	99	96	0.1	390
Thailand	63444	16522	7	8	9	4	24	99	70	90	89	1.4	2990
Yemen	21732	11482	75	100	32	12	370	67	62	87	63	-	760
Europe													
Belarus	9742	1936	12	13	4	1	10	100	69	91	88	0.3	3380
Bosnia & Herzegovina	3926	842	13	15	5	3	3	97	75	-	-	<0.1	2980
Bulgaria	7693	1331	12	14	10	-	10	99	73	94	93	<0.1	3990
Denmark	5430	1210	4	5	5	-	10x	100	78	95	96	0.2	51700
Estonia	1340	261	5	7	4	-	29	100	71	95	95	1.3	11410
Finland	5261	1097	3	4	4	-	6x	100	79	98	98	0.1	40650
France	61330	13555	4	4	7	-	10x	100	80	99	99	0.4	36550
Germany	82641	14517	4	4	7	-	8x	100	79	96	96	0.1	36620
Greece	11123	1917	4	4	8	-	1x	-	79	99	99	0.2	21690
Hungary	10058	1935	6	7	9	-	4	99	73	90	88	0.1	10950
Iceland	298	78	2	3	4	-	-	100	82	100	97	0.2	50580
Italy	58779	9886	4	4	6	-	7x	-	80	99	98	0.5	32020
Montenegro	601	145	9	10	4	3	-	-	74	-	-	-	3860
Netherlands	16379	3592	4	5		-	7x	100	79	99	98	0.2	42670
Poland	38140	7684	6	7	6	-	4	-	75	96	97	0.1	8190
Portugal	10579	1996	3	5	8	-	8x	-	78	98	98	0.4	18100
Romania	21532	4276	16	18	8	2	17	57	72	93	92	<0.1	4850
Serbia	9851	2222	7	8	5	3	-	-	74	-	-	-	3910
Spain	43887	7671	4	4	6	-	6x	100	81	100	99	0.6	27570
Sweden	9078	1925	3	3	4	-	5x	100	81	96	96	0.2	43580
Switzerland	7455	1500	4	5	6	-	5x	100	81	93	93	0.4	57230
Turkey	73922	24632	24	26	16	1	29	96	72	92	87	-	5400
Ukraine	46557	8676	20	24	4	0	13	96	68	83	83	1.4	1950

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 $) 2006
United Kingdom	60512	13155	5	9	8	-	7x	100	79	99	99	0.2	40180
Oceania													
Australia	20530	4803	5	6	7	-	-	100	81	96	97	0.1	35990
Fiji	833	321	16	18	10	-	38x	47	69	97	96	0.1	3300
New Zealand	4140	1066	5	6	6	-	15x	-	80	99	99	0.1	27250

[a] Selected Indicators – The State of the World's Children 2008 – Table 1 Basic Indicators.
[b] Selected Indicators – The State of the World's Children 2008 – Table 2 Nutrition.
[c] Selected Indicators – The State of the World's Children 2008 – Table 3 Health.
[d] Selected Indicators – The State of the World's Children 2008 – Table 5 Education.
[e] Selected Indicators – The State of the World's Children 2008 – Table 6 Demographic Indicators.
[f] Selected Indicators – The State of the World's Children 2008– 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 2008 – 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

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. As in past surveys, the most common behaviors considered child abuse and neglect across all or most subgroups were physical abuse by parents or caretakers, and also sexual abuse as defined as incest, sexual touching or pornography. These two behavioral categories were labeled as child abuse by all but three respondents (e.g., physical abuse by a parent was not listed as generally considered child abuse by respondents from Armenia, Iraq and China, nor was sexual abuse listed as a behavior commonly regarded as child abuse by respondents in Armenia and Malaysia). Other behaviors also mentioned by more than 80% of all respondents as abusive include: failure to provide adequate food, clothing or shelter; abandonment by a parent or caretaker; child prostitution; children living on the street; physical beating of a child by any adult; forcing a child to beg; female or child infanticide; and abuse or neglect occurring within foster care or educational settings.

In contrast to past years, only three items demonstrated significant regional differences in the definition of abuse or neglect, which includes failure to secure medical care for a child based on specific religious beliefs ($X^2 = 12.81$, $p < .012$), parental substance abuse ($X^2 = 11.45$, $p < .022$) and physical discipline ($X^2 = 13.96$, $p < .007$). In the case of physical discipline, this behavior was notably less likely to be listed by respondents from Africa and Asia than elsewhere in the world. In the case of parental substance abuse, respondents from the Americas and Asia were least likely to report such behavior as being commonly considered a form of child maltreatment. This variability may reflect the capacity of emerging systems in these regions to respond to any but the most serious forms of maltreatment or to very different cultural and religious contexts.

Indeed the frequency with which many of the parental behaviors and other conditions were cited as potentially reflecting child maltreatment varied based on 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 ($X^2 = 3.96$, $p < .020$); domestic violence ($X^2 = 7.07$, $p < .008$); failure to secure medical care for a child based on religious beliefs ($X^2 = 4.76$, $p < .029$); psychological neglect ($X^2 = 5.64$, $p < .020$); non-organic failure to thrive ($X^2 = 13.28$, $p < .000$); and female circumcision ($X^2 = 7.83$, $p < .002$). 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 a 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 are engaged in 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. Overall, however, the disparity between developing and developed countries on items identified as constituting child maltreatment was less pronounced this year than in past surveys that suggest professional, and perhaps public, perceptions of child maltreatment are coalescing around a common set of behaviors despite vast cultural and contextual differences.

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 50% of all respondents reported that this practice is considered abusive within their country. The proportion of respondents across regions noting this pattern ranged from a high of 100% in the three countries within the Oceania region (e.g., Australia, Fiji and New Zealand) to 15% in Asia and 38% in Africa. 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 the normative practice within many countries and is not considered, in and of itself, synonymous with child abuse.

Even within this domain, however, 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 has been the efforts of the Global Initiative's *End All Corporal Punishment of Children* (www.endcorporalpunishment.org), which is an organization supported by UNICEF, UNESCO, the UN High Commissioner for Human Rights, ISPCAN and many other international and national agencies and also human rights institutions. According to this organization, 23 countries have passed laws to protect children from all forms of corporal punishment. These countries include Austria, Bulgaria, Chile, Croatia, Cyprus, Denmark, Finland, Germany, Greece, Hungary, Iceland, Israel, Latvia, The Netherlands, New Zealand, Norway, Portugal, Romania,

Spain, Sweden, Ukraine, Uruguay and Venezuela. In addition, Belgium added a clause to its Constitution in 2000 confirmed children's rights 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 have declared corporal punishment to be unlawful.

Is the Incidence of Child Abuse Decreasing?

The survey's data collection methods do not provide an accurate method for determining changes in the incidence of maltreatment. Not only do countries and cultures differ in what is viewed as child maltreatment, countries also differ in their capacity to establish formal surveillance systems and provide an ongoing, accurate analysis of the data generated by these systems. Additionally, 10 respondents indicated that their official counts of child abuse do not include cases that may be occurring within certain subgroups such as aboriginal children, migrants, street children, or various native populations. As *Section II* of this report explains, even countries with comparable resources and relatively sophisticated administrative data systems may produce estimates of the problem that are not consistent across countries or jurisdictions. These difficulties in determining national estimates of the problem make reliable international estimates of CAN virtually impossible.

As a crude indicator of change over time, however, survey respondents were asked two sets of questions regarding changes in the incidence of maltreatment. First, all respondents were asked for their professional assessment of changes in maltreatment rates over the past 10 years. Sixty-three respondents (84% of the full sample) responded to this question. Of those responding, two-thirds indicated that they believe the number of child abuse cases have increased, about 10% reported no change, and 22% indicated the number of cases have declined. There were no differences in the distribution of responses to this question across regions or developmental status. Those factors most often viewed as having a "major" impact on the number of identified cases included changes in laws for child abuse reporting, law enforcement efforts and changes in public awareness of the problem. Important, but less critical factors were changes in the public's willingness to report suspected cases and changes in how local governments maintained their records.

Second, respondents from countries which maintain and publish official counts of child abuse cases were also asked to record recent trends with respect to the number of cases involving physical abuse, sexual abuse, neglect and psychological maltreatment. Forty-six respondents (61% of the sample) answered this set of questions. Of those responding, 61% reported increases in physical abuse cases, 71% reported increases in sexual abuse cases, 75% reported increases in neglect cases, and 64% reported increases in psychological maltreatment cases. Again, no significant differences in these patterns were observed across regions or developmental status. In general, respondents who reported increases in official counts of child abuse, generally reported such increases across all forms of maltreatment. Correlations between a respondent's judgments on these indicators and their judgment of our general question regarding child abuse trends, were substantial (r = .35 to .49), suggesting that in most cases professionals in our sample observed both an increase in the reported incidence of child maltreatment and an increase in the public's perception of the problem.

The fact that many respondents reported increases is troubling, but may be due to an increased of 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 incidences 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 (important exceptions to this pattern are discussed in greater detail in *Section II* of this report).

Surveillance Methods

Respondents answered a set of questions aimed at determining the extent to which their country adopted formal mechanisms for documenting child maltreatment. Specifically, we asked each respondent if their country had an official system for documenting reported or confirmed CAN cases, and if so, the types of behaviors captured by this system and if the country had a method for recording CAN fatalities. As summarized in *Table 5*, 61% of the sample reported that their countries maintained an official count of CAN cases, and 39% of the sample reported that their countries maintained official child abuse death records. Of the 45 respondents who reported that their country officially documents child abuse cases, all of these systems include physical and sexual abuse and the majority

include child neglect. Greater variability exists with respect to psychological maltreatment. For example, only two of the reporting systems operating within Africa, capture this form of maltreatment in their official records. Despite slight variations in the characteristics of cases documented by these systems, the use of child abuse registries is increasingly common across regions and across countries at different levels of development. This suggests 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. In the most recent sample, 68 countries (over 90% of the sample) have formal child abuse policies, a trend that compares favorably to the situation we observed in either the 2004 or 2006 samples. Similarly, the proportion of sample countries reporting child abuse registries has increased from 33% in 2004 to 45% in the current sample. Given that the 2008 sample includes a significantly higher proportion of developing countries, this trend is particularly noteworthy.

Public Awareness

One effect of instituting a surveillance system is that it will likely lead to increased awareness of a problem. Increased awareness is important because populations that have a 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, 70 respondents (93% of the full sample) felt they had sufficient information to respond to these questions. Results about public awareness of specific issues, and the factors influencing that awareness, reported by this subgroup of respondents are displayed by region and developmental status in *Table 6*. In general, the respondents were slightly more confident that the public understood how they might act to prevent child abuse than they were about the public's understanding of the problem's scope and how they might collectively, as a society, better protect children. No significant differences in these assessments were noted between developing and developed countries, although respondents from Asia and Europe were markedly less optimistic about the public's awareness and understanding of the problem than respondents in the Americas or Oceania regions.

With respect to the relative impacts of various public awareness strategies, no significant differences were observed between respondents from the developing versus developed countries, although respondents from the developing countries were slightly more confident in the ability of the government's policies and advocacy efforts to enhance public awareness and their engagement in the issue. In contrast, respondents from developed countries saw greater potential for professional education efforts for those working with children and families involved in or at-risk for child abuse. As noted in *Table 6*, over 66% of the respondents from developed countries viewed this method as an effective way to raise awareness in contrast to only 55% of the respondents from developing countries. Respondents representing various African countries were particularly dismissive of this strategy, with only 8% of respondents from the African region considering professional education as having a major impact on awareness levels.

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

	Total (N=75)	Region					Developmental Status	
		Africa (n=13)	Americas (n=11)	Asia (n=24)	Europe (n=24)	Oceania (n=3)	Developing (n=52)	Developed (n=23)
Relationship between child and parents/caretakers								
Sexual abuse (e.g., incest, sexual touching, pornography)	97.3	100.0	100.0	95.8	95.8	100.0	96.2	100.0
Physical abuse (e.g., beating, burning)	96.0	100.0	100.0	91.7	95.8	100.0	94.2	100.0
Failure to provide adequate food, clothing or shelter (neglect)	89.3	76.9	100.0	83.3	95.8	100.0	84.6	100.0*
Abandonment by parent or caretaker	88.0	62.3	90.9	75.0	95.8	100.0	84.6	95.7
Emotional abuse (e.g., repeated belittling or insulting a child)	72.0	61.5	90.9	62.5	75.0	100.0	67.3	82.6
Domestic violence	68.9	69.2	70.0	50.0	83.3	100.0	59.6	90.9**
Failure to secure medical care for child based on religious beliefs	66.7	61.5	90.9	41.7	83.3	66.7*	57.7	80.0**
Parental substance abuse	66.7	69.2	45.5	50.0	87.5	100.0*	61.5	78.3
Psychological neglect (e.g., failure to provide emotional support/attention)	62.7	69.2	81.8	41.7	66.7	100.0	53.8	82.6*
Physical discipline (e.g., spanking)	50.0	38.5	70.0	25.0	66.7	100.0**	44.2	63.6
Parental mental illness	47.3	38.5	20.0	45.8	58.3	100.0	42.3	59.1
Non-organic failure to thrive (FTT)	36.5	38.5	20.0	37.5	37.5	66.7	23.1	68.2***
Social conditions affecting child safety								
Child prostitution	92.0	100.0	90.9	91.7	87.5	100.0	90.4	95.7
Physical beating of a child by any adult	86.7	69.2	90.9	83.3	95.8	100.0	82.7	95.7
Female/child infanticide	85.3	84.6	90.9	79.2	91.7	66.7	80.8	95.7
Children living on the street	84.0	100.0	81.8	83.3	79.2	66.7	82.7	87.0
Forcing a child to beg	81.1	84.6	80.0	79.2	79.2	100.0	78.8	86.4
Child labor	74.7	76.9	81.8	62.5	83.3	66.7	75.0	73.9

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

	Total (N=75)	Region					Developmental Status	
		Africa (n=13)	Americas (n=11)	Asia (n=24)	Europe (n=24)	Oceania (n=3)	Developing (n=52)	Developed (n=23)
Abuse by another child	68.9	76.9	70.0	50.0	79.2	100.0	67.3	72.7
Children serving as soldiers	62.7	69.2	72.7	62.5	58.3	33.3	57.7	73.9
Female circumcision	51.4	58.3	45.5	37.5	62.5	66.7	39.2	78.3**
Abuse/neglect of child within specific settings								
Foster care, group home or orphanage	92.0	92.3	100.0	91.7	87.5	100.0	92.3	91.3
School or educational training center	84.0	84.6	90.9	79.2	83.3	100.0	80.8	91.3
Detention facility	74.7	69.2	100.0	66.7	70.8	100.0	75.0	73.9
Day care center	74.7	76.9	100.0	66.7	70.8	66.7	69.2	87.0
Psychiatric institution	65.3	46.2	90.9	58.3	70.8	66.7	57.7	82.6

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

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

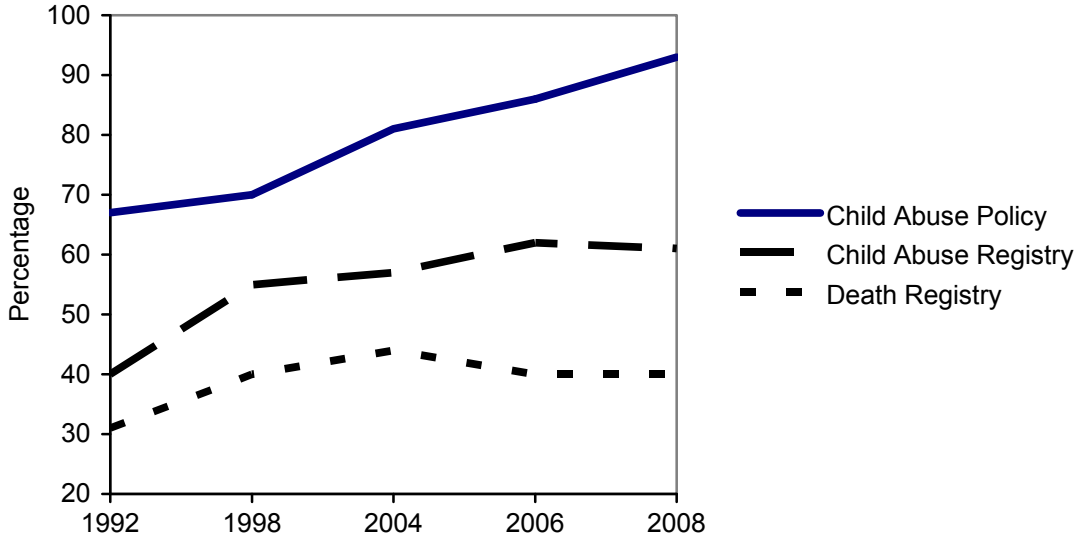
	Surveillance method				Abuse type included in official count			
	Official CAN reporting system? [a]	Tenure of CAN reporting system [b]	Official CAN fatality reporting system? [a]	Tenure of CAN fatality reporting system [b]	Phys [c]	Sexual [c]	Neglect [c]	Psych [c]
Africa								
Cameroon	✓	< 5			✓	✓	✓	✓
Congo, Rep. of	✓	5 - 10	✓	5 - 10	✓	✓	✓	✓
Egypt			✓	> 10				
Ethiopia								
Mauritius	✓	> 10	✓	> 10	✓	✓	✓	
Morocco			✓	> 10				
Nigeria	unk							
Rwanda	✓	5 – 10	✓	5 - 10	✓	✓	✓	
Sierra Leone	✓	< 5	✓	< 5	✓	✓	✓	
South Africa	✓	> 10			✓	✓	✓	
Togo								
Uganda	✓	> 10			✓	✓	✓	
Zambia								
Americas								
Argentina								
Bolivia	✓	< 5			✓	✓	✓	✓
Brazil	✓	5 - 10	✓	> 10	✓	✓	✓	✓
Canada	✓	5 - 10	✓	unk	✓	✓	✓	✓
Chile	✓	5 - 10			✓	✓	✓	✓
Colombia	✓	5 - 10	✓	unk	✓	✓	✓	✓
Guatemala								
Honduras								
Mexico	✓	> 10	✓	> 10	✓	✓	✓	✓
Peru								
USA	✓	> 10	✓	> 10	✓	✓	✓	✓
Asia								
Eastern Asia								
China								
Hong Kong	✓	> 10	✓	unk	✓	✓	✓	✓
Japan	✓	> 10	✓	< 5	✓	✓	✓	✓
Korea, Republic of	✓	5 - 10	✓	5 - 10	✓	✓	✓	✓
Taiwan	✓	> 10	✓	< 5	✓	✓	unk	✓
Central Asia								
Afghanistan	✓	< 5			✓	✓	unk	
Bangladesh	✓	> 10	✓	5 - 10	✓	unk	unk	
India								
Iraq								
Kyrgyzstan			✓	unk				
Pakistan								
Sri Lanka								
Tajikistan	✓	> 10	✓	> 10	✓	✓		

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

	Surveillance method				Abuse type included in official count			
	Official CAN reporting system? [a]	Tenure of CAN reporting system [b]	Official CAN fatality reporting system? [a]	Tenure of CAN fatality reporting system [b]	Phys [c]	Sexual [c]	Neglect [c]	Psych [c]
South-East Asia								
Malaysia	✓	> 10	✓	5 - 10	✓	✓	✓	✓
Philippines	✓	> 10			✓	✓	✓	✓
Singapore	✓	> 10	✓	> 10	✓	✓	✓	✓
Thailand								
Western Asia								
Armenia	✓	< 5	✓	5 - 10	✓	✓	✓	✓
Bahrain	✓	> 10	✓	> 10	✓	✓	✓	✓
Georgia			ukn					
Lebanon								
Saudi Arabia	✓	< 5			✓	✓	✓	
Syrian Arab Rep.	✓	< 5			✓	✓	✓	✓
Yemen								
Europe								
Belarus	✓	< 5			✓	✓		
Bosnia/ Herzegovina								
Bulgaria	✓	5 - 10			✓	✓	✓	✓
Estonia	✓	5 - 10	✓	> 10	✓	✓	✓	unk
Finland								
France	✓	> 10			✓	✓	✓	✓
Germany	✓	> 10			✓	✓		
Greece								
Hungary								
Iceland	✓	> 10			✓	✓	✓	✓
Italy	✓	< 5	✓	> 10	unk	✓	unk	
Montenegro	✓	> 10			✓	✓	✓	✓
Netherlands								
Poland								
Portugal								
Romania	✓	< 5			✓	✓	✓	✓
Russian Federation	✓	5 - 10	✓	> 10	✓	✓	✓	unk
Serbia	✓	< 5			unk	unk	unk	unk
Spain	✓	< 5			✓	✓	✓	✓
Sweden								
Switzerland								
Turkey								
Ukraine	✓	> 10			✓	✓	unk	
United Kingdom	✓	> 10			✓	✓	✓	
Oceania								
Australia	✓	> 10	✓	5 - 10	✓	✓	✓	✓
Fiji	✓	> 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 the Proportion 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 identified cases. To examine how countries responded to child abuse and neglect, we asked them 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. As reported earlier, over 90% of respondents indicated that their country has such a policy. Regarding the tenure of these policies, one-third indicated that their countries had longstanding policies (e.g., established prior to 1980), and another 30% noted their countries had established child abuse policies between 1980 and 2000. Two-thirds of the respondents indicated that these policies, once enacted, were revised from time to time, but were not subject to an annual review.

We examined four broad categories of policy elements: quality and consistency of implementation; 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 68 countries that indicated the presence of a national policy. With respect to implementation issues, policies within the sample's developing countries were significantly more likely than those within the sample's developed countries to have been recently established (e.g., post-2000) (X^2 = 16.53, p < .001), less likely to be widely enforced (X^2 = 8.36, p < .015), less likely to receive adequate, annual government support (X^2 = 6.05, p < .049) and more likely to be largely limited to the country's urban areas (X^2 = 14.51, p < .001). Although no statistically significant differences were observed across regions, respondents from Central and South America were the most likely to report the lack of adequate government support and the absence of sufficient policy implementation in the rural parts of their countries.

In terms of key similarities across countries, 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 report that their policies include language allowing for mandatory and voluntary reporting. Although some states or regions may have policies with language that requires 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 almost three-quarters of respondents reported that the policies in their respective countries contain a requirement that all victims receive some form of service or intervention and over half of countries' policies included provisions for the development and support of prevention services. In contrast, only 28% of the

sample reported that their policies included a provision to provide services to perpetrators. 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. 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 versus therapeutic vs. preventive interventions play in reducing the prevalence of child abuse and neglect (Bross, Miyoshi, Miyoshi, & Krugman, 2002).

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

Level of Awareness	Total (N=70)	Region					Developmental Status	
		Africa (n = 12)	Americas (n = 10)	Asia (n = 23)	Europe (n = 22)	Oceania (n = 3)	Developing (n=47)	Developed (n=23)
Based on poll and other information, % reporting moderate or more awareness of:								
Number of abused children	64.3	66.6	70.0	60.8	59.0	100.0	59.6	73.9
Multiple causes of child abuse and neglect	63.7	66.7	80.0	54.5	59.1	100.0	61.7	68.1
How a society can prevent child abuse and neglect	62.9	83.4	70.0	42.1	59.0	66.7	64.6	59.0
How individuals can act on their own to protect children	66.3	66.6	70.0	47.8	78.3	100.0	62.5	73.9
% viewing strategy as major impact								
Use of public awareness campaigns	61.4	58.3	60.0	70.8	54.5	50.0	62.0	60.0
Professional education	58.8	8.3	62.5	65.2	78.3	50.0**	55.3	66.7
Government policies	42.3	25.0	50.0	54.2	39.1	00.0*	44.0	38.1
Advocacy efforts to change public policies and behaviors	48.6	41.7	33.3	54.2	52.2	50.0	49.0	47.6

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

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 and whether respondents rated its availability as being adequate in two-thirds or more of their respective country. This data is presented for the full sample by region and by developmental status.

Of the 20 specific service strategies included in the survey, all but three were reported as being available in at least half of the countries. Compared to the trends observed in the past two surveys, this finding suggests that a broader array of services is becoming more available in a more diverse set of countries. Of the three broad categories we examined, service availability was most restricted among those efforts targeting parents or perpetrators. A richer array of service options were identified for child victims and general family support. Among the services least likely to be offered within the countries represented in this sample were therapy programs for sexual or physical abuse offenders, home-based services to help abusive families alter their behaviors, family resource centers and targeted home-visitation services for parents at-risk of maltreatment. In addition to these services, universal home-visitation programs for new parents also were generally not available, with only about one-third of the respondents indicating that this option existed within their country.

As expected, significant differences were observed in the range and capacity of various service models between our sample of developing and developed countries. As indicated in *Table 7*, respondents from developed countries were often twice as likely to report the availability of key service models targeting parents or offenders (e.g., therapy programs of physical abuse or sexual abuse offenders, home-based services to assist family reunification or maintenance, family resource centers and targeted home-visits for high risk new parents). The magnitude of difference in service availability was significant between the two groups of countries in all but seven cases (short-term hospitalization for mental illness, therapy programs for victims of sexual abuse, therapy programs for victims of physical abuse, institutional care for abused children, universal access to free medical care, free child care and universal home-visitation programs for new parents). The more frequent availability of various therapeutic and institutional-based services in certain developing countries over the past six years may well reflect the important role medical care providers have played in the identification and service response to maltreatment within these areas. Operating within a disease-based model, advocates within these countries may place greater emphasis on establishing an array of clinical interventions and those targeting victims rather than on establishing social service and general supports for a victim's family. Although service capacity remains woefully inadequate in developing regions (as noted below), the survey suggests that a greater array of service models are being introduced in these countries, if only on a limited basis.

Regional differences in the availability of services surfaced for all types of service models, with respondents from African countries generally reporting a less diverse pool of parent, child and general services. Those service options that appear to be particularly scarce in Africa include any type of home-based services, either for abusive, at-risk or new parents. This pattern was also true for the Asian countries in our sample, but availability in this region was not as limited as what is observed among the African countries.

Even in those cases where a given service model may 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. The only services judged by at least half of the respondents as being adequate in at-least two-thirds of their country were universal access to free medical care and universal home-visits for new parents, in those few countries offering this option. In all other cases, less than one-third of the respondents reported that a given service strategy was generally available and had adequate capacity to meet the needs of the majority of families or victims. As with service availability, issues of capacity were particularly acute within developing countries, although, respondents from very few developed countries reported that their service capacity equaled their level of need.

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

	Total (N = 68)	Region					Developmental Status	
		Africa (n = 10)	Americas (n = 11)	Asia (n = 21)	Europe (n = 23)	Oceania (n = 3)	Developing (n = 49)	Developed (n = 19)
Implementation Issues								
Policy established after 2000	35.9	45.5	18.2	45.0	36.8	00.0	45.5	15.0***
Policy is widely enforced	43.5	25.0	18.2	50.0	52.2	100.0	31.9	68.2*
Government provides adequate annual support	20.3	16.7	9.1	9.5	36.4	33.3	12.5	38.1*
Reports generally investigated as outlined in policy	55.6	60.0	40.0	38.1	73.7	100.0	46.5	75.0
Resources in urban areas exceed those in rural areas	81.7	84.6	100.0	82.6	72.7	66.7	92.0	57.1***
Nature of Reporting System								
Voluntary reporting by professionals or individuals	88.4	100.0	72.7	85.0	91.3	100.0	85.1	95.5
Mandated reporting by professionals or individuals	75.7	75.0	100.0	65.0	79.2	33.3	79.6	66.7
Initial Criminal Justice Response								
Provisions for removing child from parents/caretakers	87.0	90.9	80.0	81.0	91.7	100.0	83.0	95.5
Specific criminal penalties for abusing a child	88.6	100.0	81.8	95.0	83.3	66.7	91.7	81.8
Requires that a separate attorney or advocate be assigned to represent child's interests	67.2	66.7	70.0	60.0	68.2	100.0	68.1	65.0
Requires that reports be investigated within a specific time period	66.7	54.5	81.8	65.0	62.5	100.0	66.7	66.7
Service Provisions								
Requires that all victims receive services/intervention	74.6	81.8	81.8	78.9	65.2	66.7	76.1	71.4
Development and support for prevention services	57.4	50.0	63.6	61.9	52.2	66.7	57.4	57.1
Requires that all abusers receive services/intervention	28.8	36.4	27.3	38.9	17.4	33.3	30.4	25.0

Notes: Of the 72 respondents who address this question, 68 (or 94%) indicated that their country had a national policy regarding child abuse and neglect. Those respondents who reported that their country did not have such a policy included Ethiopia, Iraq, Saudi Arabia and Syria. In responding to specific questions regarding the explicit elements of these polices, the number of respondents for each category (outlined above) ranges from 63 to 68. * = $p < .05$, ** = $p < .01$, *** = $p < .001$

Table. 8. Available Services and Capacity Level by Region and Developmental Status (con't)

Service		Total (N=75)	Region					Developmental Status	
			Africa (n = 13)	Americas (n = 11)	Asia (n = 24)	Europe (n = 24)	Oceania (n = 3)	Developing (n = 54)	Developed (n = 21)
Parent Intervention Services									
Short-term hospitalization for mental illness	*Availability* *Adequate for >66.6%*	92.0 22.1	84.6 9.1	100.0 9.1	87.5 19.0	95.8 36.4	100.0 33.3*	88.5 11.1	100.0 43.5**
Substance abuse related treatments for parents	*Availability* *Adequate for >66.6%*	78.9 24.1	45.5 16.7	80.0 12.5	78.3 6.3	91.7 42.9	100.0* 33.3	68.8 12.9	100.0** 39.1
Family resource centers for parents to share experiences/concerns	*Availability* *Adequate for >66.6%*	47.9 17.1	25.0 0.0	63.6 14.3	45.8 18.2	47.8 18.2	100.0 33.3	38.0 10.5	69.6* 25.0*
Therapy programs for those who physically abused a child	*Availability* *Adequate for >66.6%*	47.3 5.7	30.8 0.0	63.6 0.0	45.8 18.2	45.8 0.0	100.0 0.0	37.3 0.0	69.6** 12.5
Home-based services to assist parents in changing their behaviors	*Availability* *Adequate for >66.6%*	44.3 12.1	16.7 0.0	45.5 0.0	50.0 9.1	56.5 23.1	66.7 0.0	30.0 0.0	82.6*** 22.2
Targeted home-visits for new parents at-risk	*Availability* *Adequate for >66.6%*	44.3 33.3	10.0 0.0	54.4 50.0	39.1 22.2	56.5 38.5	66.7 0.0	33.3 26.7	68.2** 40.0
Therapy programs for those who sexually abuse a child	*Availability* *Adequate for >66.6%*	41.9 6.7	30.8 0.0	60.0 0.0	33.3 12.5	41.7 0.0	100.0 50.0	31.4 0.0	65.2** 14.3
Child Intervention Services									
Therapy programs for child victims of sexual abuse	*Availability* *Adequate for >66.6%*	89.2 6.1	83.3 0.0	90.9 0.0	83.3 5.0	95.8 8.7	100.0 33.3	86.3 0.0	95.7 18.2***
Institutional care for abused children	*Availability* *Adequate for >66.6%*	82.4 25.9	75.0 12.5	100.0 10.0	79.2 26.3	87.5 40.0	33.3 0.0	80.4 17.9	87.0 42.1
Therapy programs for child victims of physical abuse	*Availability* *Adequate for >66.6%*	78.4 29.4	61.5 0.0	81.8 0.0	83.3 15.0	78.3 21.1	100.0 33.3	74.5 0.0	87.0 40.0***
Substance abuse related treatments for children	*Availability* *Adequate for >66.6%*	73.6 15.1	41.7 0.0	90.0 10.0	65.2 7.1	87.5 23.8	100.0** 33.3	65.3 6.3	91.3* 28.6

Table. 8. Available Services and Capacity Level by Region and Developmental Status (con't)

Service		Total (N=75)	Region					Developmental Status	
			Africa (n = 13)	Americas (n = 11)	Asia (n = 24)	Europe (n = 24)	Oceania (n = 3)	Developing (n = 54)	Developed (n = 21)
Group homes for abused children	*Availability* *Adequate for >66.6%*	56.2 13.2	50.0 0.0	63.6 0.0	54.2 17.7	56.5 23.1	66.7 0.0	46.01 0.0	78.3** 29.4**
General Services									
Universal access to free medical care for children	*Availability* *Adequate for >66.6%*	79.2 60.7	50.0 16.7	88.9 62.5	70.8 47.1	95.8 77.3	100.0 100.0	72.0 48.6	95.5** 81.0
Universal health screening for children	*Availability* *Adequate for >66.6%*	78.1 63.6	41.7 20.0	100.0 44.4	62.5 73.3	100.0 78.3	100.0*** 33.3	68.6 54.4	100.0** 77.3
Case management services/meeting basic needs	*Availability* *Adequate for >66.6%*	73.6 17.0	45.5 0.0	54.4 16.7	79.2 10.5	87.0 25.0	100.0* 33.3	63.3 3.2	95.7** 36.4***
Foster care with official foster parents	*Availability* *Adequate for >66.6%*	71.6 23.5	41.7 20.0	90.9 0.0	50.0 25.0	95.8 33.3	100.0*** 33.3	64.7 9.7	91.3* 45.0**
Financial and other material support	*Availability* *Adequate for >66.6%*	66.2 31.9	66.7 0.0	36.4 25.0	66.7 33.3	75.0 47.1	100.0 33.3*	54.9 11.1	91.3** 60.0***
Universal access to free medical care for all citizens	*Availability* *Adequate for >66.6%*	57.7 65.1	27.3 25.0	70.0 66.7	56.5 57.1	70.8 77.8	33.3 100.0	53.1 46.2	68.2 94.1**
Free child care	*Availability* *Adequate for >66.6%*	57.7 32.5	22.2 0.0	81.8 22.2	50.0 25.0	70.8 50.0	33.3* 0.0	54.2 28.0	65.2 40.0
Universal home-visits for all new parents	*Availability* *Adequate for >66.6%*	38.7 50.0	7.7 0.0	54.5 33.3	20.8 40.0	62.5 64.3	66.7** 50.0	32.7 37.5	52.2 66.7

Notes: *Availability* indicates the percent age of countries stating a service was available. "*Adequate for >66.6%"* indicates that, of countries that had a service available (between 28 and 68 countries, depending upon the specific service), the percent age that stated that service was adequate in more than two-thirds of the country.

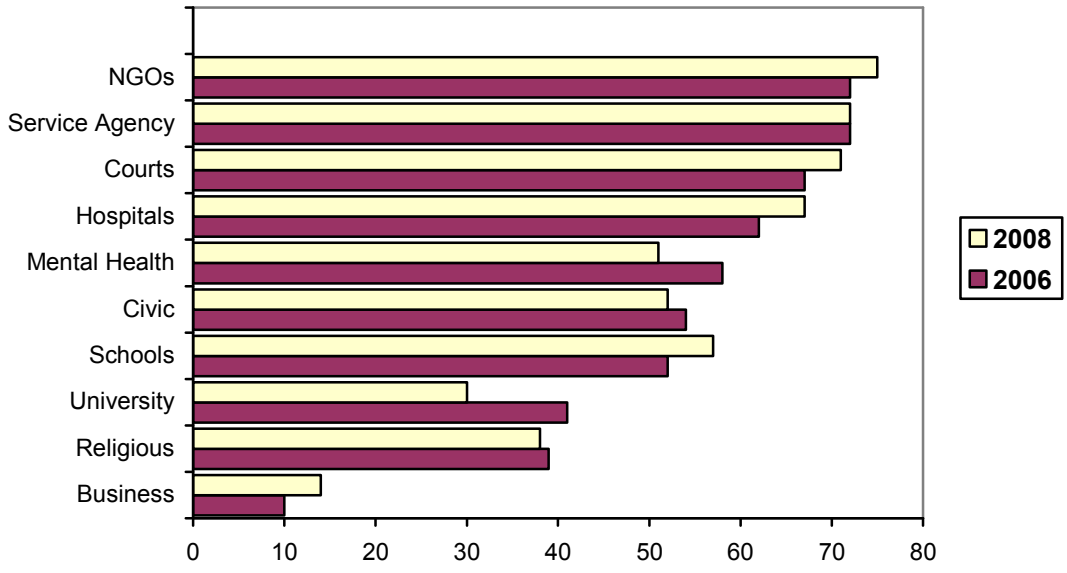
* p < .05; ** p < .01; *** p < .001

Involvement by Community Sectors

Respondents were asked to indicate the involvement of 10 different sectors in providing support for child abuse treatment and prevention services. For each sector, respondents were asked to rank the sector's level of engagement in the child maltreatment issue on a 4-point scale, where 1 = no involvement, 2 = minimal involvement, 3 = moderate involvement and 4 = full involvement. Those sectors most often reported as 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, as well as hospitals and medical centers (see *Figure 3*). As indicated in *Figure 3*, involvement levels and relative ranking of the sectors has been generally consistent over the past two surveys. Modest increases in the proportion of respondents ranking the sector as at least moderately involved in the issue between 2006 and 2007 were observed among NGOs, courts, hospitals and schools. Although small increases were observed with respect to the business sector, this domain continues to lag well behind the other sectors included in the survey. In the most recent survey, over 60% of the sample indicated that their local business community was totally inactive with respect to supporting child maltreatment policies or programs.

As summarized in *Table 9*, differences by a country's developmental status were significant for three sectors, with the strongest differences reflected in lower levels of involvement in developing countries among public social service agencies ($t = -3.27$, $p < .002$), hospitals and medical centers ($t = -3.10$, $p < .003$) as well as mental health agencies ($t = -2.34$, $p < .022$). This pattern is somewhat surprising given the profile of services generally available in these countries. It is possible that respondents in developing countries have higher expectations for the role these organizations will play in advocating and financially supporting child abuse interventions. Active support from hospitals and mental health agencies may be particularly critical given the dearth of social service infrastructure in many developing countriessw not always significant, respondents from developing countries generally rated the involvement of community-based NGOs, voluntary civic organizations and religious institutions higher than their counterparts living in developed countries.

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



Funding for Child Abuse and Neglect Prevention and Treatment

Much of what drives agency involvement, service availability and service quality is funding. Respondents were asked to indicate the relative level of funding provided to child abuse treatment and prevention services by various organizations, public entities, as well as individual or collective philanthropy. For each source, respondents ranked involvement on a 3-point scale, ranging from no funding ("1"), moderate ("2"), to major funding ("3"). Looking

across the full sample, only two funding sources (national government and state or provincial government) received a mean rating suggesting that they provide at least moderate financial support for child maltreatment services (see *Table 10*). However, when funding sources are examined separately for developing versus developed countries, we see two distinct patterns. As expected, the primary funding sources for prevention efforts in developing countries are international NGOs such as UNICEF and the World Bank and international relief organizations. In contrast, government supports (national, state or local sources) are the primary funding streams for child maltreatment interventions in developed countries. As indicated in *Table 10*, the differences between the mean ratings of developing and developed countries in all of these areas were statistically significant. In terms of regional differences, the distribution of mean scores across regions was significantly different with respect to the level of funding from the national governments ($F = 3.37$. $p < .014$) and state or provincial sources ($F = 3.04$, $p < .025$). Respondents from Africa provided the highest rating of all five regions to international NGOs and the lowest ratings for all three governmental sources. Respondents from developing countries (e.g., the Americas and Oceania) also indicated moderate to major support from international NGOs. Respondents represent more developed countries in these regions applied this rating to government funding sources. Respondents from Asian and European countries rated government funding sources, particularly national and state or provincial sources, more highly.

Perhaps somewhat surprising was the consistently low ratings that respondents gave to all private sources of support. These sources demonstrated the lowest mean scores for the overall sample as well as within each subsample we examined. Based on the information provided by survey respondents, there appears to be minimal differences in the extent to which private foundations, individuals, and corporations or businesses invest in child abuse prevention and intervention services. Although there most certainly are differences in the absolute level of support generated by these sources among countries, all of the respondents that reported major support from any of these private sources were from developing countries (e.g., Lebanon, the Philippines, Rwanda, Russia and South Africa). This pattern underscores the resourcefulness of advocates and professionals within these countries in securing additional resources for treatment and prevention services within a context lacking adequate government infrastructures. It also reflects the influence that relatively small amounts of money donated by private philanthropists or foundations can have in countries where the level of resources being devoted to CAN interventions are very modest.

Table 9. Community Agency/Institution Involvement by Region and Developmental Status (Mean Score on a 4-Point Scale)

Community Sectors	Total (N = 75)	Region					Developmental Status	
		Africa (n = 13)	Americas (n = 11)	Asia (n = 24)	Europe (n = 24)	Oceania (n = 3)	Developing (n = 51)	Developed (n = 23)
Public Social Service Agencies	3.13	3.23	2.64	2.92	3.42	4.00*	2.92	3.61**
Community-Based NGOs	3.12	3.31	3.22	3.13	2.91	4.00	3.16	3.05
Hospitals/Medical Centers	2.95	3.08	2.36	3.08	2.96	3.33	2.73	3.43**
Courts/Law Enforcement	2.87	3.23	2.46	2.96	2.67	3.67*	2.89	2.83
Voluntary Civic Organizations	2.71	3.46	2.46	2.64	2.39	3.33**	2.80	2.52
Primary/Secondary Schools	2.68	2.92	2.73	2.32	2.83	3.00	2.59	2.87
Mental Health Agencies	2.65	2.62	2.18	2.64	2.87	3.00	2.49	3.00*
Religious Institutions	2.35	3.00	2.45	2.04	2.13	3.33**	2.37	2.30
Universities	2.23	2.27	2.73	1.96	2.21	2.50	2.32	2.83
Businesses/Factories	1.55	1.27	2.55	1.57	1.17	2.67***	1.58	1.48

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 71 to 75.

* $p < .05$; ** $p < .01$; *** $p < .001$

Child Abuse and Neglect Prevention Strategies and Their Effectiveness

Respondents were asked to identify whether various CAN prevention strategies were used in their country or not, and if so, whether the strategy was effective or not. As summarized in *Table 11*, the 11 prevention strategies which we examined sorted themselves into three distinct groups – those implemented in the vast majority of countries, those implemented in two-thirds to three-quarters of the countries, and those implemented in less than half of the countries. The four most common prevention strategies utilized by this sample of countries are advocacy, professional training, media campaigns and the prosecution of child abuse offenders. Over 90% of respondents indicated that these four strategies are available in their country and in some regions (Africa, Americas and Oceania). A least two of these four approaches were reported as being used by respondents from all of the countries within these regions. Indeed, there were no significant differences in the use of these strategies across any of the subgroups we examined. However, it is often the case that a strategy can be widely available, but not considered effective at preventing child abuse and neglect. This observation proved true with respect to this set of interventions. For example, only about one-third of respondents who reported the use of prosecution of child abuse offenders as a strategy for preventing maltreatment rated this approach as effective. Of the other three most common prevention strategies used by this sample of countries, professional education was viewed as effective by approximately two-thirds of the sample and also advocacy and media campaigns were viewed as effective in nearly one-half of the cases in which they were used.

The majority of respondents also reported the availability of four additional strategies -- improving or increasing local services, universal health care and access to preventive medical care, improving living conditions, and increasing individual responsibility for child protection. Although not as common as the prior set of strategies, these efforts appear to be widely used but only within certain regions. As might be expected, respondents from developed countries reported efforts to improve or increase local services as significantly more common, and more effective, than did respondents from developing countries ($X^2 = 9.67$, $p < .008$). In terms of regional variation, respondents from Asia and Europe were more likely to report the use of universal health care and access to prevention medicine than were respondents from Africa and the Americas ($X^2 = 19.06$, $p < .015$). As with the initial set of strategies, the relative effectiveness of these four strategies varied, with respondents generally finding greater utility in preventing child abuse by improving services and providing access to preventive medical care than improving living standards or increasing individual responsibility for child protection. This variation may, in part, reflect the difficulty in achieving measurable improvements in a community's quality-of-life or in altering a culture's perception of collective responsibility for the well-being of children. Unless such reform can be widely adopted, the marginal benefits of achieving change in a small area or community may be far smaller than the potential benefits of instituting a broad service reform.

Less than half the respondents reported any of the final set of services as being used in their countries. This group included home-based services and supports for at-risk parents, risk assessment methods to better target its support services to those who are at high risk for maltreatment, and universal home-visitation programs for new parents. Respondents from developed countries were significantly more likely to report using, and finding effective, both home-based supports for at-risk parents ($X^2 = 10.68$, $p < .005$) and risk assessment methods ($X^2 = 9.54$, $p < .001$) than were their colleagues from developing countries. Also, significant regional differences were reported in the use and effectiveness of home-based services and supports for parents at risk ($X^2 = 19.21$, $p < .014$) and universal home-visitation programs for new parents ($X^2 = 15.33$, $p < .053$).

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 that were 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, etc.) or are 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 that includes a careful assessment of a family's specific set of needs and offers an array of interventions to address these needs (Daro, 2002).

To better understand a country's overall response, each CAN prevention strategy was categorized as either an individual-level strategy that targets individual behaviors (e.g., professional training, risk assessments, home-based

services for at-risk parents, and 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, etc.). Some strategies could not easily be categorized as the item 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.

In considering the last three surveys, respondents from developing countries are reporting the use of an increasingly diverse pool of prevention strategies. Although wide discrepancies still exist in prevention strategies available across the pool of developing countries and between developed and developing countries, fewer statistically significant differences are being observed between these two subgroups of respondents. Indeed, in the current survey, a higher proportion of respondents from developing countries than from developed countries reported the use of community or system-level strategies such as prosecuting child abuse offenders, media campaigns and improving living conditions. Although we continue to observe significant differences in the use and relative effectiveness of key universal health care and support services, professionals in developing countries continue to introduce new approaches in their communities and to work for the type of legal, professional and community reforms that are central to building systems that can more effectively protect children.

Table 10. Level of Activity for Agencies that Fund Child Abuse Treatment or Prevention Services by Region and Developmental Status (Mean Score on a 3-Point Scale)

Funding Sources	Total (N = 72)	Region					Developmental Status	
		Africa (n = 13)	Americas (n = 11)	Asia (n = 21)	Europe (n = 24)	Oceania (n = 3)	Developing (n = 50)	Developed (n = 22)
International Organizations								
International NGOs/Agencies (e.g., UNICEF, World Bank)	1.93	2.30	2.10	1.82	1.78	2.00	2.23	1.20***
International Relief Organizations (e.g., World Vision, Red Cross)	1.67	1.90	1.63	1.70	1.57	1.50	1.83	1.32**
Government								
National Government	2.22	1.77	2.27	2.48	2.21	2.33**	2.14	2.18*
State or Provincial Government	2.08	1.55	2.25	2.17	2.20	2.50*	1.90	2.50***
Local Government	1.93	1.58	1.82	2.00	2.13	1.67	1.73	2.36***
Private								
Private Foundations	1.78	1.92	1.73	1.83	1.68	2.00	1.78	1.79
Individuals	1.53	1.54	1.33	1.56	1.55	2.00	1.47	1.71
Corporations/Local Businesses	1.48	1.62	1.50	1.35	1.55	1.33	1.47	1.52

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 59 to 72.

* $p < .05$; ** $p < .01$; *** $p < .001$

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

Strategies		Total (N = 73)	Region					Developmental Status	
			Africa (n = 13)	Americas (n = 11)	Asia (n = 22)	Europe (n = 24)	Oceania (n = 3)	Developing (n = 50)	Developed (n = 23)
Advocacy (I,C)	Not used	6.8	0.0	0.0	9.1	12.5	0.0	6.0	8.7
	Use/no impact	37.0	23.1	45.5	36.4	41.7	33.3	32.0	47.8
	Use/effective	56.2	76.9	54.5	54.5	45.8	66.7	62.0	43.5
Professional training (I)	Not used	6.9	23.1	0.0	0.0	8.3	0.0	8.2	4.3
	Use/no impact	30.6	38.5	30.0	36.4	20.8	33.3	36.7	17.4
	Use/effective	62.5	38.5	70.0	63.6	70.8	66.7	55.1	78.3
Media campaigns (C)	Not used	7.0	0.0	0.0	9.1	13.0	0.0	6.1	9.1
	Use/no impact	35.2	23.1	30.0	36.4	43.5	33.3	34.7	36.4
	Use/effective	57.7	76.9	70.0	54.5	43.5	66.7	59.2	65.4
Prosecution of child abuse offenders (C)	Not used	7.1	0.0	9.1	9.1	9.5	0.0	6.1	9.5
	Use/no impact	62.9	69.2	63.6	63.6	52.4	100.0	65.3	57.1
	Use/effective	30.0	30.8	27.3	27.3	38.1	0.0	28.6	33.3
Improving or increasing local services (C)	Not used	24.3	45.5	36.4	18.2	17.4	0.0	31.3	9.1
	Use/no impact	30.0	45.5	18.2	27.3	26.1	66.7	35.4	18.2
	Use/effective	45.7	9.1	45.5	54.5	56.5	33.3	33.3	72.7**
Universal health care and access to preventive medical care (C)	Not used	30.6	61.5	54.5	22.7	8.7	33.3	36.0	18.2
	Use/no impact	27.8	30.8	9.1	36.4	26.1	33.3	28.0	27.3
	Use/effective	41.7	7.7	36.4	40.9	65.2	33.3*	36.0	54.5

Table 11. Strategies Used and Their Effectiveness in Preventing Child Abuse by Region and Developmental Status (con't)

Strategies		Total (N = 73)	Region					Developmental Status	
			Africa (n = 13)	Americas (n = 11)	Asia (n = 22)	Europe (n = 24)	Oceania (n = 3)	Developing (n = 50)	Developed (n = 23)
Improving living conditions (e.g. housing, clean water) (C)	Not used	20.0	30.8	30.0	14.3	25.0	0.0	21.7	23.8
	Use/no impact	30.7	30.8	30.0	33.3	30.0	100.0	39.1	23.8
	Use/effective	38.7	38.5	40.0	52.4	45.0	0.0	39.1	52.4
Increasing individual responsibility to protect children (I, C)	Not used	33.3	33.3	36.4	38.1	27.3	33.3	39.6	19.0
	Use/no impact	31.9	33.3	27.3	28.6	31.8	66.7	33.3	28.6
	Use/effective	34.8	33.3	36.4	33.3	40.9	0.0	27.1	52.4
Home-based services and supports for parents at risk (I)	Not used	53.5	76.9	63.6	63.6	31.8	0.0	65.3	27.3
	Use/no impact	19.7	7.7	0.0	27.3	22.7	66.7	18.4	22.7
	Use/effective	26.8	15.4	36.4	9.1	45.5	33.3**	16.3	50.0**
Risk assessment methods (I)	Not used	55.1	69.2	60.0	54.5	52.4	0.0	62.5	38.1
	Use/no impact	24.6	23.1	20.0	27.3	19.0	66.7	27.1	19.0
	Use/effective	20.3	7.7	20.0	18.2	28.6	33.3	10.4	42.9**
Universal home-visitation for new parents (I)	Not used	64.8	91.7	63.6	77.3	43.5	33.3	69.4	54.5
	Use/no impact	15.5	8.3	9.1	18.2	17.4	33.3	16.3	13.6
	Use/effective	19.7	0.0	27.3	4.5	39.1	33.3*	14.3	31.8

Notes: The total number of respondents commenting on the use and effectiveness of each strategy in their country ranged from 67-73. ***Not Used*** indicates the percent of respondents in that category stating a strategy was not used in their country. ***Use/no impact*** indicates the percent of respondents in that category that used a strategy but did not find it effective in preventing child abuse. ***Use/effective*** indicates the percent of respondents in that category that used the strategy and found it generally helpful in preventing child abuse. In judging the "effectiveness" of various strategies, respondents were asked to comment only on the relative merits of a given approach with respect to preventing child abuse maltreatment. It is possible that strategies not viewed as effective in preventing child abuse may have had impacts in other domains. Letters in parentheses denote (I) individual-level strategies, and (C) community-level strategies.
* $p < .05$; ** $p < .01$; *** $p < .001$

Barriers to Child Abuse and Neglect Prevention

Respondents rated the significance of a number of possible barriers to preventing child maltreatment in their country on a 3-point scale, where 1 = not a significant barrier, 2 = of moderate significance, and 3 = of major significance. Barriers were examined individually and in terms of two broad categories – those relating to a country's economic and social resources (e.g., limited government resources, poverty) and those relating to a country's social norms (e.g., sense of family privacy, support for use of physical punishment).

As summarized in *Table 12*, the most commonly cited barriers to preventing child abuse across the full sample were limited resources, strong sense of family privacy and parental rights, and a lack of effective systems to investigate abuse reports. There was substantial variation in the relative significance on the economic and social resource items across regions. Respondents from Europe and Oceania perceived these conditions as less significant barriers to making progress in preventing child abuse than did respondents from Africa and to a lesser extent the Americas and Asia. Significant regional differences regarding the relative importance of these factors were observed with respect to limited resources for government interventions ($F = 3.26$, $p < .016$), decline in family-life and informal supports ($F = 7.04$, $p < .000$), extreme poverty ($F = 6.15$, $p < .000$), inadequate and poorly developed systems of basic health care ($F = 8.70$, $p < .000$) and the overwhelming number of children living on their own ($F = 7.71$, $p < .000$). In most cases, these patterns reflect a higher level of concern regarding the negative impacts of these conditions on prevention efforts voiced by respondents from African countries. This finding makes sense given the enormous impact that HIV/AIDS has had on Africa, the continued high level of armed conflict and the threat of starvation resulting from harsh environmental conditions. Although none of the variations in the level of concern respondents expressed with respect to social norms were statistically significant, the patterns were similar, with higher levels of concern regarding these factors among African respondents and lower levels of concern among respondents from Europe and Oceania respondents.

Differences by a country's developmental status were found for nine of the 11 factors we examined, with developing countries reporting each barrier to be more significant than developed countries. The only two factors for which a significant difference was not observed between respondents from developing and developed countries were the barriers posed by a society's strong sense of family privacy and parental rights to raise children as they choose, as well as public resistance for supporting major change or program expansion. Examining the trends we have observed in the relative rankings, respondents have provided on these two issues over the past six years, we found stable or slight reductions in the importance of these issues among respondents from developing countries and a corresponding increased level of concern regarding these issues among respondents from developed countries.

Finally, we computed the mean rating each respondent gave to the seven economic and social resource barriers and to the four social norm barriers to obtain an overall level of concern for each of these two groups of barriers. In the past, we have hypothesized that given the economic status of developing countries, resource barriers would be of greater concern among these respondents than respondents from developed countries and that this difference would be more substantial than the variation between the two groups on the social norm barriers. This hypothesis was tested using ANOVA. The model was significant ($F = 27.76$, $p < .000$). As indicated in *Figure 4,* the differential between the mean ratings respondents gave to the social and economic barriers identified in the survey continued, as in the past, to be greater between the two groups than the difference in the relative challenges posed by the social norms. In the most recent survey, the difference in the mean rating between developing and developed country respondents was .77 on the social economic barriers and .51 on the social norm barriers. However, this year, respondents from developing countries rated the social norm barriers at 2.26 and the pool of social and economic barriers at 2.27. As noted above, the relative parity between these two rankings among respondents from developing countries reflects a reduction in the level of concern regarding social and economic conditions rather than a substantial increase in the level of concern regarding social norms. A comparable shift also has occurred in the relative importance of these two sets of barriers among respondents from developed countries. Comparing the 2004 and 2008 rankings among developed country respondents, we observed a 6% decline in the mean level of concern regarding the social and economic barriers (1.53 to 1.44) and an 8% increases in the level of concern regarding the social norm barriers (1.71 to 1.85).

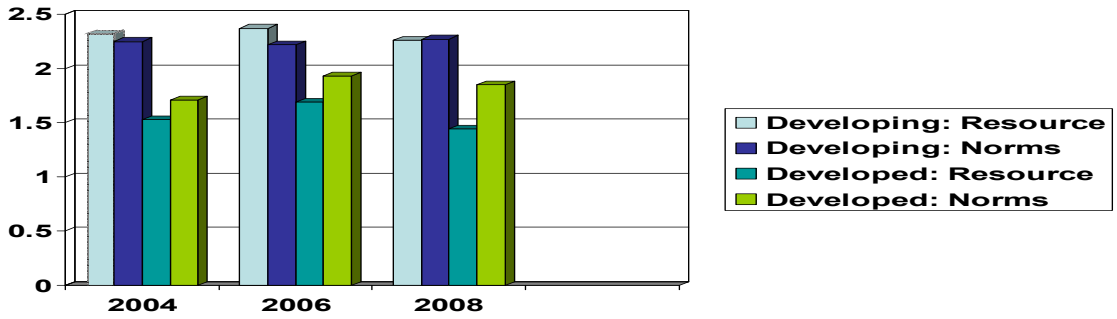
Table 12. Factors that Limit Child Abuse Prevention by Region and Developmental Status (Mean Score on a 3-Point Scale)

		Region					Developmental Status	
Factors	Total (N = 75)	Africa (n = 13)	Americas (n = 11)	Asia (n = 24)	Europe (n = 24)	Oceania (n = 3)	Developing (n = 54)	Developed (n = 21)
Social Conditions								
Limiting resources for improving the government's response to child abuse	2.59	2.92	2.82	2.65	2.26	2.33*	2.78	2.14***
Lack of effective system to investigate abuse reports	2.27	2.54	2.22	2.33	2.21	1.33	2.50	1.48***
Decline in family-life and informal support systems available for parents	2.16	2.85	2.27	2.13	1.74	2.33***	2.37	1.68***
Extreme poverty in the country	2.00	2.83	2.46	1.83	1.58	1.67***	2.35	1.22***
Inadequate and poorly developed systems of basic health care or social services	1.97	2.80	2.27	2.08	1.46	1.33***	2.29	1.30***
Country's dependency on foreign investment to sustain its local economy	1.72	2.15	1.91	1.71	1.42	1.67	1.98	1.13***
Overwhelming number of children living on their own	1.49	2.25	1.80	1.42	1.13	1.00***	1.69	1.05***
Social Norms								
Strong sense of family privacy and parental rights to raise children as they choose	2.42	2.38	2.55	2.65	2.21	2.00	2.51	2.22
Lack of commitment or support for children's rights	2.20	2.54	2.00	2.29	2.00	2.33	2.33	1.91**
General support for the use of corporal punishment/physical discipline of children	2.15	2.23	2.27	2.38	1.83	2.00	2.33	1.73***
Public resistance to supporting major change or program expansion in this area	1.80	2.08	2.00	1.79	1.58	1.67	1.90	1.57

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 72-75.

* $p < .05$; ** $p < .01$; *** $p < .001$

Figure 4: Prevention Barriers by Developmental Status



PREDICTORS OF CHILD WELL-BEING

There are many factors that can reduce the prevalence of child abuse and neglect, and that can enhance child well-being. To facilitate this discussion we have selected the Under-Five Mortality Rate (U5MR) from the *UNICEF 2008 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. Indeed, a comparison of the under-five mortality rate in 2006 to the levels reported in 1990 found a decline of over 30% within our sample countries. As noted in *Table 13*, the under-five mortality rate declined among countries in all five of the World Bank's economic categories. Of the 72 countries in our sample for which this data was available, only four countries (Cameroon, Zambia, the Congo and South Africa) reported increases during this period. Reductions in this indicator were 60% or greater in several countries in our sample, which were located in all regions and all economic strata. These countries included Brazil, Egypt, Greece, Peru, Poland, Portugal, Singapore, Syria, Thailand and Turkey. Despite these gains among some developing countries, the differential performance on this measure between countries in the highest and lowest economic categories has increased, with child mortality levels being 23 times higher among countries in the lowest strata as compared to the OECD countries in our sample. Although child mortality rates remain unacceptably high in many countries, the progress being made among middle income countries suggests that the policy and service contexts in these regions may be better received for combating child maltreatment than was in the past.

Table 13. Trends in Under-Five Mortality Rates by Economic Levels

Economic Category	(n)	Under-Five Mortality Rate 2006	Under-Five Mortality Rate 1990	% Change 1990-2006
Low income	20	117.5	147.2	-20%
Lower-middle income	15	25.9	52.5	-50%
Upper-middle income	15	19.4	34.1	-35%
High income, non-OECD	4	11.3	22.0	-49%
High income, OECD	18	4.8	9.2	-48%
Total	**72**	**43.6**	**62.4**	**-30%**

Note: These categories are established by the World Bank based on a country's Gross National Income (GNI).

In addition to the developmental status, we identified a number of contextual and policy variables that might be related to reductions in child mortality. With respect to contextual issues, we examined the correlations between U5MR rates and various indicators of economic and social well-being from UNICEF's *State of the World's Children 2008* (e.g., the 2006 crude birth rate, the change in the birth rate between 2006 and 1990, and the economic status as measured by GNI). We also examined the relationship between U5MR and a number of indicators from our survey regarding child abuse and neglect prevention efforts (e.g., mean level of involvement in CAN across key public and private sectors, mean level of CAN funding provided by various public and private sources, mean level of concern with respect to key social and economic barriers to change, and mean level of concern with respect to social norm barriers to change). With respect to policy characteristics, we examined the correlation between U5MR rates and the availability of key family, child and general support services as well as the extent to which a country's child abuse policy includes some issues such as mandatory reporting provisions, voluntary reporting provisions, a requirement that reports be investigated within a specific time frame, provisions for child victims to have independent counsel, and the requirement that prevention services be provided. As previously discussed, these provisions were as likely to be included in the CAN policies enacted within developed as in developing countries. Finally, we examined the relationship between a country's U5MR rate and the tenure of its CAN policy, the extent to which respondents judged these policies to be adequately funded by governmental sources, and the extent to which respondents judged this policy to be implemented in a fair and consistent manner. *Table 14* presents these correlations.

As reported earlier, mortality rates for young children are significantly higher within countries with fewer economic resources, 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 regions. Child mortality rates are also highly correlated with a country's birth rate. This finding suggests that the greater the number of children born per 1,000 populations, the more likely that children will experience early death. In contrast to these patterns, no substantial relationship was observed between a respondent's perception of the engagement and financial support by various sectors for child abuse policies and interventions and the country's child mortality rate.

As we have observed in other surveys, countries in which respondents reported high levels of service availability have significantly lower child mortality rates. As reported in *Table 14,* significant correlations were observed between U5MR rates and the number of parent services, child services and general services. In addition, countries with more mature policies (e.g., implemented prior to 2000) and those that receive annual and adequate government support for implementation, have lower child mortality rates. In contrast, a country's adoption of any of the policy elements we examined in the survey was rarely associated with significant reductions in child mortality. The one exception to this pattern was the provision of removing a child from his or her parents. In this case, countries that included this provision demonstrated significantly lower child mortality rates. These patterns are 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. The establishment of a formal child abuse policy appears to be a positive first step in addressing the child abuse problem. Making significant inroads toward preventing maltreatment, however, is a long-term process and will most likely involve efforts to both support families and achieve contextual change.

In order to test these relationships further, we examined a subset of these factors using hierarchical linear regression. Because a country's GNI and World Bank economic rating was highly correlated with the degree to which social and resource barriers were perceived as key limitations in improving prevention efforts (r = -.77), we included the resource barrier variable as a rough proxy of the developmental status. To further reduce the number of independent variables, and to maximize sample size, we included only the number of child-related services a respondent reported having available in their community. *Table 15* summarizes the full list of independent variables and their predictive ability. Predictors were entered in two stages. Step 1 included various contextual indicators such as change in the birth rate over time; perceptions of the degree to which various sectors are involved, on average, in preventing child abuse; perceptions regarding social and economic barriers; and perceptions regarding social norm barriers. Step 2 included various policy and service issues including the reported number of child-related services available in the country, whether the country's child abuse policy was established after 2000, whether the government provided sufficient annual support to implement the policy, and whether the policy included a provision for removing a child from his or her parents. As summarized in *Table 15*, the model accounted for 49% of the variance in the U5MR. The model indicates that after controlling for the variance was explained by social

context (e.g., resource barriers, social norms barrier and service availability), none of the policy characteristics accounted for the additional variation in U5MR.

The model presented in *Table 15* 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 in the implementation of these polices.

