CHAPTER 3

Child abuse and neglect by parents and other caregivers

Background

Child abuse has for a long time been recorded in literature, art and science in many parts of the world. Reports of infanticide, mutilation, abandonment and other forms of violence against children date back to ancient civilizations (*1*). The historical record is also filled with reports of unkempt, weak and malnourished children cast out by families to fend for themselves and of children who have been sexually abused.

For a long time also there have existed charitable groups and others concerned with children's well-being who have advocated the protection of children. Nevertheless, the issue did not receive widespread attention by the medical profession or the general public until 1962, with the publication of a seminal work, *The battered child syndrome*, by Kempe et al. (*2*).

The term ''battered child syndrome'' was coined to characterize the clinical manifestations of serious physical abuse in young children (*2*). Now, four decades later, there is clear evidence that child abuse is a global problem. It occurs in a variety of forms and is deeply rooted in cultural, economic and social practices. Solving this global problem, however, requires a much better understanding of its occurrence in a range of settings, as well as of its causes and consequences in these settings.

How are child abuse and neglect defined?

Cultural issues

Any global approach to child abuse must take into account the differing standards and expectations for parenting behaviour in the range of cultures around the world. Culture is a society's common fund of beliefs and behaviours, and its concepts of how people should conduct themselves. Included in these concepts are ideas about what acts of omission or commission might constitute abuse and neglect (*3, 4*). In other words, culture helps define the generally accepted principles of child-rearing and care of children.

Different cultures have different rules about what are acceptable parenting practices. Some researchers have suggested that views on child-rearing across cultures might diverge to such an extent that agreement on what practices are abusive or neglectful may be extremely difficult to reach (*5, 6*). Nonetheless, differences in how cultures define what is abusive have more to do with emphasizing particular aspects of parental behaviour. It appears that there is general agreement across many cultures that child abuse should not be allowed, and virtual unanimity in this respect where very harsh disciplinary practices and sexual abuse are concerned (*7*).

Types of abuse

The International Society for the Prevention of Child Abuse and Neglect recently compared definitions of abuse from 58 countries and found some commonality in what was considered abusive (*7*). In 1999, the WHO Consultation on Child Abuse Prevention drafted the following definition (*8*):

> ''Child abuse or maltreatment constitutes all forms of physical and/or emotional ill-treatment, sexual abuse, neglect or negligent treatment or commercial or other exploitation, resulting in actual or potential harm to the child's health, survival, development or dignity in the context of a relationship of responsibility, trust or power.''

Some definitions focus on the behaviours or actions of adults while others consider abuse to take place if there is harm or the threat of harm to the child (*8–13*). The distinction between behaviour – regardless of the outcome – and impact or harm is a potentially confusing one if parental intent forms part of the definition. Some experts consider as abused those children who have been inadvertently harmed through the actions of a parent, while others require that harm to the child be intended for the act to be defined as abusive. Some of the literature on child abuse explicitly includes violence against children in institutional or school settings (*14–17*).

The definition given above (*8*) covers a broad spectrum of abuse. This chapter focuses primarily on acts of commission and omission by parents or caregivers that result in harm to the child. In particular, it explores the prevalence, causes and consequences of four types of child maltreatment by caregivers, namely:

— physical abuse;
— sexual abuse;
— emotional abuse;
— neglect.

Physical abuse of a child is defined as those acts of commission by a caregiver that cause actual physical harm or have the potential for harm. Sexual abuse is defined as those acts where a caregiver uses a child for sexual gratification.

Emotional abuse includes the failure of a caregiver to provide an appropriate and supportive environment, and includes acts that have an adverse effect on the emotional health and development of a child. Such acts include restricting a child's movements, denigration, ridicule, threats and intimidation, discrimination, rejection and other non-physical forms of hostile treatment.

Neglect refers to the failure of a parent to provide for the development of the child – where the parent is in a position to do so – in one or more of the following areas: health, education, emotional development, nutrition, shelter and safe living conditions. Neglect is thus distinguished from circumstances of poverty in that neglect can occur only in cases where reasonable resources are available to the family or caregiver.

The manifestations of these types of abuse are further described in Box 3.1.

The extent of the problem

Fatal abuse

Information on the numbers of children who die each year as a result of abuse comes primarily from death registries or mortality data. According to the World Health Organization, there were an estimated 57 000 deaths attributed to homicide among children under 15 years of age in 2000. Global estimates of child homicide suggest that infants and very young children are at greatest risk, with rates for the 0–4-year-old age group more than double those of 5–14-year-olds (see Statistical annex).

The risk of fatal abuse for children varies according to the income level of a country and region of the world. For children under 5 years of age living in high-income countries, the rate of homicide is 2.2 per 100 000 for boys and 1.8 per 100 000 for girls. In low- to middle-income countries the rates are 2–3 times higher – 6.1 per 100 000 for boys and 5.1 per 100 000 for girls. The highest homicide rates for children under 5 years of age are found in the WHO African Region – 17.9 per 100 000 for boys and 12.7 per 100 000 for girls. The lowest rates are seen in high-income countries in the WHO European, Eastern Mediterranean and Western Pacific Regions (see Statistical annex).

Many child deaths, however, are not routinely investigated and postmortem examinations are not carried out, which makes it difficult to establish the precise number of fatalities from child abuse in any given country. Even in wealthy countries there are problems in properly recognizing cases of infanticide and measuring their incidence. Significant levels of misclassification in the cause of death as reported on death certificates have been found, for example, in several states of the United States of America. Deaths attributed to other causes – for instance, sudden infant death syndrome or accidents – have often been shown on reinvestigation to be homicides (*18, 19*).

Despite the apparent widespread misclassification, there is general agreement that fatalities from child abuse are far more frequent than official records suggest in every country where studies of infant deaths have been undertaken (*20–22*). Among the fatalities attributed to child abuse, the most common cause of death is injury to the head, followed by injury to the abdomen (*18, 23, 24*). Intentional suffocation has also been extensively reported as a cause of death (*19, 22*).

Non-fatal abuse

Data on non-fatal child abuse and neglect come from a variety of sources, including official statistics, case reports and population-based surveys. These sources, however, differ as regards their usefulness in describing the full extent of the problem.

Official statistics often reveal little about the patterns of child abuse. This is partly because, in many countries, there are no legal or social systems with specific responsibility for recording, let alone responding to, reports of child abuse and neglect (*7*). In addition, there are differing legal and

BOX 3.1

Manifestations of child abuse and neglect

Injuries inflicted by a caregiver on a child can take many forms. Serious damage or death in abused children is most often the consequence of a head injury or injury to the internal organs. Head trauma as a result of abuse is the most common cause of death in young children, with children in the first 2 years of life being the most vulnerable. Because force applied to the body passes through the skin, patterns of injury to the skin can provide clear signs of abuse. The skeletal manifestations of abuse include multiple fractures at different stages of healing, fractures of bones that are very rarely broken under normal circumstances, and characteristic fractures of the ribs and long bones.

The shaken infant

Shaking is a prevalent form of abuse seen in very young children. The majority of shaken children are less than 9 months old. Most perpetrators of such abuse are male, though this may be more a reflection of the fact that men, being on average stronger than women, tend to apply greater force, rather than that they are more prone than women to shake children. Intracranial haemorrhages, retinal haemorrhages and small ''chip'' fractures at the major joints of the child's extremities can result from very rapid shaking of an infant. They can also follow from a combination of shaking and the head hitting a surface. There is evidence that about one-third of severely shaken infants die and that the majority of the survivors suffer long-term consequences such as mental retardation, cerebral palsy or blindness.

The battered child

One of the syndromes of child abuse is the ''battered child''. This term is generally applied to children showing repeated and devastating injury to the skin, skeletal system or nervous system. It includes children with multiple fractures of different ages, head trauma and severe visceral trauma, with evidence of repeated infliction. Fortunately, though the cases are tragic, this pattern is rare.

Sexual abuse

Children may be brought to professional attention because of physical or behavioural concerns that, on further investigation, turn out to result from sexual abuse. It is not uncommon for children who have been sexually abused to exhibit symptoms of infection, genital injury, abdominal pain, constipation, chronic or recurrent urinary tract infections or behavioural problems. To be able to detect child sexual abuse requires a high index of suspicion and familiarity with the verbal, behavioural and physical indicators of abuse. Many children will disclose abuse to caregivers or others spontaneously, though there may also be indirect physical or behavioural signs.