Table 14. Correlations with Under-Five Mortality Rate

Variables	Univaiate (r)
Country Context	
2006 Crude Birth Rate	.88 ***
Change in Birth Rate 1990 to 2006	.34 **
World Bank economic status based on GNI (5 levels)	-.63 ***
Mean level of perceived involvement in child abuse and neglect across sectors	-.15
Mean level of perceived funding provided for CAN services across all sources	-.21
Mean perceptions of the degree to which key resource and social barriers that interfere with child abuse and neglect prevention	.55 ***
Mean perceptions of the degree to which various social norms interfere with child abuse and neglect	.27 *
Policy and Service Elements	
# of parent services/interventions reported as being available	-.48 ***
# of general services/interventions reported as being available	-.61 ***
# of child services/interventions reported as being available	-.36 **
CAN policy implemented after 2000 (0 = No; 1 = Yes)	.33 **
Government provides adequate support for policy (0 = No; 1 = Yes)	-.29 *
Consistent investigation of reports (0 = No; 1 = Yes)	-.18
Provision in policy to remove child from parents (0 = No; 1 = Yes)	-.27 *
Provision in policy to require services for victims (0 = No; 1 = Yes)	.11
Provision in policy to require services for abusers (0 = No; 1 = Yes)	-.01
Allows for mandated reporting by professionals (0 = No; 1 = Yes)	-.14
Allows for voluntary reporting by any source (0 = No; 1 = Yes)	-.08
Requires investigations within given time frame (0 = No; 1 = Yes)	-.16
Includes provision for prevention services (0 = No; 1 = Yes)	-.08
Provides separate attorney for a child (0 = No; 1 = Yes)	.10
Number of above items included in country's policy	-.08

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

Table 15. Multivariate Predictors of Under-Five Mortality Rate (N = 42)

Variables	Step 1		Step 2	
	ß	*p* =	ß	*p* =
Social and Economic Context				
Change in Birth Rate 1990 to 2006	.31	.014	.268	.026
Mean level of perceived involvement in child abuse and neglect across sectors	-.03	.799	.072	.573
Mean perceptions of the degree to which key resource and social barriers that interfere with child abuse and neglect prevention	.67	.000	.516	.005
Mean perceptions of the degree to which various social norms interfere with child abuse and neglect	-.05	.745	-.083	.607
Policy and Service Context				
# of child services/interventions reported as being available			-.401	.004
CAN policy implemented after 2000 (0 = No; 1 = Yes)			.129	.331
Government provides adequate support for policy (0 = No; 1 = Yes)			.022	.875
Policy provides for removing child from parents (0 = No; 1 = Yes)			-.004	.972
Variance Accounted For				
F statistic for model	8.09***		6.06***	
R^2	.460		.588	
Adjusted R^2	.403		.491	

*** p = .000

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 this data has several limitations, we can draw preliminary conclusions about trends in the incidences of child maltreatment, public awareness and engagement in combating the problem, as well as the public policy and service response. More detailed and analytic descriptions regarding the state of the world's children are available from a growing number of resources including peer-reviewed journals addressing the issue of child maltreatment as well as periodic publications prepared by UNICEF's Innocenti Research Center (see text box). These emerging resources provide professionals from all regions with increased learning opportunities.

Collectively, the 2008 sample represented all regions of the world with 23 countries that are classified as developed countries and 52 classified as developing countries (69% of the total sample). This year is the first time in the history of our data collection efforts that developing countries represent more than 55% of the total sample. Although it is not an exhaustive sample, the responding countries cover almost 82**%** of the world's total population and 79**%** of the world's children - the most extensive coverage we have achieved with this survey in any year.

The UNICEF Innocenti Research Centre (IRC) in Florence

The UNICEF Innocenti Research Centre (IRC) in Florence, Italy, was established in 1988 to strengthen the capacity of UNICEF and its cooperating institutions to respond to the evolving needs of children and to develop a new global ethic for children. It promotes the effective implementation of the Convention on the Rights of the Child, in both developing and industrialized countries, thereby reaffirming the universality of children's rights and of UNICEF's mandate. Three research units – Economic and Social Policy, Implementing International Standards, and Protection from Abuse, Neglect and Exploitation – generate IRC's studies. Further support derives from two additional units – Communication and Partnership, and Operations.

The following is the 2007 list of published studies from the IRC. All of the publications are available at www.unicef-irc.org).

Major publications

- *AIDS, Public Policy and Child Well-Being*, Cornia, Giovanni A. ed., 2nd edition (English).
- 'Birth Registration and Armed Conflict', *Innocenti Insight*, 2007 (in English and Portuguese).
- 'Child Poverty in Perspective: An overview of child well-being in rich countries', *Innocenti Report Card No. 7*, 2007 (in English, French, Italian, Korean, Portuguese and Spanish).
- *Child Trafficking in Europe: A broad vision to put children first – Summary Report,* Innocenti publication, 2007 (English).
- 'Promoting the Rights of Children with Disabilities', *Innocenti Digest*, 2007 (English. Also available in Chinese, version for strategic distribution at the 2007 Special Olympics World Summer Games in Shanghai, China).
- 'Reforming Child Law in South Africa: Budgeting and implementation planning', *Innocenti Case Study,* 2007 (English).
- *TransMONEE 2007 Features: Data and Analysis on the Lives of Children in CEE/CIS and Baltic States*, including CD-ROM, 2007 (in English and Russian).

Innocenti Working/Discussion Papers

- Menchini, Leonardo and Sheila Marnie (2007), 'Demographic Challenges and the Implications for Children in CEE/CIS'. *Innocenti Working Paper* 2007-01.
- Jespersen, Eva and Julia Benn (2007) 'International Support for the Realization of Children's Rights: Aid modalities and accountability in reporting, and a review of aid for basic social services'. *Innocenti Working Paper* 2007-02. Also released as WIDER Research Paper No. 2007/60, October 2007.
- Yoshikawa, Hirokazu, et al. (2007), 'Early Childhood Education in Mexico: Expansion, quality improvement and curricular reform'. *Innocenti Working Paper* 2007-03.
- ***Special Series on Child Injury*** – a series of Working Papers reporting the results of research in six Asian countries, jointly organized with Health Section, PD and EAPRO. To date:
- Linnan, Michael et al., 'Child Mortality and Injury in Asia: An overview'. *Innocenti Working Paper* 2007-04, Special Series on Child Injury No. 1.
- Linnan, Michael et al., 'Child Mortality and Injury in Asia: Survey methods' *Innocenti Working Paper* 2007-05, Special Series on Child Injury No. 2.
- Linnan, Michael et al., 'Child Mortality and Injury in Asia: Survey results and evidence', *Innocenti Working Paper* 2007-06, Special Series on Child Injury No. 3.
- Linnan, Michael et al., 'Child Mortality and Injury in Asia: Policy and programme implications' *Innocenti Working Paper* 2007-07, Special Series on Child Injury No. 4.
- Marnie, Sheila and Leonardo Menchini, 'The Transition Generation: Young people in school and work in Central and Eastern Europe and the Commonwealth of Independent States'. *Innocenti Discussion Paper* 2007-01.

Prepared by Dr. Susan Bissell

We continue to see a growing agreement regarding those behaviors that constitute child abuse. The most common behaviors considered child abuse and neglect across all, or most subgroups, were physical abuse by parents or caretakers and sexual abuse as defined as incest, sexual touching or pornography. Other behaviors also mentioned by more than 80% of all respondents as abusive include failure to provide adequate food, clothing or shelter; abandonment by a parent or caretaker; child prostitution; children living on the street; physical beating of a child by any adult; forcing a child to beg; female or child infanticide; and abuse or neglect occurring within foster care or educational settings. 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.

Although the survey does not provide a reliable estimate of the incidence of maltreatment reports, survey respondents are asked to gauge the extent to which the number of cases within their country is increasing, decreasing or remaining stable. Sixty-three respondents (84% of the full sample) responded to this question. Of those 63 respondents, two-thirds indicated that they believe the number of child abuse cases has increased, about 10% reported no change, and 22% indicated the number of cases have declined. Similar trends were reported by those respondents whose countries maintain official child abuse registries, suggesting, as in past years, child abuse remains a substantial and growing problem in most regions of the world, even in the face of significant reductions in the under-five mortality rate.

Central to the expanded number of cases, however, is the continued expansion in the number of countries establishing official child abuse policies and methods for documenting reported and substantiated cases. Both the number and proportion of respondents indicating that their country has established a formal child abuse policy and central registry of cases has increased over the past six years, growing from 52 countries in 2004 to 68 countries in the most recent survey. In this sample, over 90% of the countries in which respondents addressed this question have formal child abuse policies and almost half maintain child abuse registries. Given that the 2008 sample includes a significantly higher proportion of developing countries, this trend is particularly noteworthy.

Although formal child abuse policies are being established in many developing countries, they often are not adequately funded or consistently administered. Respondents from developing countries were significantly more likely than respondents from developed countries to report implementation and funding difficulties, particularly with respect to the availability of resources within the less populated or areas of their countries. The survey results suggest that policies in developing countries include much of the language and programmatic elements common in Western approaches to the problem (e.g., formal reporting systems, criminal penalties for abusing a child, time frames for investigating cases, and the provision of services to victims), but are rarely implemented in a manner consistent with these policy objectives.

Of the 20 specific service strategies included in the survey, all but three were reported as being available in at least half of the countries. Those services most commonly available across all regions and among countries at different developmental stages include short-term hospitalization for mental illness, therapy programs for child victims and institutional care for abused children. Far less common were therapy programs for sexual or physical abuse offenders, home-based services to help abusive families alter their behaviors, family resource centers and targeted home-visitation services for parents at risk of maltreatment. In addition to these services, universal home-visitation programs for new parents were generally not available, with only about one-third of the respondents indicating that this option existed within their country. Again, implementation of these service models was uneven across regions, with respondents from developing countries rarely indicating that service-levels in any area were proportionate with the level of need.

In considering the last three surveys, respondents from developing countries are reporting the use of an increasingly diverse pool of prevention strategies. Although wide discrepancies still exist in prevention strategies available across developing countries as compared to developed countries, fewer statistically significant differences are being observed between these two subgroups of respondents. Indeed, in the current survey, a higher proportion of respondents from developing countries than from developed countries reported the use of community or system-level strategies such as prosecuting child abuse offenders, media campaigns and improving living conditions. Although we continue to observe significant differences in the use and relative effectiveness of key universal health care and support services, professionals in developing countries continue to introduce new approaches in their communities and to work for the type of legal, professional and community reforms central to building systems that can more effectively protect children.

Much of the world's response to child abuse and neglect is inextricably linked to funding. Looking across the full sample, only two sources (national government and state or provincial government) received a mean rating suggesting that they provide at least moderate financial support for child maltreatment services. The primary funding sources for prevention efforts in developing countries continue to be international NGOs such as UNICEF and the World Bank and international relief organizations. In contrast, governmental support from national, state or local sources are the primary funding streams for child maltreatment interventions in developed countries.

Despite the significant barriers faced by poor countries, professionals and advocates in these countries continue to work toward establishing formal child abuse policies and expanding the array of interventions for meeting the needs of victims as well as prevent new cases from emerging. As noted in several of the practice and policy briefs included in *Section III*, 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, recognizing 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 available.

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SECTION II: FRAMEWORKS FOR INTERNATIONAL COMPARISON OF CHILD MALTREATMENT DATA[1]

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OVERVIEW

Child maltreatment data collection, analysis and dissemination are conducted to improve the physical, emotional, social and cognitive health and the well-being of children and youth. One important source in several countries is data regarding investigations and substantiations (officially recognized) of child maltreatment reported to child welfare agencies. This data provides estimates of the scope of the problem, and inform the development of policies and programs for at-risk children and youth. When such data collection systems are ongoing, they provide a basis for assessing trends in the incidence and nature of the problem. Such data trends can be useful in making inter-jurisdictional comparisons, and revealing patterns in investigations and substantiations. Thus, they provide more information than point estimates and are especially useful in assessing changes and outcomes of policies and practices.

Analyses of data reported to child welfare agencies have been critiqued for drawing conclusions from samples that have several known biases (e.g., under-reporting, reporting bias, worker bias, etc.) (Chadwick, 2002). Yet, it is important to balance these concerns with the limitations and biases presented in any systematic data collection effort. Further, retrospective cohort data, surveys, or other alternatives regarding incidences or the characteristics of the at-risk population, often reflect patterns at a single point in time and may suffer from their own biases with respect to sample availability and implementation issues. Although limited in scope, administrative data on child abuse reports, investigations and substantiations provide useful pathways for not only examining trends within nations but also comparing trends across nations.

Careful, cross national comparisons of child welfare data provide opportunities to further our understanding of the nature and response to child maltreatment within various contexts. One lesson is the importance of determining whether differences in incidence rates between countries at various points in time are due to methods or to social factors. Intervention services related to child protection often reflect various roles and ongoing policy changes with respect to child protection among government and other organizations; however, the focus of national data often resides in just one or two of these agencies. The analysis of single- or multi-sector sources can, and does, inform policy and practice. Understanding the different data collection methods used by nations and the service systems in which these efforts are embedded is essential for drawing appropriate comparisons across nations. Also, focusing

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on the "patterns" of investigation and substantiation rates are often more important than comparing exact point estimates.

This paper focuses on data drawn from child welfare-based information systems in four countries: *Child Protection Data Collection (CPDC),* Australia; *Canadian Incidence Study of Reported Child Abuse and Neglect (CIS),* Canada; *Child and Young People on Child Protection (CYPCP) Registers,* England; and *National Child Abuse and Neglect Data Systems (NCANDS),* the United States. In addition, brief descriptions of data collection programs being developed in France (Système d'observation longitudinale des enfants en danger [SOLED] of the Observatoire national de l'enfance en danger ([NED]) and Italy (National Childhood and Adolescence Documentation and Analysis Centre) are provided as attachments to this section.

In Australia, Canada and the United States, child protection is largely the responsibility of the territories and the states or provinces. Although the Commonwealth and Federal Governments within these nations have an interest in child protection issues, they are not responsible for day-to-day child protection activities. Separate sets of legislations, policies, practices and systems in relation to child protection services in these countries exist across the various local jurisdictions (see Mathews & Kenny, 2008). While the intervention system in England operates under a unified set of legislation and policies, the daily responsibility for protecting children from harm rests with local authorities.

In all four countries, children who come into contact with child protection agencies for protective reasons include those who are, or are at risk of being, or have been abused and/or neglected, and also whose parents are unable to provide adequate care or protection. The respective governments provide statistics on these children although the data collection methods and definitions vary between the different countries.

The purpose of this paper is to provide a brief overview of data collection methods and programmatic contexts surrounding the structure and use of national data systems to assess the scope of child maltreatment in these developed countries. The paper then examines and compares trends in child maltreatment within these countries as supported by these national data sources. The paper concludes with emerging opportunities for similar collaboration across nations and for the development of a more integrated cross-national effort to provide reliable and robust estimates the of maltreatment problem over time.

DATA COLLECTION METHODS AND SYSTEMS

Australia

Since 1993, the Australian Institute of Health and Welfare (AIHW) has worked closely with the states and territories to undertake national reporting of child protection data and make ongoing improvement to the collections. The AIHW is Australia's national statistical agency for health and welfare related information. At present, national child protection data is gathered in four data areas:

- notifications, investigations and substantiations;
- children on care and protection orders;
- children in out-of-home care; and
- intensive family support services.

From late July to early August of each year, the AIHW provides counting rules to the state and territory departments responsible for child protection. Data is requested for the previous financial year (July 1 to June 30). The counting rules specify standards for the data to ensure that they are accurate and comparable across the individual states and territories. Because child protection is a dynamic area, the counting rules are reviewed every year before dispatch to ensure that they reflect any changes that have occurred within local child protection systems. The data is returned in aggregate form from each local provider (e.g., MS Excel tables) to the AIHW in late September or early October. Child protection information is published in the following January in the AIHW publication *Child Protection, Australia*. Key Performance Indicators for child protection are in the *Report on Government Services (ROGS)*.

Canada

The Canadian government through the Public Health Agency of Canada (PHAC) initiated a study with its provincial and territorial partners to receive national information on children reported to child welfare. The study was to be

repeated every five years starting in 1998. The purpose of this system is to determine investigation and maltreatment rates over time; describe the type and severity of maltreatment; examine selected determinants of health that may be associated with maltreatment; and monitor short-term investigation outcomes (Trocmé et al., 2001).

In the first two cycles of the Canadian CIS study, data was collected during 1998 (CIS-1998) and 2003 (CIS-2003) in all provinces and territories (with the exception of Quebec in 2003). A stratified cluster design was used in the collection of CIS data in 1998 (n=7,672) and 2003 (n=14,200) during three-month periods (October to December). Annualization and regionalization weights were used to obtain estimates of population-based incidences of investigation rates and substantiation levels (Trocmé et al., 2001; 2005). Local child protection workers completed a standardized instrument capturing neglect, emotional maltreatment, as well as exposure to domestic violence, physical abuse and sexual abuse on all children investigated during the study period. In addition, information was collected about child and caregiver characteristics and environmental factors such as income source and housing (Trocmé et al., 2001; 2005).

England

Data collected about children who are the subject of child protection concerns, follows the processes set out in the government's inter-agency guidance, *Working Together to Safeguard Children* (HM Government, 2006). Data on children-in-need and child protection are collected from local agencies at an aggregate level while agencies provide child-specific data on looked-after children. Children-in-need data has been collected at the child level, but not since February 2005. Child-level data on this population will resume in 2009. Each looked-after child has a unique statistical number, thereby preserving confidentiality. These data were analyzed for each local authority and for all of England and Wales. The annual data collection cycle for England is April 1 to March 31.

The child protection statistical return, the CPR3, contains national representative data on the number of children whose names are on the child protection register. Data are also collected on the type of maltreatment experienced by children in need of protection. There are four major categories of abuse and neglect: physical, sexual, emotional, and neglect. The same data collection has been repeated annually since 1988. During that time, there have been some changes to the categories (e.g., there used to be multiple categories including physical and emotional abuse). A template is agreed with, and then completed by, local authority statisticians before being uploaded to a secure website of the responsible government department, the Department for Children, Schools and Families (DCSF).

United States

The NCANDS data collection program in the United States was initiated in 1988. NCANDS' first report was published in 1990. NCANDS data are collected from child protective service (CPS) agencies in all 50 states, the District of Columbia and from Puerto Rico. These data were collected annually and covers October 1 to September 30. Data consist of aggregate state-wide and child-specific case level information. In 2005, case level data were collected from 48 states and the District of Columbia (U.S. Department of Health and Human Services, 2007).

NCANDS aggregate data includes state-wide data collected through a survey referred to as the agency file. Data includes information on funding sources, the number of referrals including those screened out, and the number of fatalities not reported as case data.

NCANDS case-level data consist of CPS investigation events at the child level. Only reports that receive an investigation or assessment response from a CPS agency are included. Each record in the data file is referred to as a *report-child pair*, which indicates there is a record for each child in each report who receives an investigation or assessment. Each report has a unique ID and more than one child can share the same report ID. Each child also has a unique ID, thus the *report-child pair* is uniquely identified by the combination of its report and child IDs.

Data from both sources are subject to an annual process of data mapping and data validation. The process involves a thorough review of each state data system to assess for definitional consistencies and to specify how data elements are supplied to NCANDS. For the child's file, the validation process includes checks to address data formats, as well as checks for constituency across event records and identifiers. Data may be resubmitted multiple times and submissions are accepted once they meet validation requirements.

Definition of Maltreatment

Table 1 provides a brief comparison of the definitions used to describe various forms of maltreatment within these four national systems. All data collection systems capture neglect, emotional/psychological maltreatment, as well as physical and sexual abuse. Under the rubric of other types of maltreatment, Canada and England capture exposure to domestic violence, meanwhile the United States captures unknown types of maltreatment.

MALTREATMENT PATTERNS

The following figures presents data in a quasi-comparative format for each country for which this data is available. The notes under each table should be examined for caveats and limitations especially when attempting to interpret comparisons. For instance, the reporting year varies; age of the child is under 16-years-old in some countries and below 18 in others, and children can experience more than one type of maltreatment. In comparing the magnitude of the rates across countries, the data reflects the major differences in how each country addresses the provision of child protective services. Nevertheless, trends in rates may be of interest as they are somewhat consistent.

Figure 1 presents overall rates of reporting per 1,000 children for Australia, Canada and the United States[2]. For Australia, investigations increased between 1997 to 1998 and from 2005 to 2006. The rate for finalized investigations rose from 9.3 to 16.3 per 1,000 between 1997 to 1998 and 2005 to 2006. Canadian data reflects a sharp rise in the rate of reporting per 1,000 children from 21.5 in 1998 to 45.7 in 2003. For the United States, the overall rate of reporting per 1,000 children increased from 36.1 in 1990 to 48.3 in 2005. After leveling out from 1993 to 1999, a gradual increase between 2000 and 2005 occurred.

Figure 2 estimates the rates per 1,000 children from the general population of officially recognized child abuse and neglect cases each year for Australia, Canada, England and the United States. For Australia, rates of officially recognized child abuse and neglect substantiations increased from 1997 to 1998 and from 2005 to 2006, although not consistently and not for all maltreatment types. The rate for substantiations rose from 4.6 to 7.6 per 1,000 in the same period. Similarly for Canada, rates per 1,000 increased correspondingly with those of investigations rising from 9.6 per 1,000 in 1998 to 21.7 per 1,000 in 2003. Rates per 1,000 of children officially recognized as abused and neglected rose gradually from 2.5 in to 3.0 in the United States.

[2] England is excluded as all children come to the attention of local authorities as children in need, thus data regarding maltreatment becomes available only once it is considered that children may be at risk of harm, and an assessment is required to establish whether this is likely to be the situation.

Table 1: Maltreatment Definitions by Country

Type of Maltreatment	Australia (AIHW)	Canada (CIS)	England (DCSF)	United States (NCANDS)
Neglect	Any serious omissions or commissions by a person having care of a child which, within the bounds of cultural tradition, constitute a failure to provide for a child's healthy, physical, and emotional development	The child has suffered harm or the child's safety or development have been endangered as a result of the caregivers' failure to provide for or protect the child. Failure to supervise --physical harm; failure to supervise --sexual abuse; physical neglect; medical neglect; failure to provide psychological/psy-chiatric treatment; permitting criminal behaviour; abandonment; educational neglect.	The persistent failure to meet a child's basic physical and/or psychological needs, likely to result in the serious health or developmental impairment. Neglect may occur during pregnancy as a result of maternal substance abuse. Neglect may include the parent or caregiver failing to: provide adequate food, clothing, or shelter; protect a child from physical or emotional harm; ensure adequate supervision or access to appropriate medical treatment. It may also include unresponsiveness to, a child's basic needs.	**Neglect** - A type of maltreatment that refers to the failure by the caregiver to provide needed age-appropriate care although financially able to do so, either on own or through other means. **Medical Neglect**- A type of maltreatment caused by failure by the caregiver to provide for the appropriate health care of the child although financially able to do so, either on own or through other means.
Physical Abuse	Any non-accidental physical act inflicted upon a child by a person having the care of a child.	The child has suffered, or is at substantial risk of suffering, physical harm, at the hand of the child's caregiver. Includes any alleged physical assault, including abusive incidents involving some form of punishment. Shake, push, grab or throw; hit with hand; punch, kick or bite; hit with object; or other physical abuse.	Physical abuse may involve hitting, shaking, throwing, poisoning, burning or scalding, drowning, suffocating, or otherwise causing physical harm to a child. Physical harm may also be caused when a parent or carer fabricates the symptoms of, or deliberately induces, illness in a child.	The Type of maltreatment that refers to physical acts that caused or could have caused physical injury to the child.
Sexual Abuse	Any act by a person having the care of the child that exposes a child to, or involves a child in, sexual processes beyond his or her understanding or contrary to accepted community standards.	The child has been, or is at substantial risk of being sexually molested or sexually exploited. Penetration; attempted penetration; oral sex; fondling; sex talk	Involved forcing or enticing a child to take part in sexual activities including prostitution, regardless of whether the child is aware of what is happening. The activities may involve physical contact, including penetrative (e.g., rape, buggery or oral sex) or non-penetrative acts. They may include non-contact activities, such as involving children in looking at, or in the production of, sexual online images, watching sexual activities, or encouraging children to behave in sexually inappropriate ways.	Refers to the involvement of the child in sexual activity to provide sexual gratification or financial benefit to the perpetrator, including contacts for sexual purposes, molestation, statutory rape, prostitution, pornography, exposure, incest, or other sexually exploitative activities.
Emotional Maltreatment	Any act by a person having the care of a child that results in the child suffering any kind of significant emotional deprivation or trauma.	Emotional abuse (e.g., threatening and belittling); non-organic failure to thrive; emotional neglect (e.g., inadequate nurturing and affection).	Persistent emotional maltreatment of a child such as to cause severe and persistent adverse effects on emotional development. It may involve conveying to a child that she is worthless or unloved, inadequate, or valued only as she meets the other's needs. It may reflect developmentally inappropriate expectations such as interactions that are beyond the child's developmental capability, overprotection and limiting exploration and learning, or keeping the child from normal social interaction. It may involve serious bullying, causing children frequently to feel frightened or in danger, or the exploitation or corruption of children. Some level of emotional abuse is involved in all types of maltreatment of a child though emotional abuse may occur alone	Type of maltreatment that refers to acts or omissions, other than physical abuse or sexual abuse that caused, or could have caused, conduct, cognitive, affective, or other mental disorders. Includes emotional neglect, psychological abuse, and mental injury. It frequently occurs as verbal abuse or excessive demands on a child's performance and may cause the child to have a negative self-image and disturbed behaviour.

Table 1: Maltreatment Definitions by Country (cont.).

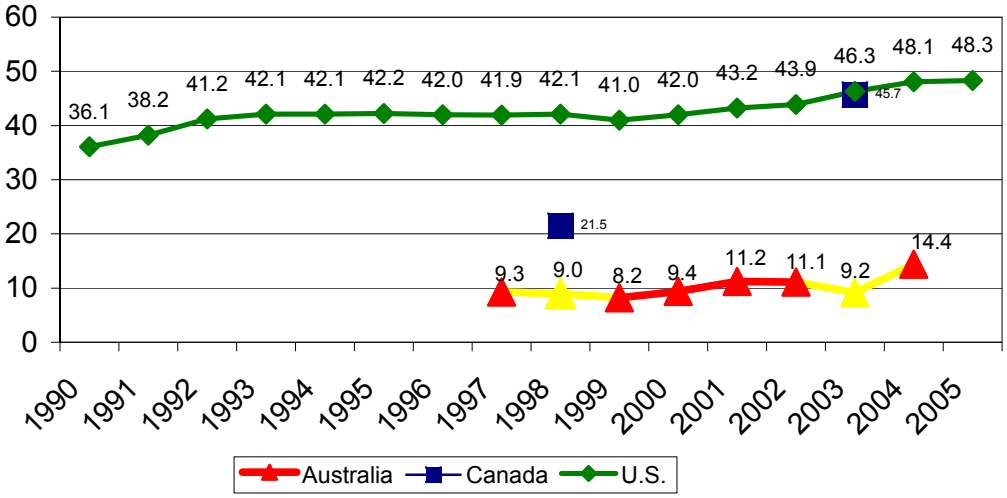
Type of Maltreatment	Australia (AIHW)	Canada (CIS)	England (DCSF)	United States (NCANDS)
Other forms of maltreatment		Exposure to domestic violence-- A child has been a witness to violence occurring between parents or caregivers. This includes situations where the child indirectly witnessed the violence (e.g., saw physical injuries on the parent or caregiver the next day or overheard the violence). Exposure to non-intimate violence (between adults other than caregivers)	Seeing or hearing the ill treatment of another (e.g., domestic violence occurring between parents or caregivers), is legally defined as harm to a child, but in relation to the child protection register, it would be classified it as emotional abuse if there was no actual physical abuse of the child involved.	No alleged maltreatment. Other Unknown or missing.

Rates per 1,000 by the four major categories of abuse and neglect are depicted in *Figures 3-6* for Australia, Canada, England and the United States. Overall the change in the rate per 1,000 of physically abused children has not changed appreciably over the last several years except in Canada. For Australia, the rates for physical abuse have been steady between 1997 and 1998 and between 2005 and 2006, with data ranging from 1.4 to 1.8 per 1,000. In Canada, the rate per 1,000 increased from 2.6 in 1998 to 5.3 in 2003. The rate in England has been fairly steady at around 0.5 per 1,000 from 2003 to 2007. The US rate declined slightly from 2.4 per 1,000 in 2000 to 2.0 per 1,000 in 2005.

In contrast, the rates for neglect increased in all four countries. In Australia, the rates of neglect rose from 1.1 per 1,000 in 1999 to 2000, to 2.0 per 1,000 in 2004 to 2005 and in 2005 to 2006. For Canada, the rate increased from 3.6 per 1,000 in 1998 to 6.4 per 1,000 in 2003. In England, the rate rose from 1.0 in 2003 to 1.3 in 2007. For the United States, the rate rose from 7.3 in 2000 to 7.6 in 2005.

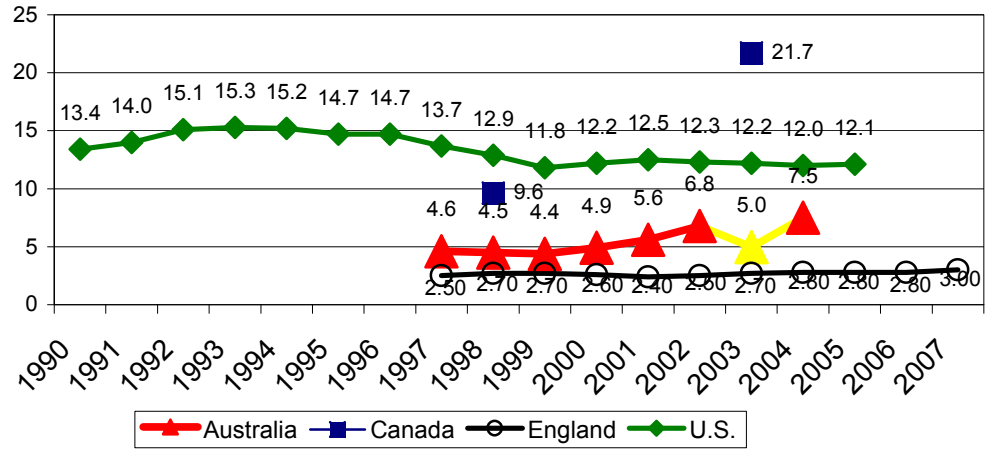
With the exception of Australia, the rates for sexual abuse decreased. In Australia, the rates have been relatively flat, hovering at 0.7 or 0.8 per 1,000 each year. The Canadian rate declined from 0.9 per 1,000 in 1998 to 0.6 in 2003. English rates declined from 0.3 to 0.2 per 1,000 between 2003 and 2007. The rate in the United States declined from 1.2 in 2000 to 1.1 per 1,000 in 2005.

Figure 1 - Official Response/Investigation Rate per 1,000 Children During the Year* 1,2,3,4,5



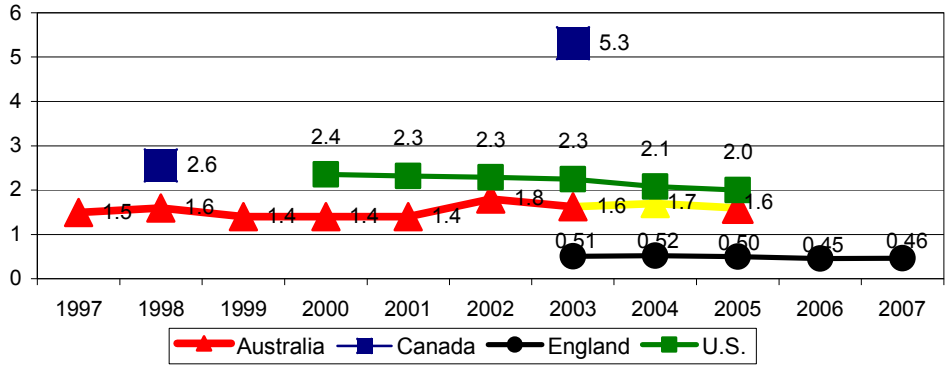
*Comparative interpretation of rates may not be appropriate. Rates also vary among jurisdictions within these countries.
[1]Unit of analysis is based on new child events during the reporting year, thus, children may be counted more than once during the year. Counts of child events are not cumulative from prior years.
[2]Child age: Australia 0-16 years-old; Canada 0-16 years-old; and U.S. 0–8 years-old.
[3]Reporting Year: Australia 1 July to 30 June; Canada Annualized 1998 and 2003; U.S. Calendar Year (1990 to 2003) 1 October to 30 September (FFY 2003 beginning October 2002).
[4]Data for England are not available for this category of information as children are enumerated to the system based on the identification of need which may or may not initially include concerns about possible maltreatment.
[5]Australia data for 1998 and 2004 is imputed.

Figure 2 - Officially Recognized as Abused or Neglected Rate per 1,000 Children During the Year* 1,2,3,4



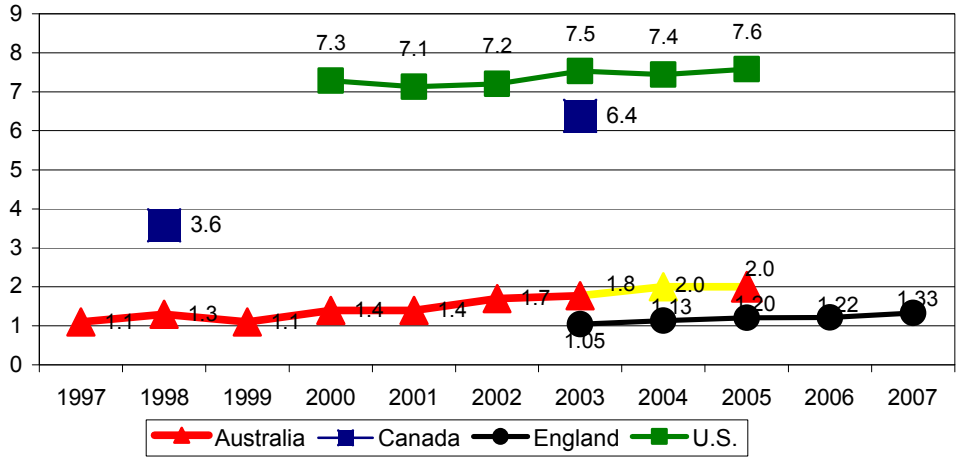
*Comparative interpretation of rates may not be appropriate. Rates also vary among jurisdictions within these countries.
[1]Unit of analysis is based on child events during the reporting year, thus children may be counted more than once during the year. Counts of child events are not cumulative from prior years.
[2]Child age: Australia 0-16 years-old; Canada 0-16; England 0-18; and U.S. 0–18.
[3]Reporting Year: Australia 1 July to 30 June; Canada Annualized 1998 and 2003; England 1 March to 27 (28) February; U.S. Calendar Year (1990 to 2003) then 1 October to 30 September (beginning October 2002).
[4]Australia data for 2004 is imputed.

Figure 3 - Officially Recognized Physical Abuse Rate per 1,000 Children During the Year*1234



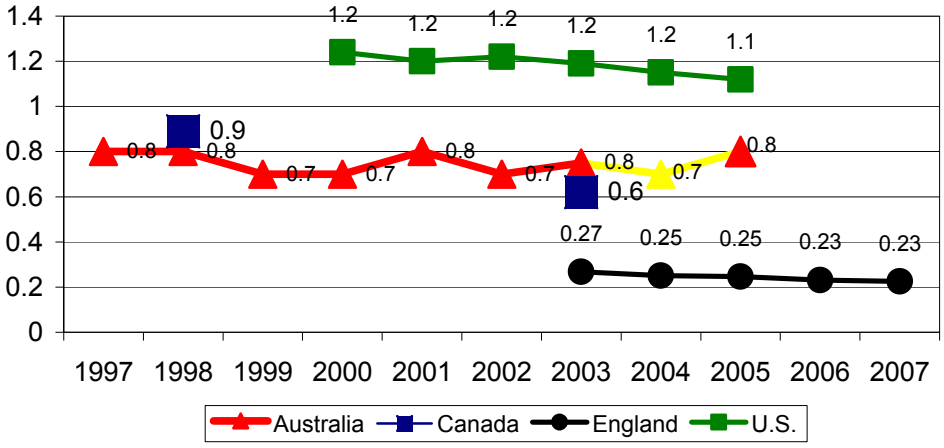
*Comparative interpretation of rates may not be appropriate. Rates also vary among jurisdictions within these countries.
[1]Unit of analysis is based on child events during the reporting year. With the exception of Australia, children may be counted more than once during the year. Counts of child events are not cumulative from prior years. For Australia, only the main type of maltreatment is enumerated, for the other countries, each form of maltreatment is enumerated during the year.
[2]Child age: Australia 0–16 years-old; Canada 0-16; England 0-18; and U.S. 0–18.
[3]Reporting Year: Australia 1 July to 30 June; Canada Annualized 1998 and 2003; England 1 March to 27 (28) February; U.S. Calendar Year (1990 to 2003) then 1 October to 30 September (beginning October 2002).
[4]Australia data for 2004 is imputed.

Figure 4 - Officially Recognized Neglect Rate per 1,000 Children During the Year*1234



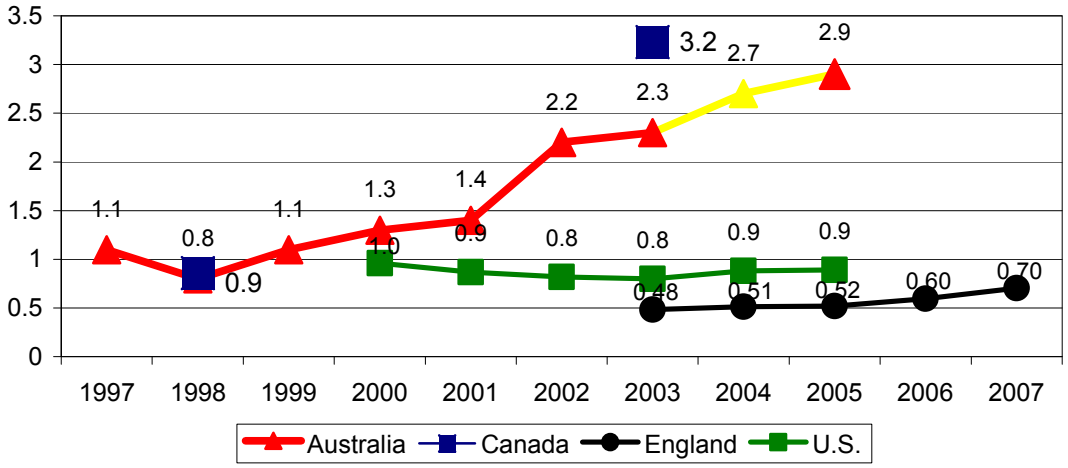
*Comparative interpretation of rates may not be appropriate. Rates also vary among jurisdictions within these countries.
[1]Unit of analysis is based on child events during the reporting year. With the exception of Australia, children may be counted more than once during the year. Counts of child events are not cumulative from prior years. For Australia, only the main type of maltreatment is enumerated, for the other countries, each form of maltreatment is enumerated during the year.
[2]Child age: Australia 0-16 years-old; Canada 0-16; England 0-18; and U.S. 0-18.
[3]Reporting Year: Australia 1 July to 30 June; Canada Annualized 1998 and 2003; England 1 March to 27 (28) February; U.S. Calendar Year (1990 to 2003) then 1 October to 30 September (beginning October 2002).
[4]Australia data for 2004 is imputed.

Figure 5 - Officially Recognized Sexual Abuse Rate per 1,000 Children During the Year*1234



*Comparative interpretation of rates may not be appropriate. Rates also vary among jurisdictions within these countries.
[1]Unit of analysis is based on child events during the reporting year. With the exception of Australia, children may be counted more than once during the year. Counts of child events are not cumulative from prior years. For Australia, only the main type of maltreatment is enumerated, for the other countries, each form of maltreatment is enumerated during the year.
[2]Child age: Australia 0-16 years-old; Canada 0-16; England 0-18; and U.S. 0–18.
[3]Reporting Year: Australia 1 July to 30 June; Canada Annualized 1998 and 2003; England 1 March to 27 (28) February; U.S. Calendar Year (1990 to 2003) then 1 October to 30 September (beginning October 2002).
[4]Australia data for 2004 is imputed.

Figure 6 - Officially Recognized Psychological Abuse Rate per 1,000 Children During the Year*1234



*Comparative interpretation of rates may not be appropriate. Rates also vary among jurisdictions within these countries.
[1]Unit of analysis is based on child events during the reporting year. With the exception of Australia, children may be counted more than once during the year. Counts of child events are not cumulative from prior years. For Australia, only the main type of maltreatment is enumerated, for the other countries, each form of maltreatment is enumerated during the year.
[2]Child age: Australia 0–16 years-old; Canada 0-16; England 0-18; and U.S. 0-18.
[3]Reporting Year: Australia 1 July to 30 June; Canada Annualized 1998 and 2003; England 1 March to 27 (28) February; U.S. Calendar Year (1990 to 2003) then 1 October to 30 September (beginning October 2002).
[4]Australia data for 2004 is imputed.

In the case of emotional abuse, the rates have risen every year in all of these countries except the United States. In Australia, the rate rose from 0.8 per 1,000 in 1998 to 1999 to 2.9 per 1,000 in 2005 to 2006. Canada's rate increased from 0.9 per 1,000 in 1998 to 3.2 per 1,000 in 2003. The rate in England increased from 0.5 per 1,000 in 2003 to 0.7 per 1,000 in 2007. For the United States, the rate declined from a high 1.0 per 1,000 in 2000, but has hovered at around 0.8 and 0.9 per 1,000 throughout 2001 to 2005.

DISCUSSION

This is an initial attempt to describe four national strategies for compiling and reporting aggregate data on child abuse investigations and substantiations and to arrange these data in a common framework. As such, this effort adds to a growing body of literature on child maltreatment trends within various jurisdictions. For example, several efforts have noted declines in sexual maltreatment (Dunne et al., 2003; Finkelhor & Jones, 2004; Jones & Finkelhor, 2002; Jones, Finkelhor, & Kopiec, 2001). Far less has been written regarding trends in other types of maltreatment (Trocmé, Fallon, MacLaurin, & Copp, 2002; Jones, Finkelhor, & Halter, 2006). And even less research has been done on cross-cultural comparison of maltreatment estimates (Sebre et al., 2004).

Data from the four nations investigated in this effort suggests trends in maltreatment investigations and substantiations vary depending upon the type of maltreatment being studied. Although cases involving child sexual abuse appear to be declining in all four countries, reports involving child neglect and emotional maltreatment have demonstrated small to moderate increases. In the case of physical abuse, the problem is trending upward in two countries but declining in two others. In all cases, the interpretation of these trends is a subject of substantial debate and continued inquiry.

For example, the Australian trend data suggest there is a steady increase over the past nine years in the rate per 1,000 children ages 0 -16 years-old who are involved in finalized investigations and substantiations. However, this increase may be due to changes in policy, practice, legislation and data systems, which may reflect increased community awareness or may represent a real rise in the incidence of abuse and neglect. Trend data by maltreatment types suggest that, while the rates of physical and sexual abuse have been largely flat over the past nine years, rates of neglect and emotional abuse have been on the rise. These variations may reflect expanding definitions of these concepts rather than a true increase in their occurrence. Similarly, in Canada the observed increase in both investigation and primary substantiation rates between the two data points (1998 and 2003) may be attributed to new procedures for substantiating a case; expanded investigations of siblings; and more knowledge about emotional maltreatment and exposure to domestic violence (Trocmé et al., 2005). It will be interesting to see whether this increase in rates holds true when additional trend data are available following the completion of the CIS-2008.

While the basic features of NCANDS data have remained consistent over time, there are notable trends such as the increase in investigations, steady rates of substantiation and the decline in rates of physical and sexual abuse. The decline of physical and sexual abuse coincided with prolonged economic prosperity, augmented hiring of law enforcement and child protection staff, and increased public awareness, and promoted a firm law enforcement response among other things (Finkelhor & Jones, 2006).

STRENGTHS AND LIMITATIONS

In general, all four systems share some common limitations in their capacity to accurately describe and track child maltreatment trends. Within a specific set of expectations, however, all four systems can be viewed as highly successful at describing the system of child welfare and child protection intervention in their respective countries and the capacity of these systems to meet the needs of children and their families.

Australia

The AIHW has been responsible for collecting administrative child protection data from the states and territories since 1993. Administrative records are the only reliable source of child protection data available in Australia at present, although it is recognized that the data reflects departmental activities rather than child abuse and neglect rates within communities. Although these data are informative and invaluable for child protection policy work, these administrative data have some limitations.

First, the data collected from the states and territories relate to situations where children have come to the attention of local child protection departments. As such, the data reflects only a proportion of all abuse and

neglect cases that occur within the community. At present, there are no reliable measures of the prevalence of child abuse and neglect in Australia.

Second, although the basic intentions of child protection in each state or territory in Australia are similar, key differences exist in the definition of the problem and public policy response across local jurisdictions (see Bromfield & Higgins, 2005). This means that, while the data is informative within a given jurisdiction, a number of the data items are not comparable across the states and territories and therefore do not produce meaningful national totals.

Lastly, as with other administrative data collections, child protection data is sensitive to system changes both within and across jurisdictions. Each time a jurisdiction changes its child protection policies, practices, developmental resources, legislation, or their data recording system, these data are influenced in ways that often cannot be quantified or fully detected and understood.

Furthermore, because the data are essentially a reflection of departmental activities, it is difficult to conclude, for example, that child abuse and neglect is worsening in Australia simply because the rates have increased. A number of states and territories in Australia have conducted various inquiries into child protection services in the past few years (AIHW, 2007). These inquiries have generated media attention and heightened public interest. Such contextual changes may impact the willingness of the public to report suspected child maltreatment and thus increase rates overtime.

Canada

The CIS is a unique collaborative effort in Canada among different orders of government and researchers across the country. The data provides information on several types of maltreatment and its correlates; however, caveats to the CIS results should be noted. The CIS is designed to capture reported cases to child welfare, thus, it does not capture unreported cases or cases reported only to other professionals. It does not include cases screened out before investigations. The CIS builds on the professional and educational knowledge and experiences of child welfare workers and is not always verified by other professionals. Regional assessments cannot be conducted except where provinces and territories have contributed financially to augment the sample to enable this comparison. In CIS-2003, the data does not include information on all variables from Quebec due to their implementation of a new data collection system. Smaller adjustments to the dataset have also been conducted between cycles. For example, the measures of physical abuse were improved between CIS-1998 and CIS-2003 (Trocmé et al., 2005).

England

The quality of data collected in England, as with all data, relies on individuals to supply accurate information both within local authorities and to the DCSF. Despite the best efforts of officials at central and local governmental levels to define the data requirements and to issue clear guidance procedures, there still remains room for interpretation. The introduction of electronic children's social care records (Department of Health, 2003), which will also enable local authorities to aggregate key data and supply it to DCSF, is intended to improve data accuracy.

As some of the data is used to measure local authority performance in England, there may be perverse incentives to apply differential standards in determining which cases to include in the system. Although every effort is made to prevent this situation, it is a challenge to draft definitions in such a way that insures comparable interpretation.

Beyond administrative variation, the data is sensitive to society's understanding of what constitutes asabuse or neglect and this understanding may change overtime. In addition, policy changes may result in official definitions changing over time. For example, policy changes in the registration criteria have had an impact on this data at different points in time. And, as is true in other nations, this data only reflects the number of children who are referred to local authorities and do not represent all abuse and neglect experienced by children in England.

United States

A fundamental strength of the NCANDS data is that it now collects a near-universal census sample of children who are reported to CPS throughout the United States at the case level. Other strengths include its capacity to produce continuous trend data over time and its capacity to examine the trajectories of children as they re-enter CPS.

One limitation of NCANDS is that the amount of data and the details of the data are not necessarily constrained by what is readily and consistently available from individual states. Also, like other systems, NCANDS does not represent all children who are maltreated, since it cannot include children who are not known or recognized by CPS as being maltreated. Another limitation is the variability in definitions used by CPS agencies in operationally defining maltreatment.

FUTURE PLANS AND DIRECTIONS

Partly in response to limitations, refinements are constantly underway in all four systems. Each nation is implementing a set of practice and policy reforms that are geared not only to improve data quality but also to structure ways to better use the information generated by these systems to enhance outcomes for children at risk.

Australia

The AIHW is undertaking a number of projects in child protection. Some of these projects contribute to improved quality of the child protection data and enable more policy-relevant data analysis to be conducted, while others contribute to better understanding of the data currently available.

Data is currently provided to the AIHW at the aggregate level, which limits the amount of analysis that can be done with them. For example, some children may be counted under all four types of maltreatment and, at present, there is no way to determine the exact magnitude of this overlap. Recognizing the limitations with the current data, the AIHW is working with the states and territories to develop a unit record format collection. New data dictionaries have been developed and pilot-testing for the new collections is currently under way.

The new unit record collection contains information that will allow the creation of a statistical linkage key (SLK) for each child. In Australia, many data collections in the community services field contain a common SLK consisting of a certain combination of letters from the person's name and the person's date of birth and gender. The SLK allows records belonging to the same individual to be matched anonymously and combined where appropriate. The SLK is not a unique identifier, and there is a small probability of error (AIHW: Ryan, Holmes, & Gibson. 1999). The advantage of this small probability of error is that, while the SLK enables linked data to be created and analyzed for statistical purposes, it does not enable the identification of particular individuals and therefore precludes linked data being used for administrative purposes. Inclusion of the SLK in the child protection dataset could facilitate linkage with other administrative datasets held at the AIHW, such as the Juvenile Justice Collection and the Supported Accommodation Assistance Program. Such linked datasets can be very valuable for statistical and policy development work, for which perfect matching is not required for valid conclusions to be drawn (AIHW: Karmel, 2005).

The AIHW is also working with the NCPASS data group and the Australian Institute of Family Studies (AIFS) to better understand the reasons behind the differences across states and territories, differences over time and between indigenous and differences between other children in the various rates per 1,000 measures. This project is expected to conclude in 2008.

Canada

The CIS is being used in policy development. For instance, Canada successfully influenced the inclusion of child neglect in *A World Fit for Children*, a United Nations document using CIS results. Data analysis for CIS supported background discussion regarding changes to the Criminal Code with respect to corporal punishment. The First Nation's Child and Family Caring Society and Indian and Northern Affairs Canada used CIS data to revise funding provided to Aboriginal child protection agencies. CIS analysis has also contributed to policy discussions about investigation priorities and procedures for child maltreatment and the development of the Alberta differential response systems and Ontario Transformation Project. Data from CIS has been included in the curricula at university and high-school levels and in continuing education for school administrators.

The third Canadian data collection for the CIS will take place in fall 2008. The instrument is being revised by the steering committee. For instance, the instrument will attempt to capture the difference between a child being at risk of harm as a consequence of maltreatment, and a child being at risk of maltreatment. In addition, the emotional maltreatment categories are being expanded to better capture this important experience. These and other changes are being focused and pilot-tested by researchers.

The First Nations sample is augmented to obtain better data for this important group. In addition, data is made available for researchers and students across Canada to ensure policy-relevant data analysis.

Since the CIS is part of PHAC's surveillance activities, knowledge-transfer activities take a more prominent role. This is guided by the dissemination experiences from the second cycle (Jack & Tonmyr, 2008). For instance, a study using a mixed-methods approach explores how the CIS data are used by senior child welfare decision-makers in Ontario (Jack et al., 2007).

England

In England, the child welfare collections are intended to collect information about the number of children receiving services from children's social care; those who are the subject of referrals or assessments and are on the child protection register; and those looked after away from home (including being adopted and leaving care) and their outcomes. Trend data on these conditions are useful for policymakers, particularly if the findings are related to policy changes.

The information generated by these systems can be used by statutory bodies that monitor the performance of local authorities. It is important, however, to remember that data needs to be understood in the context of each local authority. Examples of how the data might be used include:

- re-registrations on the register (this provides information about the number of children who have been re-abused; it is obviously desirable to have the lowest possible number of children re-abused, but a low rate may also cause concern if authorities are not re-registering children in order to keep their figures down);
- reviews of child protection cases (these are expected to be undertaken at intervals prescribed in government guidance, and data shows whether they are done on time);
- duration on the register (after two years on the register, it is expected that the child's circumstances should have changed as a result of the agencies' interventions. Hopefully, it is no longer necessary for the child to be on the register);[3] and
- completing core assessments within 35 working days (Department of Health, Department for Education and Employment & Home Office, 2000; HM Government, 2006). Data is collected to see how many are completed in time and which authorities are complying with government guidance.

Researchers in the UK make extensive use of national statistics. They compare information from their research child sample with the national picture. For example, a recent study on children in families where there was parental domestic violence and mental illness was able to compare its data with the national statistics on child protection.

Government statisticians from the Department for Children, Schools and Families (DCSF) meet regularly with local authority representatives to review data items and their utility, as well as propose changes to future data collections. These changes are agreed to with policy colleagues. They reflect changes in legislation, guidance and policy and those requested by local authorities. Making changes to national data collections is an iterative process involving statisticians, policy-makers and local authorities.

United States

In the United States, NCANDS data is used for a wide range of purposes, including the comprehensive annual report, *Child Maltreatment,* published by the federal government and findings are selectively published in other federal documents. Other key uses include the development and monitoring of outcome-measurements related to child safety as part of the Child and Family Service Reviews (CFSR, which is conducted by the federal government every three years for all 50 states. The data is used to develop sampling frames and supplement analysis from other federal data collection programs, including the NIS and the NSCAW. The aggregate and case data is available through the National Data Archive on Child Abuse and Neglect (NDACAN) and have been used for secondary analyses.

NCANDS has undergone several modifications since 1988 to improve the available data, the data's scope, as well as the data collection and analysis infrastructure. Every three years, the data collection program is assessed through the U.S. Office of Management and Budget (OMB) review process with input from a committee of state agency advisors. Other key improvements that are in progress and likely to enhance the data program include:

[3] The requirement for local authorities to maintain a separate child protection register ceased on April 1, 2008. They now will keep data on children who are subject to a Child Protection Plan. This information will be drawn from their electronic case records.

- increased attention to service trajectories, including analysis of data based on ID linkages between NCANDS and the U.S. Adoption and Foster Care Analysis and Reporting System (AFCARS);
- implementation of an On-Line Analytic Processing (OLAP) infrastructure; and
- improvements in data validation and quality through a web-based portal for data collection.

SUMMARY

The child protection data presented in this document provides an opportunity to explore rates of officially recognized (investigated and substantiated) maltreatment in several countries. The definition of maltreatment and data collection methods, among other things, varies; however, there are similarities in patterns. The information presented engenders more questions than answers and is merely a first step in analyzing the various rates across countries from a comparative contextual standpoint.

This document highlights many important issues, including that it is important to conduct in-depth analysis of the similarities and differences among child maltreatment estimates across nations and that the existing systems can identify ways of improving their data systems based on examples from other countries. We are hopeful that this will inspire other countries to initiate data collection systems that will provide solid information to better protect children from maltreatment and to effectively assist affected children and families.

Finally, this document is the product of an international collaboration demonstrating an ongoing commitment by policy and research professionals to improve the knowledge base through data. Ultimately, we believe that the most complete understanding of the global efforts to improve the lives of children and families can be advanced considerably through the availability of reliable and sustainable information.

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Attachment A: Brief Descriptions of Data Systems in Italy and France

ITALY

Project 1: Pilot for a National System to Monitor Neglected, Ill-Treated and Sexually Abused Children, Reported To and Taken Into Care by Local Services

In the Italian scenario, the available national data on child abuse comes from cases of sexual violence reported to the criminal judicial authorities or to the prosecutors of the Juvenile Courts. Currently, in Italy there is no national data regarding at-risk minors or victims of child abuse that have been reported to and assisted by, the local healthcare and social services. At this time, judicial statistics focus on the crimes committed instead of on the child. However, for children reported as victims of sexual violence are maintained in a database by the Police the Department of Public Security of the Ministry of the Interior, regarding information on the characteristics of these children.[4]

Since the approval of Constitutional Law no. 3 on 18 October 2001, "Changes to Title V in section II of the Constitution," the regional authorities, being the Provinces and Municipalities have become the exclusive authorities in charge of social issues. The law also encourages them to act jointly in order to develop and maintain the regional and local information system on social services, according to article 21 of Law no. 328 on 8 November 2000, "General policy law for the implementation of an integrated system of social services." Under the new federalist state, the collection of data on child abuse is a regional issue, deriving from the administrative activities of child protection services. Presently though, few regions collect such data, and such data is not necessarily comparable due to the use of different definitions and methodologies.

A pilot project was approved according to the 2002-2004 *National Action Plan for Childhood* which set as a priority to "identify a constant, homogeneous registration system of the incidences (number of cases per year) of child abuse in all its forms, and provide an adequate description of sub-categories as well as those characterizing features."

The main aims of the project were to:

- experiment with shared models in examining suspected or confirmed cases of ill-treatment and sexual abuse of children; and
- collect comparative data.

Interest in this pilot arose mainly from the need for data suitable for better understanding the characteristics of children and families taken care of by local services and for aiding program development and prevention initiatives. Additionally, more operative objectives were to:

- examine the severity of maltreatment as measured by specific types of child abuse, features of harm and duration;
- examine selected determinants of health for investigated children and their families; and
- monitor short-term interventions.

The activities were carried out from 2005 to 2007 through the National Childhood and Adolescence Documentation and Analysis Centre, instituted under Law No. 451 on 23 December 1997.

The pilot project was implemented with a panel of local social services in five Italian regions (Friuli Venezia Giulia, Lazio, Calabria, Molise and Puglia). The social services were chosen as sources for data because they have the duty attributed to them by current legislation for protecting children in need, at-risk or as victims of child abuse (See *Appendix 1* for a description of service flows for Italy). Most services expressed support for the project but, at the same time were concerned about workload issues. Five general categories of child abuse were surveyed: sexual abuse (including sexual exploitation for prostitution or child pornography), physical ill-treatment, psychological ill-treatment, physical and emotional neglect, and witnessing violence. Each typology is identified by a wide set of specific attitudes and behaviors in order to overcome the problem of different interpretations of "child abuse."

[4]Sexual violence includes sexual acts with or without contact, according to Act 66/96 "Provisions against sexual violence."

Witnessing violence means:

- Witnessing directly or indirectly, frequent quarrels between parents or other trusted family members with menace of death or use of weapon;
- Witnessing directly or indirectly, or being involved in situations of psychological ill-treatment against a parent or other relatives;
- Witnessing directly or indirectly, or being involved in situations of physical ill-treatment against a parent or other relatives;
- Witnessing directly or indirectly, or being involved in situations of neglect against a parent or other relatives; and
- Witnessing directly or indirectly, or being involved in sadistic acts or violence against domestic animals.

This data was prepared on a child fact-sheet, which was then entered into a user-friendly database, using software designed by the National Centre and distributed to all the services involved. For the analysis, the data extracted was individual and anonymous. An ID code made it possible to access the information on each child and their siblings who are taken into care by the service. The information gathered was: personal information on the child (e.g. sex, age, health's status, etc.); the reasons for reporting the child to the service (including information on possible previous referral[s] of the child or his/her family to the service completing the form or other); description of the family context (its structure, data on the parents, education, job, social/personal characteristics, etc.); the interventions performed by the service or others on behalf of the child and the family; and the form(s) of child abuse reported. Then for each form of abuse the frequency, duration, data on the perpetrator and interventions for the perpetrator are documented. In addition, though not required for the data collection format, the assigned professional is requested to identify specific risk factors about the child, the parents and resources for protection (material but also qualitative) at an individual (parents and child) and family/social level.

The first phase of implementation consisted of training and testing of the 0.0 version of the software. Under the supervision, support and assistance on-line and by telephone with the National Centre, the professionals collected data from the child fact-sheet for entry into the database and uploading the data. The first set of data was extracted for the year 2005 and then for 2006. At the end of each year, there was a review for missing or incoherent data and incorrect codes of maltreatment. The project was a work-in-progress activity. Then in 2007, there was a general revision to the data collection approach for the final report and the dissemination.

The results confirmed the importance of using an item-specific fact-sheet related to child abuse in order to collect a wider range of information on the situations reported to child protection services. The focus on the welfare system highlighted critical aspects, which related to recurrences or weaknesses in long-term treatment for the child and in interventions with perpetrators. The majority of cases referred to neglect, but the assessment of the data with workers pointed out a risk of undervaluation and difficulties in the detection of the other forms of abuse; ill-treatment in particular, psychological ill-treatment and witnessing violence.

Project 2. The Database within the Observatory for the Fight against Pedophilia and Child Pornography

In February 2006, the Italian Parliament adopted Act no. 38, "New provisions on the sexual exploitation of children and child pornography, expanded to also include using the Internet for such purposes." This introduced new norms against sexual violence and exploitation against children, which led to the establishment of two new institutions: the National Centre for the Fight against Child Pornography on the Web, which falls within the Ministry of the Interior - Postal and Communication Police Service; and the Observatory for the Fight against Pedophilia and Child Pornography, which falls within the Presidency of the Council of Ministers - Ministry for Family Policies.

Moreover, the law authorized the creation of a new database within the Observatory for the Fight against Pedophilia and Child Pornography. This database will help overcome the existing fragmentation in the statistical flows that are presently produced by the main Public Administrations that is involved in counteracting the phenomenon of child sexual abuse and exploitation.

The approach followed by the Observatory in the construction of the database is structured in three stages:

- review of the existing national database and extraction of relevant data;
- elaboration of the available data; and
- distribution of data and joint analysis with all the professionals dealing with the phenomenon.

The core of the database will be established by the data flows derived from the existing database under the Ministry of Justice and the Ministry of the Interior.

The other administrations called in to support the implementation of the database in the medium and long-term are: the Ministry of Social Solidarity; the Ministry of Education; the Ministry of Health; and the Department of Equal Opportunities.

Data flows which will feed the database include:

- magnitude of the crimes related to sexual abuse and exploitation;
- characteristics of the perpetrator(s);
- characteristics of the victim(s);
- procedural information on the judicial proceedings; and
- information on the measure adopted against the perpetrator and for the protection of the child.

In December 2007, the Minister for Family Policies signed agreements with the three Ministers of Interior, Justice and Reforms and Innovation in the Public Administrations, in order to set-up the database. The National Childhood and Adolescence Documentation and Analysis Centre will support the activities of the Ministries and the Observatory for the Fight against Pedophilia and Child Pornography.

FRANCE

The Système d'observation longitudinale des enfants en danger (SOLED) in planning by the Observatoire national de l'enfance en danger (ONED)

Based on a survey of databases dealing with at-risk or abused children carried out by the Observatoire national de l'enfance en danger,[5] it has been determined that monitoring in France is currently being conducted on the basis of a variety of sources designed for administrative purposes, rather than on actual knowledge of a specific population. Each of these national data sources derives its information from the field and has an "event focus" rather than a "child focus." Data uptake is usually annual and aggregate in nature.

The recent Act, section L. 226-3 of the *Code de l'action sociale et des familles* (March 5, 2007) stipulates that: "(translation) the president of the general council is charged with gathering, processing and evaluating—at any time and regardless of the source—any information of special concern regarding minors who are, or may be, at risk. The representative of the state and the judicial authority shall provide their assistance to the latter." The legislation further requires that a unit ("cellule") consistent with the provisions of this section be created within the child protection services of each of the 100 departments. All information of special concern regarding children should ideally be centralized and transmitted to the relevant unit in the department.

In conjunction with the passage of the Act, it is the goal of ONED to implement the longitudinal child-at-risk monitoring system (SOLED)[6] in approximately ten departments in France (see ISPCAN web site for full description – www.ispcan.org).

The data collected by child protection authorities and transmitted to SOLED is intended to achieve several objectives:

- track children from the time of the first disclosure of concern[7] up to the final measures taken on their behalf;
- counting children at risk and analyzing the evolution of this population at the departmental level;
- compare the population of children at risk with the general population;
- provide a basis from which to carry out more detailed intra-departmental comparisons; and
- establish a database that can be used in the future to carry out representative sample surveys.

[5] Observatoire national de l'enfance en danger, *Premier rapport annuel au Parlement et au Gouvernement*, Paris: ONED, 118 p., September 2005.
[6] Observatoire national de l'enfance en danger, *Deuxième rapport annuel au Parlement et au Gouvernement*, Paris: ONED, 92 p., November 2006.
[7] ONED uses the terms "information préoccupante" and "information inquiétante" (disclosure of concern) to describe any information that suggests that a child may be in need of assistance. Depending on the source of the information, family problems can vary considerably in nature and in intensity.