Neglect

There exist many manifestations of child neglect, including non-compliance with health care recommendations, failure to seek appropriate health care, deprivation of food resulting in hunger, and the failure of a child physically to thrive. Other causes for concern include the exposure of children to drugs and inadequate protection from environmental dangers. In addition, abandonment, inadequate supervision, poor hygiene and being deprived of an education have all been considered as evidence of neglect.

cultural definitions of abuse and neglect between countries. There is also evidence that only a small proportion of cases of child maltreatment are reported to authorities, even where mandatory reporting exists (*25*).

Case series have been published in many countries. They are important for guiding local action on child abuse, and raising awareness and concern among the public and professionals (*26–32*). Case series can reveal similarities between the experiences in different countries and suggest new hypotheses. However, they are not particularly helpful in assessing the relative importance of possible risk or protective factors in different cultural contexts (*33*).

Population-based surveys are an essential element for determining the true extent of non-fatal child abuse. Recent surveys of this type have been completed in a number of countries, including Australia, Brazil, Canada, Chile, China, Costa Rica, Egypt, Ethiopia, India, Italy, Mexico, New Zealand, Nicaragua, Norway, Philippines, the Republic of Korea, Romania, South Africa, the United States and Zimbabwe (*12, 14–17, 26, 34–43*).

Physical abuse

Estimates of physical abuse of children derived from population-based surveys vary considerably. A 1995 survey in the United States asked parents how they disciplined their children (*12*). An estimated rate of physical abuse of 49 per 1000 children was obtained from this survey when the following behaviours were included: hitting the child with an object, other than on the buttocks; kicking the child; beating the child; and threatening the child with a knife or gun.

Available research suggests that the rates for many other countries are no lower, and may be indeed higher than the estimates of physical abuse in the United States. The following findings, among others around the world, have emerged recently:

- In a cross-sectional survey of children in Egypt, 37% reported being beaten or tied up by their parents and 26% reported physical injuries such as fractures, loss of consciousness or permanent disability as a result of being beaten or tied up (*17*).
- In a recent study in the Republic of Korea, parents were questioned about their behaviour towards their children. Two-thirds of the parents reported whipping their children and 45% confirmed that they had hit, kicked or beaten them (*26*).
- A survey of households in Romania found that 4.6% of children reported suffering severe and frequent physical abuse, including being hit with an object, being burned or being deprived of food. Nearly half of Romanian parents admitted to beating their children ''regularly'' and 16% to beating their children with objects (*34*).
- In Ethiopia, 21% of urban schoolchildren and 64% of rural schoolchildren reported bruises or swellings on their bodies resulting from parental punishment (*14*).

Data that are more comparable come from the World Studies of Abuse in the Family Environment (WorldSAFE) project, a cross-national collaborative study. Investigators from Chile, Egypt, India and the Philippines administered a common core protocol to population-based samples of mothers in each country to establish comparable incidence rates for harsh and more moderate forms of child discipline. Specifically, the researchers measured the frequency of parental discipline behaviours, without labelling harsh discipline as abusive, using the Parent–Child Conflict Tactics Scale (*9–12, 40*). Other data to determine risk and protective factors were also routinely collected in these studies.

Table 3.1 presents the findings, from the four countries involved in this study, on the relative incidence of self-reported parental discipline behaviours. Identically worded questions were used in each country. The results are compared to those from a national survey conducted in the United States using the same instrument (*12*). It is clear that harsh parental punishment is not confined to a few places or a single region of the world. Parents in Egypt, rural areas of India, and the Philippines frequently reported, as a punishment, hitting their children with an object on a part of the

TABLE 3.1

Rates of harsh or moderate forms of physical punishment in the previous 6 months as reported by mothers, WorldSAFE study

Type of punishment	Incidence (%)				
	Chile	Egypt	India[a]	Philippines	USA
Severe physical punishment					
Hit the child with an object (not on buttocks)	4	26	36	21	4
Kicked the child	0	2	10	6	0
Burned the child	0	2	1	0	0
Beat the child	0	25	—[b]	3	0
Threatened the child with a knife or gun	0	0	1	1	0
Choked the child	0	1	2	1	0
Moderate physical punishment					
Spanked buttocks (with hand)	51	29	58	75	47
Hit the child on buttocks (with object)	18	28	23	51	21
Slapped the child's face or head	13	41	58	21	4
Pulled the child's hair	24	29	29	23	—[b]
Shook the child[c]	39	59	12	20	9
Hit the child with knuckles	12	25	28	8	—[b]
Pinched the child	3	45	17	60	5
Twisted the child's ear	27	31	16	31	—[b]
Forced the child to kneel or stand in an uncomfortable position	0	6	2	4	—[b]
Put hot pepper in the child's mouth	0	2	3	1	—[b]

[a] Rural areas.
[b] Question not asked in the survey.
[c] Children aged 2 years or older.

body other than the buttocks at least once during the previous 6 months. This behaviour was also reported in Chile and the United States, though at a much lower rate. Harsher forms of violence – such as choking children, burning them or threatening them with a knife or gun – were much less frequently reported.

Similar parental self-reports from other countries confirm that harsh physical punishment of children by their parents exists in significant amounts wherever it has been examined. In Italy, based on the Conflict Tactics Scales, the incidence of severe violence was 8% (*39*). Tang indicated an annual rate of severe violence against children, as reported by the parents, of 461 per 1000 in China (Hong Kong SAR) (*43*).

Another study, comparing rates of violence against primary school-aged children in China and the Republic of Korea, also used the Conflict Tactics Scales, though with the questions being directed at the children rather than their parents (*41*). In China, the rate of severe violence reported by the children was 22.6%, while in the Republic of Korea it was 51.3%.

Data from the WorldSAFE study are also illuminating about patterns of more ''moderate'' forms of physical discipline in different countries (see Table 3.1). Moderate discipline is not universally agreed to be abusive, though some professionals and parents regard such forms of discipline as unacceptable. In this area, the WorldSAFE study suggested a wider divergence among societies and cultures. Spanking children on the buttocks was the most common disciplinary measure reported in each country, with the exception of Egypt, where other measures such as shaking children, pinching them, or slapping them on the face or head were more frequently used as punishment. Parents in rural areas of India, though, reported slapping their children on the face or head about as often as slapping them on the buttocks, while in the other countries slapping children on the face or head occurred less often.

Severe and more moderate forms of discipline are not limited to the family or home environment. A substantial amount of harsh punishment occurs in schools and other institutions at the hands of teachers and others responsible for the care of children (see Box 3.2).

Sexual abuse

Estimates of the prevalence of sexual abuse vary greatly depending on the definitions used and the way in which information is collected. Some surveys are conducted with children, others with adolescents and adults reporting on their childhood, while others question parents about what their children may have experienced. These three different methods can produce very different results. For example, the survey of Romanian

BOX 3.2

Corporal punishment

Corporal punishment of children — in the form of hitting, punching, kicking or beating — is socially and legally accepted in most countries. In many, it is a significant phenomenon in schools and other institutions and in penal systems for young offenders.

The United Nations Convention on the Rights of the Child requires states to protect children from ''all forms of physical or mental violence'' while they are in the care of parents and others, and the United Nations Committee on the Rights of the Child has underlined that corporal punishment is incompatible with the Convention.

In 1979, Sweden became the first country to prohibit all forms of corporal punishment of children. Since then, at least 10 further states have banned it. Judgements from constitutional or supreme courts condemning corporal punishment in schools and penal systems have also been handed down — including in Namibia, South Africa and Zimbabwe — and, in 2000, Israel's supreme court declared all corporal punishment unlawful. Ethiopia's 1994 constitution asserts the right of children to be free of corporal punishment in schools and institutions of care. Corporal punishment in schools has also been banned in New Zealand, the Republic of Korea, Thailand and Uganda.