In order to reconstitute individual trajectories and to be exhaustive, ONED has urged the 10 departments included in the panel, and indeed, all who would wish to have such information at their disposal, to centralize the data within each department. Departments are being asked to provide data extracts regularly to ONED with individual, anonymized data for all children who are at risk.

As part of the proposed system, the population of children at risk is defined as "minors under age 18 for whom child welfare measures are in place, or for whom a legal decision to initiate a child assistance procedure has been made.[8]" This system is to be based on data gathered by child protection authorities (e.g., general councils, family courts, public prosecutors, departmental juvenile justice authorities) regarding the population of children identified by these institutions as being at risk, following an assessment of their situations. A diagram depicting case flow and interactions of the key child protection authorities, as well as points of data collection in France is available on the ISPCAN web site. The risk situation assessed will be determined with the aid of a question designed to provide information on the perpetrator of the presumed risk, as well as a series of six questions designed to characterize the risk:

1- Suspicion of sexual violence against a child
☐ yes ☐ no ☐ don't know
2- Suspicion of physical violence against a child
☐ yes ☐ no ☐ don't know
3- Suspicion of serious neglect of a child
☐ yes ☐ no ☐ don't know
4- Suspicion of psychological violence against a child
☐ yes ☐ no ☐ don't know
5- Suspicion of inadequate parenting without obvious abuse
(can only be checked if "yes" has not been checked for 1-2-3-4)
☐ yes ☐ no ☐ don't know
6- Suspicion of risk resulting from the child's own behaviour
☐ yes ☐ no ☐ don't know

Children who are at risk without suspicion of abuse can be identified by the absence of a positive response to any of the first four questions and a positive response to the fifth or sixth question.

Since the introduction of decentralization legislation, the Conseils généraux for each of France's departments have acquired computer equipment, each according to its own needs. We also observed that there are now as many ways of recording information as there are departments. Furthermore, in the area of child protection, there is no common system of identification at the national level or even between the Conseil général and the district court within individual departments. The selected anonymization method,[9] which irreversibly encrypts nominal data, offers a means of creating an identification number for each child, a number that is permanent over time and identical from one department to another or one institution to another. This number will therefore make it possible to follow children's individual care trajectories. Moreover, the family linkage mechanism will also make it possible to analyze the trajectory of siblings taken into care or of children living under the same roof at a given point in time.

[8] Decision of the judge for children pursuant to section 375 of the Civil Code.
[9] Quantin C., Gouyon B., Allaert F-A., Cohen O., "Méthodologie pour le chaînage de données sensibles tout en respectant l'anonymat: application au suivi des informations médicales," *Courrier des statistiques*, n°113-114, Paris: Insee, pp. 15-26, 2005.

SECTION III: 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, or building service systems. In order to capture some of this diversity, ISPCAN solicited brief commentaries from its members on innovative studies or major issues they have faced in developing their local child abuse response systems. Specifically, we requested commentaries in three primary areas – commentaries on the development of child abuse policies within a respondent's country; assessing the needs of minority populations within a country and the practice challenges in meeting these needs; and measuring or collecting child abuse incidence data.

Overall, a total of 16 commentaries were submitted. In some instances, the commentaries addressed the development of multi-national survey efforts. As a group, the commentaries underscore the variability that exists in how child abuse is defined and addressed worldwide, and how this variability presents unique challenges in crafting international policy or training to address child maltreatment and child protection.

The comments in each of these documents represent the opinions of the authors and do not reflect formal ISPCAN positions. Those having questions on a particular commentary should feel comfortable contacting the author of the commentary directly.

POLICY BRIEFS

ArabISPCAN and the UNSV: A Global Movement Towards Protecting Children in the MENA region

Bernard Gerbaka, LibanCAN, the Lebanese Intersectoral Board of Associations Network for the Prevention of Child abuse and Neglect

The prevention of child abuse and neglect (CAN) is based on the continuous interactions between the desire for universal child rights and actual cultural processes. ArabISPCAN became involved in the United Nations Study on Violence Against Children (UNSV) through engagement in research, advocacy and program implementation during the 2004 ISPCAN meeting in Brisbane, Australia. A number of Arab stakeholders, including Higher Councils for Children, National Committees, Ministries for women and children, and other governmental bodies, increased their engagement with ISPCAN in subsequent meetings (e.g., the 2005 regional UNSV meeting in Cairo in 2005, the 2006 International Committee of the Red Cross meeting in Geneva, and the 2007 conference in Cairo) to reduce the incidences of child abuse and neglect and violence against children.

Child protection strategies have been established in countries such as Jordan, Morocco, Tunisia and Egypt. The strategies are in the process of developing in places such as Syria, Bahrain and Yemen, while countries like Lebanon, Palestine and Iraq struggle with the development of child protection policies. The Kingdom of Saudi Arabia seems to have put child protection strategies on the fast track, while less is known about the implementation of these strategies in other Arab countries. In response to the UNSV, ISPCAN has been involved in the development of national and regional policies such as helping to establish the Arab Professional Network for the Prevention of Child Abuse and Neglect (APNPCAN), and the support of Arab national structures to improve child protection policies and child friendly practices.

APNPCAN has worked in conjunction ISPCAN to identify culturally sensitive procedures that increase the knowledge base about child abuse and neglect and reduce threshold levels of acceptance of CAN. However, these initiatives have been hindered by armed conflicts (the July 2006 war in Lebanon, the Camps war in 2007, the ongoing Palestinian struggle for peace, and the crisis in Iraq) and challenges posed by the unstable socio-political climate of some countries in the MENA region.

Despite these obstacles, a multi-sectoral perspective is able to operate in a climate of increasing levels of common and universal understanding of child rights. National and local initiatives to establish child protection systems in Arab countries rely on political decisions, local and national human resources, regional expertise and international cooperation. Drawing on these diverse perspectives, the UNSV developed a settings-based

framework to describe child abuse and efforts to reduce violence against children in Arab countries. ISPCAN also participated in discussions on the nature and conduct of the UNSV in the MENA region.

Based on an expanding knowledge base, the UNSV attempts to increase the ability of national and other representatives to build systems that integrate child protection, abuse prevention and child participation into already existing human rights commitments and implementation processes. Procedures for doing so would be based on a CRC matrix that incorporates children's rights, professional evidence, relevant social factors, and inter-sectoral responsibilities for the prevention of violence against children and the control of abuse and neglect.

The final report from the study was delivered to the UN General Assembly early in 2007. The study provided an in-depth summary of the extent that children are exposed to violence in their homes, their communities and their schools. Representatives from the Arab region and APNPCAN participated in the UNSV and contributed to the ISPCAN publication, "World Perspectives" to provide relevant, if insufficient, information about the status of children in the MENA region.

Obviously, the paucity of child-specific health and social support services are obstacles to child protection and should be made available and accessible to families and children. In reality, the capacities of those services are sometimes overwhelmed, especially in the context of armed conflict and social instability, where children are at anincreased risk for various forms of abuse and violence. In such situations, free childcare, universal health screening and universal access to free medical care become even more critical.

National strategies for child protection should comply with the United Nations Convention on the Rights of the Child (UNCRC), with special attention paid to the needs of developing, insecure and ill-resourced countries. The potential challenges and impacts of the CRC implementation should also be explored in terms of the future development of democracy and freedom to express opinions, specifically in the development of:

- Independent structures: child observatories and child defenders at local and national levels;
- Child protection acts, child-friendly and environment-centered legislation;
- Budgets for child protection and child-oriented projects;
- Help-lines for children and professionals to report on child maltreatment and to provide psychosocial support to victims of violence;
- Training programs for pilot and decentralized multi-sectoral teams and building of professional curricula;
- A study of the extent of VAC based on three I-CAST questionnaires (child, retrospective and parents);
- Participation of children and youth in the evaluation, analysis, reporting and implementation of processes and issues that affect them;
- Support for child-friendly media (auto-censorship on aggressive viewings to reduce violence and enhance educational programs); and
- A code of conduct for professionals working with children.

Despite ongoing efforts by Arab governments and many NGOs to address multiple social, cultural and professional challenges, CAN remains a serious threat to child rights implementation. Currently, dedicated child budgets and child protection acts are absent in many countries. There are few independent structures for child rights monitoring and child help-lines are scarce. Too many children are living in institutions. There are few, though increasing, numbers of therapy programs for victims. Legislation is subject to national consultation before meeting the CRC's requirements. The lives of refugees are often tense or are put on hold while they wait for the Arab-Israeli conflict to be resolved. Internally and regionally displaced children are repeatedly exposed to extreme types of violence and abuse. In some countries, religious practices take the place of civil rights. In such countries, children are exposed to problems that alter their growth, development, social interaction, safety, education and health.

It is important that ArabISPCAN not only rely on and support governments who take the initiative to build child protection systems, but contribute to the development of a framework for knowledge and practice, drawing on the observations and findings of professionals and advice from experts and NGOs who work closely with children. Efforts of this kind should increase the capacity of stakeholders to confront violence against children with peaceful methods, based on firm evidence. APNPCAN and ISPCAN have critical roles to play in the development of reliable monitoring systems, professional training, as well as increased public awareness and examination of emerging child initiatives in the Arab region.

The State of Child Abuse in Australia

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Prior to the 1970's, public awareness of child abuse in Australia was minimal, but as professionals became interested in the field, more systematic mechanisms were developed through which children with suspicious injuries could be tracked. In 1975, Henry Kempe presented the keynote speech to Australia's first National Child Abuse Conference in Perth. Kempe's influence along with a rising public and professional awareness led to calls for mandatory reporting and by 1977, the first mandatory reporting system was established in the state of New South Wales. As a result of this implementation, the number of reported cases rose dramatically.

Today, all Australian states and territories have some type of legislation that requires compulsory reporting of abuse and neglect though a range of professionals though the criteria for notification varies widely between them. The result is that cases mandated for notification in one state may not be considered reportable in another.

Over the last six years, the number of child protection notifications has almost doubled from 107,000 in 1999-2000 to 267,000 in 2005-2006 and substantiation rates vary from 41% to 67% across states. It is difficult to know whether these numbers reflect a true increase due to changes in child protection policies or because the definition of child abuse and neglect has broadened over the last decade as child protection policies have evolved. What is certain, however, is that even when using a narrower definition, the total number of reported cases is still very large. As a result of this increase in notifications, many of the systems are set up to provide services have become overloaded. Increased coordination efforts will be required, most likely at the national level, if real change is to be achieved.

Australia has a long way to go to provide public education about some key concepts of child abuse. A survey published in 2006 by the Australian Childhood Foundation found that child abuse was perceived by the community as less concerning than the rising cost of petrol and the problems with public transport. Thirty-one percent of respondents said that they would not believe children's stories about being abused and 16% were unclear about whether or not sex between a 14-year-old boy and an adult would constitute sexual abuse. Though corporal punishment is no longer allowed in schools, many parents still believe in its effectiveness despite the increasing body of evidence against this form of discipline.

Child abuse, especially child sexual abuse of children in indigenous communities (who represent 2% of the Australian population) is a particularly serious problem. Substantiation rates in aboriginal communities are five times higher than in the non-indigenous population, and despite several inquiries, the problem has largely been ignored by the government until very recently.

A wide range of government initiatives have been put in place to strengthen families and protect children such as Families First in New South Wales and ChildFIRST in Victoria. While the states and territories are primarily responsible for welfare, health, education and services for abused children, the Federal Government has developed some of its own initiatives. These include the establishment of the National Clearinghouse on Child Protection Information developed in conjunction with the Australian Institute for Family Studies and the development of a National Council on the Prevention of Child Abuse, though the focus of the latter has since shifted to a greater emphasis on family functioning.

There have also been several valuable legal reforms which emphasize respect for the child witness, making courts more child-friendly, and educating the legal profession about the difficulties that child witnesses face. *The Australian Family Law Act* was revised in 2006 to ensure that the Court protect children from physical or psychological harm and family violence, and it requires prompt action to be taken when allegations of child abuse or family violence are reported.

Community led organizations such as the National Association for the Prevention of Child Abuse and Neglect (NAPCAN), Good Beginnings (providing early support for new parents with difficulties) and the Australian Childhood Foundation have been effective in public education as well as political lobbying. National Child protection week, an initiative of NAPCAN, has been held annually for 15 years as a way of raising public awareness.

There are also a wide range of home-visiting programs and parent support programs. A recent audit of these programs, carried out by the Australian Institute for Family Studies, found that these parenting programs, such as the Triple-P Positive Parenting Program can be very effective in addressing risk factors for child maltreatment. The home-visiting programs have proven to be most successful where there are highly trained and skilled

professionals. These programs were more likely to be successful when targeted towards specific groups with a focus on improving both maternal and child well-being.

Though progress has been made over the last 30 years, many children are still being abused, leading to a large proportion of them at risk of having problems in their adult relationships and with parenting skills. While child abuse may be seen as one of Australia's most serious problems, public and political representatives often wait for a high profile incident to occur before taking action. A comprehensive, coordinated Federal approach is needed to avoid tragedy and to provide the impetus for the next major improvement in child welfare and protection efforts. This will require the political will of Australia's elected representatives that will need to be kindled and fanned by the demands of those who elect them.

World Perspectives on Child Abuse: Brazil

Dr. Evelyn Eisenstein, Medical School at the University of the State of Rio de Janeiro, Brazil; Dr Lúcia C.A. Williams, Federal University of São Carlos, Brazil; Dr. Victoria Lidchi, ISPCAN, Rio de Janeiro, Brazil; and Judge Cristiana Cordeiro, 2nd Regional Juvenile Court of Rio de Janeiro, Brazil

Brazil is a democratic republic and the largest country in South America with 180 million inhabitants living in 27 states. An estimated 40% of the population (or 68 million) are children and adolescents, 0-19 years of age. The mortality rate for children below the age of five is 35 per 1,000 inhabitants and the mortality rate for youth ages 10-19 is 46.8 per 1,000. The latter rate is five times higher for boys (77.2) than for girls (15.8 per 1,000 inhabitants), due to "external causes" such as violence, stray bullets and accidents. Brazil has a very diverse mix of cultures, races and ethnicities and it is united by one common language, Portuguese. However, many challenges remain to be overcome in a large country where poverty, social income disparities and a high unemployment rate contribute to social exclusion, increased health risks, violence, abuse and sexual exploitation. Sexual tourism, street youth, illegal and informal market laborers, institutionalized youth, elevated high school drop-out rates and participation of children in organized armed violence in the slums of major urban centers, remain obstacles for a government with the slogan of a "Country for All" (*Brasil de todos)*.

In an effort to address some of these challenges, the Brazilian government drafted Article 227 into Brazil's Constitutional Law declaring that it is an absolute duty of the family, society and the State to protect children and adolescents from 0-18 years of age. In 1990, *the Child and Adolescent Act (Estatuto da Criança e do Adolescente*) was established and Brazil signed the *Declaration and Plan for Action* proposed by World Fit for Children (which is part of the UN Millennium Developmental Goals 2002). Serious efforts have been made to translate these laws and provisions into daily practice and an increased awareness of child issues. Presently, there are more than 4,000 Councils for the Rights of Children and Adolescents and Child Protection Agencies (*Conselhos Tutelares*) present in more than 55% of the 5,000 municipalities around the country.

However, the Brazilian government is not the only representative working to ensure the well-being of children in Brazil. A growing network of civilians and professionals in the social, legal, judicial and health systems are working to ensure citizenship and health rights for every child and adolescent. In addition, many prevention and protection measures have been implemented by local institutions to address a lack of social support and community infrastructure for dealing with violence and maltreatment. Some of these initiatives have been in collaboration with international organizations such as the ILO and UNICEF. Child Line International is working with a local NGO in Rio to establish a project in Brazil that would include a free national telephone number (DIAL-100) to report any violence or abuse cases involving children and adolescents.

For the past five years, media and television have launched public service campaigns across the country to raise awareness about protecting children from violence and abuse. Many professional training meetings have been organized with the main goal of emphasizing the importance of violence prevention to children and adolescents as a future investment for the nation. Professional associations, including psychology, pediatrics, social science associations, universities, as well as NGOs have training courses and meetings on prevention, intervention and public actions. Also, several networks have been established that focus on issues directly related to gender violence and child protection, such as the Child Friendly Network (*Rede Amiga da Criança*). A Child and Adolescent Rights Network has been established through the internet, connecting many professionals and NGOs who are deeply involved in work on violence and abuse prevention.

Many activities and resources are directed to the Youth Advocacy and Support Network (*Rede de Protagonismo Juvenil*) as an effective strategy for prevention and health promotion. Reference Health Institutions Network in major urban cities have been established to examine and follow-up violence and abuse cases to decrease major

mental health problems, provide treatment interventions for pregnant teens and for those at risk of sexually transmitted diseases and to help those in need of legal and social assistance.

Brazil has many innovative initiatives for combating interpersonal and structural violence, some based on local theoretical frameworks. Brazil is unique for its range of projects developed in very poor communities that lack infrastructure. The educationalist, Paulo Freire, has been an inspiration for the "reflexive group" methodology associated with therapeutic interventions in the field of domestic violence. Professionals from the North Eastern State of Ceará have utilized the "community therapy" methodology to help communities come to terms with the effects of violence, including structural violence, and to help people develop new ways of relating socially.

It is increasingly common for research to be integrated into policy-change efforts supported by the government. Two examples of this are:

Support Network for Female Adolescents (*Projeto RAMA:Rede de Apoio à Mulher Adolescente*) which provides professional training materials developed by a multidisciplinary team at the University of Rio de Janeiro's Adolescent Health Center to deal with violence and abuse situations. It was published with the support of Brazil's Special Secretary for Women's Affairs. This module used a problem-based learning methodology that includes the description of 11 common clinical cases with practical approaches on how to intervene in health-social situations. Trainings will be implemented in 10 different states for 800 health and social services professionals in 2007-2008.

The recently organized **International Conference on Family Violence: Child Sexual Abuse** at the Universidade Federal de São Carlos (São Paulo) by the Laboratory of Violence Prevention and Intervention (LAPREV), and the University's Health School Unit (USE), received multiple sources of support (Williams, Gallo, & Brino 2005). Among them were CONDECA (State Council for the Rights of Children and Adolescents), the municipality of São Carlos, ISPCAN, the Ministry of Social Development, and the World Childhood Foundation. For three days, researchers, activists, educators, professionals and legal representatives discussed topics, such as international and Brazilian efforts to fight and prevent Child Sexual Abuse (CSA); the role of health professionals and the Judiciary System in CSA prevention; listening to sexually abused children to better understand the process of disclosure*;* the relationship between CSA and parricide; prevention of CSA in educational settings; networking to protect victimized children; the difficulties of children who testify in court, and how to help them; innovative Brazilian legal efforts to support children's testimony in court; and best practices for CSA prevention, among other topics.

Judges, prosecutors and other professionals involved in the area of child abuse and neglect agreed that there is still much to be done in order to advance the Brazilian legal system in terms of preventing child sexual abuse including**:**

- Changing the conceptualization of rape under Brazilian law (which is still typified as a female issue);
- Increasing the number of children under 12-years-old who testify in court;
- Supporting police in their efforts to press charges in CSA cases even when there is no physical evidence involved, as is typical in cases of child sexual abuse (Heger, Ticson, Velasquez & Bernier, 2002; Kellog, Menard & Santos, 2004); and
- Reforming legislation to improve the conditions of children unable to live with their biological families and those who are currently living in the youth justice system, subject to atrocious conditions.

A Judiciary project was initiated in Rio Grande do Sul State called *Depoimento sem Dano,* the Portuguese equivalent of a risk-reduction program by children who have witnessed violence (based on recommendations by Dobke, 2001). The child would testify in a separate court without the presence of the offender, and the testimony given to a trained psychologist. This project has been implemented under much scrutiny in a few Brazilian states though it may be implemented shortly in São Paulo, Rio de Janeiro, and eventually throughout Brazil.

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Child Advocacy in Thailand
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Prior to the 1980s, the government of Thailand had no established formal mechanisms for protecting children. Corporal punishment was a widely accepted form of disciplining Thai children both in the families and school contexts. There was also a widespread belief among the public that sexual abuse did not occur within the family setting—mothers and loving family members were above suspicion since it was believed that abuse of this kind could only be perpetrated by a man suffering from a mental disease. It was not until the 1990's, after a long campaign by professionals and Non-Governmental Organizations (NGOs), that the Thai government mandated the reporting of child maltreatment.

Over the course of two decades, and spearheaded by civil society and NGOs, the Thai government would establish policies and institutions to address a range of child protection issues. In 1981, the Center for the Protection of Children Rights (CPCR) and the Center of Concern for Child Labor (CCL) were set-up to address issues of child labor exploitation. At first, the Thai government responded in a hostile manner to the negative publicity and attempted to hide or deny any information on child labor exploitation in Thailand. However, under the increasing pressure of numerous high profile child labor cases brought before the courts, the government established the Division of Female and Child Labor Protection. In the mid-1980s, NGOs launched another campaign against family sexual and physical abuse and the sexual exploitation of children. Again, government agencies responded with indignation and accused NGOs of working in conjunction with foreign countries who had an interest in meddling with Thai affairs. However, NGOs working on this issue received widespread public support after news agencies reported on raids in the brothels, showing children who had been tortured, confined and forced into sexual intercourse with multiple partners a night. In response, the government vowed to reform the sex trade, transforming brothels into more formal entertainment businesses such as massage parlors, bars, restaurants, snooker clubs, etc. The relationship between the brothel owner and prostitute changed from one of master and servant to one of employer and employee. In addition, NGOs began working with social workers, child psychologists, psychiatrists and other professionals in hospital settings to strengthen their relationships and provide more coherent services through case conferences.

By the late 1980s, the government had established the National Youth Bureau under the Prime Minister's Office. This agency would work in cooperation with NGOs to explore the possibility and implications of adopting the Convention on the Rights of the Child (CRC). The Child Protection Act was enacted in 2003, after a comprehensive study and much deliberation on developing a child protection system in Thailand. The Act assigns local administrations the responsibility of protecting the health and welfare of children in their jurisdiction. Each municipality is trained in child protective services by CPCR with the use of ISPCAN curricula and support. These local officials act as national multidisciplinary leaders who, in turn, train local citizens and professionals on child protective work. In March 2004, Child Protective Services was officially operating with officers appointed to lead efforts in mandated reporting, networking professionals and volunteers, as well as child protective services based in schools, communities, hospitals and police stations. At the moment, every police station has one officer who is responsible for the protection of women and children, and 32 provincial hospitals have one-stop crisis centers serving women and children. CPCR continues to work with the Department of Social Development and Welfare to develop treatment centers for child victims of abuse and neglect. This multidisciplinary approach has been adopted nationwide though quality control efforts still need to be developed.

Throughout the 1990s, a number of child protection issues continued to be explored. Among them are: the cross-border baby trade for which a model of victim protection is under development; the decriminalization of child victims of prostitution, which refocuses blame on the trafficker rather than the child; development of the Measure and Suppression of Female and Child Trafficking Act in 1997; and establishment of the Child Witness Support Program, which assembles a multidisciplinary team to support and protect child witnesses.

The 2003 Child Protection Act has served as a foundation for the development of other governmental Acts and services such as the Criminal Witness Protection Act, which seeks to empower child witnesses, and also the Domestic Violence Act, which supports child protective services in the context of family intervention and child protection. Efforts to support and protect children continue into the present as the Thai government works to develop a national plan and programming to implement the provisions put forth in the *World Fit for Children* campaign.

RESEARCH ON IMMIGRANT AND MINORITY POPULATIONS

Study on the Children of Bangladeshi Immigrants in West Bengal, India

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Overview

Bangladeshi immigrants have been present in India for over 30 years and a large number of these are considered "illegal immigrants," defined for official purposes as someone who illegally entered India after 1971. Those immigrants entering before that time have been legalized and are now considered to be Indian residents, if not citizens. Currently, it is estimated that there are over 12 million illegal migrants from Bangladesh living in various parts of India.

There are a host of "push factors" that contribute to the exodus of Bangladeshi people from their homeland including persecutions of religious minorities and political terrorism. However, there is an equally attractive set of pull-factors in India including job opportunities, access to public distribution system, social security benefits, free education, easy acquisition of immovable property, voter registration and a congenial Indian culture. Some of these immigrants may even have family relations in India. The high stakes of some political parties hoping to capture the immigrant voting blocks, corrupt Border Security Forces (BSF), and organized rackets on both sides of the border promote cross-border infiltration on a massive scale (Nandy, 2003). West Bengal, India is a common destination for poor Bangladeshis since it is bounded by Bangladesh to the East coming into contact with nine border districts.

This study reveals that, though undocumented migration from Bangladesh to West Bengal has been a continuous process, the peak period occurred during and after Bangladeshi liberation in 1971. According to 1981 census, about 500,000 Bangladeshis came to reside in West Bengal between 1971 and 1981. The same census indicated that another 800,000 people from Bangladesh had similarly taken up residence in West Bengal between 10 to 19 years ago (Sen, 2003). The districts which figured prominently as places of residence for Bangladeshi migrants were Kolkata, Bardhaman, 24 Paraganas (North and South), Nadia, Murshidabad, West Dinajpur (North and South), Cooch Behar and Jalpaiguri (Dutta, 2005).

Methods

The primary objectives of the study are to: (1) collect information on the history of Bangladeshi social migration to West Bengal and the socio-economic status of the population; (2) identify and analyze the circumstances confronting migrant children including the demographic structure, health status (with regard to prevalence of disease, mode of treatment, and also overall health and hygiene), and any violation of basic human or child rights (with an emphasis on child labor) in the migrant population.

The study design included a pilot study conducted in January 2007, the primary study conducted in February 2007, collection of official statistics from secondary sources and data analysis. Following the preliminary investigation, a comprehensive interview schedule was prepared to keep specific study objectives in view.

Data was collected from 133 mothers of migrant children from the Nayapatti area of North 24 Paraganas. Interviews were conducted in each of the sample households using interview schedules to collect household- and individual-level information including (1) place of origin, (2) caste and ethnicity, (3) age, (4) migration history (including period of migration), (5) education level, (6) demographic profile, and (6) type of diseases and health care facilities accessible to these children in the household. To supplement the interviews, observation and focus group discussions were conducted with the respondents and other married women in the community. Community leaders were also contacted to verify the responses. Mean and standard deviations of all variables were computed for each sex. The degree of association among different parameters was determined by calculating a Pearson's Correlation Coefficient.

Key Findings

Analysis of the data produced the following findings:

Household and Individual Findings:

- About 50% of the Bangladeshi migrant population is working as mason or other laborer and earn between 2,000-3,000 Rupis;
- 14% of migrant children dropped out of school;
- 70% of migrant children lived in mud houses (Kuchha) without safe drinking water and sanitation facilities;
- Only 1.5% of migrant children had formal proof of identification.

Health Findings:

- Many children suffered from coughs and colds, diarrhea, skin diseases, jaundice typhoid and eye infections because of unhygienic living conditions;
- Only 24% of children were receiving treatment for illnesses or other conditions, and of these, 57% attempted to use government health centers but were not satisfied with the services;
- None of the children were receiving help from the Early Childhood Health and Education facilities provided by the Indian government (Aanganwadi);
- Only 9% of the children had received a complete set of vaccinations.

Child Labor:

- 12% of migrant children were working in construction, factories, shops, and as domestic workers. Of those, 37% were working more than 10 hours per day;
- 70% of migrant children were receiving less than 50 Rupis per day in wages;
- Among working migrant children, 94% were not going to school.

Conclusions

According to the United Nations Convention on Rights of the Child (UNCRC), rights are guaranteed to every child irrespective of their nationality. Therefore, it is the Indian government's responsibility to address the rights violations of any child falling under its jurisdiction. Though very few initiatives have been taken to improve the situation among Bangladeshi migrant children, some community efforts have been established. The Lutheran World Service (LWS), an NGO operating in India, has started a non-formal school for the migrant children between three and six years of age to address this particular lack of service.

If pursued, the following initiatives may greatly improve the lives of migrant children in India: (1) the development of a needs-based model of basic education for migrant children, exploring and promoting non-formal education and child-centered community learning; (2) an initiative to obtain formal identification papers for migrant children; and finally, (3) improved maternal-child health services (MCH) that would provide training for health care workers and a health awareness campaign for Bangladeshi migrants within the existing health structures in India.

Mesnmimk Wasatek: Catching a Drop of Light: Understanding the Overrepresentation of First Nations Children in Canada's Child Welfare System: An Analysis of the 2003 Canadian Incidence Study of Reported Child Abuse and Neglect (CIS-2003)

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Overview

This research brief will present select findings from *Mesnmimk Wasatek: Catching a drop of light: Understanding the overrepresentation of First Nations children in Canada's child welfare system: An analysis of the 2003 Canadian incidence study of reported child abuse and neglect* (CIS-2003) prepared under contract for the First

Nations Child and Family Caring Society of Canada. (Trocmé et al., 2005) The over-representation of First Nations children reported to child welfare in Canada is well documented, however the precise reason why it exists is not as clear (Armitage, 1993; Farris-Manning & Zanstra, 2003; McKenzie, 2002; McKenzie, et al., 1995).

The primary objective of the CIS-2003 is to provide reliable estimates of the scope and characteristics of child abuse and neglect investigated by child welfare services in Canada, in 2003. A second objective is to compare findings over time. As in the CIS-1998, cases tracked by the CIS-2003 include those in which maltreatment was substantiated, suspected or unsubstantiated, but do not include cases that were screened out before investigation or cases investigated by the police only. The CIS-2003 is not designed to document unreported cases.

The Mesnmimk Wasatek report compared children of First Nations heritage with non-Aboriginal children included in the CIS-2003 in an effort to better understand some of the factors contributing to the over-representation of First Nations children in the child welfare system in Canada.

Methods

A multi-stage sampling design was used, first to select a representative sample of 55 child welfare service areas (CWSAs) across Canada, excluding Québec, and then to sample cases within these CWSAs. A total of eight First Nations CWSAs were included in the representative sample of CWSAs selected in Canada. First Nations agencies providing child protection services to Aboriginal children were selected for inclusion in the study using a volunteer sampling strategy. Agencies were approached by a member of the study team and asked to participate in the CIS-2003.

The CIS-2003 sample included a total of 11,562 child maltreatment investigations conducted between October 1st, 2003 and December 31, 2003 in a random sample of child welfare service areas in Canada, excluding Québec. Data on Aboriginal identity was not collected for cases investigated in Québec for the CIS-2003 (N=2638). Information on a child's Aboriginal status was missing on a low percentage of cases (N=6), and these cases were dropped from the analysis. The focus of this report was on First Nations children as defined by First Nations Status or First Nations Non-Status. Child investigations noting other forms of Aboriginal heritage were removed from the data set, including Métis (N=230), Inuit (N=170) and other Indigenous cultures (N=76). Thus, from the original sample of 11,562 child investigations, excluding Québec, 482 cases were excluded, leaving an effective sample of 11,080 child investigations that were used for the analyses in this report.

To account for the non-proportional sampling design, regional weights were applied to reflect the relative sizes of the selected sites. Each study site was assigned a weight reflecting the child population of the site as a proportion of the entire child population of the stratum or region. Regionalization and annualization weights were combined so that each case was multiplied first by an annualization weight and then by a regionalization weight. The CIS-2003 utilized an alternative regionalization weighting approach for the eight First Nations CWSAs. This decision followed an extensive review of the methodological challenges inherent in the sample selection and the unique characteristics of First Nations agencies.

The overall child population figures for CIS-2003 sites are based on 2001 Census data. In this report, the national incidence estimates for First Nations children were calculated by using the First Nations child population estimates prepared by the First Nations Child and Family Caring Society based on 2001 Census data. The First Nations child population estimates were provided for children between birth and 14 years of age, for each province and territory. The child population estimate for First Nations children aged 15-years-old was based on the mean average for children under 15 years-old. The First Nations child population estimates do not include First Nations children living in the province of Québec (which was not included in the analyses for this report), or children of Métis, Inuit or other Aboriginal heritage as discussed earlier in the report.

Key Findings

An estimated 23,366 First Nations child investigations (58.34 child investigations per 1,000 children) and 187,763 non-Aboriginal child investigations (a rate of 44.11) were conducted in Canada, excluding Québec, in 2003. A higher proportion of investigations involving First Nations children were substantiated or remained suspected following the initial investigation period. Fifty-two percent of First Nations child investigations (30.24 child maltreatment investigations per 1,000 children) were substantiated by the investigating worker compared to 47% of non-Aboriginal child investigations (20.72 child investigations per 1,000; see *Table 1*).

Table 1: First Nations and Non-Aboriginal Child Maltreatment Investigations by Level of Substantiation in Canada, Excluding Quebec, in 2003

	First Nations Child Investigations			Non-Aboriginal Child Investigations			Total
Level of Substantiation	%	Incidence per 1000 children	Number of Child Investigations	%	Incidence per 1000 children	Number of Child Investigations	
Substantiated	52	30.24	12,111	47	20.72	88,215	100,326
Suspected	14	8.20	3,286	12	5.51	23,455	26,741
Unsubstantiated	34	19.90	7,969	41	17.88	76,093	84,062
Total Child Investigations	100	58.34	23,366	100	44.11	187,763	211,129

Canadian Incidence Study of Reported Child Abuse and Neglect, 2003

Analyses are based upon a sample of 11, 080 child maltreatment investigations

***X^2, p<0.05**

****X^2, p<0.01**

*****X^2, p<0.001**

Table 2 presents the primary categories of substantiated maltreatment in First Nations and non-Aboriginal child maltreatment investigations. In the First Nations child maltreatment investigations, neglect was the most common form of substantiated maltreatment in First Nations child investigations. Over half (56%) of all substantiated First Nations child investigations involved neglect as the primary category of maltreatment, an estimated 6,833 neglect investigations (17.06 child investigations per 1,000 children).

Table 2: Primary Categories of Substantiated First Nations and Non-Aboriginal Child Maltreatment Investigations in Canada, Excluding Quebec, in 2003

	First Nations Child Investigations			Non-Aboriginal Child Investigations			Total
Categories of Maltreatment	%	Incidence per 1000 children	Number of Child Investigations	%	Incidence per 1000 children	Number of Child Investigations	
Physical Abuse***	10	3.15	1,261	27	5.56	23,687	24,948
Sexual Abuse***	2	0.53	211	3	0.63	2,681	2,892
Neglect***	56	17.06	6,833	25	5.20	22,121	28,954
Emotional Maltreatment***	12	3.57	1,431	15	3.20	13,632	15,063
Exposure to Domestic Violence***	20	5.93	2,375	30	6.13	26,095	28,470
Total Child Investigations	100	30.24	12,111	100	20.72	88,216	100,327

Canadian Incidence Study of Reported Child Abuse and Neglect, 2003

Analyses are based upon a sample of 5,372 substantiated child maltreatment investigations

***X^2, p<0.05**

****X^2, p<0.01**

*****X^2, p<0.001**

Household risk factors tracked by the CIS-2003 included housing issues and source of income. A direct measure of poverty could not be tracked because in approximately 40% of substantiated child maltreatment investigations, the child welfare worker was unable to estimate family income. Seventy-nine percent of all substantiated First Nations child investigations involved children living in rental accommodations (48% private rental and 31% in public housing including Band housing). Almost half of substantiated First Nations child investigations involved families who derived their income primarily from unemployment insurance or other benefits. In approximately 20% of substantiated non-Aboriginal child investigations the primary source of family income was unemployment insurance or other benefits (*Table 3*). Housing conditions were deemed unsafe in 24% of substantiated cases and 14% of First Nations investigations involved families that moved three or more times in the previous 12 months.

Table 3: Household Risk Factors in Primary Substantiated First Nations and Non-Aboriginal Child Maltreatment Investigations in Canada, Excluding Quebec, in 2003

	First Nations Child Investigations		Non-Aboriginal Child Investigations		Total
Household Risk Factors	%	Number of Child Investigations	%	Number of Child Investigations	
Three or More Moves	14	1,733	4	3,353	5,086
Other Benefits or Unemployment	49	5,881	20	17,890	23,771
Private Rental	48	5,828	43	37,821	43,649
Public Rental Housing	31	3,712	10	8,389	12,101
Unsafe Housing Conditions noted	24	2,938	7	5,948	8,886

Canadian Incidence Study of Reported Child Abuse and Neglect, 2003

Analyses are based upon a sample of 5,372 substantiated child maltreatment investigations with information about household source of income

Admissions to out-of-home care at any time during the investigation were tracked. An estimated 16% of all substantiated First Nations child investigations led to a child being placed in formal child welfare care (kinship foster care, other family foster care, group home or residential/secure treatment) during the initial investigation. Seven percent of all substantiated non-Aboriginal child investigations resulted in a child being placed in formal child welfare care (See *Table 4*).

Table 4: Placement Decisions in Primary Substantiated First Nations and Non-Aboriginal Child Maltreatment Investigations in Canada, Excluding Quebec, in 2003

	First Nations Child Investigations		Non-Aboriginal Child Investigations		Total
Out-of-Home Placement* **	%	Number of Child Investigations	%	Number of Child Investigations	
No placement required	67	8,147	86	75,747	83,894
Placement considered	4	464	4	3,355	3,819
Informal kinship care	13	1,554	4	3,481	5,035
Any Child Welfare Placement*	16	1,946	7	5,562	7,508
Kinship foster care	5	595	1	592	1,187
Other family foster care	6	764	4	3,743	4,507
Group home	4	449	1	823	1,272
Residential/Secure treatment	1	138	1	404	542
Total Child Investigations	100	1,946	100	5,562	7,508

Canadian Incidence Study of Reported Child Abuse and Neglect, 2003

Analyses are based on a sample of 5,367 substantiated child maltreatment investigations with information about out-of-home placement

***X2, p<0.05**

****X2, p<0.01**

*****X2, p<0.001**

Overall, First Nations children were over-represented in investigated maltreatment, substantiated maltreatment, and placement in care when compared to non-Aboriginal children. This is a finding that has been reported in previous studies and can be partially explained by higher rates of socioeconomic disadvantage and other household and environmental risk factors (Trocmé, Knoke, & Blackstock, 2004).

Implications on Practice and Policy

The overrepresentation of First Nations children in the Canadian child welfare system is a complex and problematic issue for child welfare researchers, practitioners and policy-makers. The significant over-representation of First Nations children in substantiated child investigations and referrals to child welfare placement can clearly be related to the high level of caregiver, household and community risk factors. The finding that neglect is the primary type of child maltreatment experienced by First Nations children calls for a reorientation of child welfare research, policy and practice to develop culturally sensitive and effective responses. Effecting change also calls for a much greater emphasis by child protection authorities on the structural factors contributing

to child maltreatment amongst First Nations children such as poverty, poor housing and parental substance abuse.

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Emerging data about Pacific child rearing in New Zealand

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Overview

A number of factors influence discussions about Pacific child rearing practices in New Zealand. First, the Pacific community is an extremely diverse one comprising over 20 Polynesian, Melanesian and Micronesian ethnic groups and an even greater number of languages. In addition, over 54% of newborn children of Pacific ethnicity are of multiple ethnicity (42% of families have at least one partner of non-Pacific ethnicity) and today, over 58% are New Zealand born. There is also a small but steady flow of new migrants and others, such as short-term workers from the Pacific homelands. Given this diversity, many Pacific people have argued long and hard against being classified as "Pacific," as in this paper, and have stressed the importance of documenting ethnic-specific data as a finer indicator of their experiences and needs. Ethnicity-based data sets are starting to develop in NZ. Second, Pacific perceptions of parenting, and what constitutes abuse, may differ from those of mainstream NZ—more research is needed in this field. Third, the fragmented nature of existing national datasets and processes for collecting and analyzing ethnicity information and the different time-spans these employ. A centralized system for coordinating and disseminating data and information relating to Pacific child rearing practices and CAN is a priority.

Influencing Factors

Reports show that Pacific families in New Zealand are under pressure in these rapidly changing times, influenced by factors such as economic vulnerability, the effects of rapid urbanization, and increases in nuclear family units compounded by the fear that their children may begin rejecting the customary ways. A number of general points set the context for this examination of child rearing practices. First, the Pacific population is growing rapidly and currently represents over 7% of the NZ population. It is also a very young population: Pacific babies account for 15% of all births and estimates are that 51.4% of the Pacific population is under 25-years-old. Second, Pacific people are predominantly in unskilled employment and so are extremely vulnerable. Reports put the median average income for Pacific adults at $14,800, compared to $18,500 for the population as a whole. Third, using the NZ Deprivation Index as a measure, an estimated 73% of Pacific children live in the most deprived areas. (The NZDep index comprises income, employment, communication, transport, support, educational qualifications and

housing indicators). Over-crowding is a key factor in poorer health outcomes for children and can impact child mental well-being by, for example, decreasing chances for child privacy, reducing parents' ability to monitor children's behavior, and by increasing the number of social contacts and unwanted interactions to which children are subjected (MOH, 2007 p. 43).

Other more qualitative reports emphasize Pacific peoples' overwhelming desire to maintain the customary ways seen for example in the priority given to maintaining the mother tongue (e.g., over 63% of Samoans in NZ speak Samoan) and the continuing importance of the extended family systems. In addition, the ways churches in New Zealand have taken on a role of "village" or community for many families is notable: church systems have become a major avenue for the delivery of training and services for Pacific families today. Some Pacific parenting practices and expectations are being challenged today, such as the use of physical punishment as a disciplining measure and the norm that children do not question their elders. Furthermore, the vastly different life experiences of Pacific children from that of their parents increases the likelihood of intergenerational conflict as does the fact that many Pacific parents work long hours. Therefore, they leave their children to the care of grandparents, elder siblings and others. Generally speaking, Pacific parenting practices in New Zealand can be described as evolving and in a stage of transition between the old and the new as lives are forged in a new land.

Data

This cross-cutting set of data highlights different aspects of Pacific child rearing patterns today including Pacific aspirations, opportunities and constraints and it also sets a baseline for further study. The data must be treated with caution given the small numbers.

CAN related

- Pacific hospital admissions in 2002-2006 (0-14 years-old) due to assault, neglect or maltreatment of children were higher than the national average. Total admissions were higher for children living in the most deprived areas, males and those in urban areas.
- Pacific represented 9% of family violence attendances by police in 2005. Children were present in the majority of these cases.
- In 2006-2007, Pacific children comprised 11% of total Care and Protection Notifications and Pacific placements numbered 311 or 6% of the total placements in that year. Forty of these placements were for children under three years of age.
- Pacific youth comprised 9.5% of Youth Justice Family Group conferences. Of the nine Pacific offenders who were in residence in 2007, (10% of total) 77% were for some form of violence (see MSD CYPS).
- The Pacific Islands Families (PIF) study is a longitudinal study monitoring the experiences of more than 1,200 Pacific mothers whose babies were born at Middlemore Hospital in the year 2000. In looking back at their experiences of childhood, this group of mothers reported significant levels of emotional abuse (insults, swearing) by both parents and higher rates of physical abuse, though also high levels of supporting behavior by both parents.

Education: Pacific people value education—'that is why our parents came to New Zealand'

- The numbers of Pacific children attending Early Childhood Education (ECE) has increased from 76% in 2001 to 85% in 2004. The increase in Pacific provided Early Childhood Services, from 68 in 2000 to 96 in 2005, emphasizes that Pacific women and families understand the importance of education in the early years.
- 100% of Pacific children access primary education and 87% of Pacific 18-years-old were still enrolled in secondary school in 2006 despite the fact that NZ education is compulsory to 16-years-old. However, Pacific students also register higher than national average levels of school stand downs and suspensions and high levels of absenteeism.
- Pacific educational outcomes have not been so favorable. While 85% of Pacific secondary school graduates had a formal qualification in 2007, only one in five of this group had gained the University Entrance (UE) equivalent which would guarantee entry into a university course of study. Very small numbers of Pacific people access or complete higher level university studies.

Health

- Pacific fertility rates and levels of teenage pregnancies are higher than the national average. However, Pacific mothers are the only group to reach the Ministry of Health (NZ) target of 21% breastfeeding at six months of age.

- Health outcomes for Pacific children feature high rates of hospital admissions for pneumonia, skin infections, bronchiolitis, asthma, as well as escalating rates of obesity and diabetes have been noted. The Pacific rates of skin diseases are almost five times the national average (Pediatric Societies' Indicators Handbook, 2007).
- Admissions for self-inflicted injuries in Pacific young people are lower than the national average.

Pacific participation in national strategies

Pacific service providers and community leaders are seeking a more active dialogue about child raising, parenting and child abuse issues today—both at the program and policy level. This situation reflects both a Pacific demand for a voice in these decision-making forums but also the fact that national agencies are now adopting a more inclusive stance. For example, Pacific people were consulted in the preparation of NZ's 2002 *Family Violence Prevention Strategy Te Rito* which gives priority to leadership, changing attitudes and behavior, safety and accountability, and also effective support services. To support this strategy, a Taskforce for Action on Violence Within Families was established in 2005, to advise the Family Violence Ministerial team. In addition, a Pacific Advisory Group (PAG) was set up to support the Taskforce deliberations and those of other CAN related services such as the Family and Community Services (FGACS) and Ministry of Social Development (MSD) projects such as Child, Youth and Parent Services (CYPs) and SKIPS. The PAG comprises Pacific leaders, NGOs and researchers with good representation by ethnic group, gender, program and geographic location. The establishment of the PAG was welcomed by Pacific people as an important first.

In 2007, when the Taskforce for Action on Violence within Families began reviewing progress on the national plan of action and discussions on the next phase, the PAG were again invited to contribute to this process. The PAG greeted this request with two concerns. First, the PAG questioned whether the PAG role and its contribution was valued. There were doubts as to whether the information and advice the PAG dutifully provided was being taken into account during national planning or presented for discussion at the Taskforce forums. Second, the PAG asked why a place could not be made for a PAG representative on the Taskforce—the policy-making body. This would ensure the Pacific voice was heard, increase PAG understanding of the total CAN context, and provide practical experience and capacity building for the PAG about how the policy-making processes work.

The PAG requests were heard. By the end of 2007, Pacific issues and concerns had been incorporated into the national document and a draft Pacific stand-alone report and program of action to accompany the national document was in progress. Also, a PAG representative now sits on the Taskforce and acts as a valuable liaison between the two groups.

To conclude, it is becoming the norm for Pacific people and the PAG to be consulted in the preparation and piloting of national campaigns on raising awareness about family violence, education and information dissemination—such as the high profile television campaign "It's not okay." Furthermore, an increasing number of CAN information packages, including DVDs, are prepared in the vernaculars of the four major Pacific groups.

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Challenges of Addressing Child Abuse and Neglect among Roma Children in Romania

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Overview

European integration has raised the pressures on the Romanian government to implement children's rights, develop its social policies and services, and to improve quality of life for its children. Despite numerous efforts to improve conditions for children, including legislation, raising the child allowance, rethinking minimum wage, and funding foster care staff, there are still numerous categories of at-risk children in Romania (Roth, Popescu, and Rat, 2006).

Roma is the largest ethnic minority group in the enlarged European Union, and one of the most vulnerable to poverty and exclusion. The Roma population is recognized as a minority ethnic and cultural group that is subject to institutional racism and exclusion in both Western and Eastern Europe (S. Cemlyn, 2000; Carter, 2004; and AISBL, 2007).

Researchers agree that Roma children are especially disadvantaged compared to children from majority groups. They are vulnerable because of their age, exposed to discrimination by their ethnicity and their problems compounded by other risk factors such as gender, poverty, low social status, school exclusion, learning and other disabilities, as well as high morbidity and mortality (Unicef, 2006).

In Romania, 80% of Roma children are subject to poverty with 43% living in extreme poverty (I. Marginean, 2004). As Cemlyn highlighted for travelers in the UK, Roma children living in Romania are subject to a two-fold exposure to risk. First is structural in nature, based on political and social inequalities institutionalized in medical and educational child protection systems. Second is an individual risk experienced by some children living in Roma families. Cemlyn suggests that researchers focus on how children's needs are addressed by child protective services, many of them systematically ignored or taken less seriously because of a child's affiliation with a particular ethnic group.

Separating Roma from other at-risk children in the Romanian population presents a unique set of challenges. According to the 2002 Romanian National Census, there are 535,140 Roma people living in Romania (2.5% of the total population) though other estimates suggest there are between 6.91%-7.56% Roma based on dual-identification or 4.39%-4.76% based on self-identification (ICCV, 2000). The population growth of Roma compared to other Romanian groups is a sensitive political issue in the region (Ringold et al., 2003).

Number and Characteristics

The number of Roma people is controversial, as the ethnic identity itself is contextual and fluid and there are several biases attached to it. Despite an increase in Roma self-identification, there are many social and political barriers that lead them to deny their ethnic identity. Romas are far from being a homogenous social group in terms of traditionalism, class, education, views and values. They often identify themselves with other ethnicities whose language or religion they practice. Due to issues of identification, data is blurred. Child abuse, neglect and child marriage are sensitive topics that may reinforce negative stereotypes of Roma groups causing data on these issues to remain uncollected or unpublished. Indeed, a national study on the prevalence of child abuse and neglect in the home environment included a sample of Roma children, but did not publish comprehensive ethnicity-based data (World Bank, World Health Organization and the National Authority for Child Protection and Adoption, 2002).

However, there is data to show that, in Romania, Roma children are over-represented among populations of abandoned children, children living in institutions, street children, and children in conflict with the law. Infant rates, under-five mortality rates and school drop-out rates among the Roma population are twice as high as in the general population and Roma children are more often subject to trafficking (UNICEF 2006, p. 12; A. M. J. van Gaalen, 2003). The generational dynamics among Romas are particularly relevant considering that children represent a significant proportion of this minority population. Among the general population, 19.2% are children below 14-years- old, whereas more than 34% of children in the Roma population are in this age group. This number increases to 43% for Roma children under the age of 16 (CASPIS, 2002; Save the Children, 2007).

A local study for Western Romanian County investigated the relationship between ethnicity and the prevalence of abusive punishments on children (Rotaru et al, 1996). It reported that 41.7 % of Roma families used severe physical punishments to discipline their children when compared with 23.1% in Romanian families, 12% in families of Hungarian origin, and 25% of Romanian-Hungarian mixed ethnicity families. In 2001, Paunescu

conducted a study on the prevalence of sexual abuse in Romania, reporting that children living in families with low levels of education, low socio-economic status, and who are identified with the Roma ethnicity, experienced an increased risk of sexual abuse.

There is some evidence that Roma children are also disproportionately found among perpetrators. Out of 701 minor defendants subject to judicial trials in 2003-2004, 84% were identified as Romanian, 11% Roma, 2% Hungarian and 2% Turkish. In the sample of young delinquents who were not submitted to trials, but placed on the registries of the Child protection system, the percentage of Roma children was even higher: 72% Romanian, 21.7% Roma, 2% Hungarian and 3.8% other ethnic origin. This data shows an over-representation of Roma children and youth in conflict with law (UNICEF, Ministry of Justice, 2005).

Additional information on the state of Roma children is taken from demographic and health data sets. The infant mortality rate for the Roma minority is 40% compared to 16% among the general population, 30% of Roma children suffer from illnesses, such as tuberculosis, that have long been eradicated in the general population, and life expectancy is 10 years less (UNICEF, 2007; Save the Children, 2007).

Demographic data from the Centers for Disease Control and Prevention (CDC) supports the idea that, for the first decade after the Romanian transition, more infants were born to women with profiles that place infants at a higher risk of abandonment (CDC, 2001 cf.; Greenwell, 2003). One of the characteristics in this profile is being of Roma ethnicity, which is also associated with a fertility rate that is double to the non-Roma urban population (CDC, 2001 cf.; Greenwell, 2003). A 2006 UNICEF report shows that 20% of young mothers aged 15-19 years-old are of Roma origin compared to 74% Romanian and 5% Hungarian. Roma and other ethnic origin mothers also differ with respect to the average age of childbearing, with Roma mothers representing a small portion of older mothers (or, conversely, Roma mothers represent a greater proportion of younger mothers).

The abandonment of children in maternity hospitals continues to be a problem in Romania. In 2005, UNICEF Romania published a retrospective transversal study on the abandonment of children at health care institutions. The study included all children under five years of age (N=2000), who had been temporarily or permanently abandoned by their families, from 16 randomly selected counties in eight Romanian development areas. The study found that the rate of child abandonment in 2003 and 2004 was an estimated 1.8%, no different than the rate 10, 20 or 30 years ago[10] (UNICEF, 2005). The study also shows that mothers who leave their children in pediatric hospitals are mainly of Roma ethnic origin who do so to improve their child's chances at a good upbringing and are not necessarily abandoning them (UNICEF, 2005). Food insecurity and child malnutrition are important concerns for a majority of Roma families.

According to R. Carter, poverty (including poor housing, unemployment and lack of income) and social reasons (family breakdown, having multiple children, disability or illness of the child or parent) are the main reasons for parents to place their children in foster care (2004 p. 37). Because factors that are related to poverty are also highly correlated with being from the Roma ethnicity, a large number of Roma children live in poverty. It is estimated that 80% of Roma children live in poverty and 43.3% live under extreme poverty conditions (Margineanu, 2004).

The statistical data on the ethnicity of abandoned children is problematic, because of the biases of identifying an individual with one or more ethnicities. Taking these challenges into account, it is estimated that the percentage of Roma children living in institutions ranges from 40% to 52.4%, a clear over-representation when compared to the proportion of Roma children in the general population (Tobis, 2000; Children's Health Care Collaborative Study Group, 1994 cf.; Every Child, 2005).

A pervasive negative attitude towards adopting or fostering Roma children continues to persist. Taking into account the yearly abandonment rate of approximately 4,000 children and an estimated 1,400-2,000 national adoptions per year since 2004, this prejudice impacts opportunities for the permanent placement of Roma children (Greenwell, 2003; Roth-Szamoskozi, Popescu & Rat, 2006). Family reunification is also problematic since it often places the child back at risk (Roth-Szamoskozi, Popescu & Rat, 2006).

Early marriage in several traditional Roma communities has recently entered the public and political agenda as a controversial phenomenon. There are several cultural and historically inherited rationales that situate the problem at the intersection of Roma patriarchy, racism and structural inequalities including boys having more discretion to enter or reject a proposed marriage and required parental approval of an apparently consensual marriage (Oprea, 2005; Nicolae 2003). Data on arranged or forced marriages among the Roma population are not available.

[10] Defined as the number of abandoned children per 100 births/hospital admissions.

It was not until 2007 that a minimum age for marriage in Romania was finally established and girls and boys must now be 18-years-old of age to legally enter into marriage. Despite this new government policy, early marriages are often secluded to the privacy of families and tend to remain unregistered. This reproduces the cycle of vulnerability especially for girls and their children since early marriage is a practice related to the control of property in traditional and relatively affluent families, but can also be used to increase the number of family members in the workforce.

With poor land ownership, Roma children need to look for work outside their own households, where they face the risks of exploitation and abuse, in a social context where Roma child labor has a higher social acceptability than for majority population. Though child labor is not unique to the Roma community, due to the level of poverty and exclusion, they are at the highest risk of entering labor at an early age (Pantea, 2007). A recent study explored the perspectives of Roma children toward work. Data was collected from 20 children and 17 parents through semi-structured interviews. Respondents came from modern and semi-modern Roma communities, living in rural and urban areas of Transylvania and the South. It identified children who undertake seasonal work in agriculture (hoeing, shepherding, cultivation and selling of watermelons) and construction (in small adult dominated teams), as well as children engaged in other types of work such as the collection of recyclable materials, housework and daily work for households other than their own. The study also identified isolated situations in which children were rented out by their families for labor (Pantea, 2007). In extreme situations, begging and the use of children for begging was documented as a supplement to family incomes (CASPIS, 2002; Pantea, 2007). Other studies of street children revealed that 46% of children working on the streets of Bucharest in activities such as car washing, collecting recyclable waste or begging, considered themselves to be Roma (UNICEF, 2006; Save the Children, 2005). In addition, the International Organization for Migration (OIM) found that Roma girls and young women were most at risk to become victims of human trafficking due to the poverty experienced by many Roma families (2003).

Potential policy solutions might include improving the quality of education, creating employment opportunities in communities with high risk of exclusion and poverty, raising awareness of these issues, and mobilizing the community to challenge the social acceptability of child labor both for Roma and majority population (Pantea, 2007).

We not only consider the risks and exclusion of Roma children in Romania from the perspective of individual victimization but, like Atkinson did for children in the European Union, we are examining a broader developmental perspective which highlights Roma children's decreased chances for social integration. A report by the Institute for Research on Quality of Life (IRQL) found that 18.3% of 7-16 year-old Roma children had never been enrolled in school at all, thereby decreasing their chances of social inclusion (UNICEF 2006; ICCV, 2000). White Young Green International (WYG), a European social and economic development consultancy conducted a study drawing on a large sample of schools where Roma children are enrolled. The study showed disparities among Roma and non-Roma children at the preschool and secondary levels, though the relationship was weaker in primary school (2006). At the primary school level, a higher proportion of Roma students are enrolled in 1st and 2nd grade than in 3rd and 4th grade. This might indicate student failure and dropout beginning as early as 3rd grade. Dropout rates of Roma students between 5th and 8th grade are as high as 33%. The International Association Without Lucrative Purposes (AISBL) suggests that the inability of teachers and other professionals to work in a multiethnic environment, the segregation of Roma children in isolated Roma neighborhoods, and insufficient resources allocated to reduce the poverty of Roma children are partly to blame.

Finally, it is an important next step to collect data on the ethnicity and gender of children who are abused, neglected, or living in foster care. Acknowledging the biases and controversies surrounding the concept of "ethnicity," such a data gathering procedure can help to advance our understanding of Roma children's specific needs, vulnerabilities and strengths and may contribute to better understanding of the meaning of childhood in Roma communities.

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OTHER COUNTRY-SPECIFIC RESEARCH

Sexual Exploitation on Brazilian Highways

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Overview

The sexual exploitation of children is defined as a trade relation involving the payment for sexual relationships involving children. Usually this type of sexual offence is underpinned by the insufficient economic and social conditions experienced by families living in poverty relative to the power held by those who manage the sex trade (Faleiros, 2000, 2004).

An increase in the reported number of child sexual exploitation cases have transformed this issue into a problem of public health, especially for less developed countries like Brazil. Moreover, sexual abuse and exploitation is considered a child right's violation and one of the most horrible forms of child labor (ILO, 1999). According to International Labor Organization (ILO), more than 100,000 children and adolescents are victims of sexual exploitation in Brazil. The Brazilian Federal Police Department has estimated that more than 844 highways are considered scenes of sexual exploitation.

Several studies have indicated that truck drivers are one potential client of the sex traded in children and youth, however, studies have not investigated this specific group of men, their profiles, or their involvement in this particular illegal activity (Gomes, Minayo, & Fontoura, 1999; Machado, 2006). According to Santos (2004), it is imperative that this group be investigated so that the phenomenon of child sexual exploitation can be understood beyond the perspective of the exploited child or adolescent. Looking at the problem from the client's perspective shifts responsibility from the child or adolescent who prostitutes themselves to those who fuel the demand for these types of illegal services.

This study aims to compare two groups of truck drivers (clients and non-clients) on their attitudes and use of the sexual services of children and youth. Moreover, it aims to explore truck drivers' understanding of why this type of sexual exploitation persists in Brazil.

Methods

A sample of 239 Brazilian truck drivers was collected for this project. They were all male with a mean age of 38.26 years-old (SD = 10.2), 69% married, 17.6% single and 9.6% divorced. Truck drivers were categorized as "clients" or "non-clients" based on whether they answered questions 2 or 3 (where 1 = I disagree, 2 = I neither agree nor disagree, 3 = I agree) to the following survey statement: "I think that some prostitutes I have gone out with were less than 18 years-old." One hundred and fifty-four participants (63.2%) answered question 1, and were categorized as non-clients, while the other 85 participants (36.8%) who answered questions 2 or 3, were categorized as clients.

A survey instrument was designed for this study which asked 60 open and multiple choice questions to collect information about: (1) bio-socio-demographic data; (2) job configuration; (3) drugs use and sexual life; (4) knowledge of prostitution on highways; (5) values; (6) attitudes about the sexual exploitation of children and youth; and (7) knowledge of children and youth's rights.

Data was gathered based on Cecconello and Koller's Ecological Insertion Methodology, which embeds researchers within the research environment (in this case, in gas stations, ports, parking lots, etc.) in order to establish a closer relationship with the research subjects, thereby elucidating certain aspects of the survey questions. Twenty male undergraduate students of psychology were trained in the theory and methodology to be used in the project. The process began with the immersion of field staff into the research environment where they were in close contact with the truck driver culture and prepared observation journals, read relevant publications and visited gas stations.

Research participants were interviewed by field staff (either a psychologist or undergraduate student in psychology) and interviews lasted an average of 40 minutes. Sites where the interviews took place were suggested by the truck drivers based on the most convenient places for them to stop. Truck drivers also suggested strategic stop-off cities which were at intersections of major highways in order to maximize the contexts and routes frequented by study participants.

Truck drivers were approached while they were talking to peers, walking alone or in small groups and were not disturbed during their meals, rest times or when they were involved in another activity (e.g. cleaning or fixing the truck). Convenience sampling was used and the total number of interviewed participants was based on saturation data criterion. Research staff would convene to determine at what point and among which populations data collection should cease.

Key Findings

A comparison of the client and non-client groups revealed that "clients" (*n* = 85 or 36.8%) had higher loading times than "non-clients" (*n* = 154 or 63.2%). Moreover, the more often "clients" utilized prostitutes' services, the less likely they were to have knowledge of children's rights. *Table 1* shows comparisons between the two groups.

Table 1:Comparison between "Clients" and "Non-Clients" of Commercial Sexual Exploitation of Children and Youth

		Clients (G1) M (SD)	*Non-Clients* (G2) M (SD)	t(p)
Age		38.76 (10.11)	37.98 (10.22)	-0.564 (0.573)
Days per month on the highway		19.68 (7.24)	20.62 (6.45)	0.976 (0.331)
Waiting time for loading		51.24 (44.04)	39.64 (30.23)	-2.32 (0.021)
Sexual relations per week (when at home)		4.11 (1.18)	4.15 (1.05)	0.270 (0.787)
Sexual relations per week (when on the highway)		2.29 (1.19)	1.43 (0.78)	-6.545 (<.001)
Children's rights knowledge (1-5)		2.48 (1.48)	3.05 (1.37)	2.977 (0.003)
				$\chi 2$ (p)
Job configuration	For a company	41 (35.7%)	74 (64.3%)	0.183 (0.669)
	Irregular	43 (38.4%)	69 (61.6%)	
Kids	No	40 (37.4%)	67 (62.6%)	0.029 (0.864)
	Yes	45 (36.3%)	79 (63.7%)	

The difference between "clients" and "non-clients" with regard to "waiting time for loading" was significant (p=0.021), indicating that "clients" who used the sexual services of children and youth exhibited longer waiting periods for loading (M=51.24 hours; SD=44.04 hours). There was also a significant difference between the number "sexual relations per week (when on the highway)" (p>0.001), in which "clients" reported an average of 2.29 sexual relations per week compared to 1.43 for "non-clients." On the road, "clients'" main sexual partners are prostitutes (60.5%), followed by a casual partner (defined as a sexual interaction that is not paid for, 27.4%) and companion (girlfriend/wife, 11.3%). These data indicate that "clients" who use the sexual services of children and youth constitute the largest group of consumers for the sexual trade in children, youth and adults.

Logistic regression analysis on predictors of sexual exploitation of children and youth was conducted and the results reported in *Table 2*. The first model investigates labor issues and is not significant, explaining only 3.5% of the variance. The statistical significance of the "waiting time for loading" variable drops, however, when gender differences, tolerance to male cheating (infidelity), being head of household, and women's submission variables are added in *Model 2*, all of which are statistical predictors of sexual exploitation.

Table 2: Logistic Regression Analysis on Job, Gender, and Children's Rights Variables as a Predictive Model for the Sexual Exploitation of Children and Youth

Variable	Step 1			Step 2			Step 3			Step 4		
	B	SE B	Exp (b)	B	SE B	Exp (b)	B	SE B	Exp (b)	B	SE B	Exp (b)
Job configuration	.118	.292	1.125	.148	.304	1.159	.074	.350	1.077	.072	.353	1.075
Days on the road	-.030	.022	.971	-.026	.022	.974	-.023	.025	.977	-.014	.025	.986
Loading wait	.008*	.004	1.008	.007	.004	1.007	.007	.005	1.007	.007	.005	1.007
Women's submission				.475*	.205	1.608	.478*	.236	1.613	.418	.238	1.519
House holder				-.417*	.216	.659	-.374	.245	.688	-.322	.247	.725
Infidelity (male)				.530**	.179	1.698	.196	.213	1.217	.178	.217	1.195
Prostitute's service use							.959***	.183	2.610	.933***	.188	2.543
Children's Hitchhike							.451*	.225	1.569	.494*	.227	1.639
Children's rights										-.211	.127	.810
Nagelkerke R2		.035			.130			0.390			.403	
-2 log		274.41			258.83			208.58			205.79	

*p<0.05; **p<0.005; ***p<0.001

Overall, *Model 4* provides the best fit of all the models explaining 40.3% of the variance. "Going out with prostitutes" has the greatest effect on the sexual exploitation of children and youth on the highways, followed by the "giving a ride to hitchhiking children" variable. The inclusion of these two variables was powerful enough to eliminate the significance suggested by previous models.

Conclusion

This study highlighted evidence of the relationship between professional truck drivers who employ the sexual services children and youth, and those who do not. The profiles of "clients" and "non-clients" were very similar on age, marital status, number of kids, days per month on the road and labor profile (categorized as stable, working for a company or irregular). Analysis of the data showed that frequenting gas stations, which did not offer leisure or entertainment options that left truck drivers without "anything to do," became a risk factor in the involvement of truck drivers with children or adolescent prostitutes (Cerqueira-Santos, Morais, Moura, & Koller, in press).

Qualitative analysis of the data revealed that some explanatory variables in the sexual exploitation of children and youth were: social and economic inequality in children's families; a macho and adult-centered culture; lacking a sense of responsibility for children; and insufficient knowledge of children's rights and development. At no time did the "clients" put themselves in the position of protecting the rights and dignity of children and adolescents in situations of sexual exploitation. They would instead justify their behavior by creating excuses, such as "she seemed to be a woman," "she seemed to be older," "she denied her age," "she was not a virgin anymore," "she offered herself," or "that was not a sexual service, she just wanted to thank me for the ride" (Morais et al., 2007).

This study's major contribution is that it examines the role of the client in driving commercial demand for the sexual services of children and youth. The findings of this study are essential for the development of an intervention program for the sexual exploitation of children and youth in Brazil. The first step of which is the development of an innovative program called, "Na Mão Certa" ("On the Right Track"), which creates agreements with transportation companies to educate truck drivers on the sexual exploitation of children and youth. For further information about the "Na Mão Certa" Program, please visit the website at www.namaocerta.org.br.

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The National Study on Violence Against Children in Georgia: The nature and extent of violence experienced by children in the home

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Overview

In 2007 UNICEF, in collaboration with the governmental and non-governmental sectors, commissioned a National Study on Violence against Children in Georgia.[11] The implementing NGO was The Public Health and Medicine Development Fund (of Georgia).[12] The study was designed to provide data that could be used to develop national violence prevention policies and to inform the planning of services for the recognition and management of child abuse and neglect. The study included violence in the home, schools and residential institutions. This paper considers the nature and extent of discipline, punishment and violence experienced by children in the home.

The Study

The main research instruments used in the study were the ISPCAN Child Abuse Screening Tools – (ICAST). These are internationally piloted research tools developed in response to the UN Study's call for a set of common instruments to be used to assess child victimization in a multi-national/cultural/linguistic context.

This study used structured interviews that focus on acts experienced by children. While the tools do not include a definition of abuse, many if not all of the actions included can be described as distressing or degrading for a child. They include versions for use with caregivers and with children over 11-years-old. The instruments (questionnaires and manuals) were translated into Georgian and back translated into English.

The Parents questionnaire (ICAST P) provided information about both the respondent's and any other caregiver's use of physical and psychological punishment towards an index child, as well as their own view on that child's experience of neglect and sexual abuse. Parents were also asked about the use of positive methods of discipline.

The child's home version (ICAST CH) askes about experiences of exposure to violence in the home or nearby, and experiences of direct physical and psychological violence, sexual abuse and neglect. They were also asked to indicate whether the perpetrator was an adult or another child.

The sampling methodology was designed to provide nationwide representative samples of the target groups. For the section of the study addressing violence in the home 1,650 primary caregivers of children under the age of 11 were interviewed as were 1,050 children over the age of 11-years-old.

Findings

Caregivers' Reports

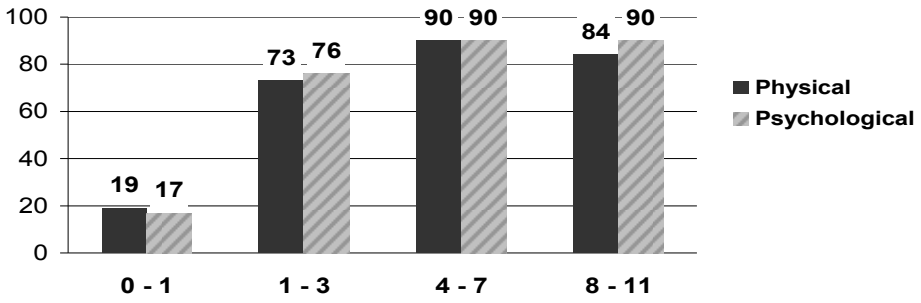
[11]We would like to acknowledge the contribution of the UNICEF Child Protection Officer, Natia Partskhaladze to the Study.

[12] The Public Health and Medicine Development Fund of Georgia (PHMDFG) is a non-governmental, non-profitable, registered organization that initiated its activity in 1999. PHMDF believes that Georgian children should live in an environment protected from abuse, to promote their development as valued members of society.

The reports from caregivers (mainly parents) show that almost all (90.8%) are using some positive management methods. Answers given to an open-ended question also show that many are aware of and subscribe to non-violent approaches to child rearing. Despite this the findings, parents in Georgia, as is common with parents in other countries, use a range of physical and psychological punishments when disciplining their children. Overall, in the year prior to the study parents admitted to subjecting 79.8% of children under the age of 11-years-old to physical discipline and 82.3% to psychological punishments.

These punishments were often introduced at an early age. See the figure for a summary of physical and psychological punishments by age. Nineteen percent of children aged one year or under were physically disciplined rising to 90% of 4-7 years-old. Psychological punishments follow a similar pattern, thus, both physical and psychological punishments are methods for controlling bad behavior, are well established for the majority of children by the time they start school. Similar rates of physical and psychological punishments were reported for boys and girls.

Figure 1: Physical and Psychological Punishments by age of child



The most common physical punishments reported by caregivers were smacking the child on the bottom with a hand (51.7%), shaking (46.1%), pulling hair and twisting ears (43.8%). Other physical punishments reported by the parents were more severe with just over one-fifth (21.5%) admitting to beating-up the child. There were also occasional reports of attempted choking and suffocation (n=8) and burning a child as punishment (n=8). In survey research, such severe forms of physical punishment are often considered equivalent to abuse. Children experiencing such severe punishments may suffer physical and psychological injury. A few may be intentionally inflicting injury on their children. Without the capacity to assess suspected cases of abuse such cases will go undetected.

Parents' attempts to use positive approaches would indicate that a campaign to promote such methods might meet with some success. It would however need to target parents early in a child's life and be inclusive of others who may be caring for children including grandparents. Parents would need ongoing encouragement to make such methods work and there are implications for the training of professionals who could give this encouragement, together with advice.

The most common reported forms of psychological violence were yelling at the child (75.1%) calling the child derisory names (31.2%), cursing the child (29.8%) and threatening to abandon (27.4%). These are actions many parents around the world admit to doing and the harm caused to the child will be dependent on how often, and in what combination, these actions occur, as well as how they are balanced out with positive interactions with the parent. Certainly the calling of names and cursing, if persistent, can damage a child's self-image and self-esteem and also provide an unfortunate model for the child to follow in his or her own interactions at home and school. Threatening to abandon can be particularly distressing to young children who may believe it will really happen. Once again, both professionals advising parents and working with children, as well as parents, can benefit from information about the detrimental effects of psychological punishments.

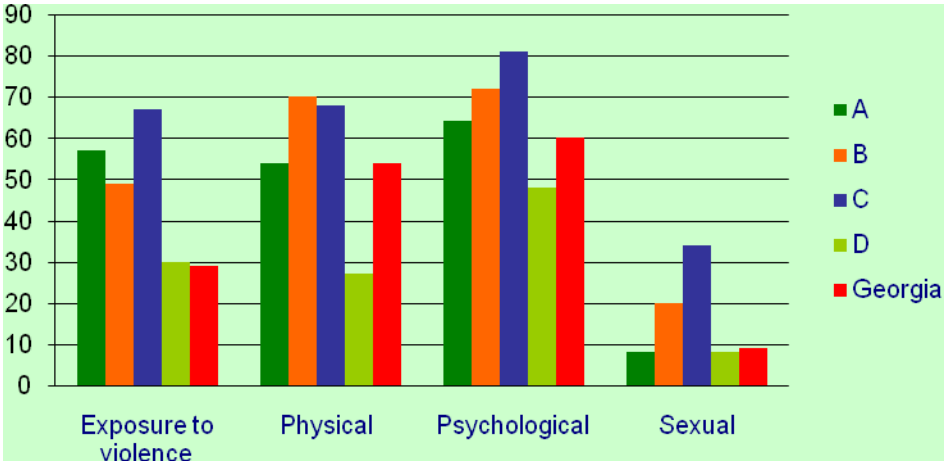
Reports of sexual abuse were low with parents only identifying 0.3% of the children as suffering such abuse. This most likely represents significant under-reporting or lack of recognition by the parent.

Children's Reports

Another perspective of violence against children in the home was obtained through the interviews with children over the age of 11-years-old. This included an additional dimension, exposure to violence in or close to the home. High exposure to such violence might be expected to influence an older child's attitudes towards the use of violence in interactions and to solve conflicts.

With the children's experiences it was possible to make some international comparisons using data from the ICAST pilot countries' (*Figure 2*).

Figure 2: International Comparisons



A N = 110; **B** N = 122; **C** N = 111; **D** = 116

This confirmed that the experiences reported by children in Georgia are similar to the ranges found elsewhere. Reports of exposure to violence in and around the home (26.6%) were relatively low compared to the pilot countries.

The most common reports for the last year were of adults yelling and shouting at each other in a frightening way (15.5%). Witnessing of physical violence between adults was low (2.3%) and much lower than in three of the four pilot countries. This indicates that children in Georgia are not reporting witnessing high rates of physical domestic violence between adults in the home.

More than half (54%) of the children reported experiencing physical violence directly involving them, and 59.1% reported psychological violence. The pattern of violence described by the children shows a continuation of the type of violence reported by parents with high rates of hair pulling or ear twisting (41.4%) and hitting or slapping with the hand (27.9%). Overall, this violence was more likely from an adult but many children were also reported as being responsible for such acts to raising concerns about peer and sibling violence in the home. If peer violence is occurring within homes, it is likely to influence the behavior of children in school.

Boys reported significantly more psychological violence than girls, showing a gender difference that was not reported for the younger children. This may in part reflect the inclusion of peer violence in this component of the study. Physical victimization was found to decrease with age.

The reports also provided evidence that a small number of children were experiencing severe disciplinary measures including repeated beating with an object (n=3 children), attempted choking (n=9), burning (n=5) or restraining (n=29). This is further evidence that there are examples of probable physical abuse within families. Only an assessment of the child, the family and the incident would confirm these as cases of abuse and indicate any action required to protect the child and support the family.

The most common forms of psychological violence were again screaming at the child, insulting the child or making him or her embarrassed. Once again the perpetrator could be an adult or child. Additionally, 17.9% of children reported bullying within the home by another child in the last year.

A total of 95 (9%) children reported some form of sexual abuse happening in the home. While the majority of incidents involved another child or young person, adults reported having sexually abused 27 of the children. These rates are far higher than reported in the parent survey and demonstrate clearly that children and families need access to facilities with staff trained to provide appropriate intervention.

Recommendations from the Study

In responding to the study findings, it will be important to build on identified strengths and on the welfare reforms already underway. Two interrelated themes dominate the recommendations: violence reduction and the development of a response to child abuse and neglect.

Reduction of violence will require an attitudinal shift in society away from an acceptance of violence against children. More specifically, education of the public, families, children and professionals is needed.

Responding to child abuse and neglect requires a coordinated approach, agreed across sectors, which includes a clear process of referral and assessment of suspected cases. The process must be accessible to all children and families, as well as professionals and the public. The development of a referral and assessment system must be supported by training and service development.

Violence to Children in Schools Perpetrated by Adults: A national study in Georgia

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Introduction

The Ministry of Education and Science of Georgia (MOES) is seeking to develop a safe school policy with the goal of creating schools as places free from violence to enhance the education and development of children and young people in Georgia's schools. To best develop a safe school policy, the MOES recognizes the need to understand the scope of school violence, including peer violence and adult-to-child violence. The school violence study was part of a broader effort in Georgia to collect data on childhood violence to inform practice and policy around violence prevention and the development of a child protection system (Lynch et al, 2008).

Violence against children and young people occurs at high rates in schools around the world (Williams, 2007). In a large multi-national study from 37 nations, an average of 28% of students reported being the victim of some form of violence in the last month (range by country 5%-75%), and an average of 48% of students reported that a friend was a victim of school violence in the last month (range 15%-80%). Rates of such violence are highest for eastern European countries, Romania and Hungary in this study, although comparable data is unavailable for Georgia (Akiba, 2002).

In 2006, the United Nations Secretary General called for a world study of violence against children. In relation to violence reduction in schools, the report of the study states:

> "Bearing in mind that all children must be able to learn free from violence, schools should be safe and child friendly. Also, curricula should be rights-based, and schools should provide an environment where attitudes that condone violence can be changed and where non-violent values and behaviors are learned."

The major focus most school violence research is on peer-to-peer violence. However, adults (teachers and staff) in the school system may also be perpetrators of some school violence. This has important implications for school violence prevention and optimal educational outcomes for children. The objective of this study is to describe the frequency of class and specific behaviors of various types of violence in Georgia.

Methods

The primary instrument in the study was the ISPCAN Child Abuse Screening Tool Child Institution version. This instrument was developed by a global panel of experts in childhood violence, translated into five languages, and pilot tested in four countries with over 400 young people. It is designed to query young people about their victimization experiences in schools or places of work and covers a range of victimization types including physical, psychological, and sexual victimization. The questions focus on specific behaviors without judgment as to the cultural or legal meaning of a particular behavior. If a child reports a particular type of victimization, he or she is asked to indicate if this was perpetrated by another child, an adult or both. The instrument and field guides were translated into Georgian and then translated back into English to ensure accuracy of the content and its meaning.

We developed a sampling plan that included a goal of 1,300 children from 93 Georgian schools, including 33 in Tbilisi and 60 in the regions of Georgia. We used a multistage cluster selection sample design, similar to the contemporaneous home violence study, to estimate national rates in a representative study design. The field manual for study conduct was translated and interviewers were trained. Ethical clearance was obtained from the ethics review board of the International Society for the Prevention of Child Abuse and Neglect. The survey was conducted using face-to-face interviews. The study was implemented in Georgia by the Public Health and Medicine Development Fund of Georgia (PHMDFG) with funding from UNICEF-Georgia in cooperation with MOES.

Results

Children were interviewed individually in schools. Six of the selected children chose not to participate, but all of those who agreed to participate completed the interviews and answered all of the questions. A total of 1,300 interviews were completed with six refusals, for a response rate of 99.5%.

The sample was evenly split between boys and girls. Nearly three quarters lived outside of Tbilisi and over half were urban residents. Age was well distributed throughout the six grade levels surveyed.

Most of the children and young people reported living with both parents. Only 4.9% of the total sample reported living without a mother, and 14.8% without a father (results not shown).

Inventories for children reporting victimization by subtype of violence by adults in the school are displayed in *Table 1.* Nearly one-third of youth reported physical victimization and over one-third reported psychological victimization. Sexual violence by adults is uncommon in the schools with just 1% of young people reporting this type of adult violence.

Table 1: Violence Perpetrated by Adults by Type, Last Year

	Number	Percent
Physical	399	31
Psychological	475	37
Sexual	9	1

The specific behaviors by which children are victimized may have relevance for prevention planning and the potential for physical and psychological harm may vary by behavior. *Table 2* displays the specific behaviors for reported physical and psychological violence in descending order of frequency. Behaviors reported by less than 1% of youth are not included in the table.

Table 2: Specific Behaviors by Adults, Last year

Physical	Percent	Psychological	Percent
Twisted ear	15	Threatened with bad remarks	17
Pulled hair	11	Shouted at you	15
Slapped hand or arm	4	Swore at you	12
Slapped head or face	3	Made you feel stupid	7
Anyone hurt you	2	Insulted you	6
Kicked you	1	Called you hurtful names	4
Threw object at you	1	Isolated you	2
Crushed fingers	1	Prejudice for health problem	2
Stayed out in cold/heat	2	Stole/broke belongings	1
Stood/kneeled for punishment	2		
Forced something dangerous	1		

Physical violence by adults is common in Georgian schools. This is particularly true with ear twisting (15% of children reporting) and hair pulling (11% reporting). These are common forms of physical punishment in Georgia by adult caretakers (Lynch, 2009). More severe types of physical violence are also reported (e.g., hurt 2%, kicked 1%). Only one child reported being choked and one child reported being cut (not shown).

Psychological violence by adults in schools is also common in Georgia. Threatening with bad remarks is reported by 17% of children, with shouting (15%) and swearing (12%) as common forms of psychological punishment. Making them feel stupid (7%), insulting them (6%) and hurtful name calling (4%) are reported with regularly by students in Georgia.

Very few adults were reported as the perpetrators of sexual violence in the schools. The only type of sexual victimization that rose to 1% was being forced to look at pornography. Forced kissing, sexual touching, and forced removal of clothes were rarely endorsed (data not shown).

Conclusion

It is clear that for schools to be free from violence, schools in Georgia must directly address the roles of adults in schools as perpetrators of violence. This is critical for both the direct role the violence plays in the life of these children, but also for the way it sets the tone for violence in the schools. Because teachers and adults are in positions of power in the schools and control grades, violence committed by these adults may be particularly damaging to the psychological health of the child. Also, especially for the younger children, adults are often more physically powerful and have the potential to inflict serious injury on children. Lastly, the adults that perpetrate violence in the schools, normalize violence as an appropriate means for conflict resolution.

To address violence prevention in the schools of Georgia, the MOES should recognize the role that adults in schools have as perpetrators of violence. They should specifically prohibit the use of physical and psychological violence in the schools. They should ensure that the staff understands how to address young people in non-violent ways both to eliminate this violence and to model alternate forms of conflict resolution.

Next steps

Further analysis of this data will focus on the relationship between adult violence and peer violence as well as the relationship between adult violence and school climate as measured by attitudes towards schools, relationship between students, treatment by teachers, and position of parents.

The report has been shared with the Ministry of Education and Science, which is currently engaging in the development of a National Safe Schools Policy.

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Study on Child Abuse in Hong Kong

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Overview

The first population study of child abuse in Hong Kong was commissioned by the Government of Hong Kong's Social Welfare Department and conducted by Dr. Ko Ling Chan at the University of Hong Kong in 2003. The aim of the research was to study different types of child abuse, including physical and psychological abuse and neglect. The objectives of this research include: (1) the estimation of the incidence and prevalence rates of child abuse in Hong Kong and (2) analysis of the demographic, social, psychological and family profiles of perpetrators and victims. It is the first study of its kind ever conducted in Hong Kong in terms of scale and coverage.

Methods

The sampling frame used in this survey was based on quartiles maintained by the Hong Kong Census and Statistics Department. A two-stage stratified sample design was used, with records stratified by geographic area and type of quartile. For the first stage, a stratified random sample of quartiles was selected. In the second stage, all household members aged 12-years-old or older in the sample with children and/or spouses were counted.

The questionnaire has three main components: (1) an introductory section with demographic questions, (2) the Parent-Child Conflict Tactics Scale (CTSPC), which was used to obtain information on child abuse, and (3) the individual and relationships profile to provide data on causality.

For the purposes of the present analysis, "victims" of child abuse refer to those who experienced severe or very severe physical abuse, as measured by the CTSPC. Those who had experienced emotional abuse, neglect or less serious physical abuse are not included in the analysis presented here. In addition, "perpetrators" of child abuse refer to adult respondents who admitted that they had ever physically maltreated their children.

The survey was conducted from December 2003 to August 2004. A total of 9,707 quartiles were sampled, of which 1,812 were excluded and 5,565 were successfully analyzed. A total of 5,049 adults and 2,062 children aged 12-17 years-old were interviewed using the adult and child questionnaires. The overall response rate achieved was 71%.

Key Findings

Physical abuse
About 45% of child respondents indicated they had encountered physical abuse by one or both of their parents. This prevalence rate of physical abuse was slightly higher for boys than for girls, however, the difference was not statistically significant. Most reports of abuse cases were described as being minor in nature, with about 41% of child respondents indicating that they had ever encountered minor physical abuse.

The prevalence rate for very severe physical abuse was approximately 9% and was slightly higher for boys than for girls though the difference was statistically not significant. About 23% of child respondents indicated that they had encountered physical abuse by one or both of their parents during the past 12 months. This annual prevalence rate of physical abuse was slightly higher for girls than for boys, but the difference was not statistically significant. The majority of reported abuse was minor in nature, with about 19% of child respondents indicating that they had encountered minor physical abuse during the past 12 months.

The annual prevalence rate for very severe physical abuse was about 4%. The rate was slightly higher for girls than for boys, though the difference was not statistically significant. The rate of very severe physical abuse perpetrated by the mother was slightly higher for girl than for boy respondents, and the difference was statistically significant.

Emotional Abuse
About 72% of child respondents indicated they had ever encountered emotional abuse by one or both of their parents and about 58% of child respondents indicated they had encountered emotional abuse by one or both of their parents in the past 12 months. The overall and annual prevalence rates of emotional abuse were slightly higher for girls than for boys, but the difference was not statistically significant.

Neglect
Approximately 36% of child respondents indicated they had ever encountered neglect by one or both of their parents and 27% indicated they had encountered neglect by either or both of their parents during the past 12 months. The overall and annual prevalence rates were slightly higher for girls than for boys though the difference was not statistically significant.

Profile of victims of child physical maltreatment
Children who had been physically abused tended to be younger compared to those who had not, and the vast majority was attending school. Girls accounted for a slightly higher proportion of abused children. Approximately 18% of abused children were not born in Hong Kong, and of those, slightly more than half (53%) were new immigrants living in Hong Kong for less than seven years.

It is estimated that about 29% of child respondents had ever experienced physical or severe physical abuse. The percentage was slightly higher for boys than girls, but the difference was not statistically significant. The overall prevalence of physical abuse carried out by mothers was slightly higher than that by fathers.

The socio-economic characteristics of perpetrators of child physical abuse were similar to those of non-perpetrators, with the exception of having attained a lower level of education, were more often self-employed, and were more likely to receive social security.

The survey showed that about 10% of adult respondents had physically maltreated their children, and among those, 2% reported that they had inflicted severe physical abuse.

Risk factors

Violence between parents of victims
A much higher proportion of children who had been physically abused had observed domestic violence between their parents, compared with those who had not been abused. About 48% of those physically abused had witnessed physical abuse between their parents during the past 12 months as compared to about 10% for those who had not been abused. Approximately 29% of those children who had been abused had also witnessed physical injury resulting from battering. Also, 84% reported witnessing emotional abuse between their parents in the past 12 months compared to 3% overall and 51% in the past year among those children who had not been abused. The difference between children who had been abused and those who had not is statistically significant.

Co-occurrence of child abuse and spouse battering
About 37% of perpetrators of child physical abuse admitted that they were also using violence against their spouse. This percentage was higher than that for non-perpetrators (14%) and the difference is statistically significant. In addition, approximately 36% of perpetrators admitted that they were also victims of spouse battering. The percentage was higher than that for non-perpetrators (13%) and the difference is statistically significant.

Individual and relationships profile of perpetrators
The average scores on the individual and relationships profile of perpetrators were significantly lower than for those who had not abused their children in terms of social desirability, self-esteem, support and anger management. For the other characteristics included on this scale, the average score of perpetrators was higher than for non-perpetrators. The difference was statistically significant for all sub-scales, with the exception of the sub-scales face.

Conclusion

The study provides useful information for policy-makers to identify the key components that contribute to effective prevention and intervention strategies in Hong Kong. It may also prove useful in the development of risk assessment tools and to inform a revision of the Domestic Violence Ordinance intended to protect children from domestic violence.

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Child Abuse in India
Dr. Loveleen Kacker, Joint Secretary (Child Welfare), Ministry of Women and Child Development, Government of India and Pravesh Kumar, Consultant, Child Protection, Save the Children and Ministry of Women and Child Development

Overview

Traditionally, the care and protection of children in India has been the responsibility of families and communities. A strongly knit patriarchal family system has seldom had the realization that children are individuals with their own rights. While the Constitution of India guarantees many fundamental rights to children, the approach to ensure the fulfillment of these rights is needs- rather than rights-based. The transition to a rights-based approach in the government and civil society is still evolving.

India has a large child population vulnerable to abuse, exploitation and neglect. There is inadequate information about the extent of child abuse in the country, barring a few sporadic studies with limited scope, making any understanding of the different forms and magnitude of child abuse across the country difficult. The only information available is the annual crime data maintained by National Crime Records Bureau (NCRB). However, there is a gross under-reporting of crimes against children.

The government, which has the onerous task of implementing constitutional and statutory provisions, is concerned about the lack of data in this area. With an increasing incidence of child abuse, India needs both legislation and large scale interventions to address this problem. There is also a general feeling that the problem of child abuse is bigger than what is commonly understood or acknowledged. It is in this context that the Ministry of Women and Child Development, with the support of UNICEF, Save the Children, and Prayas, initiated the “Study on Child Abuse: India 2007.”

Methods

The aim of the study is to develop a dependable and comprehensive understanding of the phenomenon of child abuse, with a view to facilitate the formulation of appropriate policies and programs meant to effectively curb and control the problem of child abuse. The specific objectives of the study were to: (1) assess the magnitude and forms of child abuse in India; (2) study the profile of abused children and also the social and economic circumstances leading to their abuse; (3) facilitate analysis of the existing legal framework to deal with the

problem of child abuse in the country; and (4) to recommend strategies and program interventions for preventing and addressing issues of child abuse.

For the purpose of this study, a child was defined as a person not having completed 18 years of age. The sample for this study constituted children in the age group of 5-18 years-old and were divided into three age groups: younger children (5-12 years), children (13-14 years) and adolescents (15-18 years).

A working definition of child abuse and forms of abuse was developed for the study. Child abuse refers to the intended, unintended and perceived maltreatment of the child, whether habitual or not. There are many forms of child abuse and they vary according to cultural and geographical settings. This study however, focuses on four prominent forms of child abuse including: (1) Physical Abuse; (2) Sexual Abuse; (3) Emotional Abuse; and (4) Girl Child Neglect.

Two States were selected from each of six zones: North, South, East, West, Central and North East. These states represented the upper and the lower literacy quartiles in each zone. Subsequently, data on crimes and offences against children were examined to see the status of these states in terms of crime and offences against children. The NCRB was the only source providing this information. From the Western Zone, Maharashtra was an additional State selected because it is the commercial hub of India and has a large migrant population with a growing number of children on the street and at work. Therefore, the total sample states was 13.

Respondents included children (5-18 years), young adults (18-24 years) and stakeholders. Child respondents included five specific categories of children: (1) children in a family environment, not attending school; (2) Children in schools; (3) working children; (4) street children; and (5) children in institutional care. Fifty children were selected from each of the above five evidence groups. An attempt was made to have equal number of boys and girls in each evidence group. Young adults (18-24 years-old) constituted the second category of respondents. From each block, 50 young adults were selected. The third category of respondents included stakeholders who held positions in government departments, private service, urban and rural local bodies, and also individuals from the community. From each block, 50 stakeholders were selected.

Child friendly tools and techniques were used to create an enabling environment for children to respond with ease and share their experiences on different forms of child abuse. The tools and techniques used were focus group discussions (FGDs) and one-to-one interaction with children and young adults. Guidelines for conducting FGDs were developed. FGDs were followed by one-to-one interaction with children and young adults to elicit more detailed information. Detailed ethical guidelines were developed to safeguard the child's rights, including their identity, and to protect the child from potential trauma. Written informed consent was taken for all participating children and measures were taken to ensure that the child had the right to withdraw at any stage, if he or she so wished. All the tools of data collection were pre-tested on a small proportionate sample in Delhi, and these were then appropriately modified in content, language and sequence.

Key Findings

This study provides revealing statistics on the extent and magnitude of various forms of child abuse in India. It highlights variations among age groups, gender, states and within evidence groups. The study clearly establishes four important findings across all forms of abuse: (1) younger children (5-12 years of age) reported higher levels of abuse than the other two age groups across type of abuse suffered and across evidence groups, (2) boys and girls were found to be equally at risk of abuse (of 69% of physically abused children, 54.7% were boys), (3) persons in positions of trust and authority were the major abusers and (4) the majority (70%) of abused child respondents never reported the matter to anyone.

Other findings focus on the study's four forms of abuse: physical, sexual, emotional abuse and girl child neglect.

Physical Abuse

- Two out of every three children are physically abused.
- Over 50% of children in all 13 sample states were being subjected to at least one form of physical abuse.
- Out of those children physically abused in family situations, 88.6% were physically abused by their parents.
- Two out of three (65%) school children reported facing corporal punishment.

- The state of Andhra Pradesh, Assam, Bihar and Delhi have almost consistently reported higher rates of abuse in all forms as compared to other states.

Sexual Abuse

- Approximately half (53.2%) of children reported having faced at least one form of sexual abuse including severe sexual abuse.
- Andhra Pradesh, Assam, Bihar and Delhi reported the highest percentage of sexual abuse among both boys and girls.
- Across the country, 20% of children faced severe forms of sexual abuse.
- Out of the child respondents, 5.7% reported being sexually assaulted.
- Children in Assam, Andhra Pradesh, Bihar and Delhi reported the highest incidence of sexual assault.
- Street children, working children and children in institutional care reported the highest incidence of sexual assault.

Emotional Abuse and Girl Child Neglect

- Half of children reported experiencing emotional abuse.
- Equal percentages of both girls and boys reported facing emotional abuse.
- Parents were the abusers in 83% of emotional abuse cases.
- Approximately half (48.4%) of girls wished they were boys.

Conclusion

This study is expected to place the subject of child abuse on the national agenda and will help to strengthen the understanding of all stakeholders including families, communities, civil society organizations and the state. Working together, these actors can create an environment wherein discussion on child abuse can be initiated. The media has started highlighting such issues and an understanding of their gravity is gaining momentum. This understanding must be translated into action, not only by the central government, but by state governments, civil society, families and children themselves. A better understanding of the child rights perspective can create an enabling environment wherein a child is protected from abuse and exploitation. The momentum needs to be sustained and should be carried forward in the form of a movement that will take all stakeholders along the road to sustainable development and create a protective environment for the children of India.

Children's Rights Situation in the Residential Care and Education Institutions in Lithuania
Egle Sumskiene, PhD, Vilnius University, Department of Social Work

Overview

In the autumn of 2005, six Lithuanian organizations, working in the field of children rights and mental health formed a coalition with the purpose of surveying children's rights situation in child care and special education institutions. Between November 2005 and April 2006, experts from the coalition visited 20 institutions. This brief summarizes the nature of the research and key findings.

Methods

All interviews were guided by a structured questionnaire. This interview guide covered the following topics:

- General information on the institution such as its purpose, operation, functions, services rendered, work methods used, rotation of children and staffing plans;
- Characteristics of the children cared for in the institution, information on their family, medical condition and major needs;
- How the institution's staff defined and implemented the rights of the child and how these concepts were communicated to the child's family (parents, brothers and sisters);
- Degree to which the institution cooperated with other institutions such as children's rights protection services, health care institutions, education and care, as well as social security institutions, police, etc.; and

- Major problems the institution has experienced due to post-soviet heritage, loopholes in the laws, inefficient interdepartmental cooperation, ineffective management of the child care system, etc.

Additional monitoring methods were used to detect children's rights violations within the general Lithuanian child care system.

Findings With Respect to Children's Rights Violations

Right of the Child to Protection of Private Life

The respect of child's privacy in the residential child care and education institutions is an unusual practice. Often children live in the unlocked rooms, which can be entered any time by other children or personnel without even knocking. The environment at these institutions relates more to maintaining children in the institution as opposed to returning them home. Emphasis is placed on managing children, not on fostering healthy child development.

Children's Right To Have And Express His Opinion

Lithuanian Law establishes the consent and application of the child for his admission into the institution as a duty of respecting the point of view of the child. The implementation of this right is often distorted and transformed into a disciplinary measure (e.g. children are forced to fill out an application to transfer them from a care home to special children's education and care residence). Nevertheless, it has nothing to do with the actual intentions of the child.

Children's Right To Protection From Exploitation of Any Type And Improper Treatment

In order to protect the child from improper treatment at home, a child is placed into the residential child care and education institution, where other forms of exploitation and inappropriate behavior can be found.

There are many institutions caring for children with behavior problems. Consequently, most efforts are spent correcting and suppressing a child's inadequate behavior. In this process, children may often be subject to inappropriate behavior of staff.

Quite often, the staff feels helpless in managing the aggressive behavior of children and have little understanding of the real reasons behind such behavior. According to the staff, children disobey them, "they are not even afraid of the police," and the sanctions implemented by the staff often turn out to be ineffective. Such an approach to behavior correction is often based on instilling fear in children, with the staff believing that children will not misbehave if hard punishments are applied.

None of the institutions have established a definition of violence and most acts of violence are not documented. Often, the administration denies any occurrences of violent behavior from the side of children, as well as the personnel.

Hierarchical relations based on exploitation, violence and fear ultimately form among children in these institutions. The culture of "hazing" and the punishment of "rats" are still prevalent, although in some cases, it is possible that administers in these institutions may not know the extent of the problem. Children of 13-17 years of age constitute the majority of special care and education institution residence, and most of them have had criminal experience. These experiences influence the norms of communication between children and staff and among children. Prison's jargon, violence against the weaker ones, physical and sexual exploitation all are found in the special care and education residencies. Younger children experience substantial violence, often experiencing a "prison school education."

The personnel of the institutions believe that if such cases exist they should be addressed within the institution and not through outside interference. They believe the problem should not be made public and should be solved at the discretion of the institution with the measures they have available.

Right of the Child to Live With Parents in Their Love And Care and the State's Responsibility to Secure the Support Necessary for Parent to Realize This Right

The monitoring survey showed that the administration of most of residential child care and education institutions are not in touch with the families of their residents, nor do they make attempts to initiate the contact with the parents of children in their care.

Some care institutions have social pedagogues, which are cooperating with the municipal social workers. Although according to the directors of special education and care residencies, Municipal Children's Rights Protection Service employees do not undertake any measures for bringing the children back home. Furthermore, the staff of the foregoing services requests that the directors of special children's education and care residences keep the children in the institution for the maximum term possible. When there are no problem-children – there is no responsibility for them. Sometimes, the head of the Municipal Children's Rights Protection service does not issue an agreement for the child's return to the family during the holidays. Meanwhile, the contact of children staying in residential child care and education institutions and their parents is broken, and the renewal and strengthening thereof is not encouraged.

Recommendations

The study suggests 11 recommendations.

- The view towards institutional care should be changed and the mission of residential care institutions should be clearly defined considering the principle regulations of the United Nations Convention on the Rights of the Child – the child must be raised in the family, and if the separation is unavoidable, it must be done in the best interests of the child with the condition to return the child to the family, and if there is no family – to prepare him/her for independent life.
- Child care reform should be started immediately, by gradually moving towards foster home model, which would conform to the objectives of child care and would prepare the child for independent life and public integration. This is most effectively accomplished by making the changes in the structure of staff, approximating child care and education to the model of care in a family or large family, as well as ensuring the readiness of children leaving such institutions to live in the society independently, and strengthening child's self-confidence.
- In order to keep the child living in the family, effective principles of the work with at-risk families should be implemented by providing enough specialists with proper qualifications and ensuring the mechanism of interdepartmental cooperation.
- Comprehensive, qualified and effective support should be provided to the child left without parental care.
- The number of children in the residential care institutions should be reduced gradually by encouraging child care in the family.
- Children with behavior and emotional disorders require special care and support. Specialized institutions should be established, where such children could receive all the necessary and effective support, which would allow for their successful adaptation and integration.
- In order to reorganize child care system successfully, it is very important to implement services financing mechanism that is in agreement with the interests of the child (e.g. establish the model of "services basket").
- Clearly defined criteria for the formation of child care home budget should be set. In the planning of the budget needs, the number of children staying in the care home, as well as their needs, social and educational services, and other factors should be considered. Situations could be improved by state financed target programs for improving child occupancy, renovation of buildings and premises, etc.
- Prevention of unsuccessful socialization of a child and family should be the number one priority in support planning of structural funds of the European Union to Lithuania for the period of 2007-2013.
- All the staff in child care institutions, whether working directly or indirectly with children, should have a single and clearly defined understanding of the purpose of the institution, based on the same value principles and in the best interests of the child.

A Survey of Bullying in Singapore Primary Schools
Koh Chee Wan, *Singapore Children's Society*

Overview

As part of an anti-bullying initiative by the Singapore Children's Society, a survey was conducted with primary school students to examine: (1) the prevalence of various forms of bullying behaviors experienced by children and youths, (2) the effect bullying has on them, and (3) the sources of support victims turned to and their perceived effectiveness. A profile of victims and bullies, including self-admitted bullies, was also created. The findings were

examined in relation to gender, ethnicity and educational levels. This survey is a follow-up to a survey with secondary school students aged 14-20 years-old, also conducted by the Society.

Methods

A stratified random sample of 786 primary school students aged 6-16 years-old (mean age 10.3 years) was selected for this survey. A nationally representative sample was chosen based on gender, ethnicity and level in school according to the previous school year.

The largely quantitative questionnaire was adapted from the previous questionnaire designed by the Singapore Children's Society for secondary school students, which was based on a literature review and the experiences of staff working with children and youth victims of bullying. Changes appropriate for younger respondents were made, such as the use of simplified English, with some items being pooled or deleted to shorten the interview. Pilot tests were conducted to ensure children could understand the questions and that the interview was not too long.

Children who met the sampling criteria were invited by trained interviewers to take part in a one-to-one interview at home, where they were asked to recall their bullying experiences from the previous school year. The home was chosen to avoid the biases of restricting sample selection to certain schools or catchment areas. The voluntary nature of the study was stressed to the respondents who were informed they could withdraw participation at any point during the interview. Parental consent for each child was also obtained before the interview commenced. Each interview took no more than 20 minutes to complete and all interviews were conducted in English.

To examine the prevalence of bullying and the common types of bullying behaviors faced by Singaporean children, respondents were presented with a list of common physical, verbal, relational and cyber bullying behaviors and asked to rate how often they experienced each hurtful behavior on an objective frequency scale. To determine the effects of bullying on these victims, respondents were asked if they had experienced any common effects of bullying by choosing from a list of physical, emotional and psychological reactions. Children were also asked if they informed any one about their bullying experiences, and if so, who they approached and how effective they found them to be. They were also asked to provide some demographic details of their bullies such as gender, ethnicity and educational level. If the respondent was bullied by more than one person, he or she would be asked to identify the bully he or she was most affected by. Finally, they were also asked if they themselves engaged in any bullying behaviors.

Key Findings

Results of the survey revealed that approximately one in five respondents was a victim of bullying, defined as any action apparently intended to victimize and repeated at least twice in a single month. Bullies and their victims tended to be from the same gender, ethnic group and class. However, more boys than girls were identified as bullies and victims, and there was a greater tendency for boys to bully girls than for girls to bully boys. Children of all ethnicities were equally likely to be bullied and experienced proportionately similar amounts of bullying as they progressed through school.

Sixty-seven percent of self-admitted bullies admitted that they were also victims, though they only made up a 16% of the victims' total. In other words, while bullies were often victims, victims were seldom bullies, suggesting a link between bullying and being bullied. A majority of those dual-identified as bullies and victims claimed to have bullied others as a result of provocation.

Name-calling or the use of vulgarities was the most common type of bullying. Name-calling is of particular cause for concern because it is something adults may easily dismiss as not causing any obvious (e.g., physical) damage to the victims. The most common notion of bullying, physical bullying, was experienced by less than half the victims and cyber bullying was the least common form of bullying despite the overwhelming media attention it has been receiving in recent times.

Feelings of anger and sadness were most frequently reported, followed by reportedly feeling "OK" about the experience (40%), suggesting that children in the sample were quite resilient. However, a majority of the children who reported feeling OK also reported feeling other effects of bullying. This suggests these children might have concealed their true feelings, which should serve as a caution for adults to take replies of OK at face value. School performance was also negatively affected for some victims who had difficulty paying attention in class, a few of whom missed days in school altogether as a result of being bullied.

Finally, children were more inclined to tell their parents, particularly their mothers, about being bullied, although their replies suggest that schools, and teachers in particular, were more often effective when approached. However, as we do not know what guided individual children's choice of confidant, this finding does not necessarily imply that we should encourage children to go to their teachers and principals more, though the findings may suggest it.

In conjunction with the findings collected from the earlier bullying survey on secondary school pupils, the results obtained in this study provide a clearer picture of bullying in Singapore schools and can be used to formulate more appropriate intervention policies to tackle school bullying.

Addressing Ethical and Clinical Issues in Child Maltreatment Prevention Research

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Overview

The Center for the Prevention of Child Neglect (CPCN) is a consortium of universities that collaborate in conducting multi-site research projects to improve understanding of the precursors of child neglect and to develop and test evidence-based prevention programs. As a research center, the CPCN ensures the protection of human subjects and the voluntary nature of participation, while adhering to study protocol requirements in order to deliver the program in a scientifically sound manner.

The Center conducts multiple longitudinal studies, including a randomized controlled trial designed to test the efficacy of an intervention to promote positive parenting and reduce neglect among a group of high-risk mothers. Conducting this type of research presents a number of ethical challenges since those participating in the "high intensity" treatment group receive intensive, hands-on training and support while those in the "low intensity" non-treatment group, who face the same maternal, child, and family needs as the treatment group, receive no direct service provision and limited in-person contact. Some of these needs include transient housing and childcare arrangements, inadequate access to healthcare, financial stress, legal and immigration issues and mental health issues such as untreated depression and domestic conflict or violence.

To address the ongoing, yet frequently changing clinical needs of the participants in an ethically responsive way, it was necessary to develop a systematic mechanism for addressing them. Our research team developed multiple strategies for the training and supervision of our home visitors (referred to as "Family Coaches") as well as numerous resource materials, including a Home-Visiting Guide (Baggett et al, 2004), a Clinical Challenges Manual (Guttentag et al, 2004), and a "Principles of Scientific Integrity" document (Ramey and Lanzi, 2005).

The Home-Visiting Guide and the Principles of Scientific Integrity document serve as a solid foundation for initially training the family coaches on a range of issues including expectations of staff, roles and boundaries, confidentiality and scientific integrity, safety and security, appropriate dress and appearance, interviewing techniques, being culturally responsive, as well as responding to alarm values and special issues (e.g., depression and suicide, drugs and alcohol, child maltreatment, domestic violence, developmental delay and special needs). The philosophical tenets of the program are also shared with the staff so that everyone operates under the same guidelines and with the same approach.

We then focus on helping our family coaches become "clinical thinkers" through a number of avenues. Guttentag (2004) developed a "Considering Stages of Behavior Change" document that helps guide the family coaches when working with a parent who is not making progress (either in a particular area or overall), or seems to be actively or passively resisting the material being introduced to consider which aspect of the process of behavior change might be at issue. The Clinical Challenges Manual (Guttentag et al, 2004) addresses some of the common questions and situations that may arise when working with parents, particularly during the one-on-one didactic sessions. It is stressed, however, that family coaches should always consult with their supervisor when encountered with a particular challenge. The manual exists to help them respond appropriately and help the parent implement new parenting approaches and skills. Enacting supervision in many forms has been essential to the success of these relationships including group supervision meetings that focus on collaborative problem-solving for clinical issues, individual clinical supervision meetings, field supervision and cross-site discussion.

Although training and supervision of family coaches is conducted locally, sensitivity to cross-site consistency is necessary in responding to individual ethical and clinical challenges. Regular cross-site conference calls are organized to discuss issues and challenges and then, subsequently, to develop written guidelines that document a solution. Over time, we have documented a number of ethical and clinical dilemmas including role and boundary issues, family relationships, living in a shelter, immediate crisis needs of families, depression, child maltreatment, custody cases, domestic violence, illegal activities, inappropriate expectations of children, questions about or issues with other children, cognitive impairments, safety and security issues, as well as families not taking advantage of the information and referrals. Five case scenarios with descriptions that include some of these issues and how they might be resolved are described below.

Case Scenario 1: Roles and Boundaries

Issue: Family coach is asked to attend celebratory functions for families, such as birthdays, graduations and christenings, and also is made to feel guilty he/she cannot attend.

Resolution: Address this before it becomes an issue. During the enrollment process, the family coach discusses the roles and expectations of the family coach-parent relationship. When an issue arises, the family coach responds in a supportive and understanding manner and explains the office policy. Depending on the function, there are alternative acknowledgements built into the program, such as sending a card and giving birthday gifts. It is important to note that some moms understand, yet others find it difficult, especially after the family coach has worked with the mom for a significant amount of time.

Case Scenario 2: Living in a Shelter

Issue: Mom and child are living in a shelter during participation in the program.

Resolution: The family coach discusses the situation with the mother and assesses whether she is agreeable to conducting the sessions in the shelter. If the mother is agreeable, the family coach obtains consent to share information with the shelter's administrator, discusses the program and schedule with the shelter administrator, and conducts sessions in a confidential setting. Being flexible is the key to success.

Case Scenario 3: Family Relationship Issues

Issue: A teen mother has conflict with family members (e.g., parents, grandparents, in-laws) and attempts to draw the family coach into taking sides.

Resolution: The family coach will exhibit patient listening and empathy via phone and in-person visits, and encourage the mother to meet her needs and those of her children. The family coach can use the framework discussed in the module on problem-solving, which will help open the door for discussion, lend support to the mother and her situation, and give her the opportunity to look at her own strengths in dealing with the issues before her. At times, this has required us to allot a significant portion of the session to problem-solving the issue. When new issues arise, it is helpful to link the issue with previous intervention sessions that have addressed this situation, reminding the mother what the research indicates.

Case Scenario 4: Ongoing Crises or Competing Priorities

Issue: Mothers state they have "too many crises to deal with the project" (e.g., housing, finances, partner conflict, medical appointments, etc.) and/or cancel frequently due to work, school or other priorities, thereby, affecting session consistency.

Resolution: Flexibility and persistence in scheduling have proven to be essential ingredients. Mothers need to know that the family coach is willing to work with them and that she will be there for them. We have found that assistance with concrete problem-solving and prioritizing needs helps the mother feel at ease and better able to focus. A major aspect of the project is the provision of referrals to address immediate needs. Additionally, family coaches will sensitively remind mothers that parenting interactions are still important (sometimes especially so) in times of stress and crisis.

Case Scenario 5: Participants' Lack of Follow-Through

Issue: A mother not using information provided to them and/or not following through on referrals; the mother may accept and involve self in the intervention but quickly revert to "the way they have always done it" outside of sessions.

Resolution: The family coach will continue to bring up the issue at each session, reinforce the seriousness of the concern, and make calls to the mother between sessions to follow-up. The family coach will explain potential consequences of doing nothing ("I'm worried that…") and remind the mother of how the current issue relates to their short- and long-term goals and hopes for her child. The family coach will revisit the problem-solving module that is part of the intervention and help the mother problem-solve obstacles to following through (e.g., intimidated to call professional, lack of transportation). At the same time, if it is a child-related concern, the family coach will let the mother know that she may need to be reported to Protective Services if the problem persists. It is particularly important to assist family coaches with their own frustrations associated with the limits of their influence.

Summary

The mechanism for addressing the ethical and clinical challenges of research is a developmental process. The process involves (1) focused, responsive, timely attention to the families' needs; (2) direct problem-solving strategies with the parent; and (3) ongoing "triage" to assess which issues family coaches can address directly, indirectly through referrals, or not at all. A great deal has been learned through this process and is essential for promoting the positive well-being of children and families in an ethical and sensitive manner.

References

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Guttentag, C., Baggett, K., & Willard-Noria, C. (2004). *Clinical Challenges Manual.* Washington, DC: Centers for the Prevention of Child Neglect.

Ramey, S. L., & Lanzi, R. G. (2005). *Principles of Scientific Integrity*. Washington, DC: Georgetown University Center on Health and Education.

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SECTION IV: ANNOTATED BIBLIOGRAPHY

OVERVIEW AND METHODS

Drawing on research from 32 countries, this annotated bibliography summarizes 85 journal articles, reports, and policy papers that have been published from March 2006 through the end of February 2008. Articles that focus on research conducted solely in the United States were not included in this review. In order to capture as much of the relevant published literature as possible, a search was conducted using the electronic databases FirstSearch, ScienceDirect and Wiley InterScience. An initial search included the primary key words: child abuse; child maltreatment; child neglect; and child protection. Secondary key words (e.g., child abuse and physical) included sexual; physical; mental health; health; prevention; intervention; mortality; and at-risk. In addition to the key-word database searches, the "Related Article" tool in the Science Direct database produced relevant articles from a broad number of disciplines including education, psychiatry, psychology, art, social sciences, criminology, public health, law, medicine and social welfare. Only English-language articles were included in the review, resulting in a disproportionate number represented from certain English-speaking countries such as the United Kingdom (9 articles), Canada (14 articles) and Australia (7 articles). While this review is not exhaustive of the current published research, an attempt was made to represent a diversity of research methods, country perspectives, relevant topics and disciplines as was possible given time and resource constraints.

A broad range of topics is represented in the bibliography, from the educational outcomes of sexually abused children to the role of the radiographer in assessing and reporting child maltreatment. However, in an attempt to keep the bibliography focused and within reasonable space limits, the search focused on those studies conducting or drawing on empirical research for their analysis. In addition, related topics that have produced their own body of literature were not included (e.g., child labor, child trafficking, child victimization on the internet, etc.) but warrant a separate review to better understand their relationship to the literature on child abuse and neglect.

The review begins with annotated citations from cross national studies and then organizes the literature by country.

CROSS NATIONAL

Adams, R. E. and W. M. Bukowski (2007). "Relationships with mothers and peers moderate the association between childhood sexual abuse and anxiety disorders." Child Abuse & Neglect 31(6): 645.

This study attempts to understand the effect that relationships with peers and parents can have on the presence of anxiety disorders among those who have experienced childhood sexual abuse (CSA). Data collected from a large, stratified, multistage area, probability sample provided past reports of CSA, as well as data related to the quality of relationships with mothers and peers. A modified version of the Composite International Diagnostic Interview was used to diagnose four non-phobic anxiety disorders among victims of CSA.The research shows that for victims who report having many friends and a positive relationship with their mother, a weak association between childhood sexual abuse and the number of diagnosed anxiety disorders was found, while those who reported having no friends and a poor quality relationship with their mother showed a much stronger association. The researchers conclude that understanding the quality of relationships between peers, parents and victims may help develop strategies to protect against the damaging effects of CSA.

Cavanagh, K., R. E. Dobash, et al. (2007). "The murder of children by fathers in the context of child abuse." Child Abuse & Neglect 31(7): 731.

As part of a greater study on a three-year investigation of Murder in Britain, this investigation seeks to concentrate on 26 cases in which fathers murdered children, paying particular attention to the relationship between the victim and offender, the childhood and adult background and criminal career of the offender, and the context in which the homicide took place. All victims were under 4-years-old, and the men who killed them were under-educated and unemployed with an active criminal history and had previously been cited for violence against the child and their intimate partners. The researchers found that the nature of the relationship between the offender and intimate partner (married or cohabiting) and whether the offender was the birth- or step-father were important differentiating factors in the homicides. Married and birth-fathers were less likely to commit fatally violent acts against their children.

Davis, M. and P. Reeves (2006). "The radiographer's role in child protection: Comparison of radiographers perceptions by use of focus groups." Radiography 12(2): 161.

The purpose of this paper is to explore how diagnostic radiographers in Ireland and the U.K. understand their role in relation to child protection issues. A series of focus groups were conducted, the discussion lead by a set of "trigger questions" that addressed issues such as the radiographer's contribution to the chain of evidence, training received to identify non-accidental injuries, and the radiographer's role with regard to child protection. Suggestions about what would aid fellow radiographers to more effectively identify child abuse or maltreatment were collected. Both, the radiographers in Ireland and the U.K. reported that they felt a duty to the child, as well as to any patient that they serve; that they received very little, if any, training to identify cases of non-accidental injury or other forms of child abuse; and would benefit from support and feedback related to their work in child maltreatment cases.

Gunstad, J., R. H. Paul, et al. (2006). "Exposure to early life trauma is associated with adult obesity." Psychiatry Research 142(1): 31.

The purpose of this study was to understand the relationship between early life stressors and adult obesity. Data was collected from 696 participants at sites in Australia, the Netherlands, the United Kingdom and the United States. Measures of childhood exposure to trauma, current levels of depression, anxiety, stress, intellectual functioning (IQ), and other demographic and psychosocial variables were collected and analyzed. Results of the analysis show that exposure to childhood trauma was associated with adult obesity, especially among men who had experienced bullying or rejection or those who had experienced emotional abuse. Prospective studies will be needed to explain whether early life stressors caused obesity in adulthood or whether obese children are at a higher risk of experiencing these early stressors. The relationship did not hold for obese women and is inconsistent with past studies—further investigation will be necessary to understand these results.

Hershkowitz, I., O. Lanes, et al. (2007). "Exploring the disclosure of child sexual abuse with alleged victims and their parents." Child Abuse & Neglect 31(2): 111.

Children who have experienced sexual abuse are often reluctant to disclose their victimization to parents or others, putting them at an increased risk for additional victimization and enduring negative consequences. This study examines the ways in which children disclose sexual abuse when the perpetrator is not a family member. Thirty children were interviewed by experienced youth investigators using the National Institute of Child Health and Human Development (NICHD) Investigative Interview Protocol in Northern and Central Israel. Parents were also interviewed about how, when and where they discovered that their children had been sexually abused and their reactions to the disclosure. Results showed that 57% of children spontaneously disclosed the abuse and 43% disclosed only after they were prompted. The severity and frequency of the abuse was related to whether the child disclosed the abuse after prompting. Those children whose abuse was more severe and those who were repeatedly abused disclosed their abuse only after they were prompted more often than children who experienced less serious or single incidents of abuse. Younger children (7-9 years-old) were more likely to disclose the abuse right away than older children (10-12 years-old) in the sample. Children were also very good at predicting parental response to disclosure and those who predicted a negative reaction from parents tended to delay or withhold disclosure, especially in cases where the abuse was serious.

Hershkowitz, I., Y. Orbach, et al. (2006). "Dynamics of forensic interviews with suspected abuse victims who do not disclose abuse." Child Abuse & Neglect 30(7): 753.

While many studies have explored the use of the National Institute of Child Health and Human Development (NICHD) Investigative Interview Protocol with cooperative alleged victims of abuse. None however, have attempted to explore the use of this protocol on victims who are reluctant to disclose abuse and where strong evidence that abuse has occurred is available. This study compares the interviews of victims of abuse who were cooperative (50 interviewees) with those who did not allege that abuse had occurred (50 interviewees). Interviews were then transcribed and coded-based on children's responses and the procedures used by the youth investigator. Results showed that the dynamics of the interaction between child and interviewer differed greatly between interviews in which children disclosed abuse and interviews in which they did not. Interviews in which children did not disclose abuse were characterized by less frequent use of free-recall prompts and fewer supportive comments, suggesting that the interviewer's behavior was shaped by the uninformative responses of these children. Children who did not disclose were uninformative in each stage of the interview process—from rapport building, to episodic memory training, and finally to substantive investigations. These findings suggest that interviewers should be careful not to engage non-responsive children in substantive issues too soon in the interview but instead should spend more time in rapport-building exercises or break interviews with these children into more than one session.

Lamb, M. E., Y. Orbach, et al. (2007). "A structured forensic interview protocol improves the quality and informativeness of investigative interviews with children: A review of research using the NICHD Investigative Interview Protocol." Child Abuse & Neglect 31(11-12): 1201.

This article discusses research on children's ability to remember and accurately communicate their stories of abuse in forensic interviews and explores the usefulness of the NICHD Investigative Interview Protocol to enhance the quality of investigative interviews. Since the use of focused prompts, option-posing, and suggestive questions can often lead child witnesses to a certain outcome, the protocol was designed to prioritize the early use of open-ended questions and non-suggestive prompts and techniques for drawing the child's attention back to substantive information, saving more suggestive techniques for later in the interview. Four independent field studies conducted in Francophone Canada, the United Kingdom, Israel, and the United States have shown that, when the structured protocol is used in forensic interviews, forensic investigators use fewer option-posing and suggestive prompts and more open-ended suggestive prompts, increasing credibility and avoiding contamination of the data that is collected. While studies show significant differences of recall and communication ability among children of different ages, studies have shown that children as young as 4-years-old can provide accurate information in a free-recall format. The researchers also stress the importance of continual training and the sharing of interviews with other interviewers in order to consistently conduct quality interviews that elicit accurate information from children that can stand up in court.

Leach, F. (2006). "Researching gender violence in schools: Methodological and ethical considerations." World Development 34(6): 1129.

There is an urgent need to better understand adolescent sexual beliefs and practices particularly in contexts where intervention strategies to combat the rampant spread of HIV/AIDS are badly needed. This research investigates sexual violence perpetrated against adolescent school girls in three African countries (Zimbabwe, Ghana and Malawi), and discusses the ethical considerations of conducting this type of study with children in developing countries. The study was launched in two phases. The first phase focused on secondary school girls, ranging in age from 12-17 years-old, in three coeducational schools (one rural, one suburban and one urban) in Zimbabwe. Two hundred ten girls participated in face-to-face interviews, while boys, teachers, parents and school officials participated in focus groups and workshops. In phase 2, the research replicated this initial study at three schools each in Ghana and Malawi. The population of girls in the second phase of the project was smaller and represented a younger sample population to address discoveries that sexual violence was a problem even in primary schools. In Ghana 48 girls between the ages of 10-15 years-old were interviewed, and boys, teachers, parents and school officials participated in workshops. In Malawi, 99 girls between the ages of 10-18 years-old were interviewed, boys, teachers, and one school official participated in workshops and focus group discussions. The research revealed that schools in this study tolerated a high degree of sexual violence in and around the schools including aggressive sexual advances by older male students, preferential treatment or threats by teachers to engage in sex, and tolerance of "sugar daddies" who approach girls in the school vicinity and offer money or gifts in exchange for sexual favors. A normalization of these practices has occurred in schools since there is little action taken to protect students from them. Further work of this kind must make connections to relevant policy-makers and services to protect girls and promote positive, long-lasting changes.

Maguire, S., M. Mann, et al. (2006). "Does cardiopulmonary resuscitation cause rib fractures in children? A systematic review." Child Abuse & Neglect 30(7): 739.

Rib fractures due to cardiopulmonary resuscitation (CPR) in young children may be a good indicator of physical abuse. While these fractures are fairly common in adults, children have more flexibility in their ribs and thorax making a fracture much less likely to occur in cases of CPR. This study seeks to develop an evidence base for the frequency and characteristics of rib fractures in children caused by CPR that would help professionals to distinguish them from similar fractures caused by child abuse. Six relevant studies were included representing 923 children who underwent CPR. Results of this review showed that only three children in these studies sustained rib fracture due to CPR and presented with anterior, multiple fractures—98% to 100% of cases of children undergoing CPR do not sustain rib fractures as a result. The studies reported no posterior rib fractures that were due to CPR. The researchers conclude that cases of rib fracture in children under 18 years-old due to CPR are very rare and should be further investigated for child abuse.

Sternberg, K. J., M. E. Lamb, et al. (2006). "Effects of early and later family violence on children's behavior problems and depression: A longitudinal, multi-informant perspective." Child Abuse & Neglect 30(3): 283.

While there is an increasing literature on the effects of family violence on children, little research has been done investigating the effects of this type of violence on adolescents or on the persistence of these effects over time. This study followed a cohort of Israeli children at different developmental stages who had experienced various forms of maltreatment- physical abuse, witnessing domestic violence, and those children who had been both witnesses and victims. A group of children who had neither been abused nor had witnessed domestic violence served as the comparison group. Information was collected independently from children, mothers, fathers, teachers and social workers to provide a broad perspective on the effects of maltreatment. During the first phase of the study, parents and children were interviewed by interviewers who were blind to the family's history of abuse. Children were administered the Youth Self-report questionnaire that asks questions about their own behavior problems and the Child Depression Inventory. Parents were administered the Child Behavior Checklist that asks about perceptions of their children's problems. Teachers were asked questions related to child's behavior problems in school. At the follow-up, mothers, fathers, children and social workers were asked to provide detailed information on family conflict and violence. Results in the study showed mixed results. Children who witnessed and experienced abuse reported more problems than other children, though there was little agreement about which group was most adversely affected. Recent exposure to family violence was associated with child reports of maladjustment. While younger children may be affected to a greater degree by family violence, the study reported that these effects may not carry over into adolescence if the abuse stops earlier in childhood.

AUSTRALIA

Alison, L., M. Kebbell, et al. (2006). "Considerations for Experts in Assessing the Credibility of Recovered Memories of Child Sexual Abuse: The Importance of Maintaining a Case-Specific Focus." Psychology, Public Policy, and Law 12(4): 419.

The focus of this article is to explore the difficulty of coming to a conclusion about the credibility of a complaintant's claim of sexual abuse when the testimony is derived from recovered memories. The authors review the psychological and legal challenges surrounding this debate and encourage expert witnesses to maintain a case-specific focus and keep in mind the difficulty of assessing 1) the way in which the complaintant claims to have remembered the abuse, 2) if and how the claim may have emerged in a therapeutic setting, and 3) the use of general psychological models in specific cases. In the event that the case rests upon the recovered memory without any additional supporting evidence, the authors conclude that the expert witness' testimony not be the only evidence relied upon for convincing the jury of the credibility of the complaintant.

Allan, J. (2006). "Whose job is poverty? the problems of therapeutic intervention with children who are sexually violent." Child Abuse Review 15(1): 55.

This paper examines how the current conservative political climate in Australia locates deviance within the family structure. This results in the targeting and treatment of child sex offenders and their families in isolation of the larger structural issues that are a consequence of poverty. Poverty and inherited violence then become an explanation for deviant acts and responsibility for these actions is born solely by the individual.

Anthonysamy, A. and M. J. Zimmer-Gembeck (2007). "Peer status and behaviors of maltreated children and their classmates in the early years of school." Child Abuse & Neglect 31(9): 971.

The purpose of this study is to examine whether early experiences of child maltreatment by caregivers have an impact on peer relationships and classroom behavior. The researchers hypothesized that maltreated children (especially those who exhibit physical and verbal aggression were withdrawn and less pro-social) would be rated lower by their teachers and peers as likable, and were more likely to be rejected. A sample of 400 children ages 4-8 years-old and 24 teachers from 22 schools were asked to rate the likeability of children in their classroom to acquire information on peer relationships. Teachers were also asked to report on children's verbal and physical aggression and withdrawn and pro-social behaviors. The findings showed an indirect association between the early family experiences of maltreated children and low likeability and rejection by peers though this relationship also held true for children exhibiting negative behaviors who were not maltreated. The study concludes that early home- or school-based prevention and intervention efforts are needed to help all children, especially those who are maltreated, to develop positive pro-social behaviors that can carry over into their relationships with peers.

Frederick, J. and C. Goddard (2007). "Exploring the relationship between poverty, childhood adversity and child abuse from the perspective of adulthood." Child Abuse Review 16(5): 323.

The purpose of this research is to better understand the life experiences and circumstances that lead people to seek emergency relief services (part of Australia's welfare system) in adulthood. Drawing on relevant literature, the researchers developed an interview protocol to outline the process from childhood to adulthood, paying close attention to the role that child abuse and adversity play on the path to adult poverty. A sample of 20 participants (10 men and 10 women) seeking emergency relief services was identified through relief agencies in Victoria, Australia. Semi-structured, in-depth interviews were conducted focusing on those experiences that lead from their childhood experiences to poverty as adults. The study participants outlined a series of risk factors including: problematic relationships with their parents, time away from their parents in care, experiencing violence and abuse, experiences of grief and loss, and the stress of parental separation, leading many of the participants to leave home at an early age. Interviewees developed negative life pathways that affected their education and employment opportunities and compounding issues such as mental and physical health and impacted their ability for later life success.