Nevertheless, surveys indicate that corporal punishment remains legal in at least 60 countries for juvenile offenders, and in at least 65 countries in schools and other institutions. Corporal punishment of children is legally acceptable in the home in all but 11 countries. Where the practice has not been persistently confronted by legal reform and public education, the few existing prevalence studies suggest that it remains extremely common.

Corporal punishment is dangerous for children. In the short term, it kills thousands of children each year and injures and handicaps many more. In the longer term, a large body of research has shown it to be a significant factor in the development of violent behaviour, and it is associated with other problems in childhood and later life.

families already mentioned found that 0.1% of parents admitted to having sexually abused their children, while 9.1% of children reported having suffered sexual abuse (*34*). This discrepancy might be explained in part by the fact that the children were asked to include sexual abuse by people other than their parents.

Among published studies of adults reporting retrospectively on their own childhood, prevalence rates of childhood sexual abuse among men range from 1% (*44*) – using a narrow definition of sexual contact involving pressure or force – to 19% (*38*), where a broader definition was employed. Lifetime prevalence rates for childhood sexual victimization among adult women range from 0.9% (*45*), using rape as the definition of abuse, to 45% (*38*) with a much wider definition. Findings reported in international studies conducted since 1980 reveal a mean lifetime prevalence rate of childhood sexual victimization of 20% among women and of 5–10% among men (*46, 47*).

These wide variations in published prevalence estimates could result either from real differences in risk prevailing in different cultures or from differences in the way the studies were conducted (*46*). Including abuse by peers in the definition of child sexual abuse can increase the resulting prevalence by 9% (*48*) and including cases where physical contact does not occur can raise the rates by around 16% (*49*).

Emotional and psychological abuse

Psychological abuse against children has been allotted even less attention globally than physical and sexual abuse. Cultural factors appear strongly to influence the non-physical techniques that parents

choose to discipline their children – some of which may be regarded by people from other cultural backgrounds as psychologically harmful. Defining psychological abuse is therefore very difficult. Furthermore, the consequences of psychological abuse, however defined, are likely to differ greatly depending on the context and the age of the child.

There is evidence to suggest that shouting at children is a common response by parents across many countries. Cursing children and calling them names appears to vary more greatly. In the five countries of the WorldSAFE study, the lowest incidence rate of calling children names in the previous 6 months was 15% (see Table 3.2). The practices of threatening children with abandonment or with being locked out of the house, however, varied widely among the countries. In the Philippines, for example, threats of abandonment were frequently reported by mothers as a disciplinary measure. In Chile, the rate of using such threats was much lower, at about 8%.

TABLE 3.2

Rates of verbal or psychological punishment in the previous 6 months as reported by mothers, WorldSAFE study

Verbal or psychological punishment	Incidence (%)				
	Chile	Egypt	India[a]	Philippines	USA
Yelled or screamed at the child	84	72	70	82	85
Called the child names	15	44	29	24	17
Cursed at the child	3	51	—[b]	0	24
Refused to speak to the child	17	48	31	15	—[b]
Threatened to kick the child out of the household	5	0	—[b]	26	6
Threatened abandonment	8	10	20	48	—b
Threatened evil spirits	12	6	20	24	—[b]
Locked the child out of the household	2	1	—[b]	12	—[b]

[a] Rural areas.

[b] Question not asked in the survey.

Data on the extent that non-violent and non-abusive disciplinary methods are employed by caregivers in different cultures and parts of the world are extremely scarce. Limited data from the WorldSAFE project suggest that the majority of parents use non-violent disciplinary practices. These include explaining to children why their behaviour was wrong and telling them to stop, withdrawing privileges and using other non-violent methods to change problem behaviour (see Table 3.3). Elsewhere, in Costa Rica, for instance, parents acknowledged using physical punishment to discipline children, but reported it as their least preferred method (*50*).

Neglect

Many researchers include neglect or harm caused by a lack of care on the part of parents or other caregivers as part of the definition of abuse (*29, 51–53*). Conditions such as hunger and poverty are sometimes included within the definition of neglect. Because definitions vary and laws on reporting abuse do not always require the mandatory reporting of neglect, it is difficult to estimate the global dimensions of the problem or meaningfully to compare rates between countries. Little research, for instance, has been done on how children and parents or other caregivers may differ in defining neglect.

In Kenya, abandonment and neglect were the most commonly cited aspects of child abuse when adults in the community were questioned on the subject (*51*). In this study, 21.9% of children reported that they had been neglected by their parents. In Canada, a national study of cases reported to child welfare services found that, among the substantiated cases of neglect, 19% involved physical neglect, 12% abandonment, 11% educational neglect, and 48% physical harm resulting from a parent's failure to provide adequate supervision (*54*).

What are the risk factors for child abuse and neglect?

A variety of theories and models have been developed to explain the occurrence of abuse within families. The most widely adopted explanatory model is the ecological model, described in Chapter 1. As applied to child abuse and neglect, the ecological model considers a number of factors, including the characteristics of the individual child and his or her family, those of the caregiver or perpetrator, the

TABLE 3.3
Rates of non-violent disciplinary practices in the previous 6 months as reported by mothers, WorldSAFE study

Non-violent discipline	Incidence (%)				
	Chile	Egypt	India[a]	Philippines	USA
Explained why the behaviour was wrong	91	80	94	90	94
Took privileges away	60	27	43	3	77
Told child to stop	88	69	—[b]	91	—[b]
Gave child something to do	71	43	27	66	75
Made child stay in one place	37	50	5	58	75

[a] Rural areas.
[b] Question not asked in the survey.

nature of the local community, and the social, economic and cultural environment (*55, 56*).

The limited research in this area suggests that some factors are fairly consistent, over a range of countries, in conferring risk. It is important to note, though, that these factors, which are listed below, may be only statistically associated and not causally linked (*6*).

Factors increasing a child's vulnerability

A number of studies, mostly from the developed world, have suggested that certain characteristics of children increase the risk for abuse.

Age

Vulnerability to child abuse – whether physical, sexual or through neglect – depends in part on a child's age (*14, 17, 57, 58*). Fatal cases of physical abuse are found largely among young infants (*18, 20, 21, 28*). In reviews of infant deaths in Fiji, Finland, Germany and Senegal, for instance, the majority of victims were less than 2 years of age (*20, 24, 28, 59*).

Young children are also at risk for non-fatal physical abuse, though the peak ages for such abuse vary from country to country. For example, rates of non-fatal physical abuse peak for children at 3–6 years of age in China, at 6–11 years of age in India and between 6 and 12 years of age in the United States (*11, 40, 43*). Sexual abuse rates, on the other hand, tend to rise after the onset of puberty, with the highest rates occurring during adolescence (*15, 47, 60*). Sexual abuse, however, can also be directed at young children.

Sex

In most countries, girls are at higher risk than boys for infanticide, sexual abuse, educational and nutritional neglect, and forced prostitution (see also Chapter 6). Findings from several international studies show rates of sexual abuse to be 1.5–3 times higher among girls than boys (*46*). Globally, more than 130 million children between the ages of 6 and 11 years are not in school, 60% of whom are girls (*61*). In some countries, girls are either not allowed to receive schooling or else are kept at home to help look after their siblings or to assist the family economically by working.

Male children appear to be at greater risk of harsh physical punishment in many countries (*6, 12, 16, 40, 62*). Although girls are at increased risk for infanticide in many places, it is not clear why boys are subjected to harsher physical punishment. It may be that such punishment is seen as a preparation for adult roles and responsibilities, or else that boys are considered to need more physical discipline. Clearly, the wide cultural gaps that exist between different societies with respect to the role of women and the values attached to male and female children could account for many of these differences.

Special characteristics

Premature infants, twins and handicapped children have been shown to be at increased risk for physical abuse and neglect (*6, 53, 57, 63*). There are conflicting findings from studies on the importance of mental retardation as a risk factor. It is believed that low birth weight, prematurity, illness, or physical or mental handicaps in the infant or child interfere with attachment and bonding and may make the child more vulnerable to abuse (*6*). However, these characteristics do not appear to be major risk factors for abuse when other factors are considered, such as parental and societal variables (*6*).