Goldman, J. D. G. "Primary school student-teachers' knowledge and understandings of child sexual abuse and its mandatory reporting." International Journal of Educational Research. In Press, Corrected Proof: 156.

Though teachers in Australia are mandatory reporters of child sexual abuse (CSA), very little is known about the preparation they receive to fulfill their duty. A questionnaire was administered to 81 student teachers finishing their final semester in a Bachelor of Education program focusing on primary school at a University in Queensland, Australia. They were asked questions related to their understanding of childhood sexual abuse and their future responsibility as mandatory reporters. The majority of respondents agreed that childhood sexual abuse was a prevalent problem and that primary school teachers had an important role to play in identifying and reporting suspected sexual abuse among their students. The respondents felt less confident about how to identify CSA—less than a quarter felt they could identify the characteristics of suspected sexual abuse. Only about 25% of respondents felt that they understood their responsibilities as a mandatory reporter or understood the policies and procedures of mandatory reporting. Researchers advise that enhanced pre-teacher preparation for identifying and reporting CSA is needed.

Irwin, J. and F. Waugh (2007). "Domestic violence: a priority in child protection in New South Wales, Australia?" Child Abuse Review 16(5): 311.

While there is a growing awareness of the relationship between domestic violence (DV) and child abuse, investigations are lacking on how child protective services have incorporated this information into their practice. This research examines practitioners' knowledge and understanding of domestic violence, reviews protection strategies used by child protection practitioners, and identifies strategies that practitioners use to respond to victims of domestic violence and their children. Five Department of Community Services offices, the child protection statutory authority in New South Wales, were enlisted for this study. Researchers shadowed intake practitioners, using a structured questionnaire to collect data on the process of each intake referral, both in cases involving domestic violence and those where domestic violence was not an issue. All domestic violence cases (111 cases) and other cases (106 cases) was tracked over an 18 month period to determine the outcome of the referral. The results show that, though more domestic violence cases were confirmed as abuse (75% of DV cases compared to 56% of other cases), fewer were followed-up or investigated beyond registering that the abuse had occurred (16% of DV cases vs. 63% of other cases.) Interviews with practitioners revealed that half of them

had received no training with regard to assessing the risk of child maltreatment due to domestic violence. Practitioners knowledge about the impact of domestic violence on child protection issues varied greatly, some reporting that DV was not an issue unless the child witnessed the abuse while others saw the protection of the mother and child as inter-dependant. For services to more effectively protect children, practitioners must understand, take seriously, and be willing to act in cases where domestic violence is present.

Stewart, A., M. Livingston, et al. (2008). "Transitions and turning points: Examining the links between child maltreatment and juvenile offending." Child Abuse & Neglect 32(1): 51.

There is substantial evidence in the literature of the association between child maltreatment and juvenile offending. Less is known, however, about how the patterns and timing of abuse may affect this relationship. Using the Semi-Parametric Group-Based trajectory analysis, this research examines the impact of timing and duration of child maltreatment on subsequent juvenile offending for a birth cohort of 5,849 children born between 1983 and 1984 in Queensland, Australia. Information was collected on all contact the child had with the child protective and juvenile justice systems for these children until the age of 17. Six maltreatment trajectory groups were identified: abuse that occurred in early childhood but lasted a short time-span; abuse that occurred during the transition from pre-school to primary school and was short in duration; abuse that occurred during the transition from pre-school to primary school and was chronic; abuse that occurred during the transition from primary school to secondary school and was short in duration; abuse that occurred during the transition from primary school to secondary school and was chronic; and youth who experienced abuse as adolescents for a short period of time. Analysis of the data revealed two important findings: 1) children are more susceptible to abuse during times of transition from early childhood to primary school or from primary school to secondary school, and 2) children who were abused in adolescence or who's abuse continued into adolescence were more likely to become future offenders.

AUSTRIA

Kohlberger, P. and D. Bancher-Todesca (2007). "Bacterial Colonization In Suspected Sexually Abused Children." Journal of Pediatric and Adolescent Gynecology 20(5): 289.

Physical evidence of child sexual abuse can be elusive since superficial injuries heal quickly making clinical signs of abuse time-sensitive. Alternative methods to verify the abuse has taken place include testing for sexually transmitted diseases though bacterial vaginosis. One hundred eighty patients who were suspected victims of child sexual abuse were examined by gynecologists at an outpatient clinic for child and adolescent gynecology. A physical gynecological exam was performed and specimens were taken and analyzed for the presence of sexually transmitted diseases and bacterial vaginosis. Three-quarters of the sample showed no signs of hymenal-vaginal tearing and 91% showed no signs of extra-genital injury. The percentage of patients in the sample showed low prevalence of sexually transmitted diseases though bacterial colonization was found to be common in sexually abused children. The next step will be to design a study comparing these rates with a non-abused sample population as the control group.

CANADA

Afifi, T. O., D. A. Brownridge, et al. (2006). "Physical punishment, childhood abuse and psychiatric disorders." Child Abuse & Neglect 30(10): 1093.

Testing the hypothesis that physical punishment by a loving parent does not result in negative outcomes, Affifi and Brownridge investigate the effects of three types of childhood adversity on adult psychopathology: the absence of physical punishment, physical punishment only, and child abuse. Data was collected from the National Co-morbidity Survey to determine the odds of experiencing psychiatric disorders. The study concludes that children experiencing physical punishment only increased the odds of major depression, alcohol abuse or dependence, and externalizing problems later in life compared with those children who did not experience physical punishment and were at decreased odds with those children experiencing child abuse.

Bourassa, C., C. Lavergne, et al. (2006). "Awareness and detection of the co-occurrence of interparental violence and child abuse: Child welfare worker's perspective." Children and Youth Services Review 28(11): 1312.

Though social workers are often the first responders in cases of child abuse and often have a good understanding of the multitude of problems faced in individual households, only about half of them report conducting any sort of systematic inquiry of marital violence that often co-occurs in child abuse cases. This study examines qualitative accounts of social workers awareness of domestic violence as well as how, and whether, they confirm allegations

of such violence when it is brought to their attention. Key informant interviews were conducted with 28 social workers working for child protective services in New Brunswick, Canada. Interviews were coded and categorized in order to analyze across interviews. About half of social workers report that they do not do an evaluation of domestic violence in their all of their cases, citing obstacles such as denial of violence, lack of evidence and cooperation, and the discrete nature of violence. The authors conclude that caseworkers should be trained to understand the link between domestic violence and child abuse, as well as assessing the risk of domestic violence in all cases where child abuse is present.

Carter, J. C., C. Bewell, et al. (2006). "The impact of childhood sexual abuse in anorexia nervosa." Child Abuse & Neglect 30(3): 257.

This study seeks to investigate the relationship between childhood sexual abuse, clinical characteristics and the premature termination of anorexia nervosa (AN) treatment. One hundred thirteen patients admitted to a voluntary in-patient eating disorders unit in Toronto were screened upon entry to the program. Seventy seven agreed to participate and met the requirements for the study. Patients were assessed for eating disorder symptoms, depressive symptoms, global self-esteem and other psychopathologies, as well as for experiences of childhood sexual abuse. The research revealed that 48% of participants had experienced childhood sexual abuse (CSA), confirming prior studies on the subject, though it did not find a significant link between CSA and the early termination of treatment. However, a subpopulation in the sample who exhibited a binge-purge type of AN were significantly more likely to terminate their treatment before it was complete when compared to those with the same type of AN but without a history of sexual abuse.

Clement, M. E. and C. Chamberland (2007). "Physical violence and psychological aggression towards children: Five-year trends in practices and attitudes from two population surveys." Child Abuse & Neglect 31(9): 1001.

This 2004 survey of psychological aggression and physical violence among a sample of 3,148 mothers living in Quebec is compared with the prevalence rates of the same survey administered five years earlier. The mothers had children ranging in age from 0-17 years-old and were identified through a random digit dial telephone method. They were administered a computer assisted telephone survey that employed the Parent-Child Conflict Tactics Scales. Frequencies were then compared using the 1999 and 2004 samples. Findings showed that reports of physical violence had fallen by 5% while rates of psychological aggression reportedly rose by a similar amount. In 2004, 43% of respondents reported one episode or more of minor violence and 6% reported at least one episode of severe physical violence by an adult living in the same household, while 80% of respondents reported the use of psychological aggression. The researchers attribute these findings to changing attitudes among mothers about acceptable ways to discipline their children and suggest the continued promotion of alternative methods of discipline that do not use violence.

Currie, C. L. (2006). "Animal cruelty by children exposed to domestic violence." Child Abuse & Neglect 30(4): 425.

This study explores the relationship between a child's exposure to domestic violence and consequent cruelty to animals. Power, aggression and violence are all models of acceptable behavior in homes experiencing domestic violence. The authors hypothesize that children from these homes will replicate this violent behavior against animals because it is easier to conceal or less likely to be punished. Data was collected from interviews with a matched sample of 47 mothers with two children who has been exposed to domestic violence and 45 mothers with two children who had not been exposed between September 1996 and February 2000. The interview included questions regarding demographic information and a Child Behavior Checklist for each child. Results show that children who are exposed to domestic violence are significantly more likely to commit violent acts against animals than children who are not exposed (17% vs. 7% respectively.) Gender and age was similar among children who were cruel to animals and those who were not. Within the sample of children who were cruel to animals, the children who were exposed to domestic violence tended to be older than those who were not cruel to animals. This might be explained by the fact that younger children become involved in exploratory or curious animal cruelty due to a lack of knowledge about how to care for animals while older children may abuse animals because of pathological cruelty stemming from psychological issues related to their own exposure to violence.

Dufour, S., C. Lavergne, et al. (2008). "Who are these parents involved in child neglect A differential analysis by parent gender and family structure." Children and Youth Services Review 30(2): 141.

Research on child maltreatment has historically focused on the role that women, especially single mothers play rather than on how men, either as biological or surrogate fathers, are implicated in child neglect and

maltreatment. This paper seeks to compare the characteristics and personal issues of mothers to fathers in situations where child neglect has been substantiated. Drawing on a sample of 1,266 neglecting families, the Canadian Incidence Study of Child Abuse and Neglect found that mothers (both biological and surrogate) experience more personal issues (such as poor mental health) that impact the children in their care, while fathers experience fewer problems, have stronger socio-demographic characteristics, and families in which they are present have a lower incidence of neglect. These findings are not straightforward, however, fathers also tend to be more often involved in criminal activity and surrogate-fathers have more personal problems than biological-fathers. In light of the mixed evidence presented in this study, the researchers conclude that any examination of family dynamics must consider not only the role that the mother plays, but must also consider the needs of both parental figures to develop effective strategies for supporting the family.

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

While investigations into the impact that child protection reform has on child protective services are common, systematic studies of how parents experience child protective interventions are rare. This study explores the ways in which parents experience and respond to interventions from child protective services and builds a model to help policy-makers and practitioners understand this process so that more effective intervention strategies can be developed. Eighteen parents who had received child protection services but whose cases were closed for no longer than 18 months were recruited for in-depth interviews. Results showed that the idea of power—either “power over” or “power with”—played a central role in how parents responded to intervention. If a parent perceived the case worker as wielding power over them, they were more likely to oppose or feign cooperation with the intervention. On the other-hand, those parents who perceived the case worker as using or sharing power with them, were more likely to respond positively and engage in the intervention.

Gall, T. L. (2006). "Spirituality and coping with life stress among adult survivors of childhood sexual abuse." Child Abuse & Neglect 30(7): 829.

This is one of the few studies to explore the role of spiritual coping in the well-being of survivors of childhood sexual abuse (CSA). Other studies have categorized coping responses to CSA as positive (including minimization or positive reframing) or negative (including avoidance or self-blame). Likewise, spiritual coping was found to have both positive forms (comfort and security in a higher power) and negative forms (discontent and detachment from a higher power). One hundred and one self-identified, adult survivors of childhood sexual abuse were administered a questionnaire on the nature of their abuse, current stressful life events, and coping mechanisms, including several coping scales that measured religious/spiritual function. The presence of spiritual coping in the life of a CSA survivor was able to predict the current level of distress in adult survivors—negative spiritual coping related to greater distress and greater depressive mood and positive spiritual coping associated with lower levels of distress and a lesser depressive mood. Researchers highlight the need to pay particular attention to the form of spiritual coping when trying to understand the role of spirituality in the life functioning of survivors of CSA.

Hildyard, K. and D. Wolfe (2007). "Cognitive processes associated with child neglect." Child Abuse & Neglect 31(8): 895.

This study compares various the information-processing tasks of neglectful and non-neglectful parents on responses to their child’s emotions, behavioral cues, and recall of child-related information. Neglectful mothers with a child under the age of 3-years-old in the past three years and a chronic history of neglect were referred to the program by Child Protective Services. Non-neglectful mothers with children under the age of three were recruited through community agencies (daycares or other groups serving mothers with young children). Mothers from both groups were administered the following: 1) the IFEEL pictures task which aims to understand how mothers perceive and attend to emotional cues given by their children 2) written attributional vignettes with scenarios of the behaviors of young children, and 3) a passage recall task to determine the parent’s ability to recall care-giving information in addition to collecting data on demographic and depressive symptoms. The data showed that neglectful mothers were less accurate at labeling their children’s emotions, less likely to recognize their children’s feelings of interest, and more likely to see feelings of sadness and shame than mothers who were not neglectful. Neglectful mothers often perceive a more limited range of emotions in their children, instead interpreting them in a more simplistic bi-modal fashion. Neglectful mothers were more likely to negatively attribute child behavior and had poor recall of information related to child care-giving. The researchers suggest that cognitive-behavioral interventions may help neglectful parents better recognize their child’s emotions and help to address maladaptive attributions of child behavior.

Nolin, P. and L. Ethier (2007). "Using neuropsychological profiles to classify neglected children with or without physical abuse." Child Abuse & Neglect 31(6): 631.

This study examines the relationship between cognitive functioning and child maltreatment comparing children who have been neglected and physically abused and children who have only been neglected. Three groups of children were tested. Child Protective Services referred 56 children who had been neglected and physically abused, and 28 children who had been neglected only to the study. The control group was sampled from the neglected children's classrooms and matched for age, gender and family income. Seven neuropsychological domains were tested: motor performance, attention, memory and learning, visual-motor integration, language, frontal/executive functions and intelligence. Groups of children who had suffered neglect, as well as those who had suffered neglect and abuse displayed impaired auditory attention, flexibility, response inhibition and visual-motor integration while the latter group also scored lower in tests of problem solving, abstraction and planning. The group of neglected-only children scored higher in tests of problem-solving, abstraction and planning than both the neglect and abuse group and the control. Results of the tests supported the use of neuropsychological methods in determining childhood abuse and neglect, as they were able to predict group membership in 80% of cases.

Stoltz, J.-A. M., K. Shannon, et al. (2007). "Associations between childhood maltreatment and sex work in a cohort of drug-using youth." Social Science & Medicine 65(6): 1214.

This study examines the relationship between various types of childhood maltreatment (e.g., sexual, physical and emotional abuse, physical and emotional neglect, etc.) and subsequent sex-work among a sample of high-risk, street-involved youth in Vancouver, Canada. Three-hundred sixty-one youth were recruited for the At-Risk Youth Study, a cohort study in which youth between the ages of 14-26 years-old are tested semi-annually for HIV and Hepatitis and complete an interviewer-assisted questionnaire with a section that addresses previous childhood trauma. Statistical analysis tested for levels of experienced child maltreatment, as well as the relationship between maltreatment and a range of socio-demographic variables. A high prevalence of abuse was found in the sample population: 73% had been physically abused, 32.4% had been sexually abused, 86.8% had been emotionally abused, 84.5% had been physically neglected and 93% had been emotionally neglected. Statistical analysis showed that both sexual and emotional abuse were independently associated with sex-work. This study has implications for prevention and harm reduction strategies among a group of high-risk youth, especially where emotional abuse screening procedures are lacking.

Tang, B., E. Jamieson, et al. (2006). "The influence of child abuse on the pattern of expenditures in women's adult health service utilization in Ontario, Canada." Social Science & Medicine 63(7): 1711.

This paper examines the relationship between past childhood maltreatment and the self-reported health care costs of Canadian women living in Ontario. Data for the study was drawn from the 1990 Ontario Health Survey (OHS) that collected information on physical health status and the use of health services, as well as the 1991 Ontario Mental Health Supplement (OMHSUP), which examined childhood experiences and the prevalence of psychiatric disorders among a randomly selected sample of people living in households that completed the OHS. Four groups of women: those who had experienced physical abuse, those who had experienced sexual abuse, those who had experienced both physical and sexual abuse, and those who had not experienced abuse, all were administered a survey of self-reported health service use. Researchers conclude that a history of abuse among women is associated with increased annual ambulatory health care costs compared to those with no history of abuse. The difference between abused women and those with no history of abuse reached significance for women who have experienced both physical and sexual abuse. These women report spending twice as much money on annual ambulatory health care than did the control group.

Wekerle, C., A.-M. Wall, et al. (2007). "Cumulative stress and substantiated maltreatment: The importance of caregiver vulnerability and adult partner violence." Child Abuse & Neglect 31(4): 427.

Drawing on data from the Canadian Incidence Study of Reported Child Abuse and Neglect (CIS), a secondary data analysis was conducted on single and cumulative effects of caregiver's vulnerability regarding childhood physical and sexual abuse and also child neglect. In addition to standard demographic factors, the variables of socioeconomic disadvantage, primary caregiver history of child maltreatment, inter-partner violence, and primary caregiver vulnerabilities (e.g., substance abuse, mental and physical health, criminality and social isolation) were analyzed for significance. Results of the study showed that single and multiple caregiver vulnerabilities as well as being involved with a violent partner, were related to the substantiation of abuse and neglect. The largest effect found as a single predictor on substantiation of maltreatment was a caregiver's substance use. The total number

of caregiver vulnerabilities was a robust predictor of the substantiation of maltreatment, especially neglect, while being in a violent relationship for six months or more compounded the effects of vulnerability. Caregiver vulnerability and domestic violence are important contexts in which child maltreatment unfolds and should be considered in preventive and protective intervention efforts.

CHINA

Chan, Y. C., G. L. T. Lam, et al. (2006). "Confirmatory factor analysis of the Child Abuse Potential Inventory: Results based on a sample of Chinese mothers in Hong Kong." Child Abuse & Neglect 30(9): 1005.

This study tests whether Milner's Child Abuse Potential (CAP) Inventory can be used to assess the risk of child abuse or maltreatment among a sample population of Chinese women living in Hong Kong. Eight hundred ninety-seven mothers from 13 child care centers in Hong Kong were administered the 77-item Abuse Scale of the Child Abuse Potential Inventory along with to questions about their demographics, general health and measures of loneliness. Confirmatory factor analysis was used to measure if the data fit with the original six-factor structure outlined in Milner's original CAP Inventory model. Researchers confirmed that, while there were limitations to the study, and adjustments would need to be made in future research, the original structure of the CAP Inventory was acceptable.

Chen, J., M. P. Dunne, et al. (2006). "Child sexual abuse in Henan province, China: associations with sadness, suicidality and risk behaviors among adolescent girls." Journal of Adolescent Health 38(5): 544.

Attempting to fill a gap in the literature on child sexual abuse in China, this study investigates whether CSA leads to diminished mental health and risky behaviors with in a sample population of Chinese adolescent girls from the central province of Henan. Recent studies show that exposure to CSA is related to poor mental health outcomes, health-related risk behaviors, and the early onset of sexual intercourse early in life. An anonymous, self-administered questionnaire was given to 351 female students, aged 16-23 years-old, attending a medical secondary school (similar to a technical high school) in Henan province, China. This study corroborated these findings, reporting that one in five female adolescents in the sample reported experiencing at least one type of CSA before the age of 16, with one in seven reporting unwanted physical contact. The study also showed that these results were not associated with parent's education level, the presence of siblings, or urban/rural residence. These findings are similar to those studies conducted in Western countries.

Chen, J., M. P. Dunne, et al. (2007). "Prevention of child sexual abuse in China: Knowledge, attitudes, and communication practices of parents of elementary school children." Child Abuse & Neglect 31(7): 747.

This study seeks to understand the potential for school-based programs designed to prevent childhood sexual abuse (CSA) by investigating the attitudes, knowledge, and protective practices of parents with children in elementary school. Anonymous questionnaires on knowledge, attitudes and protective practices related to CSA were administered to 652 parents of Grade 3 children in Jingzhou City, Hubei province (Central China). Results showed that a vast majority of respondents (95%) supported school programs to prevent CSA though about half were worried that such a program might teach their child "too much about sex." Many parents lacked knowledge about CSA and only about 60% actually spoke with their children about this issue (as opposed to about 95% of parents who warned their child not to go with others unless they had parental permission.) Those who did discuss CSA with their child did not necessarily have more knowledge on the subject than those who did not. The study supports the development of school-based CSA prevention programs, as well as community-wide adult education programs on this issue.

Lee, A. C. W., C. H. Li, et al. (2006). "The impact of a management protocol on the outcomes of child abuse in hospitalized children in Hong Kong." Child Abuse & Neglect 30(8): 909.

In Hong Kong, where reporting child abuse is not mandated and the primary care system is not well-developed, children who are suspected to be victims of abuse are often brought to public hospitals where they are treated in conjunction with other children who are experiencing acute medical problems. Consequently, these abused children are subject to over-investigation of their symptoms including medical tests and procedures. This study examines the effects of a medical practitioners group at the Tuen Mun Hospital in Hong Kong who organized and developed a protocol for the investigation of child abuse to strengthen the clinical management of abused children. Their protocol included three components: 1) a designated group of medical professionals and social workers to coordinate and manage all cases of child abuse in the hospital, 2) early communication between the medical staff and community professionals such as child protection workers and the police who investigate

suspected cases of abuse, and 3) a focus on the physical and medical history and also de-emphasis of clinical interventions. All the medical records of 429 children suspected of being abused in two time periods (109 taken prior to the implementation of the protocol, 320 taken after the implementation) were examined for suspected and substantiated maltreatment, severity of the maltreatment, relationship of victim to perpetrator, medical interventions, whether the victim's name was registered on the Child Protection Registry, whether a multidisciplinary conference convened on behalf of the child and demographic data. Results showed that while children in the two samples were similar in forms of abuse, rates of substantiation and inclusion on the Child Protection Registry, there was a significant drop in the number of medical interventions and shorter hospital stays for children who were admitted to the hospital after the implementation of the protocol.

Tang, C. S.-k. (2006). "Corporal punishment and physical maltreatment against children: A community study on Chinese parents in Hong Kong." Child Abuse & Neglect 30(8): 893.

In order to explore rates of parental physical aggression among Chinese parents living in Hong Kong, 542 fathers and 1,120 mothers (in 1,662 randomly selected households) were interviewed at home, away from family members and other witnesses. The survey included measures on acts of physical aggression, reasons and consequences of such aggression, marital satisfaction, social support, child behavior and demographic background information. As hypothesized, mothers were more likely than fathers to be perpetrators of physical aggression, corporal punishment was used more often against boys (though this relationship only holds for boys between the ages of 5-12 years-old), physical punishment was more often used on younger children, and parents who were unemployed or who had lower levels of educational more often resorted to corporal punishment. Overall, 57.5% of respondents reported using corporal punishment, 4.5% of which were considered severe enough to constitute physical maltreatment. Over half of parents who reported reasons for using corporal punishment said that it was to correct child behavior, 20% reported that it was used to vent their own frustrations, and 13% used corporal punishment because they did not know of any alternative strategies. Authors suggest that the information presented in this study can serve as a first step in improving prevention.

CROATIA

Vlasis-Cicvaric, I., I. Prpic, et al. (2007). "Children's reflections on corporal punishment." Public Health 121(3): 220.

While investigations into the effects of corporal punishment on children are fairly widespread, the thoughts and reflections of children with regard to this form of punishment are often lacking in the literature. This study seeks the input of children aged 8-15 years-old on their perceptions and reflections of corporal punishment. Five-hundred and eighty-seven children, with appointments for minor health problems at the Department of Paediatrics, University Hospital Center in Rijeka, Croatia, were administered a five-question survey asking about their experiences with spanking. A quarter of children were spanked daily (3%) or weekly (22%), over half were spanked once every few months (57%), and about one-fifth were never spanked. Younger children reported being spanked more often than older children and this difference was significant. Two-thirds of children reported that they thought all children received spankings and 58% of children felt threatened by physical punishment. One-third of children (31.7%) reported having been physically punished in school by the school's staff. A widespread call for early intervention and education supporting the belief that it is not acceptable to use physical force when settling disputes is needed.

FINLAND

Kalland, M., J. Sinkkonen, et al. (2006). "Maternal smoking behavior, background and neonatal health in Finnish children subsequently placed in foster care." Child Abuse & Neglect 30(9): 1037.

An investigation into the neonatal health and maternal background of children taken into foster care was conducted to better understand the relationships between medical and social risk during the neonatal period. Data from the Medical Birth Registry, with information related to the mother's background (age, marital status, antenatal health visits, and smoking) and health of the newborn (weight, length, weight by gestational age, one-minute APGAR scores and discharge age) was linked to the Child Welfare Registry, which records all children who have been taken into protective custody before the age of 18, resulting in an experimental group of 1668 children. All children born in 1987 were used as the control group (n=59,727). Analysis of the data showed that children placed in foster care were smaller, had more perinatal problems, and thus longer hospital stays than the control. While nicotine can cause low birth-weight, and other adverse outcomes in pregnancy, it was difficult for the researchers to find evidence of a direct connection between mothers who smoke and foster care placements since other social, maternal and familial factors that cause women to smoke, may also contribute to adverse

outcomes in children. It was found, however, that the majority of mothers whose children end up in foster care smoke, raising risk factors for their children. Since most of these mothers use maternity clinics, strategies to stop pregnant women from smoking should be implemented in these locations.

FRANCE

King, G., P. Guilbert, et al. (2006). "Correlates of sexual abuse and smoking among French adults." Child Abuse & Neglect 30(6): 709.

Previous studies have shown that survivors of childhood sexual abuse (CSA) are more likely to smoke or abuse other substances, however, little is known about patterns of smoking initiation and cessation among this population in France. To better understand patterns of smoking initiation, cessation and current smoking habits in survivors of CSA and the general population, this study draws on data collected from a large, random sample of adults in France (n=12,256) ranging in age from 18-75 years-old. Respondents were interviewed by telephone on their health practices, beliefs and health status; history and practice of smoking; history of sexual abuse; and other demographic variables. Results showed that 1.3% of respondents had reported being sexually abused as children (2.1% of women and .7% of men). Survivors of CSA were more likely than non-abused persons to be current smokers (45.6% vs. 34%) and began smoking earlier than non-abused persons (18.8 vs. 19.4 years-old.) Non-abused smokers were significantly more likely to quit smoking than survivors of CSA who began smoking after they had been sexually abused. The researchers suggest that early identification and treatment of survivors of CSA may help to decrease smoking among adolescents and decrease the health risks of smoking-related behaviors.

GERMANY

Goldbeck, L., A. Laib-Koehnemund, et al. (2007). "A randomized controlled trial of consensus-based child abuse case management." Child Abuse & Neglect 31(9): 919.

A randomized control trial was conducted to test the effects of expert assistance on the management of child abuse and neglect cases compared with cases in which expert assistance was not provided. The assistance was provided with the intent of increasing 1) the case worker's satisfaction that the child was protected six months after referral, 2) improving the certainty of caseworkers assessment and decisions with respect to accurately assessing and substantiating the case of abuse or neglect, 3) the range of institutions responsible for the child's security, 4) inter-departmental communication as perceived by the caseworker, and 5) child, adolescent and caregiver's input in the process of intervention. Results showed little, if any, difference between the intervention and control groups for almost all of the intervention's goals. There was a slight increase in case worker's satisfaction with the status of the child six months post-referral, though most of these cases remained open at the completion of this study and further follow-up would be necessary to confirm the child's well-being.

Leeners, B., H. Richter-Appelt, et al. (2006). "Influence of childhood sexual abuse on pregnancy, delivery, and the early postpartum period in adult women." Journal of Psychosomatic Research 61(2): 139.

This paper systematically reviews the relevant studies on the impact of childhood sexual abuse on pregnancy, delivery and early parenthood. Forty-three articles were identified from French, German and English sources and a meta-analysis was conducted on the types of methodologies used, type of data and correlational data. The studies showed that pregnant women who have survived CSA report more discomfort and health issues and subsequently, more non-scheduled visits to antenatal clinics during pregnancy, are more often abused during pregnancy and show higher levels of stress, anxiety and depression than pregnant women who have not experienced CSA. Delivery presents further challenges for survivors of CSA. Women who have experienced sexual abuse report delivery as more physically painful than women who have not experienced abuse. Many survivors of CSA refused medication for fear that it may trigger memories during labor. Survivors of CSA are also likely to be fearful of, or actually experience memories and re-traumatization of their experiences with sexual abuse. These women often have a diminished sense of trust, therefore, having a sense of control becomes an important factor in the birthing process. There is no evidence that survivors of CSA have more complicated births or experience an increased rate of birth interventions (e.g., forceps, vacuum extraction, or cesarean birth) than the general population. There were no differences found in the birth weights of babies of CSA mothers, babies were no more likely to be placed in incubation for jaundice, and conflicting reports of pre-term delivery were found. Post-partum mothers who had experienced CSA were at an increased risk for post-partum depression and severe depression. They were also cited as having more difficulty breastfeeding than mothers who have not been abused since they may associate breasts with sexual organs. Researchers stress the importance of identifying women who have been sexually abused early in pregnancy so that positive interventions can be implemented and

the women prepared for specific challenges related to CSA and childbirth. More rigorous research on the effects of CSA on pregnancy, delivery and postnatal experiences are badly needed.

GUATEMALA

Coope, C. M. and S. Theobald (2006). "Children at risk of neglect: Challenges faced by child protection practitioners in Guatemala City." Child Abuse & Neglect 30(5): 523.

The purpose of this study is to define what is meant by child neglect and the risk factors that contribute to neglect in Guatemala, as well as to highlight the challenges faced by child protection services in a context of often extreme poverty. Professionals and non-professionals working with maltreated children in Guatemala participated in semi-structured interviews, focus groups and group consensus methods. These meetings produced a working definition of child neglect with three parts: 1) that the parent is negative or indifferent toward the child, 2) that the child's basic needs are intentionally ignored by the parent, and 3) that the government does not provide adequate resources to protect the child. These are manifested through physical neglect (including abandonment, failure to care for the child's health or hygiene), educational or developmental neglect (including the failure to put child in school, sending a child to beg or work), emotional neglect (failure to give the child love and attention or to communicate with them) and governmental neglect (including a lack of medical or educational resources and failure to enact laws that protect children). The key informants of the study identified several confounding factors that made it difficult to identify neglect where it may exist such as distinguishing between poverty and neglect, influential societal or cultural norms, and the role played by gender.

IRAN

Alizadeh, H., K. F. Applequist, et al. (2007). "Parental self-confidence, parenting styles, and corporal punishment in families of ADHD children in Iran." Child Abuse & Neglect 31(5): 567.

The purpose of this study was to test whether parents of children diagnosed with ADHD would have lower self-confidence, show less warmth and involvement with their children, and be more likely to use corporal punishment then those parents in the control group. The sample consisted of 125 families with children attending public elementary schools in Tehran, Iran. Sixty five of the families included children who had been diagnosed with ADHD (determined by the Connors's Teacher Rating Scale and confirmed with DSM-IV-TR diagnostic criteria by the author) and 60 families served as the control group. Parenting styles were rated using the Parenting Styles and Dimensions Questionnaire. Results showed that parents with children diagnosed with ADHD were significantly less self-confident, showed less warmth and involvement, and were more likely to resort to corporal punishment. The authors suggest that if possible, the parents of children with ADHD should be identified, supported and educated to better understand ADHD and their own responses to it, as well as be educated on the affects of corporal punishment on children.

Stephenson, R., P. Sheikhattari, et al. (2006). "Child maltreatment among school children in the Kurdistan Province, Iran." Child Abuse & Neglect 30(3): 231.

The purpose of this study is to understand the prevalence of three types of child maltreatment (physical maltreatment, mental maltreatment and child neglect) and associated factors in the context of a developing country. Data was collected from 1,370 students between the ages of 11-18 years-old who attend school in the Kurdistan Province, Iran on various demographic and socioeconomic variables, as well as past history of maltreatment by family members, close relatives, school staff and teachers. Results show that 38.5% of children report physical maltreatment, 74.5% reported mental maltreatment, and 80.1% reported neglect in their home setting. In school, 43.3% of children report physical maltreatment, 59.9% report mental maltreatment, and 54.4% report neglect. Overall, boys were more likely to be maltreated than were girls. Living in a home with a household member who used addictive substances or where marital conflict is present resulted in increased reports of child maltreatment. Those children who reported maltreatment in school were also poorer performers. These results have important implications for targeted prevention and supportive services.

IRELAND

Buckley, H., S. Holt, et al. (2007). "Listen to Me! Children's experiences of domestic violence." Child Abuse Review 16(5): 296-310.

This study reports on the effects of domestic violence on children and young people. Eighteen focus groups were conducted, 13 with service providers, one with mothers, and four with children and young people. Though small

and qualitative in nature, the researchers reported that, while not widely generalizable, certain trends emerged in the course of their discussions. They reported that, whether or not a child or young person is a direct witness to the violence, living in a home experiencing domestic violence can have a negative impact on a child or young person's emotional and mental health, relationships, physical security, self confidence and self esteem. Police and school professionals are seen by these youth as being potentially helpful, while the school environment is a source of both feelings of safety and stress. The report concludes that proactively raising awareness among key service professionals and removing barriers that prevent children from speaking about their situation or seeking help can alleviate the affects of domestic violence on these children and youth.

ISRAEL

Amir, G. and R. Lev-Wiesel (2007). "Dissociation as depicted in the traumatic event drawings of child sexual abuse survivors: A preliminary study." The Arts in Psychotherapy 34(2): 114.

The purpose of this study is to determine whether the drawings of a "traumatic event" could depict dissociative symptoms experienced by survivors of childhood sexual abuse. A sample of 27 child sexual abuse survivors (2 male, 25 female) ranging in ages from 7-59 years-old, were recruited for this research from two sexual assault treatment centers in Israel. They were asked to draw the "traumatic event" on a piece of paper with a pencil and no eraser. They were then administered the Self Report version of the Peritraumatic Dissociative Experiences Questionnaire (PDEQ) while two art therapists assessed indicators of five dissociative symptoms (amnesia, depersonalization, de-realization, identity confusion and identity alteration). A correlation analysis was then conducted on the reports of the therapists. Results showed a significant correlation between indicators of derealization in drawings and PDEQ scores for adults only. Minors scored significantly higher on PDEQ than adults, though adults scored higher on the symptoms of identity confusion and identity alteration based on a comparison of the drawings provided by minors and adults.

Ben-Arieh, A. and M. M. Haj-Yahia (2006). "The "geography" of child maltreatment in Israel: Findings from a national data set of cases reported to the social services." Child Abuse & Neglect 30(9): 991.

This is the first national study on the "geography" of child maltreatment in Israel. Reports of child maltreatment to social service agencies, which are mandated in Israel, were collected from all 276 Israeli localities, placed into a national administrative database, and analyzed on the basis of nationality, geographic area, socioeconomic status, locality type, locality size, and the locality's predominant religion. The analysis showed that the rate of child maltreatment reports in Israel was 17.8 per 1,000, however, there was great variance among localities. Rates in Arab localities (9 per 1,000) were lower than in Jewish localities (20 per 1,000), and higher in large cities and in more affluent localities (19 per 1,000). Based on this variation, the researchers recommend that the state should develop policies and services that encourage the reporting of child maltreatment and reach out to those communities (Arab, ultraorthodox, smaller or impoverished localities) to develop trust and increase their likelihood of reporting child maltreatment.

Elbedour, S., S. Abu-Bader, et al. (2006). "The scope of sexual, physical, and psychological abuse in a Bedouin-Arab community of female adolescents: The interplay of racism, urbanization, polygamy, family honor, and the social marginalization of women." Child Abuse & Neglect 30(3): 215.

The physical, sexual, and psychological abuse of females in Israel's Arab-Bedouin tribal community are topics that have not received adequate investigation. This study seeks to examine the rates of abuse in one such community located of Southern Israel. A translated version of a survey based on Finkelhor's scale, which is used to measure the incidence of abuse, was administered to 217 female high school students in a Bedouin-Arab community in Southern Israel. The surveys were self-administered, and data was analyzed using descriptive, inferential and regression analysis. Results showed that 89% of participants had experienced some form of physical abuse, a majority (over 60%) were psychologically abused, most often by a member of their own family, while 53% had experienced sexual abuse, though a majority of these reports were committed by a stranger. Women whose father held a higher occupational status, as well as those belonging to a larger family, were more likely to experience sexual abuse, though in the case of the former, it is unclear whether the women were just more likely to report such abuse. The authors conclude that the numbers of maltreatment reports may be low because of the fact that discussing these issues (especially those related to sexual abuse) are culturally taboo and may, in fact, bring about severe punishment to the victim if divulged. The rates in this study were found to be higher than comparable studies of other Palestinian groups.

Hershkowitz, I., S. Fisher, et al. (2007). "Improving credibility assessment in child sexual abuse allegations: The role of the NICHD investigative interview protocol." Child Abuse & Neglect 31(2): 99.

This study explores the benefits of using the NICHD interview protocol to determine the plausibility of child sexual abuse allegations compared with investigative interviews not using the protocol. Twenty-four alleged child sexual abuse cases determined to be either "plausible" or "implausible" on the basis of independent evidence that were selected for review by 42 experienced Israeli youth investigators. The investigators were not given the validating information in the case, but were asked to determine the plausibility based on interviews with or without the use of the NICHD protocol. Results showed that investigators were more likely to rate a case, "No Judgment Possible" rather than "Credible" or "Incredible" when not using the protocol. This finding approached, but did not reach significance. Incredible allegations were difficult for investigators to determine either with or without the protocol. The researchers conclude that use of the NICHD protocol facilitates youth investigators in accurately assessing the credibility of childhood sexual abuse allegations.

Khoury-Kassabri, M. (2006). "Student victimization by educational staff in Israel." Child Abuse & Neglect 30(6): 691.

Though it is illegal to use corporal punishment in Israeli schools, the practice is widespread. The focus of past studies has concentrated on student violence rather than on children as victims of violence by authority figures. This study examines student victimization by school staff, focusing on both student- and school-level variables. A unique aspect of this study is that it investigates the interaction of social, contextual and individual variables that contribute to student victimization by school staff. Data for the study was taken from a large-scale national survey of school violence. The sample consisted of 17,465 students in 4th through 11th grades at 319 schools around Israel, one-third were each from primary, junior high and high schools. Students were administered a self-report questionnaire asking about student and staff violence and maltreatment in schools, as well as opinions on their own safety and school climate. High levels of maltreatment by school staff were reported by students. Emotional maltreatment was the most common with 30.9% of primary students, 35.0% of junior high students, and 34.5% of high school students reporting emotional abuse. Approximately 25% of primary and junior high schools students and 18% of high school students reported that they had been physically abused by school staff and 8% reported that they had been sexually abused. Data also revealed that boys, children living in poor neighborhoods, and children attending Arab schools were at a higher risk of experiencing abuse by school staff. The researcher concludes that teachers and school staff who engage in corporal punishment or other forms of abuse, often do so out of a lack of alternative skills and responses to deal with students, especially those who pose behavioral challenges. Special training and support should be provided for the positive resolution of difficult situations without submitting to violence.

JAPAN

Takei, T., H. Yamashita, et al. (2006). "The mental health of mothers of physically abused children: the relationship with children's behavioural problems report from Japan." Child Abuse Review 15(3): 204.

Though child guidance centers in Japan have informally reported the association between abused children and associated behavior problems, a controlled study describing the relationship and extent of this problem is lacking in the Japanese literature. The purpose of this study is to use well-established investigative instruments to examine the relationship between mother's mental health and child behavior in Japan. Twenty-one children who had been reported to child protective services and 14 children who had no history of abuse were compared on measures of behavior and emotional problems, maternal mental health, and demographic background. The data shows that mothers of abused children are more likely to be single parents (71% vs. 2.3% in the general population), and suffer from increased rates of psychological morbidity. The children of these mothers also exhibit higher rates of behavioral and emotional problems than does the comparison group. Because studies of this kind are lacking in Japan, in the past restricted to the abuse of infants, the authors call for further research to illuminate an understanding of the impact of child abuse in the Japanese context.

THE NETHERLANDS

Geraerts, E., H. Merckelbach, et al. (2006). "Dissociative symptoms and how they relate to fantasy proneness in women reporting repressed or recovered memories." Personality and Individual Differences 40(6): 1143.

Research shows that women who have recovered or repressed memories of childhood sexual abuse exhibit higher levels of dissociative symptoms when compared to survivors with continuous memories of the abuse or

women who have experienced no abuse. A lack of solid evidence for recovered memories and the suggestion that these memories might be vulnerable to distortion has caused a debate on whether survivors with recovered or repressed memories, in addition to experiencing higher dissociative symptoms, are also more susceptible to fantasy proneness. One hundred fourteen women were recruited to participate in this study: 16 women with repressed memories, 23 with recovered memories, 55 with continuous memories, and 20 control participants. A questionnaire with measures of childhood trauma, depression, anxiety, dissociative experiences, and creative experiences was administered. Results show that women with recovered, repressed, or continuous memories of childhood sexual abuse do not differ from one another in measures of depression, anxiety, and self-reported childhood trauma while all of these groups do exhibit higher levels of these traits when compared to women reporting no abuse. Second, while survivors with recovered or repressed memories had higher levels of dissociation, they did not differ from those with continuous memories in terms of fantasy proneness. However, all three groups (recovered, repressed, and continuous) did experience higher levels of fantasy proneness when compared to the control group.

NEW ZEALAND

Boden, J. M., L. J. Horwood, et al. (2007). "Exposure to childhood sexual and physical abuse and subsequent educational achievement outcomes." Child Abuse & Neglect 31(10): 1101.

This study aims to examine the impact of childhood sexual and physical abuse (CSA and CPA) on educational outcomes for a birth cohort of 1000 children to the age of 25. A survey administered to the cohort at ages 18 and 21 asked questions about exposure before the age of 16 to 1) sexual abuse based on a series of 15 unwanted sexual activities and 2) physical abuse based on self reports of parent's use of physical punishment. Self reported measures of school attainment were also collected as well as data on family socio-economic background, family functioning, and individual factors. Logistic regression models were used to analyze the data and to control for covariability among measures. While early models showed that increasing exposure to CSA and CPA significantly, and negatively, affected school achievement (failing to achieve secondary school requirements, a high school certificate, attending university, and obtaining a university degree), models that controlled for confounding variables failed to reach significance in these areas.

Carroll-Lind, J., J. W. Chapman, et al. (2006). "The key to the gatekeepers: Passive consent and other ethical issues surrounding the rights of children to speak on issues that concern them." Child Abuse & Neglect 30(9): 979.

As part of a national survey of children's experiences with violence, this paper explores the use of the passive consent procedures built into the study in order to address the ethical considerations of including children's direct voices in research. Rather than using active consent, whereby parents of children respondents must sign a form granting permission for their child to participate in the study, passive consent requires only those parents who do not wish their child to participate to sign and return a form *excluding* them from the study. The researchers justify this method on ethical grounds arguing that active consent precludes child participation since parents do not return consent forms for a multitude of reasons unrelated to the fact that they do not wish their child to participate in the study. This otherwise stifles children's voices who would be heard.

Fanslow, J. L., E. M. Robinson, et al. (2007). "Prevalence of child sexual abuse reported by a cross-sectional sample of New Zealand women." Child Abuse & Neglect 31(9): 935.

Part of the larger New Zealand Violence Against Women Study and the first to provide ethnic-specific data, this research investigates the prevalence of childhood sexual abuse, the frequency of such abuse, and the most common perpetrators in one urban, one rural location in New Zealand. A random sample of 2855 women ranging in age from 18-64 years old were administered a 13 domain questionnaire with retrospective questions about unwanted sexual experiences as well as demographic data. In-person interviews were collected from a sample of one randomly selected woman per household. Prevalence rates for urban women were 23.5% and 28.2% for women living in rural locations. However, rates were higher among Māori women for both urban (30.5% vs. 17%) and rural (35.1% vs. 20.7%) locations. Most of these offenses were most often perpetrated by a male family member and over half experienced the abuse more than once, usually by the same perpetrator. The data collected showed that victims of childhood sexual abuse were twice as likely to experience violence later in their lives, either by an intimate partner or others, highlighting the need for prevention and intervention strategies.

Fergusson, D. M., J. M. Boden, et al. (2006). "Examining the intergenerational transmission of violence in a New Zealand birth cohort." Child Abuse & Neglect 30(2): 89.

This study aims to examine the impact of childhood sexual and physical abuse (CSA and CPA) on educational outcomes for a birth cohort of 1000 children to the age of 25. A survey administered to the cohort at ages 18 and 21 asked questions about exposure, before the age of 16, to 1) sexual abuse based on a series of 15 unwanted sexual activities and 2) physical abuse based on self reports of parent's use of physical punishment. Self reported measures of school attainment were also collected as well as data on family socio-economic background, family functioning, and individual factors. Logistic regression models were used to analyze the data and to control for covariability among measures. Logistic regression models controlled for confounding factors such as SES, parental factors, and individual traits. Though initial models showed that increasing exposure to CSA and CPA significantly affected school achievement (failing to achieve secondary school requirements, a high school certificate, attending university, or obtaining a university degree), models that controlled for confounding variables failed to reach significance in these areas.

NORTHERN IRELAND

Benny McDaniel, K. D. (2007). "Can childhood neglect be assessed and prevented through childcare skills training?" Child Abuse Review 16(2): 120-129.

Six young mothers (aged 16-25), participated in a comprehensive parenting skills assessment and training program after being placed in a social services assessment facility due to serious concerns for the welfare of their children. All of the mothers had experienced child maltreatment and had been involved with social services since childhood. Two mothers participated in a bathing program, two in a feeding program, and two in both programs. The training program was designed to increase two basic parenting skills, bathing and feeding, and was assessed as a tool that might be used in the assessment and prevention of child neglect. Though the sample was small, the researchers determined that initial neglect by the mothers was the result of a skills deficit rather than for other reasons. For four of the mothers, this training was used and maintained and the children no longer experienced neglect in the trained areas. For two of the mothers who did not attain or maintain an adequate skill level in the trained areas, this tool may act as an early detection of longer-term difficulties that may evolve into more serious problems related to child neglect.

Bunting, L. (2007). "Dealing with a problem that doesn't exist? Professional responses to female perpetrated child sexual abuse." Child Abuse Review 16(4): 252-267.

Female sexual offending represents a small but significant percentage (approximately 5%) of child sexual abuse in the U.K. Despite its prevalence, assumptions about female sexuality and aggression can prevent professionals from identifying and intervening in cases where abuse is taking place. Researchers drew data from an electronic survey of Multi- Agency Public Protection Panels (MAPPPs) in England, Northern Ireland, and Wales which supervise the risks posed by dangerous sexual offenders in the U.K., a comprehensive literature review, and examination of relevant legislation. Results show that often, female sexual offending is disguised as child care and can be further convoluted by the fact that, in many cases, the female offender acted in conjunction with another, and may be perceived as a "coerced" victim. The researchers propose that opening an active debate over female sexual offending, developing treatment programs and therapeutic intervention for female offenders, developing national policies, and properly training professionals are some initial steps toward changing attitudes and reducing the risk of female-perpetrated child sexual abuse.

NORWAY

Gulla, K., G. E. Fenheim, et al. (2007). "Non-abused preschool children's perception of an anogenital examination." Child Abuse & Neglect 31(8): 885.

In an attempt to understand the least traumatic way for a child to experience an anogenital examination, researchers in Norway conducted a study in which non-abused pre-school children were given a full "top-to-toe" medical examination and then asked their reactions to the various parts of the examination. Children were recruited by self-selection from a town in Norway to undergo a full examination, including an anogenital exam with the use of a colposcope and microbiological swabbing. A Faces Rating Scale—five faces with emotions ranging from smiling to crying—was then used to determine children's reactions to the different parts of the examination. Parents and nurses were also asked to provide their own perceptions of the children's reactions. Results showed that a small portion of children (7.7%) rated the anogenital examination as a negative experience and

data from the parents highlighted the importance of good preparation and creating a child friendly atmosphere during the exam. This information is important for the design of examinations that are sensitive to the reaction of children, especially those who have been sexually abused.

PALESTINE

Qouta, S., R.-L. Punamaki, et al. (2007). "Predictors of psychological distress and positive resources among Palestinian adolescents: Trauma, child, and mothering characteristics." Child Abuse & Neglect 31(7): 699.

Children are especially vulnerable to the effects of war, especially when they have witnessed atrocities or have been coerced into military activity themselves. This study examines how a child's exposure to traumatic stress (in this case, military violence and stressful events in Palestine during the First Intifada), individual characteristics, ability to cope with stress, and quality of mothering can affect a child's mental health in adolescence. Sixty-five adolescents who had been exposed to military violence in Gaza were tested for military trauma, intelligence, cognitive capacity, neuroticism, and active coping at time 1 (during the First Intifada.) They were tested again at time 2 (during the relative calm of the Palestinian Authority rule) for stressful life-events and mother's disciplining style. Finally they were tested at time 3 (during the Second Intifada) for psychological distress, resilient attitudes, and satisfaction with quality of life, as well as demographic factors that were unable to be collected during time 1. Analysis of the data shows that exposure to military violence and stressful life events were the sole predictors of increased depressive symptoms and low quality of life reports in this sample of adolescents. Child characteristics such as cognitive ability and neuroticism contributed to explanations of Post Traumatic Stress. While this study reveals that some children show remarkable resilience within this context, it may be difficult for others to defend against the negative effects of violent life events during critical developmental phases in their lives.

PORTUGAL

Machado, C., M. Goncalves, et al. (2007). "Child and partner abuse: Self-reported prevalence and attitudes in the north of Portugal." Child Abuse & Neglect 31(6): 657.

Research on the prevalence of family violence in Portugal is lacking, and where it does exist, the methods used are not robust and include small or non-representative samples. This study aims to fill this information gap with a representative, self-report study on the prevalence of and attitudes toward child and domestic physical abuse. A questionnaire was administered to 2,391 parents from two-parent households with children under the age of 18. Questions on the prevalence of abuse and attitudes toward abuse were investigated separately for domestic and child abuse. For child abuse, parents were administered the Inventory of Educational Practices on 29 forms of disciplinary strategies used by parents and then were given the Scale of Belief about Physical Punishment to determine parental attitudes toward a range of physical disciplinary actions. Participants were also issued the Marital Violence Inventory investigating 21 acts of violence used toward their partner and the Scale of Beliefs about Marital Violence that measures the degree of support for various forms of domestic violence and the factors that justify such actions. Twenty-six percent of respondents reported using some form of physical or emotional abuse against their children in the past year, 12.3% reporting the use of physical violence while approximately 70% of respondents reported that they either strongly or moderately disagreed with the use of physical punishment. The numbers for domestic violence were similar—26% of respondents reported that they had used some form of emotional or physical abuse against their partner in the past year, 12.1% of these reporting physical abuse, while about 67% of respondents either strongly or moderately disagreed with partner violence. Respondents who used physical or emotional punishment with their children or a domestic partner were also more likely to hold attitudes legitimizing its use.

SCOTLAND

Kay, H., A. Kendrick, I. Stevens, and J. Davidson (2007). "Safer recruitment? Protecting children, improving practice in residential child care." Child Abuse Review 16(4): 223-226.

A two stage study was conducted in the wake of a number of high-profile child abuse cases in residential care facilities and the subsequent country-wide launch of the Toolkit for Safer Recruitment Practice in Scotland. First, the researchers sent a postal survey to operational and human resource managers responsible for recruitment of staff in local authorities and voluntary organizations around the country about their knowledge and use of the Toolkit. Based on information gleaned in these surveys, a variety of organizations were selected to participate in in-depth interviews that focused, in detail, on specific aspects of the Toolkit. Findings from the surveys and interviews reveal that all of the local authorities reported being aware of the Toolkit, while only two-thirds of the

voluntary organizations knew about it. Further, while some local authorities referred to its contents and implemented some of the procedures outlined, voluntary organizations did less so, neither group referring to its recruitment procedures in any systematic fashion. Improved recruitment and selection of residential care staff is one possible way to have a positive impact on child abuse, however, the cause of maltreatment of children within these facilities is multidimensional and institutions prioritize their focus based on their own procedures and culture. It is important to train human resource departments and monitor staff if one hopes to reduce the incidence of child abuse in residential care facilities.

SOUTH AFRICA

Liang, H., A. J. Flisher, et al. (2007). "Bullying, violence, and risk behavior in South African school students." Child Abuse & Neglect 31(2): 161.

The first study of its kind in South Africa, this research attempts to fill a lack of quantitative studies on the topic of bullying in developing countries. This study aims to report the prevalence of bullying behavior in South Africa, differentiating between bullies, bully-victims, and victims on measures of violence, antisocial, and risk-taking behavior. Data was drawn from a larger study—the South African Community Epidemiological Network on Drug Use (SACENDU) which examined the health and risk-taking behaviors of South African adolescents in Durban and Cape Town, South Africa. A sample of 5,074 adolescent school children in grades 8 and 11 at 72 schools was used for this analysis. Results show that 36.3% of all students are involved in bullying either as perpetrators (8.2%), victim-perpetrators (8.7%), or victims (19.3%). Male adolescents were more likely to be involved in bullying and younger boys were more likely to be victimized. Bullies were more likely to use alcohol and engage in violent, risk-taking, and anti-social behaviors than the control. Victims and bully-victims also tended to exhibit higher levels of violent and anti-social behaviors with the later group showing a tendency for greater suicidal ideation. These results are similar to those found in Western countries. Teachers, parents, and practitioners should be aware that bullying can be an indicator of violent, anti-social, and risk-seeking behaviors and may be used to develop prevention and intervention strategies among this population of children.

SPAIN

Gracia, E. and J. Herrero (2006). "Perceived neighborhood social disorder and residents' attitudes toward reporting child physical abuse." Child Abuse & Neglect 30(4): 357.

This study examines the effect of perceived neighborhood social disorder on attitudes toward reporting childhood physical abuse. While reporting child abuse might be seen as one way of exerting social control, residents inhabiting a neighborhood which is characterized by social disorder may fear retaliation or feel powerless, thereby reducing the probability that they would report cases of child abuse. A probabilistic sample of 9,759 Spanish residents were asked questions in in-person interviews about their perceptions of neighborhood social disorder, the frequency of child physical abuse, and whether they were willing to report such child maltreatment to police. This study confirmed that residents living in communities where there is low to medium levels of perceived social disorder are twice as likely to report child physical abuse than those living in a community with high perceived levels of social disorder. The research suggests that disadvantage and disorder in these communities needs to be targeted in order to enhance their capacity to address child abuse.

Matud, M. P. (2007). "Domestic Abuse and Children's Health in the Canary Islands, Spain." European Psychologist 12(1): 45.

Only recently has research in Spain focused on the relationship between domestic violence and children's health. This is an exploratory study examining the health of children residing in homes where women are subject to abuse by their intimate partners, paying particular attention to the differences among children who are only witnesses to the abuse and those children who experience abuse themselves. The sample was drawn from women in the Canary Islands who were taking advantage of women's assistance and information centers and had at least one child. Approximately 40% of these women were still living with the perpetrator of the abuse while the rest were in various states of separation (in shelters, divorcing, separated, or in the process of separation.) Four hundred twenty women were interviewed about their experiences with domestic violence as well as the type, extent, and frequency of abuse of their children; questions related to physical and psychological abuse of themselves and their children; and questions related to their mental health and self-esteem. Results show that 55% of women reported that the perpetrator who abused them also the abused their children while 65% of the women interviewed said they, themselves, were not violent with their children. One third of the time, child abuse was reported to occur daily or frequently. About one third of mothers reported that they had one or more children

who had mental health problems, 13.6% reported physical health problems, and 7.6% reported both mental and physical health problems. It seemed that having a young mother who had suffered fewer years of abuse and had fewer children served as a protective factor for children in the sample.

Rodrigo, M. J., M. L. Maiquez, et al. (2006). "Outcome evaluation of a community center-based program for mothers at high psychosocial risk." Child Abuse & Neglect 30(9): 1049.

In the late 1990's the government of the Canary Islands, Spain, enacted a law that would reduce the number of children placed in foster care by developing community-based programs that support families and parenting. This paper reports an outcomes evaluation of one of these community-based programs. One hundred eighty-five mothers who had been referred to social services in Tenerife, Spain participated in the program Apoyo Personal y Familiar (APF) and 155 women served as the control group. The women participating in the APF program had little education, a history of poor parenting, and were living in families with multiple problems. The program was designed to help parents build awareness of the consequences of their parenting styles and to help them build the competencies that are needed to foster good parenting skills. Five modules are presented in the program: organizing family life, coping with children who have problems, parenting in challenging circumstances (single parenthood, substance abuse, unemployment, with a special needs child), communication and problem solving, and coping responses to difficult situations. During the evaluation of the program mothers were administered a questionnaire asking about their knowledge of child education and development, personal agency, and child rearing practices. Mothers participating in the program filled out pre- and post-test evaluations while the control filled out post-test evaluations only. The evaluation reported that mothers who had completed the APF program significantly reduced their use of negative child rearing practices, instead reporting an increase in explanations of rules and showing more confidence in their children. Levels of self-efficacy and internal control, especially among mothers with lower education levels, were also increased. The evaluation concluded that the program was effective at changing mothers' levels of self-competency and moderately good at changing negative beliefs about child development.

SUDAN

Plummer, M. L., M. Kudrati, et al. (2007). "Beginning street life: Factors contributing to children working and living on the streets of Khartoum, Sudan." Children and Youth Services Review 29(12): 1520.

The small amount of research that has been conducted on street children in Sudan has consisted of small, qualitative studies with children who are full-time residents of the street. This is the first study to examine, not only "street children"—those who live on the street full-time—but also "working children" who spend time in money-making activities in the street but return to a home environment at the end of the day. Thirteen adult and 11 child researchers interviewed 500 working and street children in focus groups and individual interviews and approximately 1,600 street- and working-children in a street-based survey on how they came to work/live on the street and the attractions of street life. Forty-three percent of "street" boys (n=397) reported leaving home because of a disagreement with their family, 27% reported that they had been physically abused, and 18% reported that their family had thrown them out (less than 1% reported sexual abuse.) While the population of "street" girls surveyed was very small (n=35), they also reported disagreement with their family (54%), physical abuse (40%), being thrown out of their home (17%), and sexual abuse (3%) as reasons for leaving home. Working children were not asked questions related to abuse or neglect. The reasons that children end up on the streets are multiple and complex, including "push" factors (abuse, poverty, and displacement), and "pull" factors such as social networks and a desire for nice things. "Street" children tended to have fewer social resources and had experienced more hardship than their "working" counterparts but both groups of children are in desperate need of health and safety services, counseling and re-integration programs, and might benefit from community-based prevention strategies.

SWEDEN

Cederborg, A.-C. and M. E. Lamb (2006). "How does the legal system respond when children with learning difficulties are victimized?" Child Abuse & Neglect 30(5): 537.

The focus of this study is to investigate how the Swedish legal system treats mentally handicapped children in cases where they have allegedly been victimized. Thirty-nine cases involving mentally handicapped children (25 girls and 14 boys) who had been victimized, and their cases brought to trial, were included in this study. Court files were carefully examined for reference to the defendant's disability with special attention paid to any

commentary about the defendant's behavior and credibility while giving their testimony. The transcripts of the cases, court files, and expert testimony were then coded and compared for similarities and differences among the courts. Case analysis showed that children who are handicapped or have other learning difficulties are expected to provide as rigorous and credible a testimony as children with no such challenge. In many of these instances, expert reports were not available or inadequately addressed the particular challenges faced by the child in providing testimony and the court was left to rely on its own limited knowledge to evaluate the credibility of the witness. The study concludes that the use of assessments in court prepared by capable and expert health professionals would strengthen the testimony of these vulnerable witnesses.

Jonzon, E. and F. Lindblad (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.

The purpose of this study is to investigate the risk and protective factors that contribute to or deplete the health of adult survivors of childhood sexual abuse (CSA.) A questionnaire with measures on risk factors (child sexual abuse, child physical abuse, and negative life events) and protective factors (social support, coping, and self-esteem) was given to 152 women who had been sexually abused. The study found that positive outcomes were possible, even in groups of women who had been severely abused. Two resilient sub-groups within the sample of those who had been severely abused included survivors with good coping skills and those who received high levels of social support. Both of these sub-groups exhibited higher levels of health when compared with those groups who had poor coping skills, low social support, and scarce resources. However, the study also found that not all protective factors worked the same way for different groups of survivors. For instance, those resilient individuals who received high levels of social support also had low levels of self esteem, suggesting that while self-esteem can contribute to wellbeing in some survivors of sexual abuse, it represents only one element in a complex set of variables that contribute to healing.

TANZANIA

McCrann, D., K. Lalor, et al. (2006). "Childhood sexual abuse among university students in Tanzania." Child Abuse & Neglect 30(12): 1343.

To address the paucity of data on sexual abuse in sub-Saharan Africa, this study investigates the prevalence and nature of childhood sexual abuse (CSA) among Tanzanian University students. In Tanzania, studies on CSA are needed to fill in gaps in knowledge and to combat myths and rumors. Two hundred eighty-two male and 204 female students were administered a survey developed by Lisak and Luster and adapted for the Tanzanian context. Information related to early sexual experiences, type, extent, and duration of sexual abuse, as well as information about the perpetrator, level of coercion, and demographic information was collected. Twenty seven percent of respondents (31% of females and 25% of males) reported experiencing sexual abuse before the age of 18 (average age 13.6 years), with the percentage of unwanted sexual intercourse reported at 11.2% for females and 8.8% for males. The vast majority of respondents knew their perpetrator. Respondents also reported a large number of female perpetrators of CSA and high levels of coercion or force used in the abuse. Respondents identified poverty (as an impetus for engaging in transactional sex) and superstition (sleeping with a virgin or younger people as a way to avoid HIV infection) as two common explanations for the abuse.

TURKEY

Alikasifoglu, M., E. Erginoz, et al. (2006). "Sexual abuse among female high school students in Istanbul, Turkey." Child Abuse & Neglect 30(3): 247.

The first school-based study on the prevalence of sexual abuse among children and adolescents in Turkey, this report draws from a self-reported population survey of health and health behaviors among adolescents in 26 randomly selected high schools in Istanbul, Turkey. The survey collected information from 1,955 female students in grades 9-11 who were asked 4 questions as part of the present study: two to determine whether the respondent had experienced sexual abuse and two that determined the respondent's relationship to the perpetrator. The research concluded that 13.4% of students responding to the survey reported experiencing sexual abuse; 11.3% experienced unwanted touching of their private parts; 4.9% reported forced sexual intercourse; 3% reported experiencing both unwanted touching and forced sexual intercourse; and 1.4% reported that they were the victims of incest.

Orhon, F. S., B. Ulukol, et al. (2006). "Attitudes of Turkish parents, pediatric residents, and medical students toward child disciplinary practices." Child Abuse & Neglect 30(10): 1081.

Child abuse, neglect, and maltreatment are new topics in Turkish society, with low levels of awareness among the public and professional communities. Consequently, studies on the prevalence and impact of child maltreatment are few, though the studies that do exist report that about one third of children have been abused. This study aims to understand attitudes about child discipline in relation to respondents own history of child maltreatment and their attitudes about the types of child discipline that should be reported to authorities as abuse. A sample of parents, medical students, and pediatric residents in Ankara, Turkey were administered the Survey of Standards of Discipline translated into Turkish. A severity scale was developed to evaluate the seriousness of accepted physical and verbal disciplinary actions with higher scores representing acceptance of more severe acts of discipline. Analysis of the data showed that 69.2% of parents, 64.1% of residents, and 65.1% of medical students reported having been abused as children. This was associated with higher severity scores in the sample of residents and medical students. A total of 43.3% of respondents (40.0% of parents, 56% of residents, and 56.5% of medical students) reported that beating a child was an acceptable form of discipline, and while many corporal disciplinary measures were also widely accepted, acts that would be considered life-threatening were not accepted by any of the respondents as a form of acceptable discipline. The severity scores of parents were lower than those of the residents or medical students and parents with two children had lower scores than those with one child. Appropriate educational programs must be developed for medical professionals and others to raise awareness of child abuse and its impact on children.