Caregiver and family characteristics

Research has linked certain characteristics of the caregiver, as well as features of the family environ-

ment, to child abuse and neglect. While some factors – including demographic ones – are related to variation in risk, others are related to the psychological and behavioural characteristics of the caregiver or to aspects of the family environment that may compromise parenting and lead to child maltreatment.

Sex

Whether abusers are more likely to be male or female, depends, in part, on the type of abuse. Research conducted in China, Chile, Finland, India and the United States suggests that women report using more physical discipline than men (*12, 40, 43, 64, 65*). In Kenya, reports from children also show more violence by mothers than fathers (*51*). However, men are the most common perpetrators of life-threatening head injuries, abusive fractures and other fatal injuries (*66–68*).

Sexual abusers of children, in the cases of both female and male victims, are predominantly men in many countries (*46, 69, 70*). Studies have consistently shown that in the case of female victims of sexual abuse, over 90% of the perpetrators are men, and in the case of male victims, between 63% and 86% of the perpetrators are men (*46, 71, 72*).

Family structure and resources

Physically abusive parents are more likely to be young, single, poor and unemployed and to have less education than their non-abusing counterparts. In both developing and industrialized countries, poor, young, single mothers are among those at greatest risk for using violence towards their children (*6, 12, 65, 73*). In the United States, for instance, single mothers are three times more likely to report using harsh physical discipline than mothers in two-parent families (*12*). Similar findings have been reported in Argentina (*73*).

Studies from Bangladesh, Colombia, Italy, Kenya, Sweden, Thailand and the United Kingdom have also found that low education and a lack of income to meet the family's needs increase the potential of physical violence towards children (*39, 52, 62, 67, 74–76*), though exceptions to this pattern have been noted elsewhere (*14*). In a study of Palestinian families, lack of money for the child's needs was one of the primary reasons given by parents for psychologically abusing their children (*77*).

Family size and household composition

The size of the family can also increase the risk for abuse. A study of parents in Chile, for example, found that families with four or more children were three times more likely to be violent towards their children than parents with fewer children (*78*). However, it is not always simply the size of the family that matters. Data from a range of countries indicate that household overcrowding increases the risk of child abuse (*17, 41, 52, 57, 74, 79*). Unstable family environments, in which the composition of the household frequently changes as family members and others move in and out, are a feature particularly noted in cases of chronic neglect (*6, 57*).

Personality and behavioural characteristics

A number of personality and behavioural characteristics have been linked, in many studies, to child abuse and neglect. Parents more likely to abuse their children physically tend to have low self-esteem, poor control of their impulses, mental health problems, and to display antisocial behaviour (*6, 67, 75, 76, 79*). Neglectful parents have many of these same problems and may also have difficulty planning important life events such as marriage, having children or seeking employment. Many of these characteristics compromise parenting and are associated with disrupted social relationships, an inability to cope with stress and difficulty in reaching social support systems (*6*).

Abusive parents may also be uninformed and have unrealistic expectations about child development (*6, 57, 67, 80*). Research has found that abusive parents show greater irritation and annoyance in response to their children's moods and behaviour, that they are less supportive, affectionate, playful and responsive to their children, and that they are more controlling and hostile (*6, 39*).

Prior history of abuse

Studies have shown that parents maltreated as children are at higher risk of abusing their own

children (*6, 58, 67, 81, 82*). The relationship here is complex, though (*81–83*), and some investigations have suggested that the majority of abusing parents were not, in fact, themselves abused (*58*). While empirical data suggest that there is indeed a relationship, the importance of this risk factor may have been overstated. Other factors that have been linked to child abuse – such as young parental age, stress, isolation, overcrowding in the home, substance abuse and poverty – may be more predictive.

Violence in the home

Increasing attention is being given to intimate partner violence and its relationship to child abuse. Data from studies in countries as geographically and culturally distinct as China, Colombia, Egypt, India, Mexico, the Philippines, South Africa and the United States have all found a strong relationship between these two forms of violence (*6, 15, 17, 37, 40, 43, 67*). In a recent study in India, the occurrence of domestic violence in the home doubled the risk of child abuse (*40*). Among known victims of child abuse, 40% or more have also reported domestic violence in the home (*84*). In fact, the relationship may be even stronger, since many agencies charged with protecting children do not routinely collect data on other forms of violence in families.

Other characteristics

Stress and social isolation of the parent have also been linked to child abuse and neglect (*6, 39, 57, 73, 85*). It is believed that stress resulting from job changes, loss of income, health problems or other aspects of the family environment can heighten the level of conflict in the home and the ability of members to cope or find support. Those better able to find social support may be less likely to abuse children, even when other known risk factors are present. In a case–control study in Buenos Aires, Argentina, for instance, children living in single-parent families were at significantly greater risk for abuse than those in two-parent families. The risk for abuse was lower, though, among those who were better able to gain access to social support (*73*).

Child abuse has also been linked in many studies to substance abuse (*6, 37, 40, 67, 76*), though further research is needed to disentangle the independent effects of substance abuse from the related issues of poverty, overcrowding, mental disorders and health problems associated with this behaviour.

Community factors

Poverty

Numerous studies across many countries have shown a strong association between poverty and child maltreatment (*6, 37, 40, 62, 86–88*). Rates of abuse are higher in communities with high levels of unemployment and concentrated poverty (*89–91*). Such communities are also characterized by high levels of population turnover and overcrowded housing. Research shows that chronic poverty adversely affects children through its impact on parental behaviour and the availability of community resources (*92*). Communities with high levels of poverty tend to have deteriorating physical and social infrastructures and fewer of the resources and amenities found in wealthier communities.

Social capital

Social capital represents the degree of cohesion and solidarity that exists within communities (*85*). Children living in areas with less ''social capital'' or social investment in the community appear to be at greater risk of abuse and have more psychological or behavioural problems (*85*). On the other hand, social networks and neighbourhood connections have been shown to be protective of children (*4, 58, 93*). This is true even for children with a number of risk factors – such as poverty, violence, substance abuse and parents with low levels of educational achievement – who appear to be protected by high levels of social capital (*85*).

Societal factors

A range of society-level factors are considered to have important influences on the well-being of children and families. These factors – not examined to date in most countries as risk factors for child abuse – include:

- The role of cultural values and economic forces in shaping the choices facing families and shaping their response to these forces.
- Inequalities related to sex and income – factors present in other types of violence and likely to be related to child maltreatment as well.
- Cultural norms surrounding gender roles, parent–child relationships and the privacy of the family.
- Child and family policies – such as those related to parental leave, maternal employment and child care arrangements.
- The nature and extent of preventive health care for infants and children, as an aid in identifying cases of abuse in children.
- The strength of the social welfare system – that is, the sources of support that provide a safety net for children and families.
- The nature and extent of social protection and the responsiveness of the criminal justice system.
- Larger social conflicts and war.

Many of these broader cultural and social factors can affect the ability of parents to care for children – enhancing or lessening the stresses associated with family life and influencing the resources available to families.

The consequences of child abuse

Health burden

Ill health caused by child abuse forms a significant portion of the global burden of disease. While some of the health consequences have been researched (*21, 35, 72, 94–96*), others have only recently been given attention, including psychiatric disorders and suicidal behaviour (*53, 97, 98*). Importantly, there is now evidence that major adult forms of illness – including ischaemic heart disease, cancer, chronic lung disease, irritable bowel syndrome and fibromyalgia – are related to experiences of abuse during childhood (*99–101*). The apparent mechanism to explain these results is the adoption of behavioural risk factors such as smoking, alcohol abuse, poor diet and lack of exercise. Research has also highlighted important direct acute and long-term consequences (*21, 23, 99–103*) (see Table 3.4).

TABLE 3.4
Health consequences of child abuse

Physical
Abdominal/thoracic injuries
Brain injuries
Bruises and welts
Burns and scalds
Central nervous system injuries
Disability
Fractures
Lacerations and abrasions
Ocular damage
Sexual and reproductive
Reproductive health problems
Sexual dysfunction
Sexually transmitted diseases, including HIV/AIDS
Unwanted pregnancy
Psychological and behavioural
Alcohol and drug abuse
Cognitive impairment
Delinquent, violent and other risk-taking behaviours
Depression and anxiety
Developmental delays
Eating and sleep disorders
Feelings of shame and guilt
Hyperactivity
Poor relationships
Poor school performance
Poor self-esteem
Post-traumatic stress disorder
Psychosomatic disorders
Suicidal behaviour and self-harm
Other longer-term health consequences
Cancer
Chronic lung disease
Fibromyalgia
Irritable bowel syndrome
Ischaemic heart disease
Liver disease
Reproductive health problems such as infertility

Similarly, there are many studies demonstrating short-term and long-term psychological damage (*35, 45, 53, 94, 97*). Some children have a few symptoms that do not reach clinical levels of concern, or else are at clinical levels but not as high as in children generally seen in clinical settings. Other survivors have serious psychiatric symptoms, such as depression, anxiety, substance abuse, aggression, shame or cognitive impairments. Finally, some children meet the full criteria for psychiatric illnesses that include post-traumatic

stress disorder, major depression, anxiety disorders and sleep disorders (*53, 97, 98*). A recent longitudinal cohort study in Christchurch, New Zealand, for instance, found significant associations between sexual abuse during childhood and subsequent mental health problems such as depression, anxiety disorders and suicidal thoughts and behaviour (*97*).

Physical, behavioural and emotional manifestations of abuse vary between children, depending on the child's stage of development when the abuse occurs, the severity of the abuse, the relationship of the perpetrator to the child, the length of time over which the abuse continues and other factors in the child's environment (*6, 23, 72, 95–101*).

Financial burden

The financial costs associated with both the short-term and long-term care of victims form a significant proportion of the overall burden created by child abuse and neglect. Included in the calculation are the direct costs associated with treatment, visits to the hospital and doctor, and other health services. A range of indirect costs are related to lost productivity, disability, decreased quality of life and premature death. There are also costs borne by the criminal justice system and other institutions, including:

- — expenditures related to apprehending and prosecuting offenders;
- — the costs to social welfare organizations of investigating reports of maltreatment and protecting children from abuse;
- — costs associated with foster care;
- — costs to the education system;
- — costs to the employment sector arising from absenteeism and low productivity.

Available data from a few developed countries illustrate the potential financial burden. In 1996, the financial cost associated with child abuse and neglect in the United States was estimated at some US$12.4 billion (*8*). This figure included estimates for future lost earnings, educational costs and adult mental health services. In the United Kingdom, an estimated annual cost of nearly US$1.2 billion has been cited for immediate welfare and legal services alone (*104*). The costs of preventive interventions are likely to be exceeded many times over by the combined total of short-term and long-term costs of child abuse and neglect to individuals, families and society.

What can be done to prevent child abuse and neglect?

While the prevention of child abuse is almost universally proclaimed to be an important social policy, surprisingly little work has been done to investigate the effectiveness of preventive interventions. Careful work has been done on a few interventions, such as home visitation (*105–107*), but many more interventions in this field lack adequate evaluation (*108*).

The majority of programmes focus on victims or perpetrators of child abuse and neglect. Very few emphasize primary prevention approaches aimed at preventing child abuse and neglect from occurring in the first place. The more common responses are described below.

Family support approaches

Training in parenting

A number of interventions for improving parenting practices and providing family support have been developed. These types of programmes generally educate parents on child development and help them improve their skills in managing their children's behaviour. While most of these programmes are intended for use with high-risk families or those families in which abuse has already occurred, it is increasingly considered that providing education and training in this area for all parents or prospective parents can be beneficial. In Singapore, for instance, education and training in parenting begins in secondary school, with ''preparation for parenthood'' classes. Students learn about child care and development, and gain direct experience by working with young children at preschool and child care centres (*8*).

For families in which child abuse has already occurred, the principal aim is to prevent further abuse, as well as other negative outcomes for the child, such as emotional problems or delayed development. While evaluations of programmes

on education and training in parenting have shown promising results in reducing youth violence, few studies have specifically examined the impact of such programmes on rates of child abuse and neglect. Instead, for many of the interventions, proximal outcomes – such as parental competence and skills, parent–child conflict and parental mental health – have been used to measure their effectiveness.

As an example, Wolfe et al. evaluated a behavioural intervention to provide training in parenting, specifically designed for families considered at risk (*109*). Mother–child pairs were randomly assigned to either the intervention or a comparison group. Mothers who received the training in parenting reported fewer behavioural problems with their children and fewer adjustment problems associated with potential maltreatment compared with mothers in the comparison group. Furthermore, a follow-up evaluation by the caseworkers showed that there was a lower risk of maltreatment by the mothers who had received the training in parenting.

Home visitation and other family support programmes

Home visitation programmes bring community resources to families in their homes. This type of intervention has been identified as one of the most promising for preventing a number of negative outcomes, including youth violence (see Chapter 2) and child abuse (*105–107*). During the home visits, information, support and other services to improve the functioning of the family are offered. A number of different models for home visitation have been developed and studied. In some, home visits are provided to all families, regardless of their risk status, whereas others focus on families at risk for violence, such as first-time parents or single and adolescent parents living in communities with high rates of poverty.

In a survey of more than 1900 home visitation programmes, Wasik & Roberts (*110*) identified 224 that primarily provided services for abused and neglected children. Among these, the enhancement of parenting skills and raising the parents' level of coping were considered the most important services, followed by emotional support. Families were generally visited weekly or every 2 weeks, with the services provided over a period ranging from 6 months to 2 years.

An example of such a programme is the one run by the Parent Centre in Cape Town, South Africa. Home visitors are recruited from the community, trained by the centre and supervised by professional social workers. Families are visited monthly during the prenatal period, weekly for the first 2 months after birth, from then on once every 2 weeks up to 2 months of age and then monthly until the baby reaches 6 months. At that time, visits may continue or be terminated, depending on the supervisor's assessment. Families may be referred to other agencies for services where this is felt appropriate.

One of the few studies on the long-term effects of home visitation on child abuse and neglect was conducted by Olds et al. (*106*). They concluded that, throughout the 15-year period after the birth of a first child, women who were visited by nurses during their pregnancy and during their child's infancy were less likely to be identified as perpetrators of child abuse than women who were not visited.

Intensive family preservation services

This type of service is designed to keep the family together and to prevent children from being placed in substitute care. Targeted towards families in which child maltreatment has been confirmed, the intervention is short (lasting a few weeks or months) and intense, with generally 10–30 hours a week devoted to a particular family, either in the home or somewhere else that is familiar to the child. A broad array of services are usually offered, according to the needs of the family, including various forms of therapy and more practical services such as temporary rent subsidies.

An example of such a programme in the United States is Homebuilders, an intensive in-home family crisis intervention and education programme (*111*). Families who have one or more children in imminent danger of being placed in

care are referred to this programme by state workers. Over a period of 4 months, the families receive intensive services from therapists who are on call 24 hours a day. The wide range of services being offered includes help with basic needs such as food and shelter and with learning new skills.

Evaluations of this type of intervention have been limited and their findings somewhat inconclusive, mainly because of the fact that programmes offer a large variety of services and relatively few studies have included a control group. There is some evidence suggesting that programmes to preserve the family unit may help avoid placing children in care, at least in the short term. However, there is little to suggest that the underlying family dysfunction at the root of the problem can be resolved with short, intensive services of this type. One meta-analysis of several different intensive family preservation programmes found that those with high levels of participant involvement, using an approach that built on the strengths of the family and involved an element of social support, produced better results than programmes without these components (*112*).

Health service approaches

Screening by health care professionals

Health care professionals have a key part to play in identifying, treating and referring cases of abuse and neglect and in reporting suspected cases of maltreatment to the appropriate authorities. It is vital that cases of child maltreatment are detected early on, so as to minimize the consequences for the child and to launch the necessary services as soon as possible.

Screening, traditionally, is the identification of a health problem before signs and symptoms appear. In the case of child abuse and neglect, screening could present problems, since it would need to rely on information obtained directly from the perpetrator or from observers. For this reason, relatively few approaches to screening have been described, and for the most part the focus has been on improving the early recognition by health care providers of child abuse and neglect, primarily through greater levels of training and education.