UKRAINE

Kerfoot, M., V. Koshyl, et al. (2007). "The health and well-being of neglected, abused and exploited children: The Kyiv Street Children Project." Child Abuse & Neglect 31(1): 27.

Street children have historically been an elusive population at risk of a multitude of health and psychological issues that can lead to negative outcomes later in life. This study explores the backgrounds and physical and emotional health in a sample population of 97 street children who were in contact with two street shelters in Kyiv, Ukraine. The Kyiv Safe Street Interview Schedule was developed for this study and included questions about how the child came to be homeless or living on the street; social life; education history; family structure, background, and history; and other questions related to personal and social difficulties. In addition, the Strength and Difficulties Questionnaire and the Mood and Feelings Questionnaire were also administered to the children. Findings indicated that these children experienced a series of cumulative developmental disturbances including the abandonment by or death of a parent, abuse, poverty, and criminality that seriously impacted the children's trajectory. Children were also found to be in poorer physical and mental health than children in the general population but showed similar profiles to children from a British study of children living in residential facilities and to profiles of street children in Latin America. Outcomes were partially explained by the homeless status of the children: "connected children," who still slept at home but spent most of their wakeful hours on the street, "partially connected children," who occasionally stayed at home but would often spend long periods away from home, and "disconnected children," who spent all of their time on the streets. Researchers suggest that these profiles may be useful in developing service strategies for this population of children.

UNITED KINGDOM

Bull, L. (2007). "A study of Accident and Emergency department attendances by infants under 1 in London: An epidemiological study." Journal of Neonatal Nursing 13(1): 19.

An examination of Accident and Emergency department visits by children under 1 year old was conducted to determine common reasons for such visits. In a sample of 3423 visits over a two year period, the researchers found that the vast majority (91%) were illness-related while 298 (9 %) were related to accidental injury and 2 to non-accidental injury. The researchers recommend that health care professionals (in the A & E department as well as general practitioners, midwives, and nurses) be trained to help parents understand child safety measures and to provide practical advice to lower rates of accidental injury. Professionals should also understand reporting requirements and safety measures for children who have been injured purposefully by a parent or guardian. Parents, for their part need to be educated on the proper use of A & E department visits so that these departments are used only in case of urgency and not out of convenience.

Collishaw, S., A. Pickles, et al. (2007). "Resilience to adult psychopathology following childhood maltreatment: Evidence from a community sample." Child Abuse & Neglect 31(3): 211.

Drawing on data collected during the research subjects' adolescence (14-15 years) and mid-life (44-45 years), this study examines the effects of child abuse on the manifestation of mental health problems in adulthood. Data in the study are taken from the Isle of Wight Study which interviewed adolescents and their parents about a range of socio-economic variables, psychopathology, peer relationships, and family functioning. A follow-up study using the same respondents was modeled after the original study and included questions on retrospective childhood sexual and physical abuse, adult psychopathology, childhood experience of their parents, self-rated health, adult illegal activities, history and quality of relationships, and personality assessments. Approximately 10% of respondents reported having experienced physical or sexual abuse in childhood while about 8% reported severe or repeated physical or sexual abuse. Of those reporting abuse, a substantial percentage (around 45%) reported no psychopathology over their adult lives and were considered "resilient" by the researchers. This resiliency was attributed to parental care, peer relationships in adolescence, personality, and the quality of adult relationships.

Craig, L. A., K. D. Browne, et al. (2008). "Sexual reconviction rates in the United Kingdom and actuarial risk estimates." Child Abuse & Neglect 32(1): 121.

A literature review was conducted to compare the power of clinical and actuarial approaches to predict further sexual offending among sexual perpetrators in the U.K. Data from these studies was compiled and analyzed using actuarial risk estimates and then compared to estimates of sexual reconviction rates in North America and Europe. The authors argue that while clinical models rely heavily on the clinician's own judgment based on past experience with offending behavior, actuarial models have the potential to be less subjective by drawing on a set of risk factors. Each approach has limitations and further research would benefit from testing the two in similar situations. In the second part of the study, the authors conduct an analysis of the "base rate" for reconviction among a sample population of sexual offenders in the U.K. using an actuarial model. The study compared the reconviction rates for a sample of incarcerated sex offenders and a sample of non-incarcerated offenders. Results showed that incarcerated offenders had higher rates of reconviction than the non-incarcerated sample and overall reconviction rates were 5.8% at the 2 year follow up and 17.5% after 6 or more years. This is similar to studies conducted of sexual offenders in North America and Europe.

Craissati, J. and A. Beech (2006). "The role of key developmental variables in identifying sex offenders likely to fail in the community: An enhanced risk prediction model." Child Abuse & Neglect 30(4): 327.

Prior studies on community integration of sex offenders have tended to focus either (a) on developmental variables that form the foundation for creating pathways or typologies, or (b) on the contribution of childhood sexual abuse. By analyzing data collected by the Challenge Project, this paper concludes that incorporating key developmental variables (childhood experiences of sexual, emotional and/ or physical abuse and neglect, childhood emotional/behavioral difficulties, and insecure attachments to primary caregivers) with static risk prediction variables is the best way of modeling the risk of whether a sexual offender will integrate within their community.

Jaffee, S. R., A. Caspi, et al. (2007). "Individual, family, and neighborhood factors distinguish resilient from non-resilient maltreated children: A cumulative stressors model." Child Abuse & Neglect 31(3): 231.

Despite growing up in families that are characterized by a multitude of problems such as poverty, drug abuse, domestic violence, and dangerous neighborhood conditions, some maltreated children exhibit a resiliency that allows them to function similar to children who have not been maltreated. This study examines multiple ecological and individual factors that contribute to child resiliency over time. For the purposes of this study, resilient children are defined as those who had been physically abused before the age of 5 years and who, according to teacher reports, exhibited the same levels of anti-social behavior as children of the same age and sex who had not been abused. A sample was drawn from the Environmental Risk Longitudinal Study, a nationally representative sample of twin pairs and their families in England and Wales. Home visits were conducted when the children were 5 and 7 years old and teachers were questioned about the child's behavior at school. Individual measures (cognitive ability and behavior), family measures (maternal warmth, social deprivation, mother's depressive symptoms, parental history of anti-social behavior, drug and alcohol problems, domestic violence, and sibling warmth), and neighborhood measures (crime, informal social control, social cohesion) were analyzed using multinomial logistic regression analysis. Results showed that children who belonged to families free from substance abuse problems and who lived in low-crime, socially cohesive neighborhoods were more resilient to maltreatment compared with those children who lived in contexts of multiple family and neighborhood stressors. For the latter children, individual factors that would have protected them in a lower stress context, ceased to provide a protective function

when multiple stressors were present.

Jonathan, D. (2007). "Child neglect and the law: catapults, thresholds and Delay." Child Abuse Review 16(2): 77-92.

This paper explores the fundamental professional differences between social work and law in cases of child neglect serious enough to be brought to trial. For a child neglect case to be brought to trial, certain "threshold criteria" must be met. A child must be suffering, or at risk of suffering, significant harm—which centers on the child's health and development, rather than a particular neglectful or abusive incident. However, both the fields of law and social work tend to concentrate on a particular dramatic event, or what this paper refers to as a "catapult," that can justify removing children from the home and bringing a case to trial. Forty-six interviews were conducted on the professional relationship between lawyers and social workers in child neglect case proceedings. Twenty-three pairs of lawyers and social workers described the conflicts and tensions that result when working together on these cases, revealing underlying professional tensions—social workers must work to comply with nuanced policy recommendations to preserve family autonomy and protect children, while lawyers require rigorous, decisive, and well-documented evidence to be able to prove their case in court. Ultimately, the tensions that lie between these two professions can also be to their benefit in severe cases of child neglect and should be recognized as such.

Lewin, D. and H. Herron (2007). "Signs, symptoms and risk factors: health visitors' perspectives of child neglect." Child Abuse Review 16(2): 93-107.

Based on the perceptions of experienced child protection health visitors working in East Anglia, U.K., this study examines the degree to which child protection practitioners agree about the relative importance of 45 signs, symptoms, and risk factors contributing to child neglect. Ninety two health visitors with child protection experience responded to a questionnaire sent to them through the mail asking them to rank a set of 45 risk factors that contribute to child neglect. These factors were grouped into four main categories: parent behavior toward the child, child characteristics, parent characteristics, and environmental characteristics. The top ten items were: violence to the child, child exclusion by the family, child left unattended or left to care for other children, violence within the home, an atmosphere of high criticism and little warmth, evidence of human or animal excrement, an unsafe environment, little or no food, a family history of child abuse or poor parenting, and unmet medical needs. For the top ranked factors of concern, there was a high degree of professional agreement shown by small measures of variability among respondents. And while the items of poverty, animals present, and unemployment ranked toward the bottom of the list, there was a higher degree of variability among respondents.

Salmon, P., J. Hill, et al. (2006). "The role of child abuse and age in vulnerability to emotional problems after surgery for breast cancer." European Journal of Cancer 42(15): 2517.

While emotional problems are common in women who have undergone surgery for breast cancer, some women exhibit more severe reactions including clinical anxiety, depression, or post-traumatic stress disorder. There is some evidence that stressful life events can have an impact on responses to breast cancer surgery and this study seeks to explore the impact that a history of child abuse has on post-operative reactions to breast cancer surgery. Two to four days after their surgery, 355 women were administered self-report questionnaires asking about emotional distress, post-traumatic stress, and retrospective reporting on child sexual, physical, and emotional abuse. Older women, especially those over 65 year of age, were less likely to recall abuse than younger women. Ten percent of women reported sexual abuse, 28% reported physical abuse, and 25% reported emotional abuse. Statistical analysis of the data revealed that recall of sexual and emotional abuse was associated with emotional distress while recall of physical and emotional abuse was associated with post-traumatic stress in this sample. Older women experienced less post-traumatic stress, bodily shame, and blamed themselves less often. The study urges those providing support for women undergoing breast cancer surgery to be aware that a patient's history of childhood abuse can effect their emotional responses.

Sidebotham, P. and J. Heron (2006). "Child maltreatment in the "children of the nineties": A cohort study of risk factors." Child Abuse & Neglect 30(5): 497.

Drawing on Belsky's ecological framework of child maltreatment, this study tests Belsky's four-domain model in a sample of children in the U.K.. Belsky's model investigates the impact and interactions of 1) parental background, 2) socio-economic environment, 3) family structure and 3) the children themselves. Data was collected the Avon Longitudinal Study of Parents and Children (ALSPAC), a large-scale survey that gathered information on a birth cohort of children born between April 1991 and the end of December 1992. Children within the cohort who had been investigated by child protective services or placed on the child protection registry before their 6th birthday

were identified by social services. Variables related to parental medical, social, and environmental background; indicators of material deprivation; family environment including birth order, domestic violence, and presence of step-siblings; and birth weight, gender, and early child temperament were analyzed. Young parents, parents with low educational achievement, and parents with a history of child abuse or psychiatric problems were more likely to have a child investigated or placed on the register by child protective services. While poverty, unstable family life, poor social networks, and low birth weight increase the odds of having a child investigated or recorded by protective services, maternal employment seems to have a slight protective effect.

Speight, N. (2006). "Child abuse." Current Paediatrics 16(2): 100.

This article reviews the history of child protection and examines the processes paediatricians use to diagnose, manage, and confront the challenges of determining non-accidental injuries. Procedures that should be followed in cases of suspected child abuse and in cases of uncertainty are outlined. The importance of mobilizing professional support and protection for the paediatritians involved in child protective work are emphasized in light of high-profile cases where the reputation and careers of senior paediatricians were threatened.

ZAMBIA

Slonim-Nevo, V. and L. Mukuka (2007). "Child abuse and AIDS-related knowledge, attitudes and behavior among adolescents in Zambia." Child Abuse & Neglect 31(2): 143.

Large-scale empirically-based studies on rates of child abuse and neglect in sub-Saharan Africa are not available. Where information does exist, it is generally uses small sample-sizes or is focused on South Africa. The purpose of this study is to understand child and adolescent physical and sexual abuse among a population of Zambian adolescents while taking into account school, socioeconomic, and demographic variables. A sample of 3,360 adolescents from 10-19 years of age were recruited for the study, roughly one third of them did not attend school. Adolescents in the study were asked questions to determine their knowledge and attitudes about AIDS, their ability to protect themselves from infection, risk-seeking behaviors that would expose them to HIV, as well as questions related to the prevalence of physical and sexual abuse experienced in the family context. Twenty-three percent of adolescents reported having been physically abused and less than 10% reported sexual abuse. Results of regression analysis show that abuse by a family member was associated with an increase in high-risk behaviors associated with HIV infection. In addition, as levels of abuse increase, knowledge about HIV/AIDS and positive attitudes toward prevention, as well as implementing measures to protect oneself from HIV, diminishes. Future studies on mediating the effects of childhood sexual and physical abuse in sub-Saharan Africa are needed.

Appendix A

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Appendix B

ISPCAN Survey

ISPCAN 'S WORLD PERSPECTIVES ON CHILD ABUSE
EIGHTH EDITION (2008)

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: _____teaching social workers_____

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. Based on population surveys, your perceptions or the perceptions of those working with child abuse victims and their families, 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

3 (a) **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?

Factors	Please indicate the correct response.			
	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. Based on your interpretation of public opinion polls and other indicators of public attitudes and beliefs, how aware is the **general public** in your country about the following issues?

Issue	Please indicate 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

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

Issue	Please indicate 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

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

Factors	Please indicate 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

7. 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 is only part of the official police crime statistic
___ 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 indicate 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.

Types of Cases	Please check the correct box		
	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:
_____
_____

8. 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

9. Does your country have an identified government agency (or agencies) at the national, state or local levels that are responsible for responding to cases of child abuse and neglect?

___ YES
___ NO

10. Does your country have national laws or laws implemented at the state/territorial level 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 were such laws or policies first established?

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

b. Since these laws or policies were originally adopted, how many times have they been revised (e.g., had new components added or altered the reporting mechanism, provided substantial new funding, etc.)?

___ Law/policies are regularly updated on an annual basis
___ Law/policies have had some revisions but not annually
___ Law/policies have remained essentially unchanged
___ Do not know

c. In the table below, please indicate which, if any, of the following elements are specified in these laws or policies.

Law/Policy	Please indicate 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 SOME 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. Are these laws or policies currently being enforced?
   ____ They are widely enforced.
   ____ They are inconsistently enforced.
   ____ They are never or almost never enforced.
   ____ Do not know

e. Are government resources provided to implement these laws or policies?
   ____ Government provides adequate annual support.
   ____ Government provides annual support but not enough to fully implement the policies.
   ____ Government support is inconsistent.
   ____ 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

11. 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

12. 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 indicate 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	YESx	NO	1	2	
Universal access to free medical care for all citizens	YES	NO	1	2	3x

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

Agency Type	Please indicate 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

14. 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 indicate 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

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

Issue	Please indicate 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

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

Strategy	Please indicate correct response		
	Strategy NOT used in country	Strategy used BUT not effective	Strategy used AND 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

17. 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 indicate 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 N0	1	2	3
ISPCAN-sponsored Regional Conferences	YES NO			
The LINK: ISPCAN Newsletter	YES N0	1	2	3
ITPI training project	YES N0	1	2	3
Other ISPCAN training efforts	YES N0	1	2	3
Developing Countries Scholarships	YES NO	1	2	3
ISPCAN List serv	YES N0	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 N0	1	2	3
Informal networking/ links to other professionals	YES NO	1	2	3

18. 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.	

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

Appendix C

Country Specific Profiles

AFGHANISTAN

Region: 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:

- Case management/meeting basic needs
- Home-base services intended to assist parents in changing their behaviors
- Financial and other material support available
- Short-term hospitalization for mental illnesses
- Access to free medical care for children
- 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

- Reports investigated within a specific time period
- All victims receive some form of service or intervention
- Support for specific prevention services
- Separate attorney assigned to represent child

Enforcement Level: Inconsistently enforced

Level of Government Support: Annual support but an inefficient amount

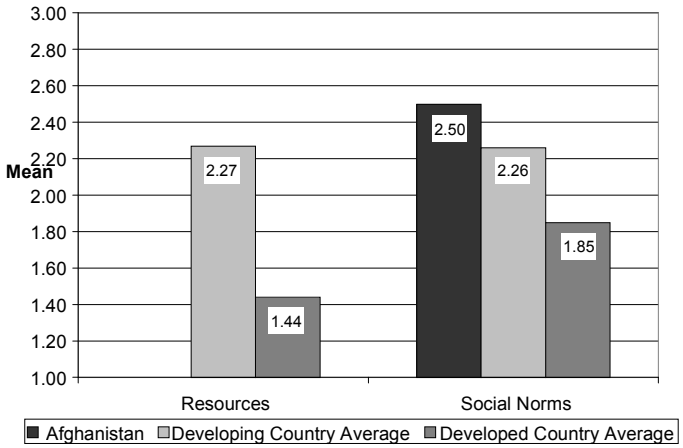
SERVICE PROVIDERS

Level of involvement in child abuse treatment and prevention services.

	None	Minimal	Moderate	Very
Hospital/Medical			◆	
Mental Health Agencies				
Businesses/ Factories	◆			
Schools		◆		
Social Service Agencies			◆	
Community-based NGOs			◆	
Religious		◆		
Voluntary Civic Organizations				
Courts/Law			◆	
Universities	◆			

BARRIERS

Average rating of limiting factors to CAN prevention,
(List several factors?)
(Scale: 1="Not important " to 3="Very significant")


3.00
2.80
2.60
2.40
2.20
2.00
1.80
1.60
1.40
1.20
1.00
Mean
2.27
1.44
2.50
2.26
1.85
Resources
Social Norms
Afghanistan
Developing Country Average
Developed Country Average

ARGENTINA

Region: Americas

Previous World Perspectives surveys completed: 1996, 1998, 2000, 2002, 2004, 2006

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 child abusers
- Therapy programs available for child victims of physical abuse
- Therapy programs available for child victims of sexual abuse
- Home-base services intended to assist parents in changing their behaviors
- Foster care with official foster parents
- Group homes for abused children
- Short-term hospitalization for mental illnesses
- Substance abuse related treatments for parents
- Family Resource Centers available to parents
- Universal home-visits for new parents
- Targeted home-visits for new parents at-risk

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

- Case management/meeting basic needs
- Institutional care available for abused children
- Substance abuse related treatments for children

Adequate in more than ***2/3*** of Country

- Universal health screening for children
- Access to free medical care for children
- 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
- Separate attorney assigned to represent child

Enforcement Level: Almost never enforced

Level of Government Support: Inconsistent

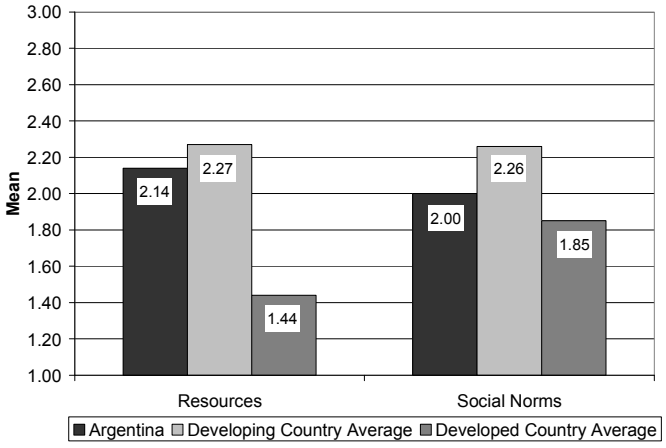
SERVICE PROVIDERS

Level of involvement in child abuse treatment and prevention services.

	None	Minimal	Moderate	Very
Hospital/Medical		◆		
Mental Health Agencies		◆		
Businesses/ Factories	◆			
Schools		◆		
Social Service Agencies	◆			
Community-based NGOs				◆
Religious		◆		
Voluntary Civic Organizations		◆		
Courts/Law		◆		
Universities			◆	

BARRIERS

Average rating of limiting factors to CAN prevention,
(List several factors?)
(Scale: 1="Not important " to 3="Very significant")



ARMENIA

Region: Western Asia

Previous World Perspectives surveys completed: 2004, 2006

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 available for child victims of physical abuse
- Therapy programs available for child victims of sexual abuse
- Foster care with official foster parents
- Institutional care available for abused children
- Financial and other material support available
- Short-term hospitalization for mental illnesses
- Family Resource Centers available to parents

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

- Universal home-visits for new parents
- Available free child care
- Universal health screening for children
- Access to free medical care for children
- 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
- Specific criminal penalties
- All victims receive some form of service or intervention

Enforcement Level: Inconsistently enforced

Level of Government Support: Inconsistent

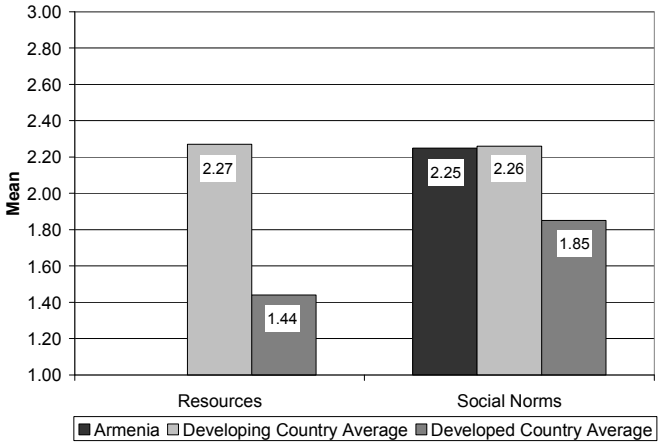
SERVICE PROVIDERS

Level of involvement in child abuse treatment and prevention services.

	None	Minimal	Moderate	Very
Hospital/Medical		◆		
Mental Health Agencies			◆	
Businesses/ Factories	◆			
Schools			◆	
Social Service Agencies			◆	
Community-based NGOs				◆
Religious		◆		
Voluntary Civic Organizations			◆	
Courts/Law		◆		
Universities		◆		

BARRIERS

Average rating of limiting factors to CAN prevention,
(List several factors?)
(Scale: 1="Not important " to 3="Very significant")



AUSTRALIA

Region: Oceania

Previous World Perspectives surveys completed:
1992, 1996, 1998, 2000, 2002, 2004, 2006

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 child abusers
- Foster care with official foster parents
- Group homes for abused children
- Short-term hospitalization for mental illnesses
- Substance abuse related treatments for children
- Targeted home-visits for new parents at-risk

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

- Therapy programs available for child victims of physical abuse
- Therapy programs available for child victims of sexual abuse
- Home-base services intended to assist parents in changing their behaviors
- Financial and other material support available
- Substance abuse related treatments for parents
- Family Resource Centers available to parents
- Universal home-visits for new parents
- Available free child care
- Universal health screening for children
- Case management/meeting basic needs

Adequate in more than ***2/3*** of Country

- Universal access to free medical care for all citizens
- Access to free medical care for 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
- Voluntary reporting of suspected abuse
- Reports investigated within a specific time period
- Remove abused child from abusive parents
- Separate attorney assigned to represent child

Enforcement Level: Widely enforced

Level of Government Support: Adequately supported

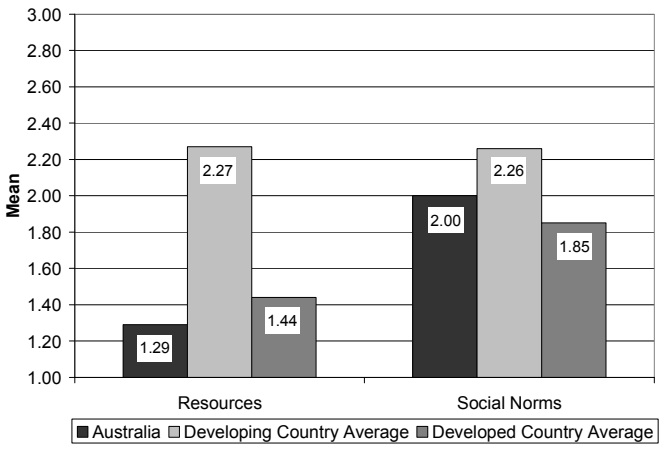
SERVICE PROVIDERS

Level of involvement in child abuse treatment and prevention services.

	None	Minimal	Moderate	Very
Hospital/Medical		◆		
Mental Health Agencies		◆		
Businesses/ Factories	◆			
Schools			◆	
Social Service Agencies				◆
Community-based NGOs				◆
Religious			◆	
Voluntary Civic Organizations			◆	
Courts/Law			◆	
Universities		◆		

BARRIERS

Average rating of limiting factors to CAN prevention,
(List several factors?)
(Scale: 1="Not important " to 3="Very significant")



BAHRAIN

Region: Western Asia

Previous World Perspectives surveys completed: 2002, 2004, 2006

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 available for child victims of physical abuse
- Substance abuse related treatments for parents
- Substance abuse related treatments for children
- Universal health screening for children

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

- Therapy programs available for child victims of sexual abuse
- Case management/meeting basic needs

Adequate in more than ***2/3*** of Country

- Short-term hospitalization for mental illnesses
- Access to free medical care for children
- 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 abuse
- Remove abused child from abusive parents
- Specific criminal penalties
- All victims receive some form of service or intervention

Enforcement Level: Inconsistently enforced

Level of Government Support: Annual support but an inefficient amount

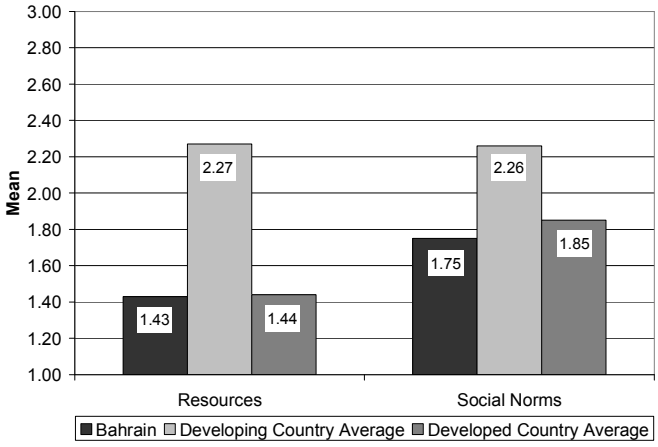
SERVICE PROVIDERS

Level of involvement in child abuse treatment and prevention services.

	None	Minimal	Moderate	Very
Hospital/Medical				◆
Mental Health Agencies				◆
Businesses/ Factories		◆		
Schools		◆		
Social Service Agencies		◆		
Community-based NGOs				
Religious		◆		
Voluntary Civic Organizations			◆	
Courts/Law		◆		
Universities		◆		

BARRIERS

Average rating of limiting factors to CAN prevention,
(List several factors?)
(Scale: 1="Not important " to 3="Very significant")



BANGLADESH

Region: Southern Asia

Previous World Perspectives surveys completed: 1996, 1998, 2006

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 available for child victims of physical abuse
- Therapy programs available for child victims of sexual abuse
- Case management/meeting basic needs
- Institutional care available for abused children
- Financial and other material support available
- Short-term hospitalization for mental illnesses
- Available 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: NA

Core Elements

- Mandated reporting of suspected child abuse for specific groups of professionals
- Voluntary reporting of suspected abuse
- Reports investigated within a specific time period
- Specific criminal penalties
- Support for specific prevention services
- Separate attorney assigned to represent child

Enforcement Level: Inconsistently enforced

Level of Government Support: Annual support but an inefficient amount

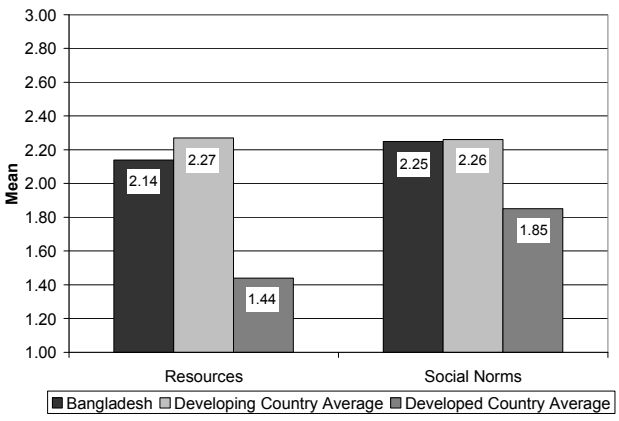
SERVICE PROVIDERS

Level of involvement in child abuse treatment and prevention services.

	None	Minimal	Moderate	Very
Hospital/Medical			◆	
Mental Health Agencies				
Businesses/ Factories				
Schools	◆			
Social Service Agencies		◆		
Community-based NGOs			◆	
Religious	◆			
Voluntary Civic Organizations				
Courts/Law			◆	
Universities	◆			

BARRIERS

Average rating of limiting factors to CAN prevention,
(List several factors?)
(Scale: 1="Not important " to 3="Very significant")



BELARUS

Region: Europe

Previous World Perspectives surveys completed: 2006

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 available for child victims of sexual abuse
- Substance abuse related treatments for parents
- Substance abuse related treatments for children

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

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

Adequate in more than ***2/3*** of Country

- Institutional care available for abused children
- Family Resource Centers available to parents
- Universal home-visits for new parents
- Targeted home-visits for new parents at-risk
- Available free child care
- Access to free medical care for 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: After 2000

Core Elements

- Mandated reporting of suspected child abuse for specific groups of professionals
- Voluntary reporting of suspected abuse
- Reports investigated within a specific time period
- Remove abused child from abusive parents
- Specific criminal penalties
- Separate attorney assigned to represent child

Enforcement Level: Inconsistently enforced

Level of Government Support: Adequately supported

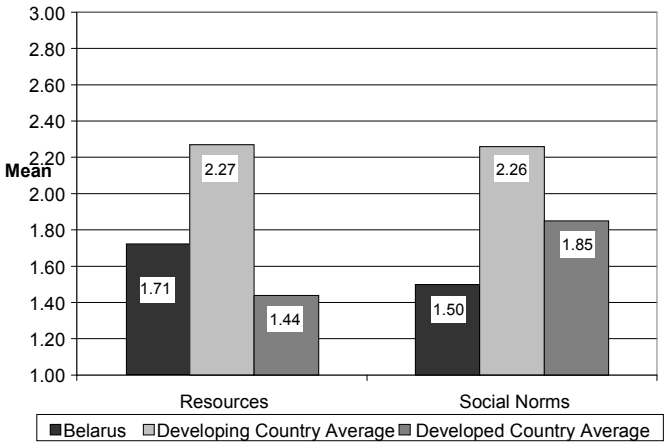
SERVICE PROVIDERS

Level of involvement in child abuse treatment and prevention services.

	None	Minimal	Moderate	Very
Hospital/Medical			◆	
Mental Health Agencies		◆		
Businesses/ Factories	◆			
Schools			◆	
Social Service Agencies			◆	
Community-based NGOs				
Religious		◆		
Voluntary Civic Organizations			◆	
Courts/Law		◆		
Universities		◆		

BARRIERS

Average rating of limiting factors to CAN prevention,
(List several factors?)
(Scale: 1="Not important " to 3="Very significant")



BOLIVIA

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:

- Therapy programs available for child victims of physical abuse
- Therapy programs available for child victims of sexual abuse
- Foster care with official foster parents
- Short-term hospitalization for mental illnesses
- Substance abuse related treatments for children
- Available free child care

Adequate in more than ***2/3*** of Country

- Institutional care available for abused children
- Universal health screening for children
- Access to free medical care for 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: After 2000

Core Elements

- Mandated reporting of suspected child abuse for specific groups of professionals
- Voluntary reporting of suspected abuse
- Reports investigated within a specific time period
- Specific criminal penalties
- All victims receive some form of service or intervention
- Support for specific prevention services

Enforcement Level: Inconsistently enforced
Level of Government Support: Inconsistent

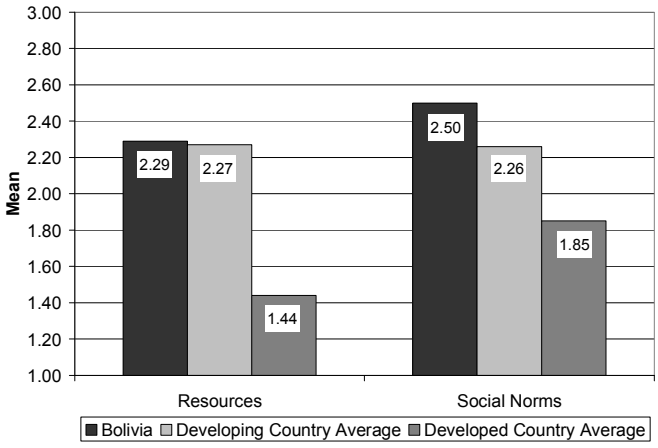
SERVICE PROVIDERS

Level of involvement in child abuse treatment and prevention services.

	None	Minimal	Moderate	Very
Hospital/Medical		◆		
Mental Health Agencies		◆		
Businesses/ Factories		◆		
Schools		◆		
Social Service Agencies			◆	
Community-based NGOs			◆	
Religious			◆	
Voluntary Civic Organizations			◆	
Courts/Law			◆	
Universities		◆		

BARRIERS

Average rating of limiting factors to CAN prevention,
(List several factors?)
(Scale: 1="Not important " to 3="Very significant")



BOSNIA AND HERZEGOVINA

Region: Europe

Previous World Perspectives surveys completed: 2006

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 child abusers
- Therapy programs available for child victims of physical abuse
- Therapy available for child sexual abusers
- Therapy programs available for child victims of sexual abuse
- Foster care with official foster parents
- Short-term hospitalization for mental illnesses
- Substance abuse related treatments for parents
- Substance abuse related treatments for children
- Family Resource Centers available to parents

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

- Case management/meeting basic needs
- Universal home-visits for new parents
- Universal health screening for children
- Access to free medical care for 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
- Voluntary reporting of suspected abuse
- Reports investigated within a specific time period
- Remove abused child from abusive parents
- Specific criminal penalties
- All victims receive some form of service or intervention
- All abusers receive some form of service/intervention
- Separate attorney assigned to represent child

Enforcement Level: Inconsistently enforced

Level of Government Support: Annual support but an inefficient amount

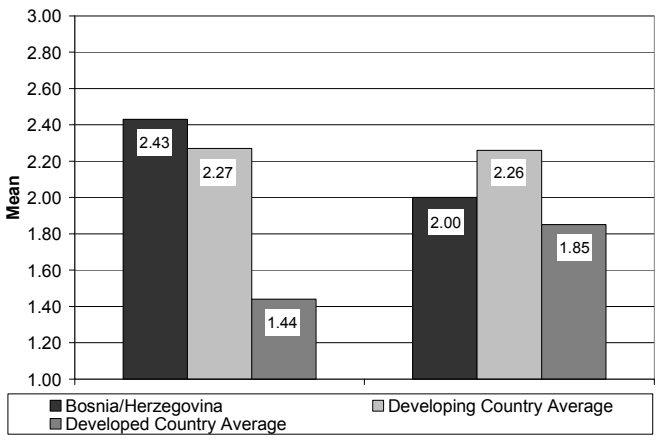
SERVICE PROVIDERS

Level of involvement in child abuse treatment and prevention services.

	None	Minimal	Moderate	Very
Hospital/Medical	◆			
Mental Health Agencies		◆		
Businesses/ Factories	◆			
Schools			◆	
Social Service Agencies			◆	
Community-based NGOs				◆
Religious		◆		
Voluntary Civic Organizations			◆	
Courts/Law		◆		
Universities			◆	

BARRIERS

Average rating of limiting factors to CAN prevention,
(List several factors?)
(Scale: 1="Not important " to 3="Very significant")



BRAZIL

Region: Americas

Previous World Perspectives surveys completed:
1992, 1996, 1998, 2000, 2002, 2004, 2006

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 available for child victims of physical abuse
- Foster care with official foster parents

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

- Therapy programs available for child victims of sexual abuse
- Case management/meeting basic needs
- Home-base services intended to assist parents in changing their behaviors
- Group homes for abused children
- Institutional care available for abused children
- Financial and other material support available
- Short-term hospitalization for mental illnesses

Adequate in more than ***2/3*** of Country

- Substance abuse related treatments for children
- Family Resource Centers available to parents
- Universal home-visits for new parents
- Targeted home-visits for new parents at-risk
- Available free child care
- Universal health screening for children
- Access to free medical care for children
- 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
- Voluntary reporting of suspected abuse
- Reports investigated within a specific time period
- Remove abused child from abusive parents
- Specific criminal penalties
- All victims receive some form of service or intervention
- Support for specific prevention services
- All abusers receive some form of service/intervention
- Separate attorney assigned to represent child

Enforcement Level: Widely enforced

Level of Government Support: Annual support but an inefficient amount

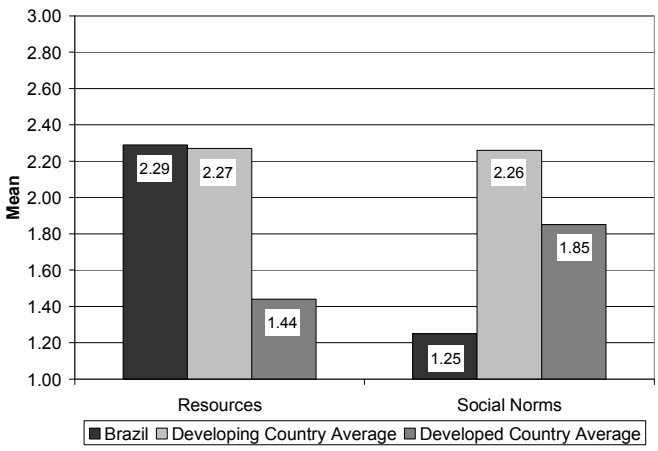
SERVICE PROVIDERS

Level of involvement in child abuse treatment and prevention services.

	None	Minimal	Moderate	Very
Hospital/Medical				◆
Mental Health Agencies				◆
Businesses/ Factories			◆	
Schools				◆
Social Service Agencies				◆
Community-based NGOs				◆
Religious			◆	
Voluntary Civic Organizations				◆
Courts/Law				◆
Universities			◆	

BARRIERS

Average rating of limiting factors to CAN prevention,
(List several factors?)
(Scale: 1="Not important " to 3="Very significant")



BULGARIA

Region: Europe

Previous World Perspectives surveys completed: 2002, 2004, 2006

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 available for child victims of physical abuse
- Therapy programs available for child victims of sexual abuse
- Case management/meeting basic needs
- Institutional care available for abused children

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

- Foster care with official foster parents
- Short-term hospitalization for mental illnesses
- Substance abuse related treatments for parents
- Substance abuse related treatments for children

Adequate in more than ***2/3*** of Country

- Universal home-visits for new parents
- Targeted home-visits for new parents at-risk
- Available free child care
- Universal health screening for children
- Access to free medical care for 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: After 2000

Core Elements

- Mandated reporting of suspected child abuse for specific groups of professionals
- Voluntary reporting of suspected abuse
- Reports investigated within a specific time period
- Remove abused child from abusive parents
- Specific criminal penalties
- All victims receive some form of service or intervention
- Support for specific prevention services
- Separate attorney assigned to represent child

Enforcement Level: Widely enforced

Level of Government Support: Adequately supported

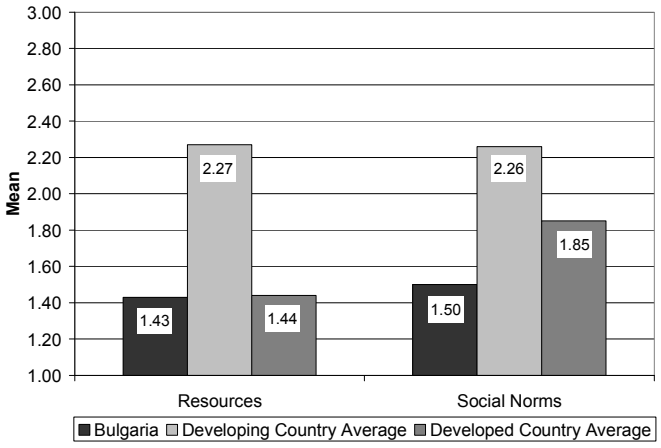
SERVICE PROVIDERS

Level of involvement in child abuse treatment and prevention services.

	None	Minimal	Moderate	Very
Hospital/Medical				
Mental Health Agencies				
Businesses/ Factories				
Schools				
Social Service Agencies				◆
Community-based NGOs				◆
Religious		◆		
Voluntary Civic Organizations			◆	
Courts/Law			◆	
Universities			◆	

BARRIERS

Average rating of limiting factors to CAN prevention,
(List several factors?)
(Scale: 1="Not important " to 3="Very significant")



CAMEROON

Region: Africa

Previous World Perspectives surveys completed: 1998, 2000, 2004, 2006

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 available for child victims of sexual abuse
- Case management/meeting basic needs
- Short-term hospitalization for mental illnesses
- Substance abuse related treatments for parents

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

- Institutional care available 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 abuse
- Remove abused child from abusive parents
- Specific criminal penalties
- All victims receive some form of service or intervention
- Support for specific prevention services

Enforcement Level: Inconsistently enforced

Level of Government Support: Annual support but an inefficient amount

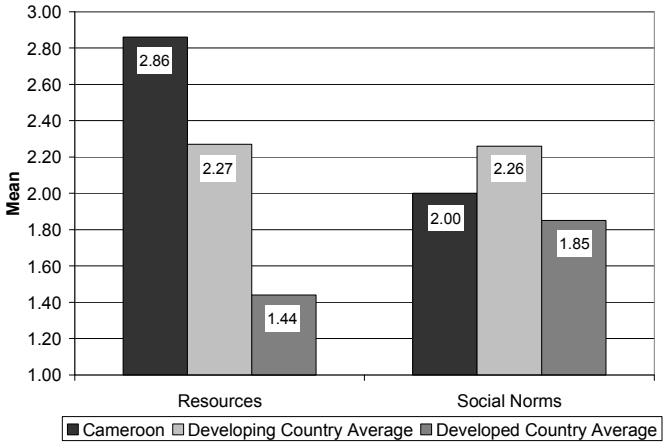
SERVICE PROVIDERS

Level of involvement in child abuse treatment and prevention services.

	None	Minimal	Moderate	Very
Hospital/Medical				◆
Mental Health Agencies				◆
Businesses/ Factories	◆			
Schools			◆	
Social Service Agencies				◆
Community-based NGOs				◆
Religious				◆
Voluntary Civic Organizations				◆
Courts/Law		◆		
Universities		◆		

BARRIERS

Average rating of limiting factors to CAN prevention,
(List several factors?)
(Scale: 1="Not important " to 3="Very significant")



CANADA

Region: Americas

Previous World Perspectives surveys completed:
1992, 1996, 1998, 2000, 2002, 2004, 2006

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 child abusers
- Therapy available for child sexual abusers
- Home-base services intended to assist parents in changing their behaviors
- Universal home-visits for new parents

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

- Therapy programs available for child victims of physical abuse
- Therapy programs available for child victims of sexual abuse
- Foster care with official foster parents
- Group homes for abused children
- Institutional care available for abused children
- Substance abuse related treatments for children
- Family Resource Centers available to parents
- Available free child care
- Universal health screening for children

Adequate in more than ***2/3*** of Country

- Case management/meeting basic needs
- Financial and other material support available
- Short-term hospitalization for mental illnesses
- Substance abuse related treatments for parents
- Targeted home-visits for new parents at-risk
- Access to free medical care for children
- 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
- Voluntary reporting of suspected abuse
- Reports investigated within a specific time period
- Remove abused child from abusive parents
- Specific criminal penalties
- All victims receive some form of service or intervention
- All abusers receive some form of service/intervention
- Support for specific prevention services

Enforcement Level: Widely enforced

Level of Government Support: Adequately supported

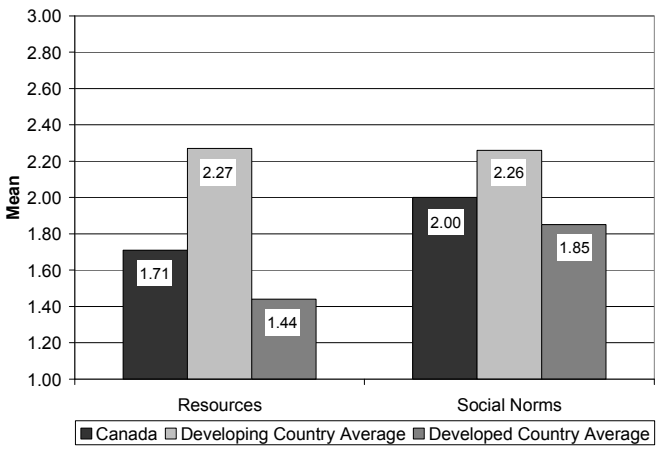
SERVICE PROVIDERS

Level of involvement in child abuse treatment and prevention services.

	None	Minimal	Moderate	Very
Hospital/Medical				◆
Mental Health Agencies			◆	
Businesses/ Factories		◆		
Schools			◆	
Social Service Agencies				◆
Community-based NGOs				◆
Religious		◆		
Voluntary Civic Organizations		◆		
Courts/Law			◆	
Universities		◆		

BARRIERS

Average rating of limiting factors to CAN prevention,
(List several factors?)
(Scale: 1="Not important " to 3="Very significant")



CHILE

Region: Americas

Previous World Perspectives surveys completed: 1992, 2002, 2006

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 child abusers
- Therapy available for child sexual abusers
- Foster care with official foster parents
- Short-term hospitalization for mental illnesses
- Substance abuse related treatments for children
- Universal home-visits for new parents

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

- Therapy programs available for child victims of physical abuse
- Therapy programs available for child victims of sexual abuse
- Institutional care available for abused children
- Substance abuse related treatments for parents

Adequate in more than ***2/3*** of Country

- Targeted home-visits for new parents at-risk
- Available free child care
- Universal health screening for children
- Access to free medical care for children
- 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
- Voluntary reporting of suspected abuse
- Reports investigated within a specific time period
- Remove abused child from abusive parents
- Specific criminal penalties
- All victims receive some form of service or intervention
- All abusers receive some form of service/intervention
- Separate attorney assigned to represent child

Enforcement Level: Inconsistently enforced

Level of Government Support: Annual support but an inefficient amount

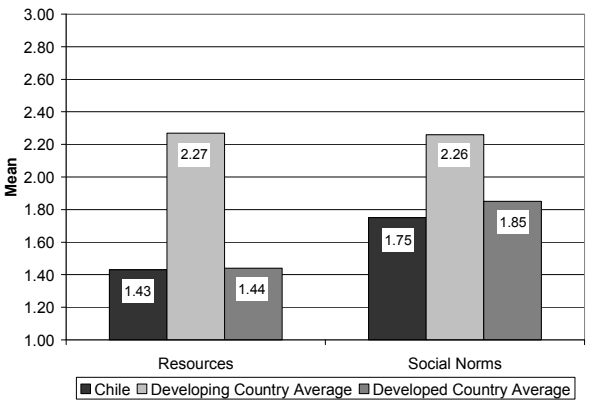
SERVICE PROVIDERS

Level of involvement in child abuse treatment and prevention services.

	None	Minimal	Moderate	Very
Hospital/Medical			◆	
Mental Health Agencies			◆	
Businesses/ Factories		◆		
Schools			◆	
Social Service Agencies				◆
Community-based NGOs			◆	
Religious		◆		
Voluntary Civic Organizations		◆		
Courts/Law			◆	
Universities			◆	

BARRIERS

Average rating of limiting factors to CAN prevention,
(List several factors?)
(Scale: 1="Not important " to 3="Very significant")



CHINA

Region: Eastern Asia

Previous World Perspectives surveys completed: 1998, 2002, 2004, 2006

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 child abusers
- Therapy programs available for child victims of physical abuse
- Therapy available for child sexual abusers
- Therapy programs available for child victims of sexual abuse
- Case management/meeting basic needs
- Home-base services intended to assist parents in changing their behaviors
- Foster care with official foster parents
- Group homes for abused children
- Institutional care available for abused children
- Financial and other material support available
- Short-term hospitalization for mental illnesses
- Substance abuse related treatments for parents
- Substance abuse related treatments for children
- Family Resource Centers available to parents
- Universal home-visits for new parents
- Targeted home-visits for new parents at-risk
- Available free child care
- Universal health screening for children
- Access to free medical care for children
- 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

- Specific criminal penalties
- Support for specific prevention services
- Separate attorney assigned to represent child

Enforcement Level: Widely enforced

Level of Government Support: Annual support but an inefficient amount

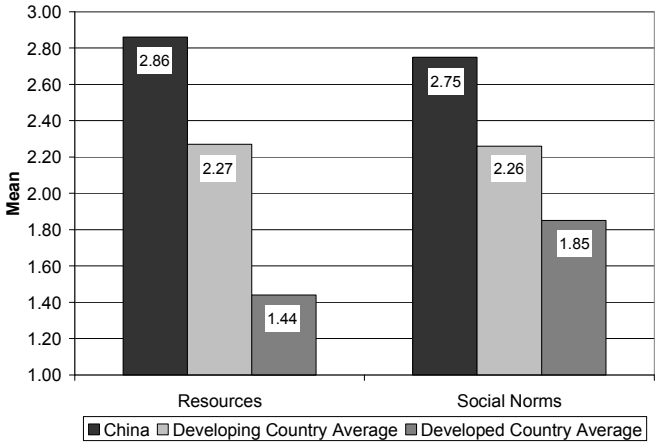
SERVICE PROVIDERS

Level of involvement in child abuse treatment and prevention services.

	None	Minimal	Moderate	Very
Hospital/Medical				◆
Mental Health Agencies			◆	
Businesses/ Factories		◆		
Schools		◆		
Social Service Agencies			◆	
Community-based NGOs				◆
Religious		◆		
Voluntary Civic Organizations			◆	
Courts/Law				◆
Universities			◆	

BARRIERS

Average rating of limiting factors to CAN prevention,
(List several factors?)
(Scale: 1="Not important " to 3="Very significant")



COLOMBIA

Region: Americas

Previous World Perspectives surveys completed: 1998, 2002, 2004, 2006

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 available for child sexual abusers
- Foster care with official foster parents
- Substance abuse related treatments for children
- Family Resource Centers available to parents
- Universal health screening for children
- Access to free medical care for children

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

- Short-term hospitalization for mental illnesses
- Substance abuse related treatments for parents
- Available 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
- Voluntary reporting of suspected abuse
- Specific criminal penalties
- All victims receive some form of service or intervention

Enforcement Level: Inconsistently enforced

Level of Government Support: Annual support but an inefficient amount

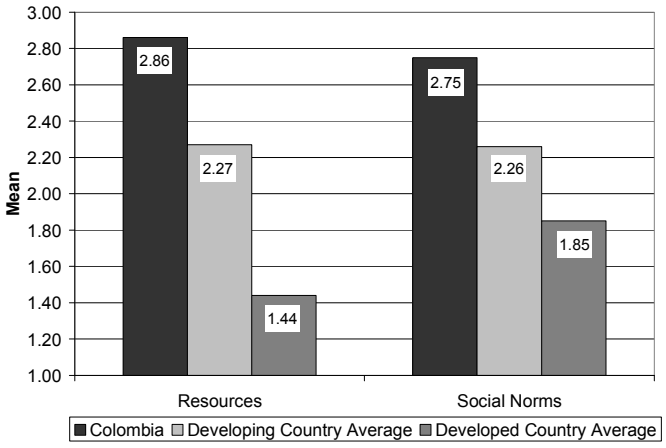
SERVICE PROVIDERS

Level of involvement in child abuse treatment and prevention services.

	None	Minimal	Moderate	Very
Hospital/Medical	◆			
Mental Health Agencies		◆		
Businesses/ Factories				◆
Schools			◆	
Social Service Agencies		◆		
Community-based NGOs			◆	
Religious				◆
Voluntary Civic Organizations				◆
Courts/Law		◆		
Universities				◆

BARRIERS

Average rating of limiting factors to CAN prevention,
(List several factors?)
(Scale: 1="Not important " to 3="Very significant")



CONGO, DEM. REP OF

Region: Africa

Previous World Perspectives surveys completed: 2002, 2004, 2006

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

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
- Voluntary reporting of suspected abuse
- Remove abused child from abusive parents
- Specific criminal penalties
- All victims receive some form of service or intervention
- Separate attorney assigned to represent child

Enforcement Level: Inconsistently enforced

Level of Government Support: Inconsistent

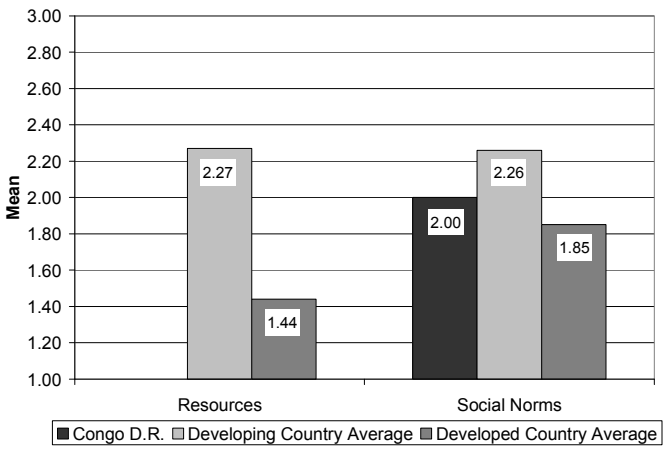
SERVICE PROVIDERS

Level of involvement in child abuse treatment and prevention services.

	None	Minimal	Moderate	Very
Hospital/Medical				◆
Mental Health Agencies				◆
Businesses/ Factories				
Schools		◆		
Social Service Agencies		◆		
Community-based NGOs		◆		
Religious			◆	
Voluntary Civic Organizations			◆	
Courts/Law			◆	
Universities			◆	

BARRIERS

Average rating of limiting factors to CAN prevention,
(List several factors?)
(Scale: 1="Not important " to 3="Very significant")



EGYPT

Region: Africa

Previous World Perspectives surveys completed: 2002, 2004, 206

OFFICIAL RECORDS

Country maintains official count of CAN cases: NO

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:

- Therapy programs for physical child abusers
- Therapy programs available for child victims of sexual abuse
- Case management/meeting basic needs
- Home-base services intended to assist parents in changing their behaviors
- Foster care with official foster parents
- Group homes for abused children
- Institutional care available for abused children
- Financial and other material support available
- Short-term hospitalization for mental illnesses
- Substance abuse related treatments for parents
- Substance abuse related treatments for children
- Family Resource Centers available to parents
- Available free child care
- Access to free medical care for children
- Universal access to free medical care for all citizens

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

- Therapy programs available for child victims of physical 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
- Voluntary reporting of suspected abuse
- Reports investigated within a specific time period
- Remove abused child from abusive parents
- Specific criminal penalties
- All victims receive some form of service or intervention
- Support for specific prevention services

Enforcement Level: Inconsistently enforced

Level of Government Support: Adequately supported

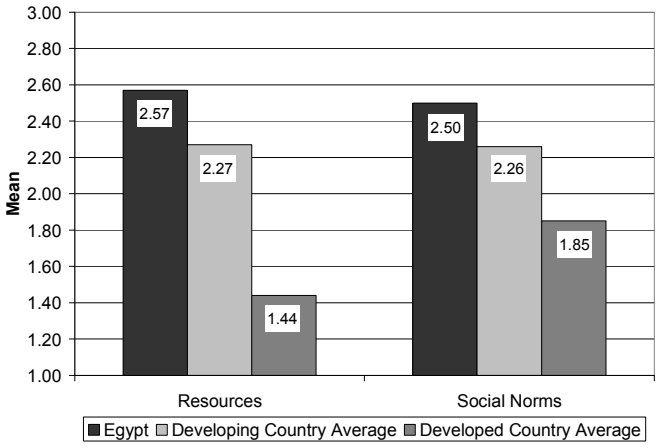
SERVICE PROVIDERS

Level of involvement in child abuse treatment and prevention services.

	None	Minimal	Moderate	Very
Hospital/Medical			◆	
Mental Health Agencies		◆		
Businesses/ Factories	◆			
Schools		◆		
Social Service Agencies			◆	
Community-based NGOs			◆	
Religious			◆	
Voluntary Civic Organizations		◆		
Courts/Law		◆		
Universities		◆		

BARRIERS

Average rating of limiting factors to CAN prevention,
(List several factors?)
(Scale: 1="Not important " to 3="Very significant")



ESTONIA

Region: Europe

Previous World Perspectives surveys completed: 1996, 2000, 2002, 2004, 2006

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/meeting basic needs
- Home-base services intended to assist parents in changing their behaviors
- Substance abuse related treatments for parents
- Substance abuse related treatments for children
- Targeted home-visits for new parents at-risk

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

- Therapy programs available for child victims of physical abuse
- Therapy programs available for child victims of sexual abuse
- Foster care with official foster parents
- Group homes for abused children
- Institutional care available for abused children

Adequate in more than ***2/3*** of Country

- Financial and other material support available
- Short-term hospitalization for mental illnesses
- Universal home-visits for new parents
- Universal health screening for children
- Access to free medical care for 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: Between 1990-2000

Core Elements

- Mandated reporting of suspected child abuse for specific groups of professionals
- Voluntary reporting of suspected abuse
- Reports investigated within a specific time period
- Remove abused child from abusive parents
- Specific criminal penalties
- Separate attorney assigned to represent child

Enforcement Level: Widely enforced

Level of Government Support: Annual support but an inefficient amount

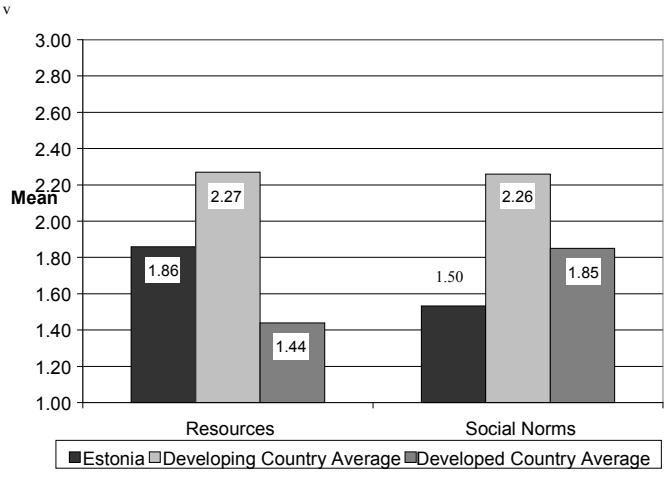
SERVICE PROVIDERS

Level of involvement in child abuse treatment and prevention services.

	None	Minimal	Moderate	Very
Hospital/Medical				◆
Mental Health Agencies			◆	
Businesses/ Factories		◆		
Schools			◆	
Social Service Agencies				◆
Community-based NGOs				◆
Religious		◆		
Voluntary Civic Organizations				◆
Courts/Law			◆	
Universities			◆	

BARRIERS

Average rating of limiting factors to CAN prevention,
(List several factors?)
(Scale: 1="Not important " to 3="Very significant")



ETHIOPIA

Region: Africa

Previous World Perspectives surveys completed: 2006

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 available 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? NO

If yes, date established: NA

Core Elements

- NA

Enforcement Level: NA

Level of Government Support: NA

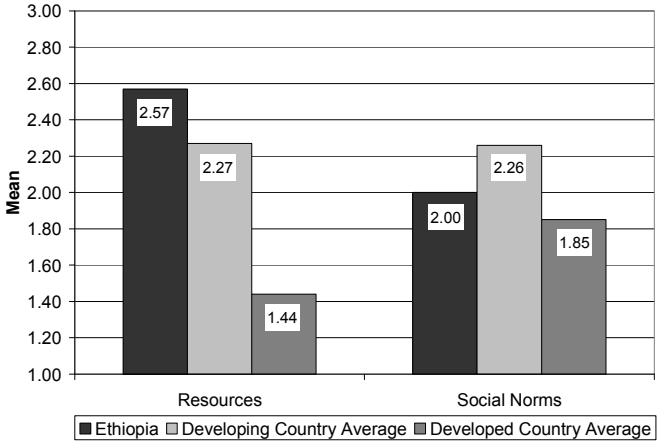
SERVICE PROVIDERS

Level of involvement in child abuse treatment and prevention services.

	None	Minimal	Moderate	Very
Hospital/Medical		◆		
Mental Health Agencies		◆		
Businesses/ Factories	◆			
Schools			◆	
Social Service Agencies			◆	
Community-based NGOs			◆	
Religious		◆		
Voluntary Civic Organizations			◆	
Courts/Law			◆	
Universities			◆	

BARRIERS

Average rating of limiting factors to CAN prevention,
(List several factors?)
(Scale: 1="Not important " to 3="Very significant")



FIJI

Region: Oceania

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 available for child sexual abusers
- Therapy programs available for child victims of sexual abuse
- Home-base services intended to assist parents in changing their behaviors
- Substance abuse related treatments for parents
- Substance abuse related treatments for children
- Family Resource Centers available to parents

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

- Therapy programs available for child victims of physical abuse
- Foster care with official foster parents
- Group homes for abused children
- Institutional care available for abused children
- Financial and other material support available
- Short-term hospitalization for mental illnesses
- Universal health screening for children

Adequate in more than ***2/3*** of Country

- Case management/meeting basic needs
- Access to free medical care for 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 abuse
- Reports investigated within a specific time period
- Remove abused child from abusive parents
- Specific criminal penalties
- All victims receive some form of service or intervention
- Support for specific prevention services
- Separate attorney assigned to represent child

Enforcement Level: Widely enforced

Level of Government Support: Annual support but an inefficient amount

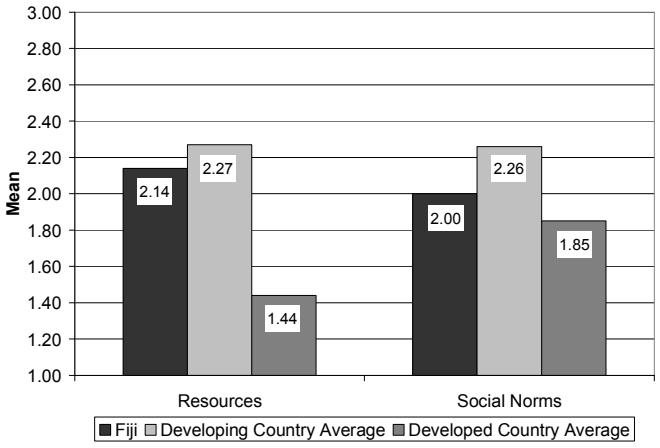
SERVICE PROVIDERS

Level of involvement in child abuse treatment and prevention services.

	None	Minimal	Moderate	Very
Hospital/Medical				◆
Mental Health Agencies			◆	
Businesses/ Factories		◆		
Schools				◆
Social Service Agencies				◆
Community-based NGOs				◆
Religious				◆
Voluntary Civic Organizations				◆
Courts/Law				◆
Universities				◆

BARRIERS

Average rating of limiting factors to CAN prevention,
(List several factors?)
(Scale: 1="Not important " to 3="Very significant")



FINLAND

Region: Europe

Previous World Perspectives surveys completed: 1992, 1996, 2000, 2006

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 child abusers
- Therapy programs available for child victims of physical abuse
- Therapy available for child sexual abusers
- Therapy programs available for child victims of sexual abuse
- Home-base services intended to assist parents in changing their behaviors
- Short-term hospitalization for mental illnesses
- Substance abuse related treatments for children
- Substance abuse related treatments for parents

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

- Case management/meeting basic needs
- Foster care with official foster parents
- Group homes for abused children
- Institutional care available for abused children
- Financial and other material support available
- Family Resource Centers available to parents

Adequate in more than ***2/3*** of Country

- Available free child care
- Targeted home-visits for new parents at-risk
- Universal health screening for children
- Access to free medical care for children
- 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
- Voluntary reporting of suspected abuse
- Reports investigated within a specific time period
- Remove abused child from abusive parents
- Specific criminal penalties
- All victims receive some form of service or intervention
- Support for specific prevention services

Enforcement Level: Widely enforced

Level of Government Support: Annual support but an inefficient amount

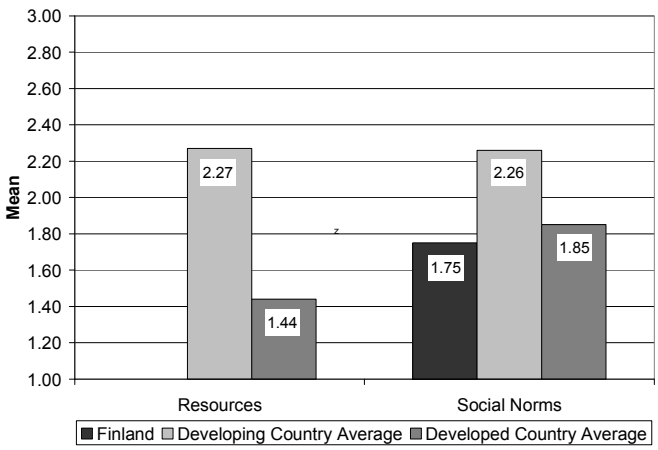
SERVICE PROVIDERS

Level of involvement in child abuse treatment and prevention services.