Training for health care professionals

Studies in various countries have highlighted the need for the continuing education of health care professionals on the detection and reporting of early signs and symptoms of child abuse and neglect (*113–115*). Consequently, a number of health care organizations have developed training programmes so as to improve both the detection and reporting of abuse and neglect, and the knowledge among health care workers of available community services. In the United States, for example, the American Medical Association and the American Academy of Pediatrics have produced diagnostic and treatment guidelines for child maltreatment (*116*) and sexual abuse (*117*). In New York state, health care professionals are required to take a 2-hour course on identifying and reporting child abuse and neglect as a prerequisite to gain a licence (*118*). There have also been moves in several European countries and elsewhere to increase such training for health care professionals (*7, 119–121*).

The detection of child abuse and neglect, however, is not always straightforward (*122–124*). Specific interview techniques and types of physical examination are generally required. Medical professionals should also be alert to the presence of family or other risk factors that might suggest child abuse.

To maintain a continuing and dynamic process of education, some researchers have suggested multicomponent, structured curricula for health professionals, according to their particular level of involvement with child abuse cases (*125*). Under this proposal, separate but integrated courses of training would be developed for medical students and physicians in training, on the one hand, and for those with a specific interest in child abuse on the other.

Evaluations of training programmes have focused principally on the health care worker's knowledge of child abuse and behaviour. The impact of training programmes on other outcomes, such as improved care and referral for children, is not known.

Therapeutic approaches

Responses to child abuse and neglect depend on many factors, including the age and developmental level of the child and the presence of environmental stress factors. For this reason, a broad range of therapeutic services have been designed for use with individuals. Therapeutic programmes have been set up throughout the world, including in Argentina, China (Hong Kong SAR), Greece, Panama, the Russian Federation, Senegal and Slovakia (*7*).

Services for victims

A review of treatment programmes for physically abused children found that therapeutic day care – with an emphasis on improving cognitive and developmental skills – was the most popular approach (*126*). Therapeutic day care has been advocated for a range of conditions related to abuse, such as emotional, behavioural or attachment-related problems and cognitive or developmental delays. The approach incorporates therapy and specific treatment methods in the course of the child's daily activities at a child care facility. Most programmes of this type also include therapy and education for the parents.

An example of a specific treatment method for socially withdrawn, abused children has been described by Fantuzzo et al. (*127*). Maltreated preschool children who were highly withdrawn socially were placed in playgroups together with children with higher levels of social functioning. The better-functioning children were taught to act as role models for the more withdrawn children and to encourage them to participate in play sessions. Their tasks included making appropriate verbal and physical overtures to the withdrawn children – for instance, offering a toy. Improvements in the social behaviour of the withdrawn children were observed, though the long-term effects of this strategy were not assessed. Most of the other treatment programmes described in the review mentioned above have also had little or no evaluation (*126*).

As with physical abuse, the manifestations of sexual abuse can vary considerably, depending on a number of factors, such as the individual characteristics of the victim, the relationship of the perpetrator to the victim and the circumstances of the abuse. Consequently, a wide variety of intervention approaches and treatment methods have been adopted to treat child victims of sexual abuse, including individual, group and family therapy (*128–131*). Although limited research suggests that the mental health of victims is improved as a result of such interventions, there is considerably less information on other benefits.

Services for children who witness violence

One of the more recent additions to the collection of intervention strategies is services for children who witness domestic violence (*132–134*). Research has shown that such exposure may have numerous negative consequences. For instance, children who witness violence are more likely to reproduce, as adults, dysfunctional relationships within their own families.

As with cases of direct physical or sexual assault, children who witness violence may exhibit a range of symptoms, including behavioural, emotional or social problems and delays in cognitive or physical development, although some may not develop problems at all. Given this variability, different intervention strategies and treatment methods have been developed, taking into account the developmental age of the child. The evidence to date for the effectiveness of these programmes is limited and often contradictory. Two evaluations, for example, of the same 10-week group counselling programme produced differing results. In one, the children in the intervention group were able to describe more skills and strategies to avoid getting involved in violent conflicts between their parents and to seek out support than the children in the comparison group, while in the other, no differences between treatment and comparison groups were observed (*135, 136*).

Services for adults abused as children

A number of studies have found a link between a history of child abuse and a range of conditions, including substance abuse, mental health problems

and alcohol dependence (*96–99, 137*). In addition, victims of child abuse may not be identified as such until later in life and may not have symptoms until long after the abuse has occurred. For these reasons, there has been a recent increase in services for adults who were abused as children, and particularly in referrals to mental health services. Unfortunately, few evaluations have been published on the impact of interventions for adults who were abused during childhood. Most of the studies that have been conducted have focused on girls who were abused by their fathers (*138*).

Legal and related remedies

Mandatory and voluntary reporting

The reporting by health professionals of suspected child abuse and neglect is mandated by law in various countries, including Argentina, Finland, Israel, Kyrgyzstan, the Republic of Korea, Rwanda, Spain, Sri Lanka and the United States. Even so, relatively few countries have mandatory reporting laws for child abuse and neglect. A recent worldwide survey found that, of the 58 countries that responded, 33 had mandatory reporting laws in place and 20 had voluntary reporting laws (*7*).

The reasoning behind the introduction of mandatory reporting laws was that early detection of abuse would help forestall the occurrence of serious injuries, increase the safety of victims by relieving them of the necessity to make reports, and foster coordination between legal, health care and service responses.

In Brazil, there is mandatory reporting to a five-member ''Council of Guardians'' (*8*). Council members, elected to serve a 2-year term, have the duty to protect victims of child abuse and neglect by all social means, including temporary foster care and hospitalization. The legal aspects of child abuse and neglect – such as the prosecution of perpetrators and revoking parental rights – are not handled by the Council.

Mandatory laws are potentially useful for data gathering purposes, but it is not known how effective they are in preventing cases of abuse and neglect. Critics of this approach have raised various concerns, such as whether underfunded social agencies are in a position to benefit the child and his or her family, and whether instead they may do more harm than good by raising false hopes (*139*).

Various types of voluntary reporting systems exist around the world, in countries such as Barbados, Cameroon, Croatia, Japan, Romania and the United Republic of Tanzania (*7*). In the Netherlands, suspected cases of child abuse can be reported voluntarily to one of two separate public agencies – the Child Care and Protection Board and the Confidential Doctor's Office. Both these bodies exist to protect children from abuse and neglect, and both act to investigate suspected reports of maltreatment. Neither agency provides direct services to the child or the family, instead referring children and family members elsewhere for appropriate services (*140*).

Child protection services

Child protection service agencies investigate and try to substantiate reports of suspected child abuse. The initial reports may come from a variety of sources, including health care personnel, police, teachers and neighbours.

If the reports are verified, then staff of the child protection services have to decide on appropriate treatment and referral. Such decisions are often difficult, since a balance has to be found between various potentially competing demands – such as the need to protect the child and the wish to keep a family intact. The services offered to children and families thus vary widely. While some research has been published on the process of decision-making with regard to appropriate treatment, as well as on current shortcomings – such as the need for specific, standard criteria to identify families and children at risk of child abuse – there has been little investigation of the effectiveness of child protection services in reducing rates of abuse.

Child fatality review teams

In the United States, increased awareness of severe violence against children has led to the establishment of teams to review child fatalities in many states (*141*). These multidisciplinary teams review deaths among children, drawing on data and resources of the police, prosecution lawyers, health care profes-

sionals, child protection services and coroners or medical examiners. Researchers have found that these specialized review teams are more likely to detect signs of child abuse and neglect than those without relevant training. One of the objectives of this type of intervention, therefore, is to improve the accuracy of classification of child deaths.

Improved accuracy of classification, in turn, may contribute to more successful prosecutions through the collection of better evidence. In an analysis of data gathered from child fatality reviews in the state of Georgia, United States (*142*), researchers found that child fatality reviews were most sensitive for investigating death from maltreatment and sudden infant death syndrome. After investigation by the child fatality review team, 2% of deaths during the study year not initially classified as related to abuse or neglect were later reclassified as due to maltreatment.

Other review team objectives include preventing future child deaths from maltreatment through the review, analysis and putting in place of corrective actions, and promoting better coordination between the various agencies and disciplines involved.

Arrest and prosecution policies

Criminal justice policies vary markedly, reflecting different views about the role of the justice system with regard to child maltreatment. The decision whether to prosecute alleged perpetrators of abuse depends on a number of factors, including the seriousness of the abuse, the strength of evidence, whether the child would make a competent witness and whether there are any viable alternatives to prosecution (*143*). One review of the criminal prosecution of child sexual abuse cases (*144*) found that 72% of 451 allegations filed during a 2-year period were considered probable sexual abuse cases. Formal charges, however, were filed in a little over half of these cases. In another study of allegations of child sexual abuse (*145*), prosecutors accepted 60% of the cases referred to them.

Mandatory treatment for offenders

Court-mandated treatment for child abuse offenders is an approach recommended in many countries. There is a debate among researchers, though, as to whether treatment mandated through the court system is preferable to voluntary enrolment in treatment programmes. Mandatory treatment follows from the belief that, in the absence of legal repercussions, some offenders will refuse to undergo treatment. Against that, there is the view that enforced treatment imposed by a court could actually create resistance to treatment on the part of the offenders, and that the willing participation of offenders is essential for successful treatment.

Community-based efforts

Community-based interventions often focus on a selected population group or are implemented in a specific setting, such as in schools. They may also be conducted on a wider scale – over a number of population segments, for instance, or even the entire community – with the involvement of many sectors.

School programmes

School-based programmes to prevent child sexual abuse are one of the most widely applied preventive strategies and have been incorporated into the regular school curriculum in several countries. In Ireland, for example, the Stay Safe primary prevention programme is now implemented in almost all primary schools, with the full support of the Department of Education and religious leaders (*146*).

These programmes are generally designed to teach children how to recognize threatening situations and to provide them with skills to protect themselves against abuse. The concepts underlying the programmes are that children own and can control access to their bodies and that there are different types of physical contact. Children are taught how to tell an adult if they are asked to do something they find uncomfortable. School programmes vary widely in terms of their content and presentation and many also involve parents or caregivers.

Although there is agreement among researchers that children can develop knowledge and acquire skills to protect themselves against abuse, questions have been asked about whether these skills are retained over time and whether they would protect a child in an abusive situation, particularly if the

perpetrator was someone well known to and trusted by the child. In an evaluation of the Irish Stay Safe programme mentioned above, for instance, children in the programme showed significant improvements in knowledge and skills (*146*). The skills were maintained at a follow-up after 3 months.

One recent meta-analysis (*147*) concluded that programmes to prevent victimization were fairly effective in teaching children concepts and skills related to protection against sexual abuse. The authors also found that retention of this information was satisfactory. However, they concluded that proof of the ultimate effectiveness of these programmes would require showing that the skills learned had been successfully transferred to real-life situations.

Prevention and educational campaigns

Widespread prevention and educational campaigns are another approach to reducing child abuse and neglect. These interventions stem from the belief that increasing awareness and understanding of the phenomenon among the general population will result in a lower level of abuse. This could occur directly – with perpetrators recognizing their own behaviour as abusive and wrong and seeking treatment – or indirectly, with increased recognition and reporting of abuse either by victims or third parties.

In 1991–1992, a multimedia campaign was conducted in the Netherlands (*148, 149*). The goal was to increase disclosure of child abuse, both by victims and those in close contact with children, such as teachers. The campaign included a televised documentary, short films and commercials, a radio programme and printed materials such as posters, stickers, booklets and newspaper articles. Regional training sessions were provided for teachers. In an evaluation of this intervention, Hoefnagels & Baartman (*149*) concluded that the mass media campaign increased the level of disclosure, as measured by the rate of telephone calls to the National Child Line service before and after the campaign. The effect of increased disclosure on rates of child abuse and on the mental health of the victims, however, needs to be studied further.

Interventions to change community attitudes and behaviour

Another approach to prevent child abuse and neglect is to develop coordinated interventions to change community attitudes and behaviour, effective across a range of sectors. One example of such a programme is the comprehensive response to child abuse and neglect in Kenya (see Box 3.3).

In Zimbabwe, the Training and Research Support Centre set up a participatory, multisectoral programme to address child sexual abuse (*8*). The Centre convened a diverse group of individuals, including some professionals, from rural and urban areas across the country. Role plays, drama, paintings and discussion sessions were used to bring out the experiences and perceptions of child sexual abuse and to consider what could be done to prevent and detect the problem.

Following on from this first stage, the group of participants subsequently set up and implemented two action programmes. The first, a school programme developed in collaboration with the Ministries of Education and Culture, covered training, capacity building and the development of materials for school psychologists, teachers, administrative staff and children. The second was a legal programme developed jointly with the Ministry of Justice, Legal and Parliamentary Affairs. This programme – designed for nurses, nongovernmental organization workers, police and other law enforcement officials – set up training courses on how to manage young sexual offenders. The training also dealt with the issue of creating victim-friendly courts for vulnerable witnesses. Guidelines for reporting were also developed.

Societal approaches

National policies and programmes

Most prevention efforts for child maltreatment focus on victims and perpetrators without necessarily addressing the root causes of the problem. It is believed, though, that by successfully tackling poverty, improving educational levels and employment opportunities, and increasing the availability and quality of child care, rates of child abuse and neglect can be significantly reduced. Research from

BOX 3.3

Preventing child abuse and neglect in Kenya

In 1996, a coalition was formed in Kenya with the goal of raising public awareness of child abuse and neglect, and improving the provision of services to victims. An earlier study in four areas of Kenya had shown that child abuse and neglect were relatively prevalent in the country, though no organized response systems existed. Members of the coalition came initially from key government ministries as well as from nongovernmental organizations with community-based programmes. They were subsequently joined by representatives from the private sector, the police and judicial system, and the main hospitals.

All coalition members received training on child abuse and neglect. Three working groups were established, one to deal with training, one with advocacy and the third with child protection. Each group collaborated with specific governmental and nongovernmental bodies. The working group on training, for instance, worked in conjunction with the Ministries of Education, Health, Home Affairs and Labour, running workshops for school staff, health professionals, lawyers, social workers and the police. The advocacy group worked with the Ministry of Information and Broadcasting and various nongovernmental organizations, producing radio and television programmes, and also collaborated with the press in rural areas.

Importantly, children themselves became involved in the project through drama, music and essay competitions. These were held initially at the local level and subsequently at district, provincial and national levels. These competitions are now a regular activity within the Kenyan school system.

The coalition also worked to strengthen the reporting and management of cases of child abuse and neglect. It assisted the Department for Children of the Ministry of Home Affairs in setting up a database on child abuse and neglect and helped create a legal network for abused children, the ''Children Legal Action Network''. In 1998 and 1999, the coalition organized national and regional conferences to bring together researchers and practitioners in the field of child abuse and neglect.

As a result of these various efforts, more Kenyans are now aware of the problem of child abuse and neglect, and a system has been established to address the needs of victims and their families.

several countries in Western Europe, as well as Canada, Colombia and parts of Asia and the Pacific, indicates that the availability of high-quality early-childhood programmes may offset social and economic inequalities and improve child outcomes (*150*). Evidence directly linking the availability of such programmes to a decrease in child maltreatment, though, is lacking. Studies of these programmes have usually measured outcomes such as child development and school success.

Other policies that can indirectly affect levels of child abuse and neglect are those related to reproductive health. It has been suggested that liberal policies on reproductive health provide families with a greater sense of control over the size of their families and that this, in turn, benefits women and children. Such policies, for instance, have allowed for more flexibility in maternal employment and child care arrangements.

The nature and scope of these policies is, however, also important. Some researchers have claimed that policies limiting the size of families, such as the ''one-child'' policy in China, have had the indirect effect of reducing rates of child abuse and neglect (*151*), though others point to the increased numbers of abandoned girls in China as evidence that such policies may actually increase the incidence of abuse.

International treaties

In November 1989, the United Nations General Assembly adopted the Convention on the Rights of

the Child. A guiding principle of the Convention is that children are individuals with equal rights to those of adults. Since children are dependent on adults, though, their views are rarely taken into account when governments set out policies. At the same time, children are often the most vulnerable group as regards government-sponsored activities relating to the environment, living conditions, health care and nutrition. The Convention on the Rights of the Child provides clear standards and obligations for all signatory nations for the protection of children.