	None	Minimal	Moderate	Very
Hospital/Medical			◆	
Mental Health Agencies			◆	
Businesses/ Factories	◆			
Schools			◆	
Social Service Agencies				◆
Community-based NGOs			◆	
Religious		◆		
Voluntary Civic Organizations		◆		
Courts/Law			◆	
Universities		◆		

BARRIERS

Average rating of limiting factors to CAN prevention,
(List several factors?)
(Scale: 1="Not important " to 3="Very significant")



FRANCE

Region: Europe

Previous World Perspectives surveys completed:
1992, 1996, 1998, 2000, 2002, 2004, 2006

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 child abusers
- Therapy available for child sexual abusers
- Family Resource Centers available to parents

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

- Therapy programs available for child victims of sexual abuse

Adequate in more than ***2/3*** of Country

- Therapy programs available for child victims of physical abuse
- Case management/meeting basic needs
- Home-base services intended to assist parents in changing their behaviors
- Foster care with official foster parents
- Institutional care available for abused children
- Financial and other material support available
- Short-term hospitalization for mental illnesses
- Substance abuse related treatments for parents
- Substance abuse related treatments for children
- Universal home-visits for new parents
- Targeted home-visits for new parents at-risk
- Available free child care
- Universal health screening for children
- Access to free medical care for children
- 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
- Voluntary reporting of suspected abuse
- Reports investigated within a specific time period
- Remove abused child from abusive parents
- Specific criminal penalties
- Support for specific prevention services
- Separate attorney assigned to represent child

Enforcement Level: Widely enforced

Level of Government Support: Adequately supported

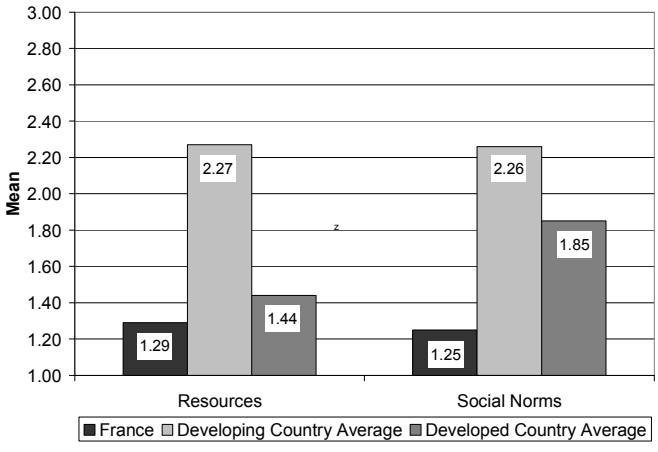
SERVICE PROVIDERS

Level of involvement in child abuse treatment and prevention services.

	None	Minimal	Moderate	Very
Hospital/Medical				◆
Mental Health Agencies				◆
Businesses/ Factories	◆			
Schools				◆
Social Service Agencies				◆
Community-based NGOs	◆			
Religious				◆
Voluntary Civic Organizations				◆
Courts/Law				◆
Universities				◆

BARRIERS

Average rating of limiting factors to CAN prevention,
(List several factors?)
(Scale: 1="Not important " to 3="Very significant")



GEORGIA

Region: Western Asia

Previous World Perspectives surveys completed: 2004, 2006

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 available for child victims of sexual abuse
- Case management/meeting basic needs
- Foster care with official foster parents
- Substance abuse related treatments for parents

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

- Therapy programs available for child victims of physical abuse
- Available 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

- Voluntary reporting of suspected abuse
- Remove abused child from abusive parents
- Specific criminal penalties

Enforcement Level: Inconsistently enforced

Level of Government Support: Inconsistent

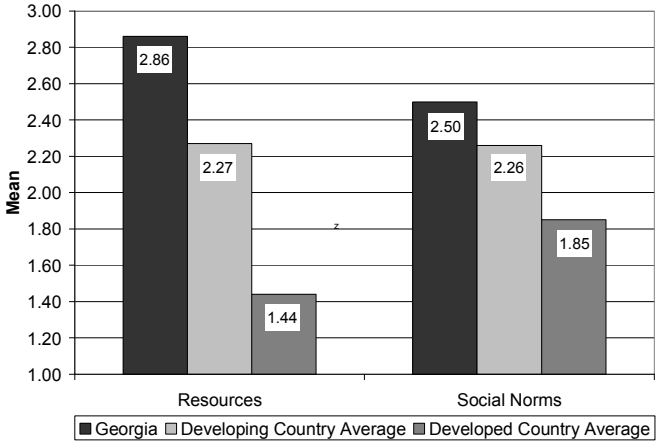
SERVICE PROVIDERS

Level of involvement in child abuse treatment and prevention services.

	None	Minimal	Moderate	Very
Hospital/Medical		◆		
Mental Health Agencies		◆		
Businesses/ Factories	◆			
Schools	◆			
Social Service Agencies		◆		
Community-based NGOs			◆	
Religious		◆		
Voluntary Civic Organizations		◆		
Courts/Law			◆	
Universities		◆		

BARRIERS

Average rating of limiting factors to CAN prevention,
(List several factors?)
(Scale: 1="Not important " to 3="Very significant")



GERMANY

Region: Europe

Previous World Perspectives surveys completed:
1992, 1996, 1998, 2000, 2002, 2004, 2006

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 child abusers
- Therapy available for child sexual abusers
- Home-base services intended to assist parents in changing their behaviors
- Financial and other material support available
- Family Resource Centers available to parents

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

- Therapy programs available for child victims of sexual abuse
- Case management/meeting basic needs
- Institutional care available for abused children
- Short-term hospitalization for mental illnesses
- Substance abuse related treatments for children
- Available free child care

Adequate in more than ***2/3*** of Country

- Therapy programs available for child victims of physical abuse
- Foster care with official foster parents
- Group homes for abused children
- Substance abuse related treatments for parents
- Universal health screening for children
- Access to free medical care for children
- 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

- Remove abused child from abusive parents
- All victims receive some form of service or intervention
- All abusers receive some form of service/intervention
- Support for specific prevention services
- Separate attorney assigned to represent child

Enforcement Level: Inconsistently enforced
Level of Government Support: Annual support but an inefficient amount

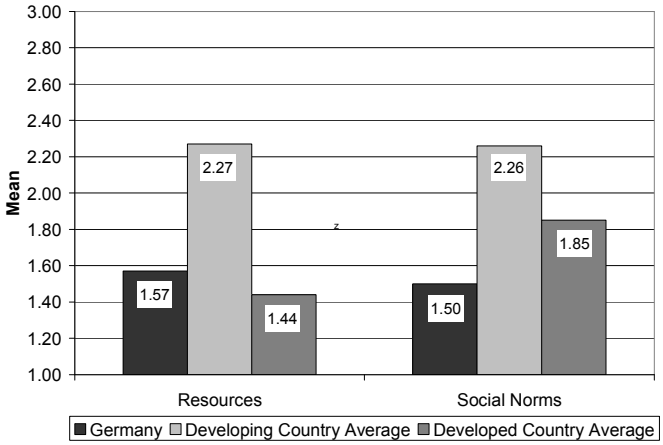
SERVICE PROVIDERS

Level of involvement in child abuse treatment and prevention services.

	None	Minimal	Moderate	Very
Hospital/Medical				◆
Mental Health Agencies				◆
Businesses/ Factories	◆			
Schools			◆	
Social Service Agencies			◆	
Community-based NGOs				◆
Religious			◆	
Voluntary Civic Organizations		◆		
Courts/Law			◆	
Universities		◆		

BARRIERS

Average rating of limiting factors to CAN prevention,
(List several factors?)
(Scale: 1="Not important " to 3="Very significant")



GREECE

Region: Europe

Previous World Perspectives surveys completed:
1992, 1996, 1998, 2000, 2002, 2006

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 available for child victims of physical abuse
- Therapy programs available for child victims of sexual abuse
- Case management/meeting basic needs
- Home-base services intended to assist parents in changing their behaviors
- Foster care with official foster parents
- Group homes for abused children
- Institutional care available for abused children
- Financial and other material support available
- Substance abuse related treatments for parents
- Substance abuse related treatments for children

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

- Universal health screening for children
- Access to free medical care for children
- Universal access to free medical care for all citizens
- Short-term hospitalization for mental illnesses
- Available 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
- Voluntary reporting of suspected abuse
- Remove abused child from abusive parents
- Specific criminal penalties

Enforcement Level: Inconsistently enforced

Level of Government Support: Inconsistent

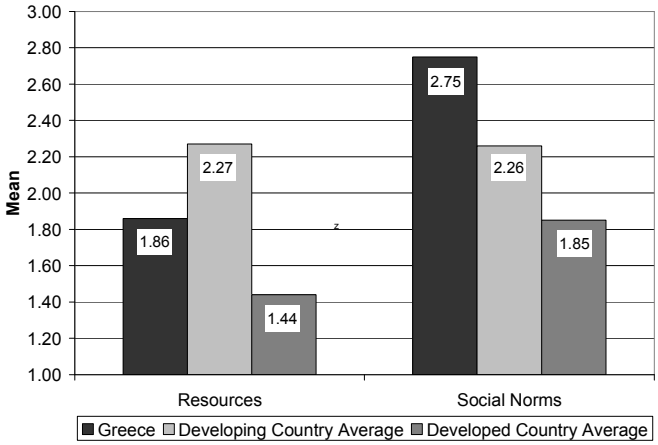
SERVICE PROVIDERS

Level of involvement in child abuse treatment and prevention services.

	None	Minimal	Moderate	Very
Hospital/Medical			◆	
Mental Health Agencies				◆
Businesses/ Factories	◆			
Schools			◆	
Social Service Agencies				◆
Community-based NGOs				◆
Religious		◆		
Voluntary Civic Organizations		◆		
Courts/Law		◆		
Universities		◆		

BARRIERS

Average rating of limiting factors to CAN prevention,
(List several factors?)
(Scale: 1="Not important " to 3="Very significant")



GUATEMALA

Region: Americas

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 child abusers
- Therapy programs available for child victims of physical abuse
- Therapy available for child sexual abusers
- Therapy programs available for child victims of sexual abuse
- Case management/meeting basic needs
- Foster care with official foster parents
- Group homes for abused children
- Institutional care available for abused children
- Short-term hospitalization for mental illnesses
- Substance abuse related treatments for parents
- Family Resource Centers available to parents
- Available free child care
- Universal health screening for children
- Access to free medical care for children
- 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
- Voluntary reporting of suspected abuse
- Reports investigated within a specific time period
- Remove abused child from abusive parents
- All victims receive some form of service or intervention
- Support for specific prevention services

Enforcement Level: Inconsistently enforced

Level of Government Support: Annual support but an inefficient amount

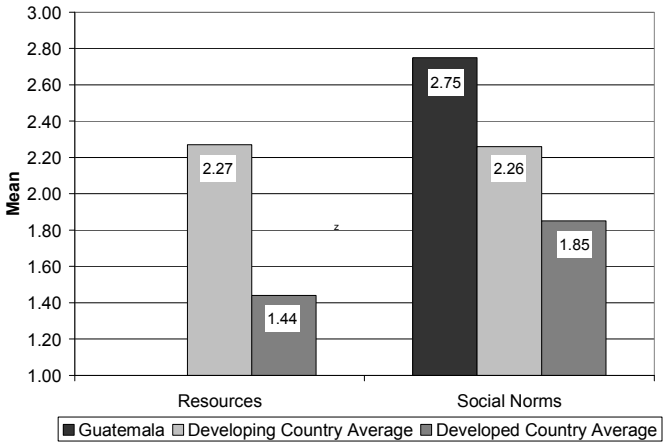
SERVICE PROVIDERS

Level of involvement in child abuse treatment and prevention services.

	None	Minimal	Moderate	Very
Hospital/Medical		◆		
Mental Health Agencies		◆		
Businesses/ Factories				◆
Schools				◆
Social Service Agencies		◆		
Community-based NGOs				◆
Religious				◆
Voluntary Civic Organizations		◆		
Courts/Law	◆			
Universities				◆

BARRIERS

Average rating of limiting factors to CAN prevention,
(List several factors?)
(Scale: 1="Not important " to 3="Very significant")



HONDURAS

Region: Americas

Previous World Perspectives surveys completed: 2006

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 available for child victims of sexual abuse
- Foster care with official foster parents
- Institutional care available for abused children
- Short-term hospitalization for mental illnesses
- Substance abuse related treatments for 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
- Voluntary reporting of suspected abuse
- Reports investigated within a specific time period
- Remove abused child from abusive parents
- Specific criminal penalties
- All victims receive some form of service or intervention
- Support for specific prevention services
- Separate attorney assigned to represent child

Enforcement Level: Inconsistently enforced

Level of Government Support: Inconsistent

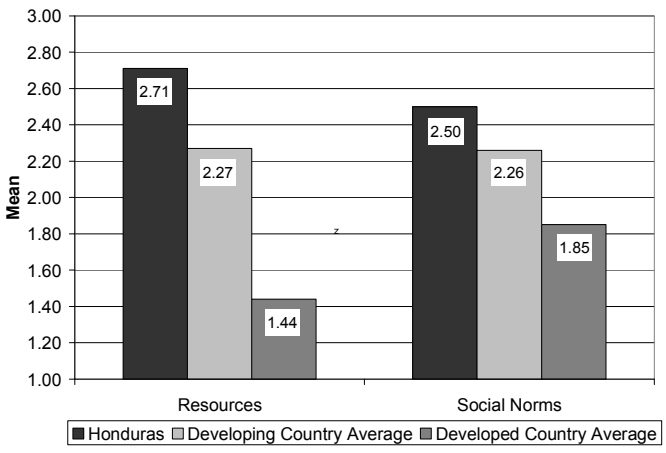
SERVICE PROVIDERS

Level of involvement in child abuse treatment and prevention services.

	None	Minimal	Moderate	Very
Hospital/Medical	◆			
Mental Health Agencies	◆			
Businesses/ Factories	◆			
Schools		◆		
Social Service Agencies		◆		
Community-based NGOs		◆		
Religious		◆		
Voluntary Civic Organizations		◆		
Courts/Law	◆			
Universities		◆		

BARRIERS

Average rating of limiting factors to CAN prevention,
(List several factors?)
(Scale: 1="Not important " to 3="Very significant")



HONG KONG, SARC*

Region: Eastern Asia

Previous World Perspectives surveys completed: 1996, 1998, 2000, 2002, 2004, 2006

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:

- Targeted home-visits for new parents at-risk

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

- Therapy programs available for child victims of physical abuse
- Therapy programs available for child victims of sexual abuse
- Therapy available for child sexual abusers
- Home-base services intended to assist parents in changing their behaviors
- Group homes for abused children
- Short-term hospitalization for mental illnesses
- Substance abuse related treatments for parents
- Substance abuse related treatments for children
- Family Resource Centers available to parents

Adequate in more than ***2/3*** of Country

- Therapy programs for physical child abusers
- Case management/meeting basic needs
- Foster care with official foster parents
- Institutional care available for abused children
- Financial and other material support available
- Universal health screening for 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 abuse
- Reports investigated within a specific time period
- Remove abused child from abusive parents
- Specific criminal penalties
- All victims receive some form of service or intervention

Enforcement Level: Widely enforced

Level of Government Support: Annual support but an inefficient amount

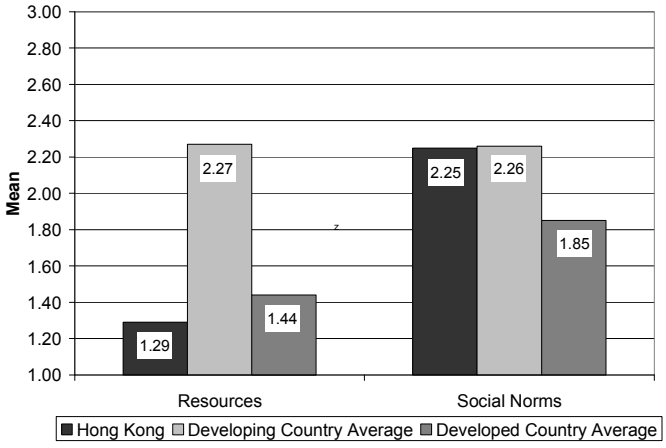
SERVICE PROVIDERS

Level of involvement in child abuse treatment and prevention services.

	None	Minimal	Moderate	Very
Hospital/Medical				◆
Mental Health Agencies			◆	
Businesses/ Factories		◆		
Schools			◆	
Social Service Agencies				◆
Community-based NGOs				◆
Religious			◆	
Voluntary Civic Organizations			◆	
Courts/Law			◆	
Universities			◆	

BARRIERS

Average rating of limiting factors to CAN prevention,
(List several factors?)
(Scale: 1="Not important " to 3="Very significant")



*Special Administrative Region of China

HUNGARY

Region: Europe

Previous World Perspectives surveys completed: 2000, 2002, 2004, 2006

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 available for child victims of sexual abuse
- Case management/meeting basic needs
- Foster care with official foster 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
- Voluntary reporting of suspected abuse
- Remove abused child from abusive parents
- Specific criminal penalties

Enforcement Level: Inconsistently enforced

Level of Government Support: Annual support but an inefficient amount

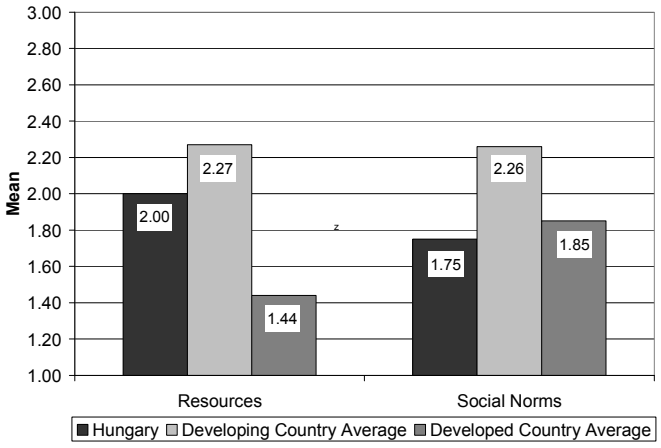
SERVICE PROVIDERS

Level of involvement in child abuse treatment and prevention services.

	None	Minimal	Moderate	Very
Hospital/Medical	◆			
Mental Health Agencies	◆			
Businesses/ Factories	◆			
Schools	◆			
Social Service Agencies	◆			
Community-based NGOs	◆			
Religious	◆			
Voluntary Civic Organizations		◆		
Courts/Law	◆			
Universities	◆			

BARRIERS

Average rating of limiting factors to CAN prevention,
(List several factors?)
(Scale: 1="Not important " to 3="Very significant")



ICELAND

Region: Europe

Previous World Perspectives surveys completed: 2002, 2006

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 child abusers

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

- Group homes for abused children

Adequate in more than ***2/3*** of Country

- Therapy programs available for child victims of physical abuse
- Therapy programs available for child victims of sexual abuse
- Case management/meeting basic needs
- Home-base services intended to assist parents in changing their behaviors
- Foster care with official foster parents
- Institutional care available for abused children
- Financial and other material support available
- Short-term hospitalization for mental illnesses
- Substance abuse related treatments for parents
- Substance abuse related treatments for children
- Universal home-visits for new parents
- Targeted home-visits for new parents at-risk
- Universal health screening for children
- Access to free medical care for children
- 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
- Voluntary reporting of suspected abuse
- Reports investigated within a specific time period
- Remove abused child from abusive parents
- Specific criminal penalties
- All victims receive some form of service or intervention
- Support for specific prevention services
- Separate attorney assigned to represent child

Enforcement Level: Widely enforced

Level of Government Support: Adequately supported

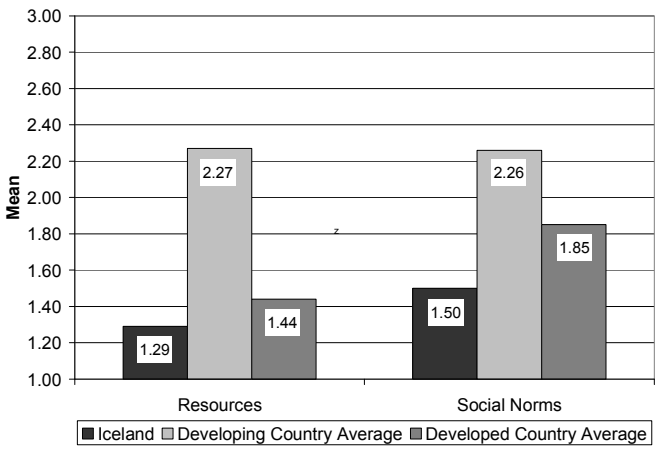
SERVICE PROVIDERS

Level of involvement in child abuse treatment and prevention services.

	None	Minimal	Moderate	Very
Hospital/Medical			◆	
Mental Health Agencies			◆	
Businesses/ Factories	◆			
Schools			◆	
Social Service Agencies				◆
Community-based NGOs		◆		
Religious	◆			
Voluntary Civic Organizations	◆			
Courts/Law			◆	
Universities		◆		

BARRIERS

Average rating of limiting factors to CAN prevention,
(List several factors?)
(Scale: 1="Not important " to 3="Very significant")



INDIA

Region: South-Central Asia

Previous World Perspectives surveys completed: 1992, 2004, 2006

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 available for child victims of physical abuse
- Therapy programs available for child victims of sexual abuse
- Case management/meeting basic needs
- Foster care with official foster parents
- Group homes for abused children
- Institutional care available for abused children
- Financial and other material support available
- Short-term hospitalization for mental illnesses
- Available 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 by any pofessional or individual
- Voluntary reporting of suspected abuse
- Reports investigated within a specific time period
- Remove abused child from abusive parents
- Specific criminal penalties
- All victims receive some form of service or intervention
- All abusers receive some form of service
- Support for specific prevention services
- Separate attorney assigned to represent child

Enforcement Level: Widely enforced

Level of Government Support: Annual support but an inefficient amount

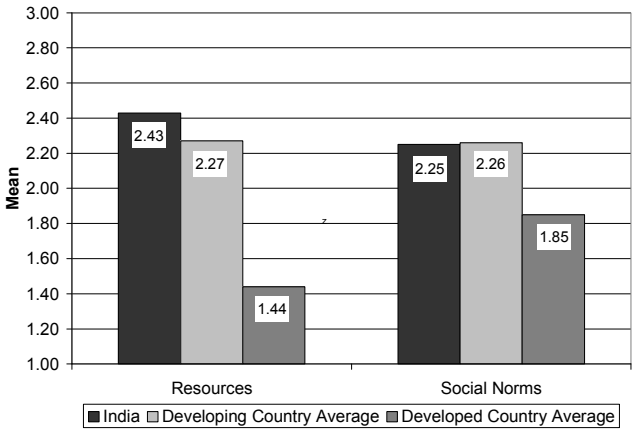
SERVICE PROVIDERS

Level of involvement in child abuse treatment and prevention services.

	None	Minimal	Moderate	Very
Hospital/Medical		◆		
Mental Health Agencies		◆		
Businesses/ Factories	◆			
Schools		◆		
Social Service Agencies		◆		
Community-based NGOs				◆
Religious		◆		
Voluntary Civic Organizations			◆	
Courts/Law			◆	
Universities		◆		

BARRIERS

Average rating of limiting factors to CAN prevention, (List several factors?) (Scale: 1="Not important " to 3="Very significant")



IRAQ

Region: Central 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.

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

- Short-term hospitalization for mental illnesses
- Substance abuse related treatments for parents
- Substance abuse related treatments for children

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

- Access to free medical care for children
- 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

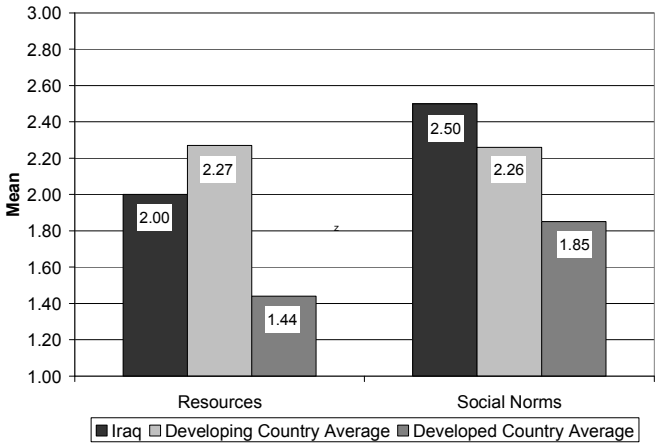
SERVICE PROVIDERS

Level of involvement in child abuse treatment and prevention services.

	None	Minimal	Moderate	Very
Hospital/Medical		◆		
Mental Health Agencies		◆		
Businesses/ Factories	◆			
Schools		◆		
Social Service Agencies		◆		
Community-based NGOs		◆		
Religious		◆		
Voluntary Civic Organizations		◆		
Courts/Law		◆		
Universities		◆		

BARRIERS

Average rating of limiting factors to CAN prevention,
(List several factors?)
(Scale: 1="Not important " to 3="Very significant")



ITALY

Region: Europe

Previous World Perspectives surveys completed:
1992, 1996, 1998, 2000, 2002, 2004, 2006

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 child abusers
- Therapy programs available for child victims of physical abuse
- Therapy programs available for child victims of sexual abuse
- Home-base services intended to assist parents in changing their behaviors
- Group homes for abused children
- Institutional care available for abused children
- Substance abuse related treatments for parents
- Substance abuse related treatments for children
- Targeted home-visits for new parents at-risk
- Available free child care

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

- Foster care with official foster parents
- Financial and other material support available
- Short-term hospitalization for mental illnesses
- Family Resource Centers available to parents
- Case management/meeting basic needs

Adequate in more than ***2/3*** of Country

- Universal health screening for children
- Access to free medical care for children
- 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
- Voluntary reporting of suspected abuse
- Remove abused child from abusive parents
- Specific criminal penalties
- All victims receive some form of service or intervention
- Support for specific prevention services
- Separate attorney assigned to represent child

Enforcement Level: Inconsistently enforced

Level of Government Support: Annual support but an inefficient amount

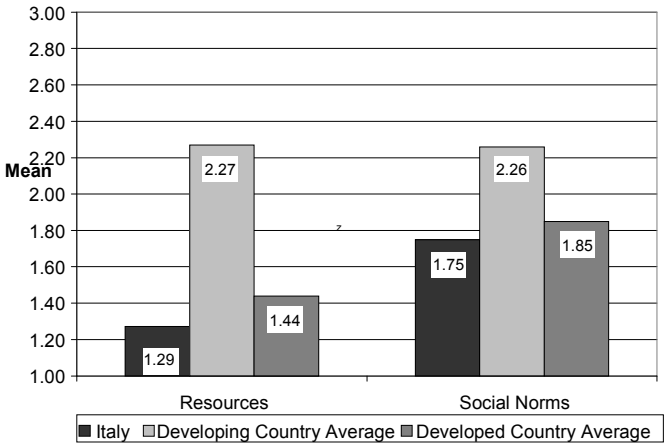
SERVICE PROVIDERS

Level of involvement in child abuse treatment and prevention services.

	None	Minimal	Moderate	Very
Hospital/Medical			◆	
Mental Health Agencies		◆		
Businesses/ Factories		◆		
Schools			◆	
Social Service Agencies				◆
Community-based NGOs			◆	
Religious	◆			
Voluntary Civic Organizations		◆		
Courts/Law			◆	
Universities		◆		

BARRIERS

Average rating of limiting factors to CAN prevention,
(List several factors?)
(Scale: 1="Not important " to 3="Very significant")



JAPAN

Region: Eastern Asia

Previous World Perspectives surveys completed: 1996, 1998, 2000, 2002, 2006

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 child abusers
- Therapy programs available for child victims of sexual abuse
- Case management/meeting basic needs
- Home-base services intended to assist parents in changing their behaviors
- Foster care with official foster parents
- Group homes for abused children
- Substance abuse related treatments for parents

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

- Substance abuse related treatments for children
- Access to free medical care for children

Adequate in more than ***2/3*** of Country

- Therapy programs available for child victims of physical abuse
- Institutional care available for abused children
- Financial and other material support available
- Short-term hospitalization for mental illnesses
- Family Resource Centers available to parents
- Universal home-visits for new parents
- Targeted home-visits for new parents at-risk
- Universal health screening for children
- 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
- Voluntary reporting of suspected abuse
- Remove abused child from abusive parents

Enforcement Level: Widely enforced

Level of Government Support: Annual support but an inefficient amount

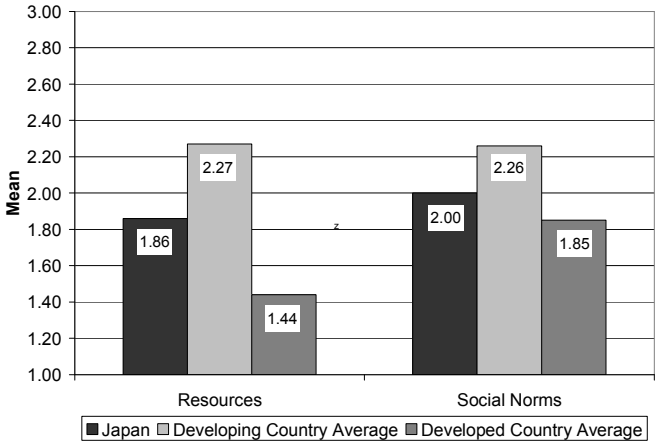
SERVICE PROVIDERS

Level of involvement in child abuse treatment and prevention services.

	None	Minimal	Moderate	Very
Hospital/Medical				◆
Mental Health Agencies				◆
Businesses/ Factories		◆		
Schools				◆
Social Service Agencies				◆
Community-based NGOs				◆
Religious				◆
Voluntary Civic Organizations				◆
Courts/Law			◆	
Universities			◆	

BARRIERS

Average rating of limiting factors to CAN prevention,
(List several factors?)
(Scale: 1="Not important " to 3="Very significant")



KOREA, REP. OF

Region: Eastern Asia

Previous World Perspectives surveys completed: 2000, 2002, 2004, 2006

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 child abusers
- Therapy available for child sexual abusers
- Short-term hospitalization for mental illnesses
- Available free child care
- Access to free medical care for children

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

- Therapy programs available for child victims of sexual abuse
- Case management/meeting basic needs
- Home-base services intended to assist parents in changing their behaviors
- Foster care with official foster parents
- Substance abuse related treatments for parents
- Substance abuse related treatments for children
- Family Resource Centers available to parents

Adequate in more than ***2/3*** of Country

- Therapy programs available for child victims of physical abuse
- Group homes for abused children
- Financial and other material support available
- Universal health screening for children
- Institutional care available 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: After 2000

Core Elements

- Mandated reporting of suspected child abuse for specific groups of professionals
- Voluntary reporting of suspected abuse
- Reports investigated within a specific time period
- Remove abused child from abusive parents
- Specific criminal penalties
- All victims receive some form of service or intervention
- Support for specific prevention services

Enforcement Level: Widely enforced

Level of Government Support: Annual support but an inefficient amount

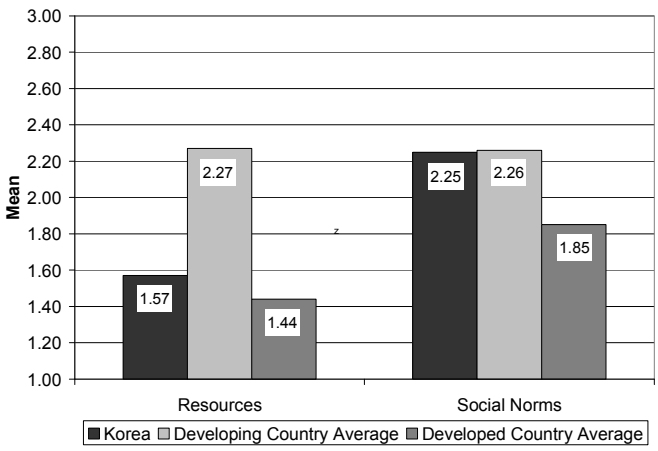
SERVICE PROVIDERS

Level of involvement in child abuse treatment and prevention services.

	None	Minimal	Moderate	Very
Hospital/Medical			◆	
Mental Health Agencies		◆		
Businesses/ Factories		◆		
Schools		◆		
Social Service Agencies				◆
Community-based NGOs				◆
Religious		◆		
Voluntary Civic Organizations		◆		
Courts/Law		◆		
Universities	◆			

BARRIERS

Average rating of limiting factors to CAN prevention,
(List several factors?)
(Scale: 1="Not important " to 3="Very significant")



KYRGYZSTAN

Region: Central 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.

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

- Home-base services intended to assist parents in changing their behaviors
- Short-term hospitalization for mental illnesses
- Substance abuse related treatments for parents
- Substance abuse related treatments for children
- Family Resource Centers available to parents
- Universal home-visits for new parents
- Targeted home-visits for new parents at-risk
- Available free child care
- Case management/meeting basic needs

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

- Therapy programs for physical child abusers
- Therapy programs available for child victims of physical abuse
- Therapy available for child sexual abusers
- Therapy programs available for child victims of sexual abuse
- Institutional care available for abused children

Adequate in more than ***2/3*** of Country

- Universal health screening for children
- Access to free medical care for 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: After 2000

Core Elements

- Mandated reporting of suspected child abuse for specific groups of professionals
- Voluntary reporting of suspected abuse
- Remove abused child from abusive parents
- Specific criminal penalties
- All victims receive some form of service or intervention
- All abusers receive some form of service/intervention
- Support for specific prevention services
- Separate attorney assigned to represent child

Enforcement Level: Inconsistently enforced

Level of Government Support: Inconsistent

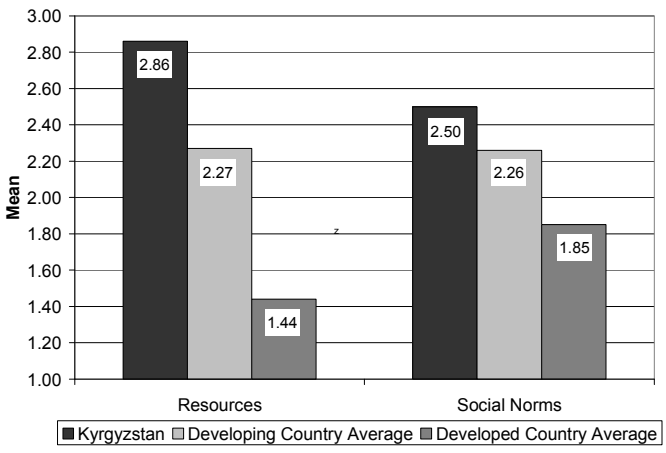
SERVICE PROVIDERS

Level of involvement in child abuse treatment and prevention services.

	None	Minimal	Moderate	Very
Hospital/Medical			◆	
Mental Health Agencies			◆	
Businesses/ Factories	◆			
Schools		◆		
Social Service Agencies			◆	
Community-based NGOs			◆	
Religious		◆		
Voluntary Civic Organizations			◆	
Courts/Law			◆	
Universities		◆		

BARRIERS

Average rating of limiting factors to CAN prevention,
(List several factors?)
(Scale: 1="Not important " to 3="Very significant")



LEBANON

Region: Western Asia

Previous World Perspectives surveys completed: 2004, 2006

OFFICIAL RECORDS

Country maintains official count of CAN cases: NO

If yes, classifications included:

- ☐ Physical abuse
- ☐ Sexual abuse
- ☐ Psychological maltreatment
- ☐ Neglect
- ☐ 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 available for child victims of physical abuse
- Therapy programs available for child victims of sexual abuse
- Case management/meeting basic needs
- Institutional care available 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: After 2000

Core Elements

- Mandated reporting of suspected child abuse for specific groups of professionals
- Reports investigated within a specific time period
- Remove abused child from abusive parents
- Specific criminal penalties
- All victims receive some form of service or intervention

Enforcement Level: Widely enforced

Level of Government Support: Annual support but an inefficient amount

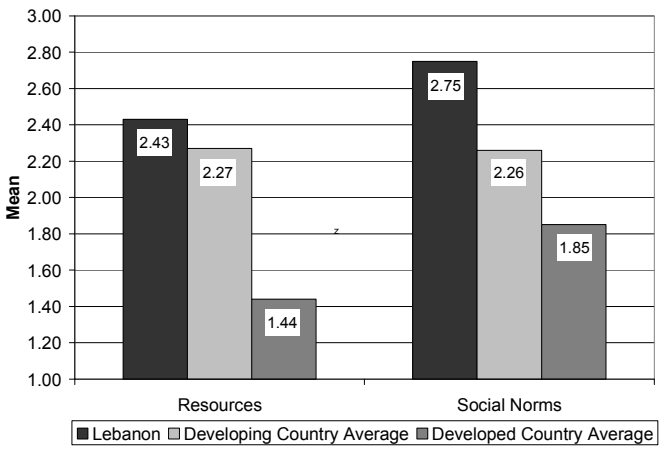
SERVICE PROVIDERS

Level of involvement in child abuse treatment and prevention services.

	None	Minimal	Moderate	Very
Hospital/Medical			◆	
Mental Health Agencies			◆	
Businesses/ Factories			◆	
Schools				
Social Service Agencies			◆	
Community-based NGOs				◆
Religious		◆		
Voluntary Civic Organizations				◆
Courts/Law			◆	
Universities		◆		

BARRIERS

Average rating of limiting factors to CAN prevention,
(List several factors?)
(Scale: 1="Not important " to 3="Very significant")



MALAYSIA

Region: South-Eastern Asia

Previous World Perspectives surveys completed:
1992, 1996, 1998, 2000, 2002, 2004, 2006

OFFICIAL RECORDS

Country maintains official count of CAN cases: YES

If yes, classifications included:

- ☑ Physical abuse
- ☑ Sexual abuse
- ☑ Psychological maltreatment
- ☑ Neglect
- ☐ 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-base services intended to assist parents in changing their behaviors
- Foster care with official foster parents
- Short-term hospitalization for mental illnesses
- Substance abuse related treatments for parents
- Case management/meeting basic needs

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

- Therapy programs available for child victims of physical abuse
- Therapy programs available for child victims of sexual abuse
- Institutional care available for abused children
- Family Resource Centers available to parents

Adequate in more than ***2/3*** of Country

- Financial and other material support available
- Available free child care
- Universal health screening for children
- Access to free medical care for children
- 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
- Voluntary reporting of suspected abuse
- Remove abused child from abusive parents
- Specific criminal penalties

Enforcement Level: Widely enforced

Level of Government Support: Adequately supported

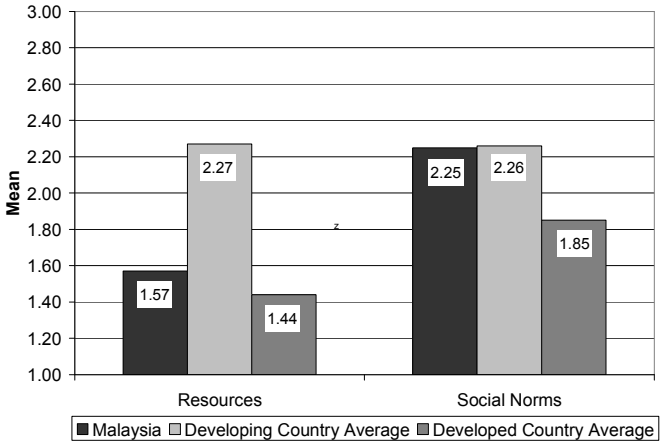
SERVICE PROVIDERS

Level of involvement in child abuse treatment and prevention services.

	None	Minimal	Moderate	Very
Hospital/Medical				◆
Mental Health Agencies				◆
Businesses/ Factories		◆		
Schools			◆	
Social Service Agencies			◆	
Community-based NGOs				◆
Religious		◆		
Voluntary Civic Organizations		◆		
Courts/Law				◆
Universities		◆		

BARRIERS

Average rating of limiting factors to CAN prevention,
(List several factors?)
(Scale: 1="Not important " to 3="Very significant")



MAURITIUS

Region: Africa

Previous World Perspectives surveys completed: 2004, 2006

OFFICIAL RECORDS

Country maintains official count of CAN cases: YES

If yes, classifications included:

- ☑ Physical abuse
- ☑ Sexual abuse
- ☐ Psychological maltreatment
- ☑ Neglect
- ☐ 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/meeting basic needs
- Therapy programs available for child victims of sexual abuse
- Foster care with official foster parents
- Financial and other material support available

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

- Therapy programs available for child victims of physical abuse
- Group homes for abused children
- Available free child care

Adequate in more than ***2/3*** of Country

- Institutional care available for abused children
- Short-term hospitalization for mental illnesses
- Substance abuse related treatments for parents
- Universal health screening for children
- Access to free medical care for children
- 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: NA

Core Elements

- Mandated reporting of suspected child abuse for specific groups of professionals
- Voluntary reporting of suspected abuse
- Reports investigated within a specific time period
- Remove abused child from abusive parents
- Specific criminal penalties
- All victims receive some form of service or intervention

Enforcement Level: Widely enforced

Level of Government Support: Adequately supported

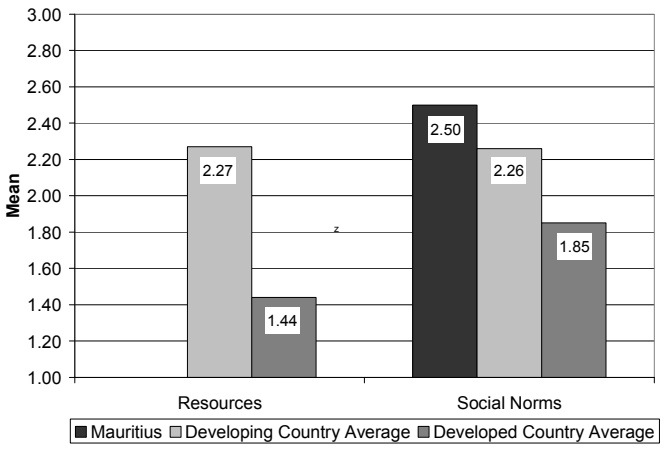
SERVICE PROVIDERS

Level of involvement in child abuse treatment and prevention services.

	None	Minimal	Moderate	Very
Hospital/Medical				◆
Mental Health Agencies			◆	
Businesses/ Factories			◆	
Schools				◆
Social Service Agencies				◆
Community-based NGOs				◆
Religious				◆
Voluntary Civic Organizations				◆
Courts/Law				◆
Universities				◆

BARRIERS

Average rating of limiting factors to CAN prevention,
(List several factors?)
(Scale: 1="Not important " to 3="Very significant")



MEXICO

Region: Americas

Previous World Perspectives surveys completed: 1998, 2000, 2002, 2004, 2006

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 child abusers
- Therapy programs available for child victims of physical abuse
- Therapy available for child sexual abusers
- Therapy programs available for child victims of sexual abuse
- Case management/meeting basic needs
- Home-base services intended to assist parents in changing their behaviors
- Foster care with official foster parents
- Group homes for abused children
- Institutional care available for abused children
- Financial and other material support available
- Short-term hospitalization for mental illnesses
- Substance abuse related treatments for parents
- Substance abuse related treatments for children
- Family Resource Centers available to parents
- Universal home-visits for new parents
- Targeted home-visits for new parents at-risk
- Available free child care
- Universal access to free medical care for all citizens

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

- Universal health screening for children
- Access to free medical care for 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: Between 1990-2000

Core Elements

- Mandated reporting of suspected child abuse for specific groups of professionals
- Voluntary reporting of suspected abuse
- Reports investigated within a specific time period
- Remove abused child from abusive parents
- Specific criminal penalties
- Support for specific prevention services
- Separate attorney assigned to represent child

Enforcement Level: Inconsistently enforced

Level of Government Support: Annual support but an inefficient amount

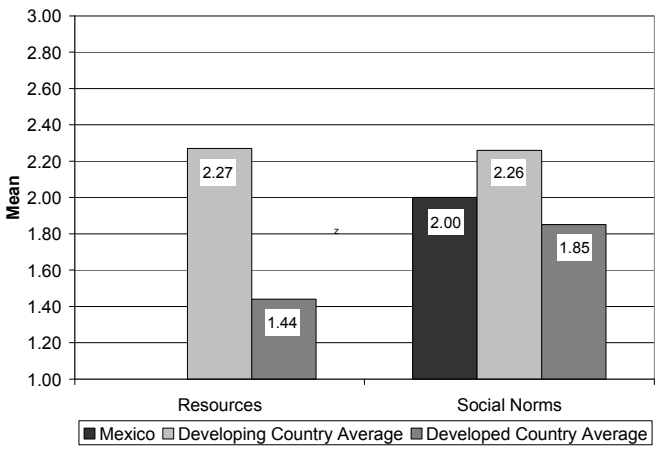
SERVICE PROVIDERS

Level of involvement in child abuse treatment and prevention services.

	None	Minimal	Moderate	Very
Hospital/Medical		◆		
Mental Health Agencies		◆		
Businesses/ Factories				◆
Schools		◆		
Social Service Agencies		◆		
Community-based NGOs		◆		
Religious		◆		
Voluntary Civic Organizations		◆		
Courts/Law			◆	
Universities			◆	

BARRIERS

Average rating of limiting factors to CAN prevention,
(List several factors?)
(Scale: 1="Not important " to 3="Very significant")



MONTENEGRO

Region: Europe

Previous World Perspectives surveys completed: 2006

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 available for child victims of physical abuse
- Therapy programs available for child victims of sexual abuse
- Home-base services intended to assist parents in changing their behaviors
- Group homes for abused children
- Financial and other material support available
- Substance abuse related treatments for parents
- Substance abuse related treatments for children

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

- Case management/meeting basic needs
- Short-term hospitalization for mental illnesses
- Universal home-visits for new parents
- Targeted home-visits for new parents at-risk

Adequate in more than ***2/3*** of Country

- Universal health screening for children
- Access to free medical care for children
- 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: NA

Core Elements

- Mandated reporting of suspected child abuse for specific groups of professionals
- Voluntary reporting of suspected abuse
- Reports investigated within a specific time period
- Remove abused child from abusive parents
- Specific criminal penalties
- All victims receive some form of service or intervention
- Support for specific prevention services

Enforcement Level: Inconsistently enforced

Level of Government Support: Annual support but an inefficient amount

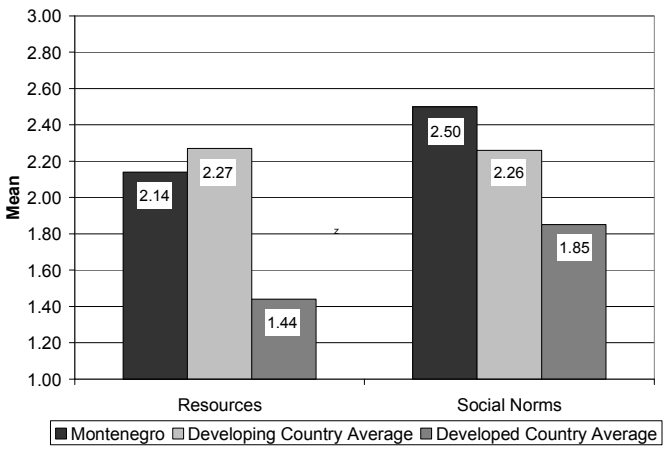
SERVICE PROVIDERS

Level of involvement in child abuse treatment and prevention services.

	None	Minimal	Moderate	Very
Hospital/Medical		◆		
Mental Health Agencies		◆		
Businesses/ Factories	◆			
Schools		◆		
Social Service Agencies				◆
Community-based NGOs		◆		
Religious	◆			
Voluntary Civic Organizations		◆		
Courts/Law			◆	
Universities	◆			

BARRIERS

Average rating of limiting factors to CAN prevention,
(List several factors?)
(Scale: 1="Not important " to 3="Very significant")



MOROCCO

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 available for child victims of physical abuse
- Therapy programs available for child victims of sexual abuse
- Case management/meeting basic needs
- Group homes for abused children
- Institutional care available for abused children
- Financial and other material support available
- Short-term hospitalization for mental illnesses
- Substance abuse related treatments for parents
- Substance abuse related treatments for children
- Family Resource Centers available to parents
- Universal health screening for children
- Access to free medical care for 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: Between 1990-2000

Core Elements

- Mandated reporting of suspected child abuse for specific groups of professionals
- Voluntary reporting of suspected abuse
- Reports investigated within a specific time period
- Remove abused child from abusive parents
- Specific criminal penalties
- All victims receive some form of service or intervention
- All abusers receive some form of service/intervention
- Support for specific prevention services
- Separate attorney assigned to represent child

Enforcement Level: Widely enforced

Level of Government Support: Annual support but an inefficient amount

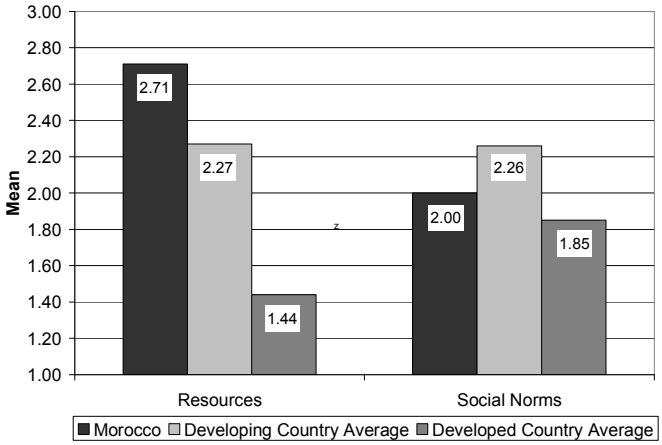
SERVICE PROVIDERS

Level of involvement in child abuse treatment and prevention services.

	None	Minimal	Moderate	Very
Hospital/Medical			◆	
Mental Health Agencies		◆		
Businesses/ Factories		◆		
Schools		◆		
Social Service Agencies			◆	
Community-based NGOs			◆	
Religious		◆		
Voluntary Civic Organizations				◆
Courts/Law			◆	
Universities	◆			

BARRIERS

Average rating of limiting factors to CAN prevention,
(List several factors?)
(Scale: 1="Not important " to 3="Very significant")



NETHERLANDS

Region: Europe

Previous World Perspectives surveys completed:
1992, 1996, 1998, 2000, 2002, 2004, 2006

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 available for child victims of sexual abuse
- Case management/meeting basic needs
- Short-term hospitalization for mental illnesses
- Home-base services intended to assist parents in changing their behaviors
- Substance abuse related treatments for children
- Family Resource Centers available to parents

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

- Therapy available for child sexual abusers
- Substance abuse related treatments for parents
- Available free child care

Adequate in more than ***2/3*** of Country

- Universal health screening for children
- Access to free medical care for children
- 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: NA

Core Elements

- Voluntary reporting of suspected abuse

Enforcement Level: Almost never enforced

Level of Government Support: NA

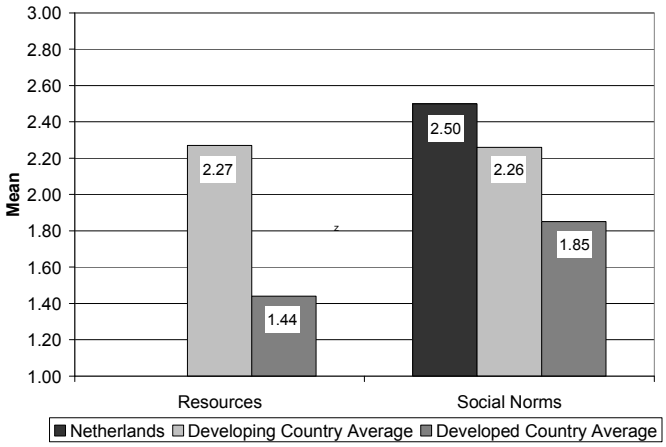
SERVICE PROVIDERS

Level of involvement in child abuse treatment and prevention services.

	None	Minimal	Moderate	Very
Hospital/Medical		◆		
Mental Health Agencies			◆	
Businesses/ Factories	◆			
Schools		◆		
Social Service Agencies		◆		
Community-based NGOs	◆			
Religious	◆			
Voluntary Civic Organizations		◆		
Courts/Law		◆		
Universities		◆		

BARRIERS

Average rating of limiting factors to CAN prevention,
(List several factors?)
(Scale: 1="Not important " to 3="Very significant")



NEW ZEALAND

Region: Oceania

Previous World Perspectives surveys completed:
1996, 1998, 2000, 2002, 2004, 2006

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:

- Therapy programs for physical child abusers
- Case management/meeting basic needs
- Targeted home-visits for new parents at-risk

Adequate in more than ***2/3*** of Country

- Therapy programs available for child victims of physical abuse
- Therapy available for child sexual abusers
- Therapy programs available for child victims of sexual abuse
- Foster care with official foster parents
- Financial and other material support available
- Short-term hospitalization for mental illnesses
- Substance abuse related treatments for parents
- Substance abuse related treatments for children
- Family Resource Centers available to parents
- Universal home-visits for new parents
- Universal health screening for children
- Access to free medical care for 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 abuse
- Reports investigated within a specific time period
- Remove abused child from abusive parents
- Specific criminal penalties
- All victims receive some form of service or intervention
- All abusers receive some form of service/intervention
- Support for specific prevention services
- Separate attorney assigned to represent child

Enforcement Level: Widely enforced

Level of Government Support: Annual support but an inefficient amount

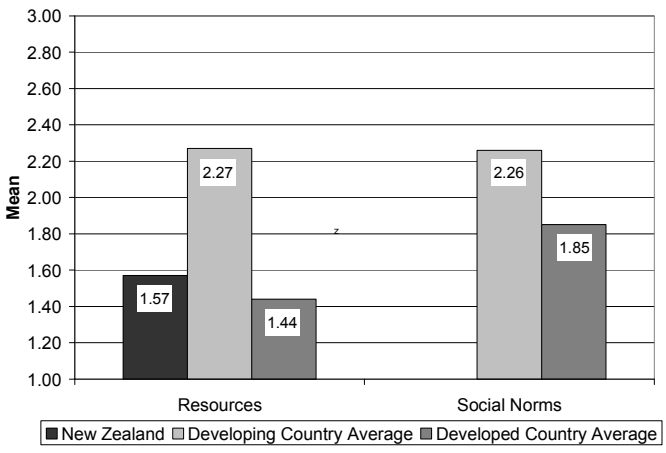
SERVICE PROVIDERS

Level of involvement in child abuse treatment and prevention services.

	None	Minimal	Moderate	Very
Hospital/Medical				◆
Mental Health Agencies				◆
Businesses/ Factories		◆		
Schools		◆		
Social Service Agencies				◆
Community-based NGOs				◆
Religious			◆	
Voluntary Civic Organizations			◆	
Courts/Law				◆
Universities		◆		

BARRIERS

Average rating of limiting factors to CAN prevention,
(List several factors?)
(Scale: 1="Not important " to 3="Very significant")



NIGERIA

Region: Africa

Previous World Perspectives surveys completed: None

OFFICIAL RECORDS

Country maintains official count of CAN cases: UNKNOWN

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 available for child victims of physical abuse
- Foster care with official foster parents
- Financial and other material support available
- Short-term hospitalization for mental illnesses
- Universal health screening for children

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

- Substance abuse related treatments for parents
- Substance abuse related treatments for 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: After 2000

Core Elements

- Voluntary reporting of suspected abuse
- Remove abused child from abusive parents
- Specific criminal penalties
- All victims receive some form of service or intervention
- All abusers receive some form of service/intervention

Enforcement Level: Inconsistently enforced

Level of Government Support: Inconsistent

SERVICE PROVIDERS

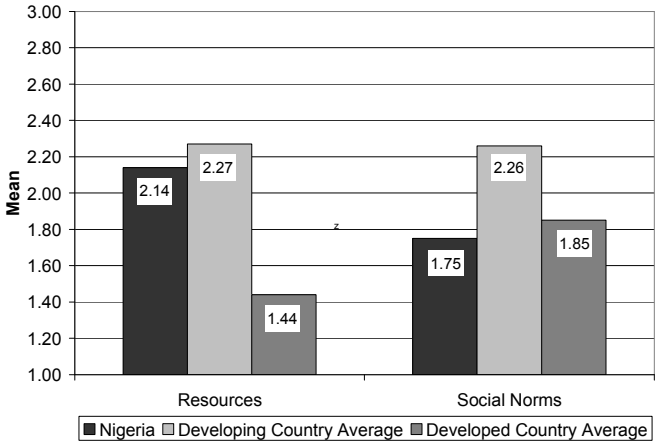
Level of involvement in child abuse treatment and prevention services.

	None	Minimal	Moderate	Very
Hospital/Medical			◆	
Mental Health Agencies		◆		
Businesses/ Factories				
Schools				◆
Social Service Agencies			◆	
Community-based NGOs				◆
Religious				◆
Voluntary Civic Organizations				◆
Courts/Law			◆	
Universities		◆		

BARRIERS

Average rating of limiting factors to CAN prevention, (List several factors?)

(Scale: 1="Not important " to 3="Very significant")



PAKISTAN

Region: South-Central Asia

Previous World Perspectives surveys completed:
1992, 1996, 1998, 2002, 2004, 2006

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 available for child victims of physical abuse
- Therapy programs available for child victims of sexual abuse
- Institutional care available for abused children
- Short-term hospitalization for mental illnesses
- Substance abuse related treatments for children
- Access to free medical care for children
- Universal access to free medical care for all citizens

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

- 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 abuse
- Specific criminal penalties
- All victims receive some form of service or intervention

Enforcement Level: Inconsistently enforced

Level of Government Support: Inconsistent

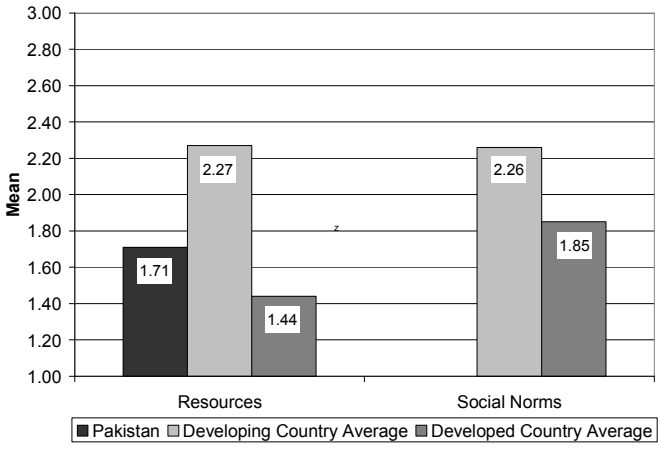
SERVICE PROVIDERS

Level of involvement in child abuse treatment and prevention services.

	None	Minimal	Moderate	Very
Hospital/Medical		◆		
Mental Health Agencies		◆		
Businesses/ Factories	◆			
Schools	◆			
Social Service Agencies		◆		
Community-based NGOs		◆		
Religious	◆			
Voluntary Civic Organizations		◆		
Courts/Law			◆	
Universities	◆			

BARRIERS

Average rating of limiting factors to CAN prevention,
(List several factors?)
(Scale: 1="Not important " to 3="Very significant")



PERU

Region: Americas

Previous World Perspectives surveys completed: 1992, 2002, 2004, 2006

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 child abusers
- Therapy programs available for child victims of physical abuse
- Therapy programs available for child victims of sexual abuse
- Institutional care available for abused children
- Short-term hospitalization for mental illnesses
- Substance abuse related treatments for parents
- Substance abuse related treatments for children
- Available free child care

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

- Universal health screening for 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: Between 1990- 2000

Core Elements

- Mandated reporting of suspected child abuse for specific groups of professionals
- Reports investigated within a specific time period
- Remove abused child from abusive parents
- Specific criminal penalties
- All victims receive some form of service or intervention
- Support for specific prevention services
- Separate attorney assigned to represent child

Enforcement Level: Inconsistently enforced

Level of Government Support: Annual support but an inefficient amount

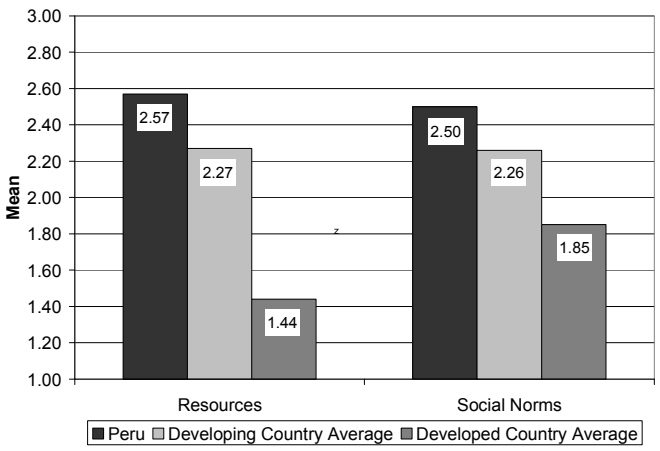
SERVICE PROVIDERS

Level of involvement in child abuse treatment and prevention services.

	None	Minimal	Moderate	Very
Hospital/Medical		◆		
Mental Health Agencies	◆			
Businesses/ Factories				◆
Schools		◆		
Social Service Agencies		◆		
Community-based NGOs	◆			
Religious	◆			
Voluntary Civic Organizations		◆		
Courts/Law		◆		
Universities		◆		

BARRIERS

Average rating of limiting factors to CAN prevention,
(List several factors?)
(Scale: 1="Not important " to 3="Very significant"



PHILIPPINES

Region: South-Eastern Asia

Previous World Perspectives surveys completed: 1996, 2000, 2002, 2004, 2006

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 child abusers
- Therapy programs available for child victims of physical abuse
- Therapy programs available for child victims of sexual abuse
- Therapy available for child sexual abusers
- Case management/meeting basic needs
- Foster care with official foster parents
- Group homes for abused children
- Institutional care available for abused children
- Financial and other material support available
- Short-term hospitalization for mental illnesses
- Substance abuse related treatments for parents
- Substance abuse related treatments for children
- Family Resource Centers available to parents
- Targeted home-visits for new parents at-risk
- Available free child care

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

- Access to free medical care for children
- Universal access to free medical care for all citizens

Adequate in more than ***2/3*** of Country

- Universal health screening for 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: Between 1990-2000

Core Elements

- Mandated reporting of suspected child abuse for specific groups of professionals
- Voluntary reporting of suspected abuse
- Reports investigated within a specific time period
- Remove abused child from abusive parents
- Specific criminal penalties
- All abusers receive some form of service/intervention
- Support for specific prevention services
- Separate attorney assigned to represent child

Enforcement Level: Inconsistently enforced

Level of Government Support: Annual support but an inefficient amount

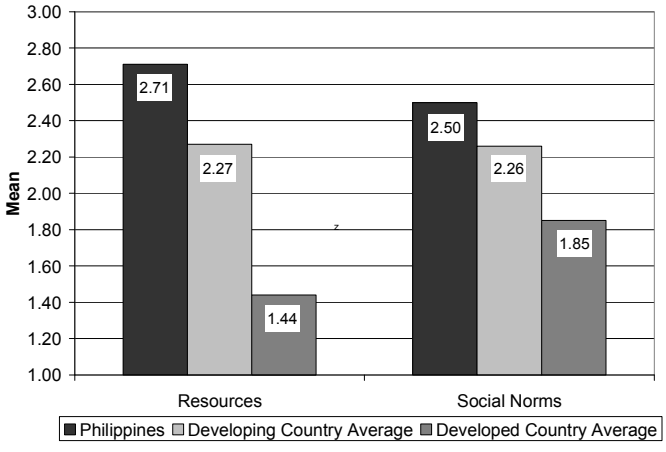
SERVICE PROVIDERS

Level of involvement in child abuse treatment and prevention services.