The Convention on the Rights of the Child is one of the most widely ratified of all the international treaties and conventions. Its impact, though, in protecting children from abuse and neglect has yet to be fully realized (see Box 3.4).

Recommendations

There are several major areas for action that need to be addressed by governments, researchers, health care and social workers, the teaching and legal professions, nongovernmental organizations and other groups with an interest in preventing child abuse and neglect.

Better assessment and monitoring

Governments should monitor cases of child abuse and neglect and the harm they cause. Such monitoring may consist of collecting case reports, conducting periodic surveys or using other appropriate methods, and may be assisted by academic institutions, the health care system and nongovernmental organizations. Because in many countries professionals are not trained in the subject and because government programmes are generally lacking, reliance on official reports will probably not be sufficient in most places to raise public concern about child abuse and neglect. Instead, periodic population-based surveys of the public are likely to be needed.

Better response systems

It is essential that systems for responding to child abuse and neglect are in place and are operational. In the Philippines, for example, private and public hospitals provide the first line of response to child abuse, followed by the national criminal justice system (*152*). Clearly, it is vital that children should receive expert and sensitively conducted services at all stages. Investigations, medical evaluations, medical and mental health care, family interventions and legal services all need to be completely safe for the children and families concerned. In countries where there is a tradition of private children's aid societies providing these services, it may be necessary to monitor only the child's care. It is important, though, for governments to guarantee the quality and availability of services, and to provide them if no other provider is available.

Policy development

Governments should assist local agencies to implement effective protection services for children. New policies may be needed:

- to ensure a well-trained workforce;
- to develop responses using a range of disciplines;
- to provide alternative care placements for children;
- to ensure access to health resources;
- to provide resources for families.

An important policy area that needs to be addressed is the way the justice system operates with regard to victims of child abuse and neglect. Some countries have put resources into improving juvenile courts, finding ways to minimize the need for testimony from children, and ensuring that when a child does give evidence in court, there are supportive people present.

Better data

Lack of good data on the extent and consequences of abuse and neglect has held back the development of appropriate responses in most parts of the world. Without good local data, it is also difficult to develop a proper awareness of child abuse and neglect and expertise in addressing the problem within the health care, legal and social service professions. While a systematic study of child abuse and neglect within each country is essential, researchers should be encouraged to use the

BOX 3.4

The Convention on the Rights of the Child

The Convention on the Rights of the Child recognizes and urges respect for the human rights of children. In particular, Article 19 calls for legislative, administrative, social and educational actions to protect children from all forms of violence, including abuse and neglect.

It is difficult, however, to assess the precise impact of the Convention on levels of child abuse. Most countries include the protection of children from violence within family law, making it difficult to extract detailed information on the progress that signatories to the Convention have made in preventing child abuse. Furthermore, no global study has tried specifically to determine the impact of the Convention on the prevention of abuse.

All the same, the Convention has stimulated legal reform and the setting up of statutory bodies to oversee issues affecting children. In Latin America, a pioneer in the global process of ratifying the Convention and reforming legislation accordingly, national parliaments have passed laws stipulating that children must be protected from situations of risk, including neglect, violence and exploitation. Incorporating the Convention into national law has led to official recognition of the key role of the family in child care and development. In the case of child abuse, it has resulted in a shift from the institutionalization of abused children to policies of increased support for the family and of removing perpetrators of abuse from the family environment.

In Europe, Poland is one of the countries that have integrated the stipulations of the Convention into their domestic law. Local government bodies in that country now have a responsibility to provide social, psychiatric and legal aid for children. In Africa, Ghana has also amended its criminal code, raised the penalties for rape and molestation, and abolished the option of fines for offences involving sexual violence. The government has also conducted educational campaigns on issues relating to the rights of children, including child abuse.

Only a few countries, though, have legal provisions covering all forms of violence against children. Furthermore, lack of coordination between different government departments and between authorities at the national and local level, as well as other factors, have resulted in the often fragmented implementation of those measures that have been ratified. In Ecuador, for example, a national body to protect minors has been set up, but reform of the child protection system is required before the proper enforcement of children's rights is possible. In Ghana, the legal reforms have had only a limited effect, as funds to disseminate information and provide the necessary training are lacking.

Nongovernmental organizations have expended considerable efforts on behalf of the rights of children and have campaigned for the Convention to be strongly supported. Child protection bodies in a number of countries, including the Gambia, Pakistan and Peru, have used the Convention to justify calls for greater state investment in child protection and for increased governmental and nongovernmental involvement generally in preventing child abuse. In Pakistan, for example, the Coalition for Child Rights works in North-West Frontier Province, training community activists on child rights and carrying out research on issues such as child abuse. Using its own findings and the legal framework of the Convention, it tries to make other community-based organizations more sensitive to the issue of abuse.

There is a need for more countries to incorporate the rights of children in their social policies and to mandate local government institutions to implement these rights. Specific data on violence against children and on interventions addressing the issue are also needed, so that existing programmes can be monitored and new ones implemented effectively.

measuring techniques already successfully employed elsewhere, so that cross-cultural comparisons can meaningfully be made and the reasons behind variations between countries examined.

More research

Disciplinary practices

More research is needed to explore variations across cultures in the definition of acceptable disciplinary behaviours. Patterns of cultural variations in child discipline can help all countries develop workable definitions of abuse and attend to issues of cultural variations within countries. Such cultural variations may indeed be the underlying reason for some of the unusual manifestations of child abuse reported in the medical literature (*153*). Some of the data cited above suggest that there may well be more general agreement than previously thought across cultures on what disciplinary practices are considered unacceptable and abusive. Research is needed, though, to explore further whether a broader consensus can also be reached concerning very harsh discipline.

Neglect

There is also a great need for more study of the problem of neglect of children. Because neglect is so closely associated with low education and low income, it is important to discover how best to distinguish neglect by parents from deprivation through poverty.

Risk factors

Many risk factors appear to operate similarly across all societies, yet there are some, requiring further research, that seem dependent on culture. While there appears to be a clear association between the risk of abuse and the age of the child, the peak rates of physical abuse occur at different ages in different countries. This phenomenon requires further investigation. In particular, it is necessary to understand more about how parental expectations of child behaviour vary across cultures, as well as what role child characteristics play in the occurrence of abuse.

Other factors that have been suggested as either risk factors or protective factors in child abuse – including stress, social capital, social support, the availability of an extended family to help with the care of children, domestic violence and substance abuse – also need further research.

Equally necessary is a better understanding of how broader social, cultural and economic factors influence family life. Such forces are believed to interact with individual and family factors to produce coercive and violent patterns of behaviour. Most of them, however, have been largely neglected in studies of child maltreatment.

Documentation of effective responses

Relatively few studies have been carried out on the effectiveness of responses to prevent child abuse and neglect. There is thus an urgent need, in both industrialized and developing countries, for the rigorous evaluation of many of the preventive responses described above. Other existing interventions should also be assessed with regard to their potential for preventing abuse – for instance, child-support payments, paid paternity and maternity leave, and early childhood programmes. Finally, new approaches should be developed and tested, especially those focusing on primary prevention.

Improved training and education for professionals

Health and education professionals have a special responsibility. Researchers in the fields of medicine and public health must have the skills to design and conduct investigations of abuse. Curricula for medical and nursing students, graduate training programmes in the social and behavioural sciences, and teacher training programmes should all include the subject of child abuse and the development within organizations of responses to it. Leading professionals in all these fields should actively work to attract resources to enable such curricula to be properly implemented.

Conclusion

Child abuse is a serious global health problem. Although most studies on it have been conducted in developed countries, there is compelling evidence that the phenomenon is common throughout the world.

Much more can and should be done about the problem. In many countries, there is little recognition of child abuse among the public or health

professionals. Recognition and awareness, although essential elements for effective prevention, are only part of the solution. Prevention efforts and policies must directly address children, their caregivers and the environments in which they live in order to prevent potential abuse from occurring and to deal effectively with cases of abuse and neglect that have taken place. The concerted and coordinated efforts of a whole range of sectors are required here, and public health researchers and practitioners can play a key role by leading and facilitating the process.

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