	None	Minimal	Moderate	Very
Hospital/Medical			◆	
Mental Health Agencies		◆		
Businesses/ Factories	◆			
Schools		◆		
Social Service Agencies			◆	
Community-based NGOs				◆
Religious			◆	
Voluntary Civic Organizations			◆	
Courts/Law			◆	
Universities		◆		

BARRIERS

Average rating of limiting factors to CAN prevention,
(List several factors?)
(Scale: 1="Not important " to 3="Very significant")



POLAND

Region: Europe

Previous World Perspectives surveys completed: 1998, 2002, 2004, 2006

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 available for child victims of physical abuse
- Therapy programs available for child victims of sexual abuse
- Foster care with official foster parents
- Available free child care
- Universal access to free medical care for all citizens

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

- Substance abuse related treatments for children

Adequate in more than ***2/3*** of Country

- Institutional care available for abused children
- Short-term hospitalization for mental illnesses
- Substance abuse related treatments for parents
- Universal health screening for children
- Access to free medical care for 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? NA

If yes, date established: NA

Core Elements

- Voluntary reporting of suspected abuse
- Remove abused child from abusive parents

Enforcement Level: NA

Level of Government Support: NA

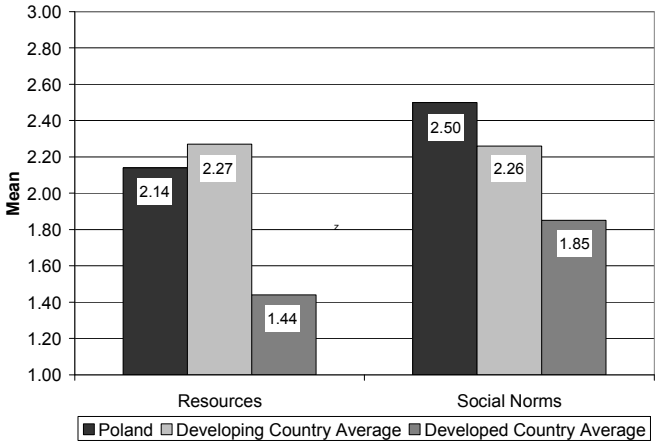
SERVICE PROVIDERS

Level of involvement in child abuse treatment and prevention services.

	None	Minimal	Moderate	Very
Hospital/Medical		◆		
Mental Health Agencies			◆	
Businesses/ Factories	◆			
Schools			◆	
Social Service Agencies			◆	
Community-based NGOs				◆
Religious		◆		
Voluntary Civic Organizations				
Courts/Law			◆	
Universities	◆			

BARRIERS

Average rating of limiting factors to CAN prevention,
(List several factors?)
(Scale: 1="Not important " to 3="Very significant")



PORTUGAL

Region: Europe

Previous World Perspectives surveys completed:
1998, 2002, 2004, 2006

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:

- Foster care with official foster parents
- Institutional care available for abused children
- Short-term hospitalization for mental illnesses
- Substance abuse related treatments for parents
- Available free child care
- Universal health screening for children
- Access to free medical care for 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: NA

Core Elements

- Voluntary reporting of suspected abuse
- Remove abused child from abusive parents
- Specific criminal penalties
- All victims receive some form of service or intervention
- Separate attorney assigned to represent child

Enforcement Level: Widely enforced

Level of Government Support: Inconsistent

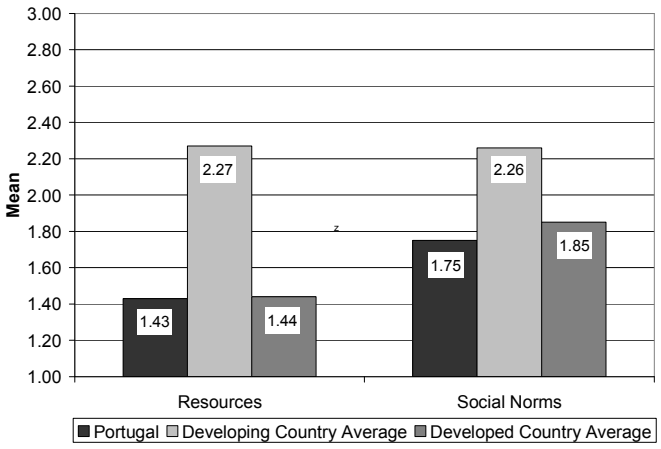
SERVICE PROVIDERS

Level of involvement in child abuse treatment and prevention services.

	None	Minimal	Moderate	Very
Hospital/Medical			◆	
Mental Health Agencies		◆		
Businesses/ Factories	◆			
Schools		◆		
Social Service Agencies			◆	
Community-based NGOs			◆	
Religious		◆		
Voluntary Civic Organizations		◆		
Courts/Law		◆		
Universities		◆		

BARRIERS

Average rating of limiting factors to CAN prevention,
(List several factors?)
(Scale: 1="Not important " to 3="Very significant")



ROMANIA

Region: Europe

Previous World Perspectives surveys completed: 2000, 2004, 2006

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 child abusers
- Therapy programs available for child victims of physical abuse
- Therapy programs available for child victims of sexual abuse
- Case management/meeting basic needs
- Financial and other material support available
- Short-term hospitalization for mental illnesses
- Substance abuse related treatments for children

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

- Institutional care available for abused children

Adequate in more than ***2/3*** of Country

- Foster care with official foster parents
- Universal health screening for 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: After 2000

Core Elements

- Mandated reporting of suspected child abuse for specific groups of professionals
- Voluntary reporting of suspected abuse
- Reports investigated within a specific time period
- Remove abused child from abusive parents
- Support for specific prevention services

Enforcement Level: Inconsistently enforced

Level of Government Support: Annual support but an inefficient amount

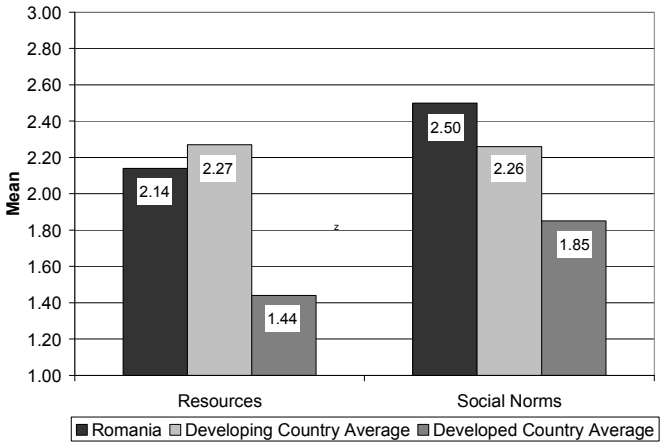
SERVICE PROVIDERS

Level of involvement in child abuse treatment and prevention services.

	None	Minimal	Moderate	Very
Hospital/Medical		◆		
Mental Health Agencies		◆		
Businesses/ Factories	◆			
Schools		◆		
Social Service Agencies				◆
Community-based NGOs			◆	
Religious			◆	
Voluntary Civic Organizations		◆		
Courts/Law			◆	
Universities			◆	

BARRIERS

Average rating of limiting factors to CAN prevention,
(List several factors?)
(Scale: 1="Not important " to 3="Very significant")



RUSSIA

Region: Europe

Previous World Perspectives surveys completed:
1998, 2000, 2002, 2004, 2006

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 other material support available

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

- Therapy programs available for child victims of physical abuse
- Therapy programs available for child victims of sexual abuse
- Case management/meeting basic needs
- Home-base services intended to assist parents in changing their behaviors
- Short-term hospitalization for mental illnesses
- Substance abuse related treatments for parents
- Family Resource Centers available to parents
- Targeted home-visits for new parents at-risk
- Available free child care
- Access to free medical care for children
- Universal access to free medical care for all citizens

Adequate in more than ***2/3*** of Country

- Institutional care available for abused children
- Substance abuse related treatments for children
- Universal home-visits for new parents
- Universal health screening for 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: NA

Core Elements

- Mandated reporting of suspected child abuse for specific groups of professionals
- Voluntary reporting of suspected abuse
- Reports investigated within a specific time period
- Remove abused child from abusive parents
- Specific criminal penalties
- All victims receive some form of service or intervention
- Support for specific prevention services
- Separate attorney assigned to represent child

Enforcement Level: Widely enforced

Level of Government Support: Annual support but an inefficient amount

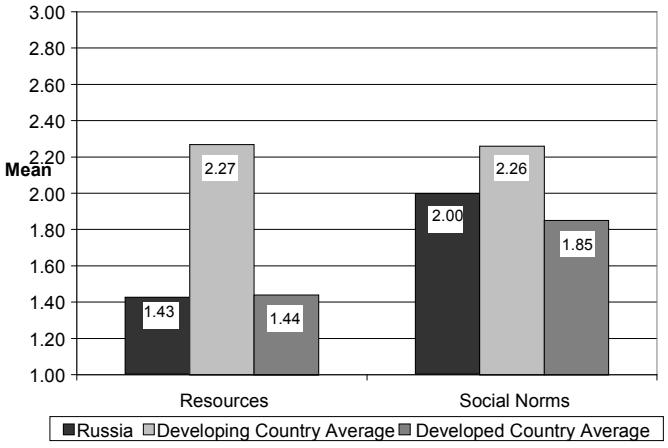
SERVICE PROVIDERS

Level of involvement in child abuse treatment and prevention services.

	None	Minimal	Moderate	Very
Hospital/Medical				◆
Mental Health Agencies				◆
Businesses/ Factories			◆	
Schools				◆
Social Service Agencies				◆
Community-based NGOs			◆	
Religious			◆	
Voluntary Civic Organizations			◆	
Courts/Law			◆	
Universities			◆	

BARRIERS

Average rating of limiting factors to CAN prevention,
(List several factors?)
(Scale: 1="Not important " to 3="Very significant")



RWANDA

Region: Africa

Previous World Perspectives surveys completed: 2000, 2002, 2004, 2006

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 illnesses

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

- Therapy programs available for child victims of physical abuse
- Therapy programs available for child victims of sexual abuse
- Institutional care available for abused children

Adequate in more than ***2/3*** of Country

- Foster care with official foster 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
- Voluntary reporting of suspected abuse
- Reports investigated within a specific time period
- Remove abused child from abusive parents
- Specific criminal penalties
- Separate attorney assigned to represent child

Enforcement Level: Widely enforced
Level of Government Support: Annual support but an inefficient amount

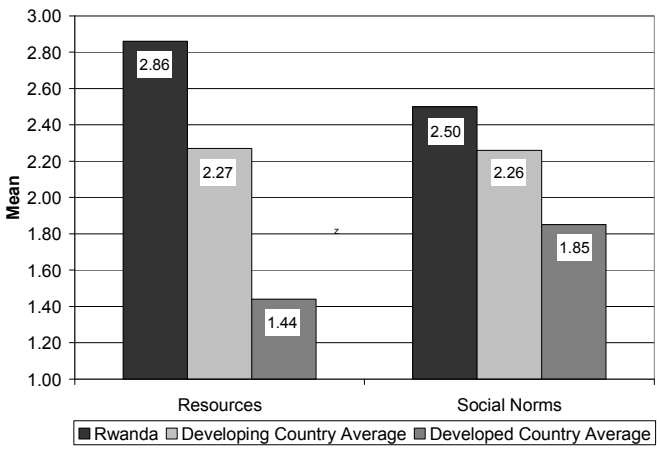
SERVICE PROVIDERS

Level of involvement in child abuse treatment and prevention services.

	None	Minimal	Moderate	Very
Hospital/Medical				◆
Mental Health Agencies		◆		
Businesses/ Factories	◆			
Schools				◆
Social Service Agencies				◆
Community-based NGOs				◆
Religious				◆
Voluntary Civic Organizations				◆
Courts/Law				◆
Universities				

BARRIERS

Average rating of limiting factors to CAN prevention,
(List several factors?)
(Scale: 1="Not important " to 3="Very significant")



SAUDI ARABIA

Region: Western 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 available for child victims of physical abuse
- Therapy programs available for child victims of sexual abuse
- Case management/meeting basic needs
- Group homes for abused children
- Institutional care available for abused children
- Financial and other material support available
- Short-term hospitalization for mental illnesses
- Substance abuse related treatments for parents

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

- Universal health screening for children

Adequate in more than ***2/3*** of Country

- Access to free medical care for children
- 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

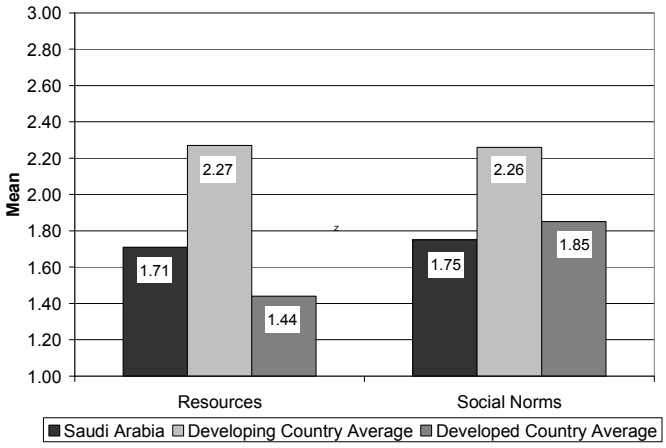
SERVICE PROVIDERS

Level of involvement in child abuse treatment and prevention services.

	None	Minimal	Moderate	Very
Hospital/Medical				◆
Mental Health Agencies		◆		
Businesses/ Factories	◆			
Schools		◆		
Social Service Agencies				◆
Community-based NGOs		◆		
Religious		◆		
Voluntary Civic Organizations		◆		
Courts/Law		◆		
Universities	◆			

BARRIERS

Average rating of limiting factors to CAN prevention,
(List several factors?)
(Scale: 1="Not important " to 3="Very significant")



SERBIA

Region: Europe

Previous World Perspectives surveys completed: 2000, 2002, 2004, 2006

OFFICIAL RECORDS

Country maintains official count of CAN cases: YES BUT CLASSIFICATIONS UNKNOWN

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 child abusers
- Therapy programs available for child victims of physical abuse
- Therapy programs available for child victims of sexual abuse
- Group homes for abused children
- Institutional care available for abused children

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

- Case management/meeting basic needs
- Home-base services intended to assist parents in changing their behaviors
- Foster care with official foster parents
- Financial and other material support available
- Substance abuse related treatments for children
- Targeted home-visits for new parents at-risk

Adequate in more than ***2/3*** of Country

- Short-term hospitalization for mental illnesses
- Substance abuse related treatments for parents
- Universal home-visits for new parents
- Available free child care
- Universal health screening for children
- Access to free medical care for children
- 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
- Reports investigated within a specific time period
- Remove abused child from abusive parents
- Specific criminal penalties
- All victims receive some form of service or intervention
- Separate attorney assigned to represent child

Enforcement Level: Widely enforced

Level of Government Support: Adequately supported

SERVICE PROVIDERS

Level of involvement in child abuse treatment and prevention services.

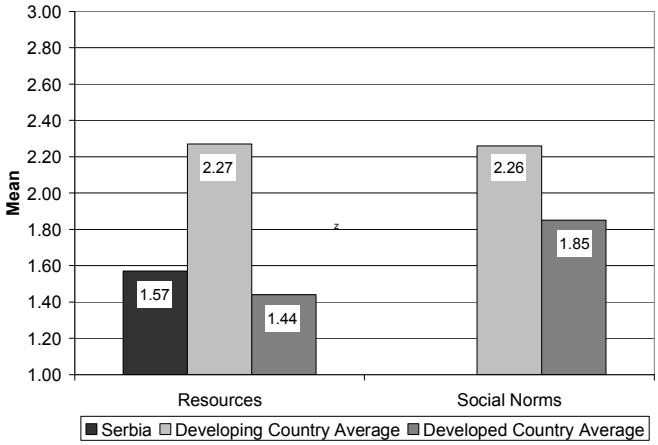
	None	Minimal	Moderate	Very
Hospital/Medical			◆	
Mental Health Agencies			◆	
Businesses/ Factories	◆			
Schools			◆	
Social Service Agencies				◆
Community-based NGOs				◆
Religious		◆		
Voluntary Civic Organizations		◆		
Courts/Law			◆	
Universities			◆	

BARRIERS

Average rating of limiting factors to CAN prevention,

(List several factors?)

(Scale: 1="Not important " to 3="Very significant")



SIERRA LEONE

Region: Africa

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 physical child abusers
- Therapy programs available for child victims of physical abuse
- Therapy available for child sexual abusers
- Therapy programs available for child victims of sexual abuse
- Financial and other material support available
- Short-term hospitalization for mental illnesses

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

- Institutional care available for abused children
- Substance abuse related treatments for 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: After 2000

Core Elements

- Mandated reporting of suspected child abuse for specific groups of professionals
- Voluntary reporting of suspected abuse
- Specific criminal penalties
- All victims receive some form of service or intervention
- Separate attorney assigned to represent child

Enforcement Level: Inconsistently enforced

Level of Government Support: Inconsistent

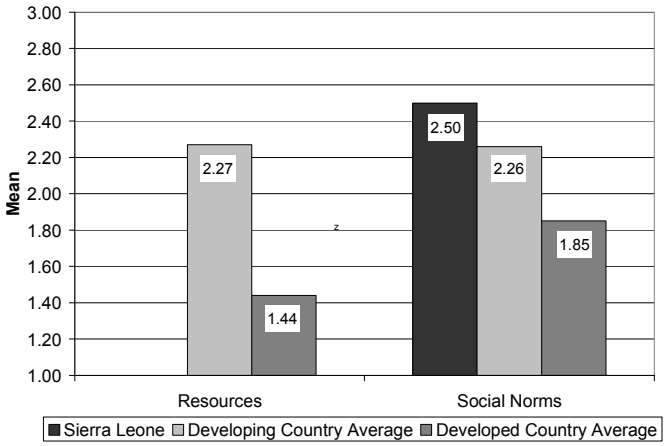
SERVICE PROVIDERS

Level of involvement in child abuse treatment and prevention services.

	None	Minimal	Moderate	Very
Hospital/Medical	◆			
Mental Health Agencies			◆	
Businesses/ Factories	◆			
Schools		◆		
Social Service Agencies		◆		
Community-based NGOs			◆	
Religious	◆			
Voluntary Civic Organizations				◆
Courts/Law				◆
Universities		◆		

BARRIERS

Average rating of limiting factors to CAN prevention,
(List several factors?)
(Scale: 1="Not important " to 3="Very significant")



SINGAPORE

Region: South-Eastern Asia

Previous World Perspectives surveys completed:
1996, 1998, 2000, 2004, 2006

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 physical child abusers
- Therapy programs available for child victims of physical abuse
- Therapy available for child sexual abusers
- Therapy programs available for child victims of sexual abuse
- Case management/meeting basic needs
- Home-base services intended to assist parents in changing their behaviors
- Foster care with official foster parents
- Group homes for abused children
- Institutional care available for abused children
- Financial and other material support available
- Short-term hospitalization for mental illnesses
- Substance abuse related treatments for parents
- Substance abuse related treatments for children
- Family Resource Centers available to parents
- Universal home-visits for new parents
- Targeted home-visits for new parents at-risk
- Available free child care
- Universal health screening for children
- Access to free medical care for children
- 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
- Reports investigated within a specific time period
- Remove abused child from abusive parents
- Specific criminal penalties
- All victims receive some form of service or intervention
- All abusers receive some form of service/intervention
- Support for specific prevention services
- Separate attorney assigned to represent child

Enforcement Level: Widely enforced

Level of Government Support: Adequately supported

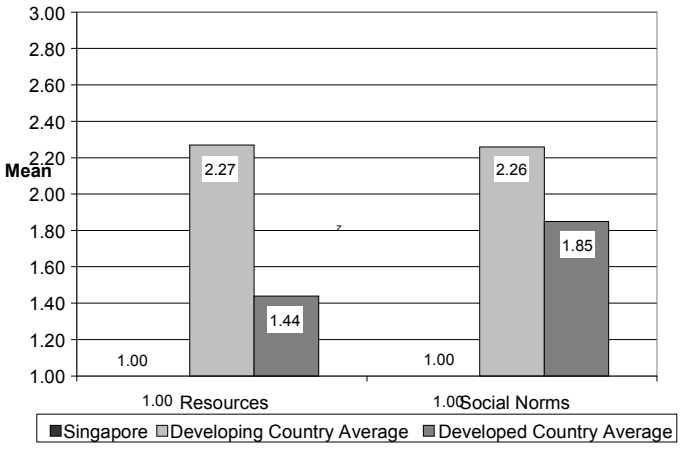
SERVICE PROVIDERS

Level of involvement in child abuse treatment and prevention services.

	None	Minimal	Moderate	Very
Hospital/Medical				◆
Mental Health Agencies				◆
Businesses/ Factories			◆	
Schools				◆
Social Service Agencies				◆
Community-based NGOs				◆
Religious			◆	
Voluntary Civic Organizations				◆
Courts/Law				◆
Universities		◆		

BARRIERS

Average rating of limiting factors to CAN prevention,
(List several factors?)
(Scale: 1="Not important " to 3="Very significant")



SOUTH AFRICA

Region: Africa

Previous World Perspectives surveys completed:
1992, 1996, 1998, 2000, 2002, 2004, 2006

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 available for child sexual abusers
- Home-base services intended to assist parents in changing their behaviors
- Group homes for abused children
- Institutional care available for abused children
- Financial and other material support available
- Short-term hospitalization for mental illnesses
- Substance abuse related treatments for parents
- Substance abuse related treatments for children
- Family Resource Centers available to parents

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

- Therapy programs available for child victims of sexual abuse
- Case management/meeting basic needs
- Foster care with official foster parents
- Universal health screening for children
- Access to free medical care for 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
- Voluntary reporting of suspected abuse
- Reports investigated within a specific time period
- Remove abused child from abusive parents
- Specific criminal penalties
- All victims receive some form of service or intervention
- Support for specific prevention services
- Separate attorney assigned to represent child

Enforcement Level: Inconsistently enforced

Level of Government Support: Annual support but an inefficient amount

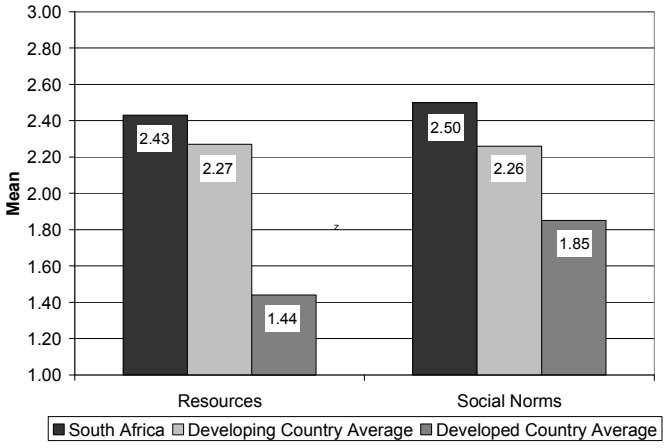
SERVICE PROVIDERS

Level of involvement in child abuse treatment and prevention services.

	None	Minimal	Moderate	Very
Hospital/Medical			◆	
Mental Health Agencies		◆		
Businesses/ Factories	◆			
Schools			◆	
Social Service Agencies				◆
Community-based NGOs				◆
Religious			◆	
Voluntary Civic Organizations			◆	
Courts/Law				◆
Universities				

BARRIERS

Average rating of limiting factors to CAN prevention,
(List several factors?)
(Scale: 1="Not important " to 3="Very significant")



SPAIN

Region: Europe

Previous World Perspectives surveys completed:
1992, 1996, 1998, 2000, 2002, 2004, 2006

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 child abusers
- Therapy available for child sexual abusers
- Home-base services intended to assist parents in changing their behaviors
- Family Resource Centers available to parents
- Universal home-visits for new parents
- Targeted home-visits for new parents at-risk

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

- Therapy programs available for child victims of sexual abuse
- Case management/meeting basic needs
- Short-term hospitalization for mental illnesses
- Available free child care

Adequate in more than ***2/3*** of Country

- Therapy programs available for child victims of physical abuse
- Foster care with official foster parents
- Institutional care available for abused children
- Financial and other material support available
- Substance abuse related treatments for parents
- Substance abuse related treatments for children
- Universal health screening for children
- Access to free medical care for children
- 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
- Voluntary reporting of suspected abuse
- Reports investigated within a specific time period
- Remove abused child from abusive parents
- Specific criminal penalties
- All victims receive some form of service or intervention
- All abusers receive some form of service/intervention
- Support for specific prevention services
- Separate attorney assigned to represent child

Enforcement Level: Widely enforced

Level of Government Support: Adequately supported

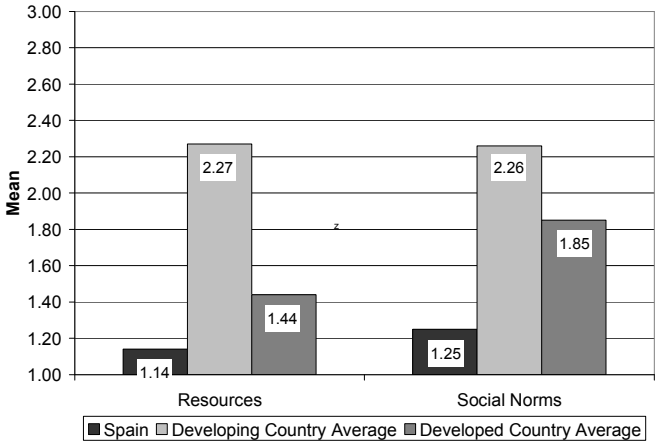
SERVICE PROVIDERS

Level of involvement in child abuse treatment and prevention services.

	None	Minimal	Moderate	Very
Hospital/Medical				◆
Mental Health Agencies			◆	
Businesses/ Factories		◆		
Schools			◆	
Social Service Agencies				◆
Community-based NGOs			◆	
Religious			◆	
Voluntary Civic Organizations			◆	
Courts/Law			◆	
Universities		◆		

BARRIERS

Average rating of limiting factors to CAN prevention,
(List several factors?)
(Scale: 1="Not important " to 3="Very significant")



SRI LANKA

Region: South-Central Asia

Previous World Perspectives surveys completed: 1998, 2000, 2002, 2004, 2006

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:

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

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

- Therapy programs for physical child abusers
- Therapy programs available for child victims of physical abuse.
- Therapy programs available for child victims of sexual abuse
- Therapy available for child sexual abusers

Adequate in more than ***2/3*** of Country

- Institutional care available for abused children
- Short-term hospitalization for mental illnesses

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 abuse
- Reports investigated within a specific time period
- Remove abused child from abusive parents
- Specific criminal penalties
- All victims receive some form of service or intervention
- All abusers receive some form of service/intervention
- Support for specific prevention services
- Separate attorney assigned to represent child

Enforcement Level: Widely enforced

Level of Government Support: Annual support but an inefficient amount

SERVICE PROVIDERS

Level of involvement in child abuse treatment and prevention services.

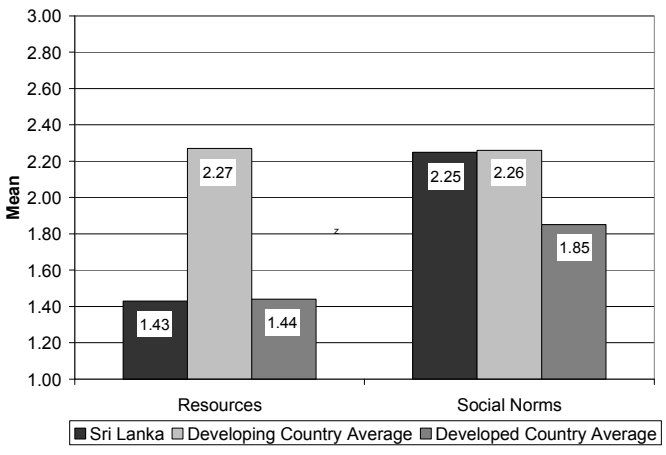
	None	Minimal	Moderate	Very
Hospital/Medical				◆
Mental Health Agencies				◆
Businesses/ Factories	◆			
Schools			◆	
Social Service Agencies				◆
Community-based NGOs				◆
Religious		◆		
Voluntary Civic Organizations				◆
Courts/Law				◆
Universities				◆

BARRIERS

Average rating of limiting factors to CAN prevention,

(List several factors?)

(Scale: 1="Not important " to 3="Very significant")



SWEDEN

Region: Europe

Previous World Perspectives surveys completed: 1992, 1996, 2002, 2004, 2006

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 available for child sexual abusers
- Family Resource Centers available to parents
- Targeted home-visits for new parents at-risk
- Available free child care

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

- Therapy programs available for child victims of sexual abuse
- Institutional care available for abused children
- Short-term hospitalization for mental illnesses
- Substance abuse related treatments for children

Adequate in more than ***2/3*** of Country

- Case management/meeting basic needs
- Home-base services intended to assist parents in changing their behaviors
- Foster care with official foster parents
- Group homes for abused children
- Financial and other material support available
- Substance abuse related treatments for parents
- Universal home-visits for new parents
- Universal health screening for children
- Access to free medical care for children
- 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
- Voluntary reporting of suspected abuse
- Reports investigated within a specific time period
- Remove abused child from abusive parents
- Specific criminal penalties
- All victims receive some form of service or intervention
- Support for specific prevention services
- Separate attorney assigned to represent child

Enforcement Level: Widely enforced

Level of Government Support: Adequately supported

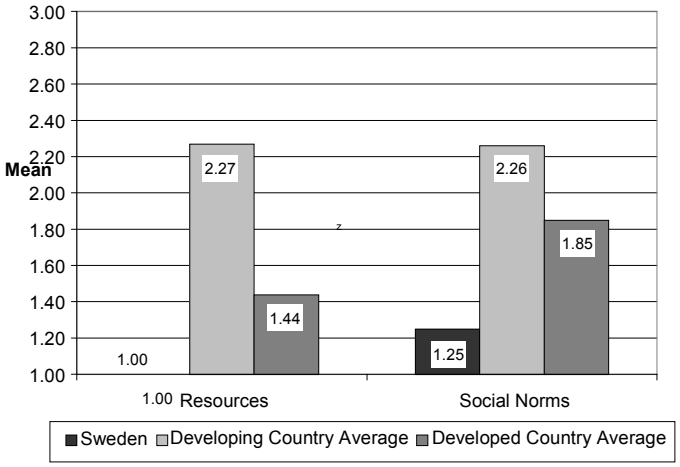
SERVICE PROVIDERS

Level of involvement in child abuse treatment and prevention services.

	None	Minimal	Moderate	Very
Hospital/Medical			◆	
Mental Health Agencies			◆	
Businesses/ Factories	◆			
Schools			◆	
Social Service Agencies				◆
Community-based NGOs	◆			
Religious	◆			
Voluntary Civic Organizations		◆		
Courts/Law			◆	
Universities	◆			

BARRIERS

Average rating of limiting factors to CAN prevention,
(List several factors?)
(Scale: 1="Not important " to 3="Very significant")



SWITZERLAND

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 available for child sexual abusers
- Foster care with official foster parents
- Group homes for abused children
- Substance abuse related treatments for children

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

- Therapy programs for physical child abusers
- Therapy programs available for child victims of physical abuse
- Institutional care available for abused children

Adequate in more than ***2/3*** of Country

- Therapy programs available for child victims of sexual abuse
- Case management/meeting basic needs
- Financial and other material support available
- Short-term hospitalization for mental illnesses
- Substance abuse related treatments for parents
- Available free child care
- Universal health screening for children
- Access to free medical care for children
- 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
- Remove abused child from abusive parents
- Specific criminal penalties
- Support for specific prevention services

Enforcement Level: Inconsistently enforced

Level of Government Support: Inconsistent

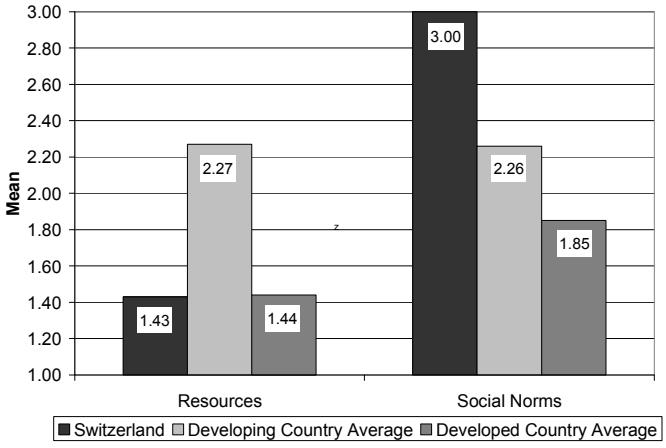
SERVICE PROVIDERS

Level of involvement in child abuse treatment and prevention services.

	None	Minimal	Moderate	Very
Hospital/Medical			◆	
Mental Health Agencies		◆		
Businesses/ Factories	◆			
Schools		◆		
Social Service Agencies		◆		
Community-based NGOs			◆	
Religious		◆		
Voluntary Civic Organizations		◆		
Courts/Law	◆			
Universities		◆		

BARRIERS

Average rating of limiting factors to CAN prevention,
(List several factors?)
(Scale: 1="Not important " to 3="Very significant")



SYRIA

Region: Western Asia

Previous World Perspectives surveys completed: 2004, 2006

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:

- Group homes for abused children
- Institutional care available for abused children
- Financial and other material support available
- Short-term hospitalization for mental illnesses

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

- Substance abuse related treatments for parents

Adequate in more than ***2/3*** of Country

- Universal health screening for children
- Access to free medical care for children
- 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

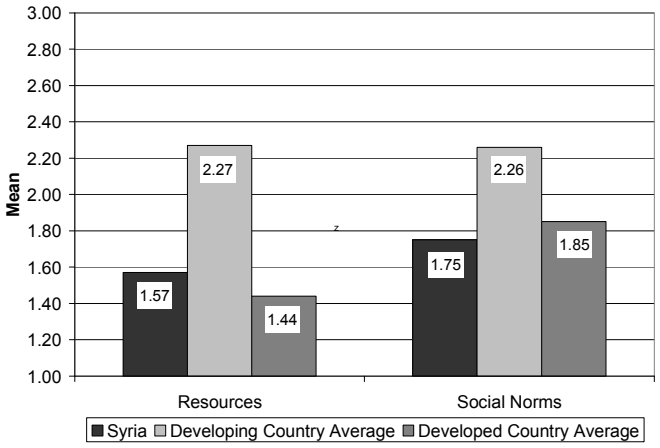
SERVICE PROVIDERS

Level of involvement in child abuse treatment and prevention services.

	None	Minimal	Moderate	Very
Hospital/Medical			◆	
Mental Health Agencies			◆	
Businesses/ Factories	◆			
Schools		◆		
Social Service Agencies		◆		
Community-based NGOs		◆		
Religious		◆		
Voluntary Civic Organizations	◆			
Courts/Law		◆		
Universities		◆		

BARRIERS

Average rating of limiting factors to CAN prevention,
(List several factors?)
(Scale: 1="Not important " to 3="Very significant")



TAIWAN

Region: Eastern Asia

Previous World Perspectives surveys completed: 1998, 2000, 2002, 2006

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 child abusers
- Therapy programs available for child victims of physical abuse.
- Therapy programs available for child victims of sexual abuse
- Therapy available for child sexual abusers
- Home-base services intended to assist parents in changing their behaviors
- Substance abuse related treatments for parents
- Substance abuse related treatments for children
- Family Resource Centers available to parents
- Available free child care

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

- Case management/meeting basic needs
- Group homes for abused children
- Institutional care available for abused children
- Financial and other material support available
- Short-term hospitalization for mental illnesses
- Universal health screening for children
- Access to free medical care for children

Adequate in more than ***2/3*** of Country

- Foster care with official foster 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 1980-1989

Core Elements

- Mandated reporting of suspected child abuse for specific groups of professionals
- Voluntary reporting of suspected abuse
- Reports investigated within a specific time period
- Remove abused child from abusive parents
- Specific criminal penalties
- All victims receive some form of service or intervention
- All abusers receive some form of service/intervention
- Support for specific prevention services
- Separate attorney assigned to represent child

Enforcement Level: Widely enforced

Level of Government Support: Annual support but an inefficient amount

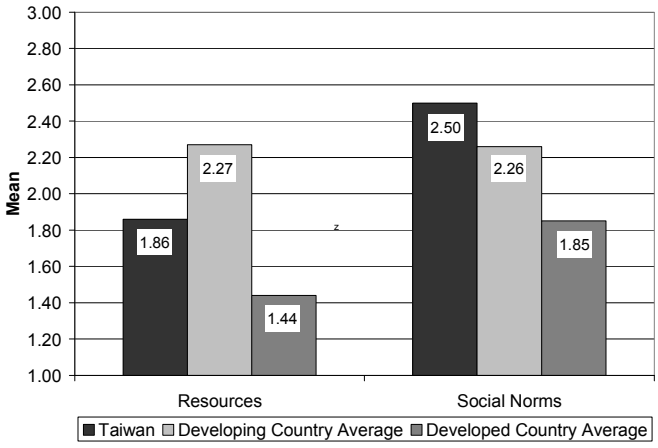
SERVICE PROVIDERS

Level of involvement in child abuse treatment and prevention services.

	None	Minimal	Moderate	Very
Hospital/Medical		◆		
Mental Health Agencies	◆			
Businesses/ Factories			◆	
Schools			◆	
Social Service Agencies			◆	
Community-based NGOs			◆	
Religious			◆	
Voluntary Civic Organizations			◆	
Courts/Law				◆
Universities		◆		

BARRIERS

Average rating of limiting factors to CAN prevention,
(List several factors?)
(Scale: 1="Not important " to 3="Very significant")



TAJIKISTAN

Region: South-Central Asia

Previous World Perspectives surveys completed: 2006

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 available for child victims of sexual abuse
- Institutional care available for abused children
- Targeted home-visits for new parents at-risk

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

- Therapy programs available for child victims of physical abuse
- Short-term hospitalization for mental illnesses
- Universal health screening for children
- Access to free medical care for 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: Between 1990-2000

Core Elements

- Mandated reporting of suspected child abuse for specific groups of professionals
- Reports investigated within a specific time period
- Remove abused child from abusive parents
- Specific criminal penalties
- All victims receive some form of service or intervention
- Support for specific prevention services
- Separate attorney assigned to represent child

Enforcement Level: NA

Level of Government Support: Inconsistent

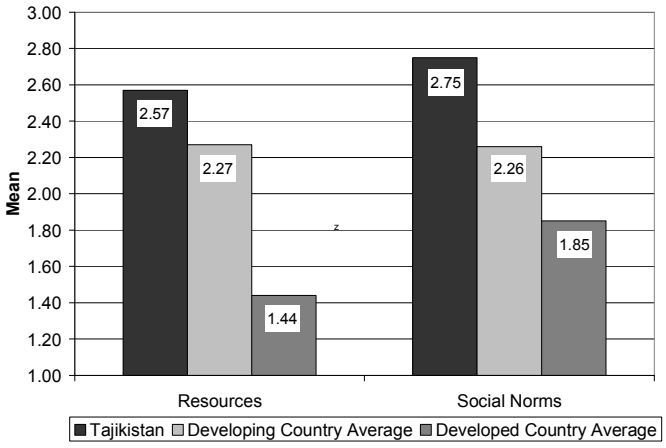
SERVICE PROVIDERS

Level of involvement in child abuse treatment and prevention services.

	None	Minimal	Moderate	Very
Hospital/Medical				◆
Mental Health Agencies			◆	
Businesses/ Factories	◆			
Schools		◆		
Social Service Agencies		◆		
Community-based NGOs			◆	
Religious		◆		
Voluntary Civic Organizations		◆		
Courts/Law			◆	
Universities	◆			

BARRIERS

Average rating of limiting factors to CAN prevention,
(List several factors?)
(Scale: 1="Not important " to 3="Very significant")



THAILAND

Region: South-Eastern Asia

Previous World Perspectives surveys completed: 1998, 2002, 2004, 2006

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 child abusers
- Therapy programs for child victims of sexual abuse
- Case management/meeting basic needs
- Home-base services intended to assist parents in changing their behaviors
- Foster care with official foster parents
- Group homes for abused children
- Financial and other material support available
- Short-term hospitalization for mental illnesses
- Substance abuse related treatments for parents
- Family Resource Centers available to parents
- Universal home-visits for new parents
- Targeted home-visits for new parents at-risk
- Available free child care

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

- Therapy programs available for child victims of physical abuse
- Institutional care available for abused children
- Substance abuse related treatments for children

Adequate in more than ***2/3*** of Country

- Universal health screening for children
- Access to free medical care for children
- 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
- Voluntary reporting of suspected abuse
- Reports be investigated within a specific time period
- Remove abused child from abusive parents
- Specific criminal penalties
- All victims receive some form of service or intervention
- All abusers receive some form of service/intervention
- Support for specific prevention services

Enforcement Level: Inconsistently enforced

Level of Government Support: Annual support but an inefficient amount

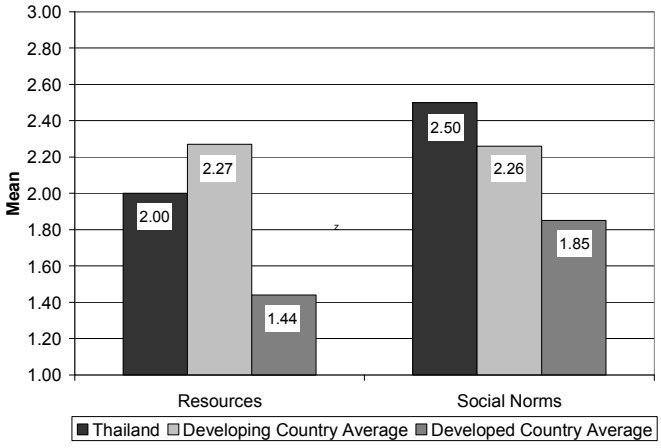
SERVICE PROVIDERS

Level of involvement in child abuse treatment and prevention services.

	None	Minimal	Moderate	Very
Hospital/Medical			◆	
Mental Health Agencies		◆		
Businesses/ Factories	◆			
Schools			◆	
Social Service Agencies			◆	
Community-based NGOs			◆	
Religious	◆			
Voluntary Civic Organizations			◆	
Courts/Law			◆	
Universities		◆		

BARRIERS

Average rating of limiting factors to CAN prevention,
(List several factors?)
(Scale: 1="Not important " to 3="Very significant")



TOGO

Region: Africa

Previous World Perspectives surveys completed: 2000, 2002, 2006

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 child abusers
- Therapy programs available for child victims of physical abuse
- Therapy available for child sexual abusers
- Therapy programs available for child victims of sexual abuse
- Short-term hospitalization for mental illnesses
- Universal home-visits for 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
- Voluntary reporting of suspected abuse
- Reports investigated within a specific time period
- Remove abused child from abusive parents
- Specific criminal penalties
- All victims receive some form of service or intervention
- All abusers receive some form of service/intervention
- Support for specific prevention services
- Separate attorney assigned to represent child

Enforcement Level: Inconsistently enforced

Level of Government Support: Annual support but an inefficient amount

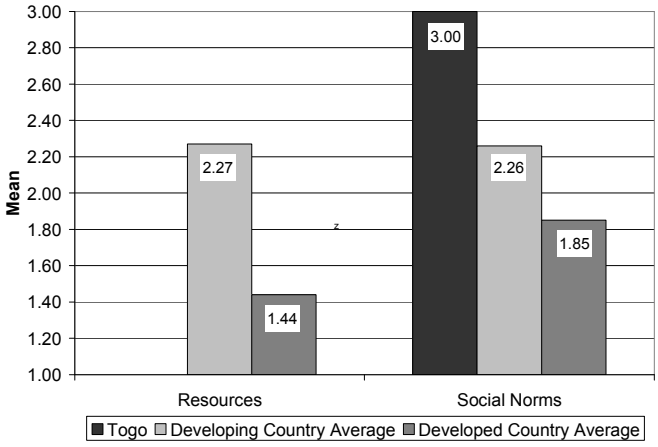
SERVICE PROVIDERS

Level of involvement in child abuse treatment and prevention services.

	None	Minimal	Moderate	Very
Hospital/Medical				◆
Mental Health Agencies				◆
Businesses/ Factories		◆		
Schools			◆	
Social Service Agencies				◆
Community-based NGOs				◆
Religious				◆
Voluntary Civic Organizations				◆
Courts/Law				◆
Universities		◆		

BARRIERS

Average rating of limiting factors to CAN prevention,
(List several factors?)
(Scale: 1="Not important " to 3="Very significant")



TURKEY

Region: Europe

Previous World Perspectives surveys completed: 2002, 2006

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 available for child victims of physical abuse
- Therapy programs available for child victims of sexual abuse
- Case management/meeting basic needs
- Foster care with official foster parents
- Group homes for abused children
- Substance abuse related treatments for parents
- Substance abuse related treatments for children

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

- Short-term hospitalization for mental illnesses

Adequate in more than ***2/3*** of Country

- Institutional care available for abused children
- Financial and other material support available
- Universal health screening for children
- Access to free medical care for children
- 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
- Voluntary reporting of suspected abuse
- Remove abused child from abusive parents
- Specific criminal penalties
- All victims receive some form of service or intervention
- Separate attorney assigned to represent child

Enforcement Level: Inconsistently enforced

Level of Government Support: Annual support but an inefficient amount

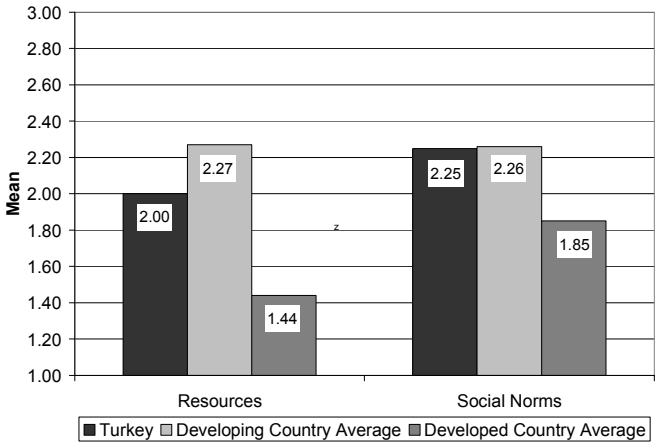
SERVICE PROVIDERS

Level of involvement in child abuse treatment and prevention services.

	None	Minimal	Moderate	Very
Hospital/Medical				◆
Mental Health Agencies				◆
Businesses/ Factories	◆			
Schools			◆	
Social Service Agencies				◆
Community-based NGOs				◆
Religious		◆		
Voluntary Civic Organizations		◆		
Courts/Law			◆	
Universities				◆

BARRIERS

Average rating of limiting factors to CAN prevention,
(List several factors?)
(Scale: 1="Not important " to 3="Very significant")



UGANDA

Region: Africa

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:

- Financial and other material support available
- Short-term hospitalization for mental illnesses
- Access to free medical care for children
- 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

- Voluntary reporting of suspected abuse
- Remove abused child from abusive parents
- Specific criminal penalties
- All abusers receive some form of service/intervention
- Separate attorney assigned to represent child

Enforcement Level: Inconsistently enforced

Level of Government Support: Annual support but an inefficient amount

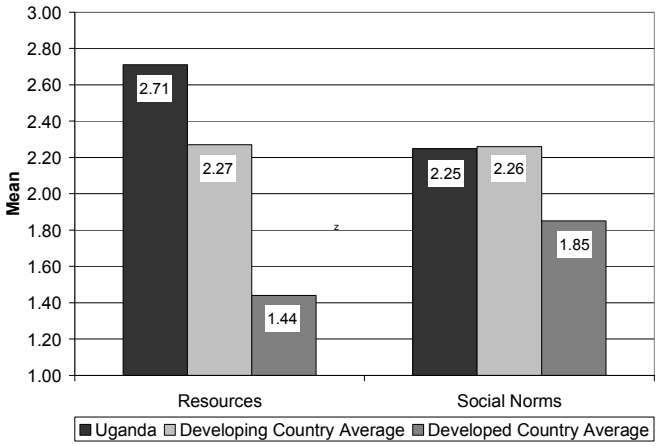
SERVICE PROVIDERS

Level of involvement in child abuse treatment and prevention services.

	None	Minimal	Moderate	Very
Hospital/Medical			◆	
Mental Health Agencies		◆		
Businesses/ Factories	◆			
Schools				◆
Social Service Agencies				◆
Community-based NGOs			◆	
Religious			◆	
Voluntary Civic Organizations				◆
Courts/Law				◆
Universities		◆		

BARRIERS

Average rating of limiting factors to CAN prevention,
(List several factors?)
(Scale: 1="Not important " to 3="Very significant")



UKRAINE

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:

- Therapy available for child sexual abusers
- Case management/meeting basic needs
- Institutional care available for abused children
- Universal home-visits for new parents

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

- Therapy programs for physical child abusers
- Therapy programs available for child victims of physical abuse
- Therapy programs available for child victims of sexual abuse
- Foster care with official foster parents
- Group homes for abused children
- Substance abuse related treatments for children
- Targeted home-visits for new parents at-risk

Adequate in more than ***2/3*** of Country

- Financial and other material support available
- Short-term hospitalization for mental illnesses
- Substance abuse related treatments for parents
- Available free child care
- Universal health screening for children
- Access to free medical care for children
- 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
- Voluntary reporting of suspected abuse
- Reports investigated within a specific time period
- Remove abused child from abusive parents
- Specific criminal penalties
- All victims receive some form of service or intervention
- All abusers receive some form of service/intervention
- Support for specific prevention services
- Separate attorney assigned to represent child

Enforcement Level: Widely enforced

Level of Government Support: Annual support but an inefficient amount

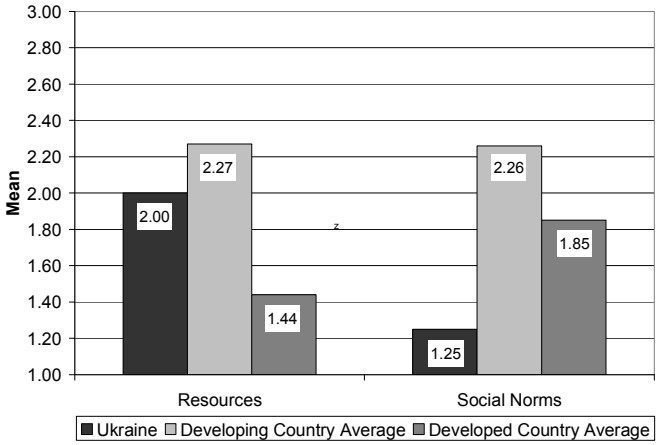
SERVICE PROVIDERS

Level of involvement in child abuse treatment and prevention services.

	None	Minimal	Moderate	Very
Hospital/Medical				◆
Mental Health Agencies			◆	
Businesses/ Factories	◆			
Schools			◆	
Social Service Agencies			◆	
Community-based NGOs		◆		
Religious			◆	
Voluntary Civic Organizations		◆		
Courts/Law			◆	
Universities		◆		

BARRIERS

Average rating of limiting factors to CAN prevention,
(List several factors?)
(Scale: 1="Not important " to 3="Very significant")



UNITED KINGDOM

Region: Europe

Previous World Perspectives surveys completed:
1992, 1996, 1998, 2000, 2002, 2004, 2006

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:

- Therapy programs for physical child abusers
- Therapy programs available for child victims of physical abuse
- Therapy available for child sexual abusers
- Therapy programs available for child victims of sexual abuse
- Home-base services intended to assist parents in changing their behaviors
- Financial and other material support available
- Substance abuse related treatments for parents
- Targeted home-visits for new parents at-risk

Adequate in more than ***2/3*** of Country

- Case management/meeting basic needs
- Foster care with official foster parents
- Group homes for abused children
- Institutional care available for abused children
- Short-term hospitalization for mental illnesses
- Substance abuse related treatments for children
- Family Resource Centers available to parents
- Universal home-visits for new parents
- Access to free medical care for children
- Universal access to free medical care for all citizens
- Universal health screening for 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
- Voluntary reporting of suspected abuse
- Reports investigated within a specific time period
- Remove abused child from abusive parents
- Specific criminal penalties
- All victims receive some form of service or intervention
- Separate attorney assigned to represent child

Enforcement Level: Widely enforced

Level of Government Support: Adequately supported

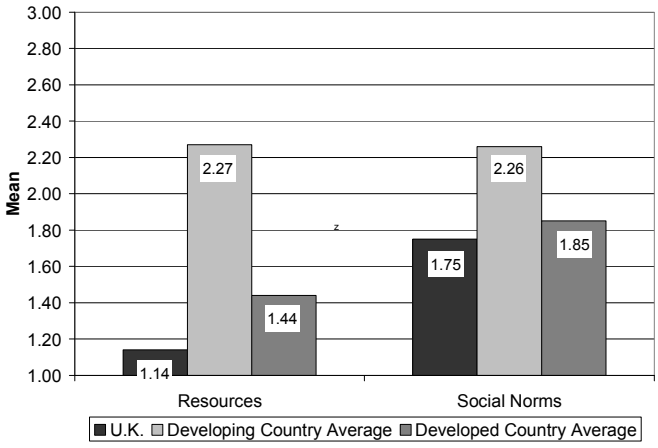
SERVICE PROVIDERS

Level of involvement in child abuse treatment and prevention services.

	None	Minimal	Moderate	Very
Hospital/Medical				◆
Mental Health Agencies			◆	
Businesses/ Factories	◆			
Schools				◆
Social Service Agencies				◆
Community-based NGOs			◆	
Religious			◆	
Voluntary Civic Organizations		◆		
Courts/Law				◆
Universities	◆			

BARRIERS

Average rating of limiting factors to CAN prevention,
(List several factors?)
(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, 2006

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 child abusers
- Therapy programs available for child victims of physical abuse
- Therapy available for child sexual abusers
- Therapy programs available for child victims of sexual abuse
- Case management/meeting basic needs
- Home-base services intended to assist parents in changing their behaviors
- Foster care with official foster parents
- Group homes for abused children
- Institutional care available for abused children
- Financial and other material support available
- Short-term hospitalization for mental illnesses
- Substance abuse related treatments for parents
- Substance abuse related treatments for children
- Universal home-visits for new parents
- Targeted home-visits for new parents at-risk
- Available free child care

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

- Family Resource Centers available to 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
- Voluntary reporting of suspected abuse
- Reports investigated within a specific time period
- Remove abused child from abusive parents
- Specific criminal penalties
- All victims receive some form of service or intervention
- Separate attorney assigned to represent child

Enforcement Level: Inconsistently enforced

Level of Government Support: Annual support but an inefficient amount

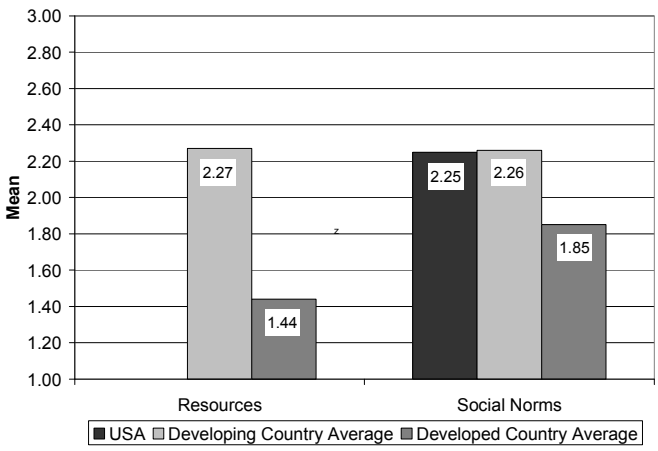
SERVICE PROVIDERS

Level of involvement in child abuse treatment and prevention services.

	None	Minimal	Moderate	Very
Hospital/Medical			◆	
Mental Health Agencies		◆		
Businesses/ Factories	◆			
Schools			◆	
Social Service Agencies			◆	
Community-based NGOs		◆		
Religious		◆		
Voluntary Civic Organizations		◆		
Courts/Law			◆	
Universities		◆		

BARRIERS

Average rating of limiting factors to CAN prevention,
(List several factors?)
(Scale: 1="Not important " to 3="Very significant")



YEMEN

Region: Western Asia

Previous World Perspectives surveys completed: 2006

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.

None of the service capacities were reported

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
- Voluntary reporting of suspected abuse
- Reports investigated within a specific time period
- Remove abused child from abusive parents
- Specific criminal penalties
- All victims receive some form of service or intervention
- Separate attorney assigned to represent child

Enforcement Level: Almost never enforced

Level of Government Support: Inconsistent

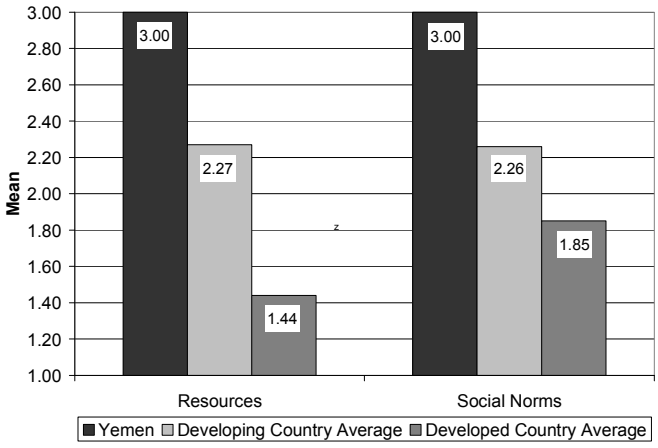
SERVICE PROVIDERS

Level of involvement in child abuse treatment and prevention services.

	None	Minimal	Moderate	Very
Hospital/Medical	◆			
Mental Health Agencies	◆			
Businesses/ Factories	◆			
Schools		◆		
Social Service Agencies		◆		
Community-based NGOs		◆		
Religious	◆			
Voluntary Civic Organizations	◆			
Courts/Law		◆		
Universities		◆		

BARRIERS

Average rating of limiting factors to CAN prevention,
(List several factors?)
(Scale: 1="Not important " to 3="Very significant")



ZAMBIA

Region: Africa

Previous World Perspectives surveys completed: 2006

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:

- Group homes for abused children
- Institutional care available for abused children
- Short-term hospitalization for mental illnesses

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

- Access to free medical care for children
- Universal health screening for children
- 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
- Voluntary reporting of suspected abuse
- Specific criminal penalties
- Separate attorney assigned to represent child

Enforcement Level: Inconsistently enforced

Level of Government Support: Annual support but an inefficient amount

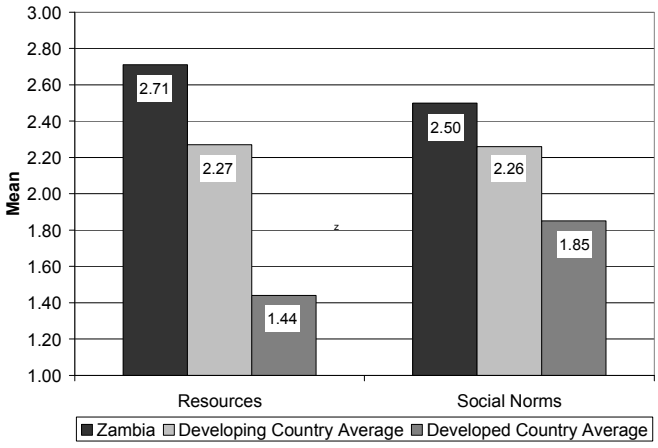
SERVICE PROVIDERS

Level of involvement in child abuse treatment and prevention services.

	None	Minimal	Moderate	Very
Hospital/Medical		◆		
Mental Health Agencies		◆		
Businesses/ Factories	◆			
Schools		◆		
Social Service Agencies		◆		
Community-based NGOs		◆		
Religious		◆		
Voluntary Civic Organizations		◆		
Courts/Law		◆		
Universities		◆		

BARRIERS

Average rating of limiting factors to CAN prevention,
(List several factors?)
(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 right, 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 - Kenya

www.anppcankenya.co.ke
Chemusian Apartments, No. B3
Opp. Nairobi Women's Hospital
Argwings Kodhek Road, Hurlingham
P. O. Box 46516, 00100 - Gpo
NAIROBI KENYA
Telephone: 254 020. 27228351
Facsimile: 254 020. 2723104
E-mail: admin@anppcankenya.co.ke

ANPPCAN - Kenya functions as a national resource centre on child abuse and neglect and African children's rights. This ANPPCAN chapter provides information and technical expertise regarding child protection and child rights issues, promotes research on emerging children's issues and helps governmental bodies, donors, NGOs and communities on behalf of children.

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 26901, CHO 3B3406
Oklahoma City, OK 73190, USA
Telephone: 405 271 8202 Facsimile: 405 271 2931
E-mail: john-madden@ouhsc.edu

APSAC seeks to improve the quality of practice provided by professionals who work in child abuse and neglect by providing professional education that promotes effective, culturally sensitive, & interdisciplinary approaches to identification, intervention, treatment, & prevention of child abuse and neglect, & promoting research & practice guidelines to inform all forms of professional practice in child maltreatment.

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.

Asociacin Aregentina de Prevención del Maltrato Infanto Juvenil (ASAPMI)
www.asapmi.org.ar
Av. Las Heras 3361 9apiso dept O
43 Capital Ferderal
AREGENTINA
E-mail: info@asapmi.org.ar

ASAPMI – **is** a group of professionals dedicated to the prevention and treatment of child abuse and neglect. This group of professionals intended to form an association that would centralize the efforts of all child protection workers in Argentina.

Asian Regional Network of Child Abuse and Neglect Professionals (ARN)
www.childprotection.org.ph
Child Protection Unit, Network Philippines
Unit 1704 Marbella 2 Building, Roxas Boulevard
Manila 1004
PHILIPPINES
Telephone: 632.404.3954
Facsimile: 632.404.3955
E-mail: madridb@cpu-net.org.ph

ARN is a network of professionals serving as a forum to support child maltreament prevention efforts in Asia Pacific countries. The network allows professionals to share practices and resources; facilitate multi-country training, research and education; develop alliances; and participate in the organization of Asian Regional Conferences - all for the overall goal of preventing child abuse and neglect throughout Asia.

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
Facsimile:
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.

Enfants Solidaires d'Afrique et du Monde
www.crin.org
08 BP 0049 TRI
Contonou, Benin
BENIN
Telephone: 00.229.30.52.37 Facsimile: 00.229.31.38.09
E-mail: esam@firstnet.bj

ESAM – is committed to ensuring the total development of child (survival, health protection, education, rights, protection from child labor, maltreatment and trafficking). ESAM offers programs designed to inform NGOs about awareness of women and children's rights, health education, nutrition, etc.

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.

IUS et VITA - Democratic Republic of Congo

IUS et VITA
Boulevard du 30 juin n 100/D
Kinshasa, Gombe 5745
D.R.. 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.ispcan.org/jaspcan
JaSPCAN
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 - Australia

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.

INOG “Ponimanie”

www.ponimanie.org
8 Leschinskogo Street
Building 5, Suite 404
Minsk, Belarus 220121
BELARUS
Telephone: 375.29.761.1202 Facsimile: 375.17.259.4883
E-mail: amakhanko@ponimanie.org

INGO “Ponimanie” is nationwide/international NGO focused on child protection. They are dedicated to creating a world fit for children through the professional contributions and help for difficult situations. Children in residential institutions and shelters, abused and neglected children and children-at-risk are the target population.

Singapore Children's Society

www.childrensociety.org.sg
Singapore Children's Society
6 Jalan Klapa (off North Bridge Road)
Singapore 199318
SINGAPORE
Telephone: 6296 9909
Facsimile: 6297 5755
E-mail: info@childrensociety.org.sg

They are 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 X 30500
Houghton, 2041
SOUTH AFRICA
Telephone: 27 11 481 5145
Facsimile: 27 11 481 5200
E-mail: saspcan@absamail.co.za

SASPCAN provides support for anyone who wishes to assist in the combating of 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 – Romania

SN-CAN
Str Costache Negruzzi Nr11 Ap3, 1900 Timisoara
ROMANIA
Telephone: 40 56 194985
Facsimile: 40 56 194985
E-mail: cepcopil@rdslind.ro

SN-CAN mission is to develop child abuse and neglect prevention in Romania by supporting de development of services for CAN, by developing trainings for professionals, as well as net working 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
Oyak sitesi 7. blok No. 7
Cankaya, Ankara 6610
TURKEY
Telephone: 90.312.4398947 Facsimile: 90.312.4413352
E-mail: fsahin@gazi.edu.tr

TSPCAN is committed to the prevention of child abuse and neglect of human and child abuse and neglect within the framework of human and child rights law and practice. It has a very dynamic and multidisciplinary membership profile. TSPCAn is dedicated to raising awareness and building capacities of professionals and volunteers.