

REPORT ON

CHILD MALTREATMENT PREVENTION

READINESS ASSESSMENT IN REPUBLIC OF

MACEDONIA

**Safe Childhood-Macedonia in collaboration with WHO's Prevention of Violence
Unit, Geneva and Fetzer Institute**

Acronyms

CM	Child maltreatment
CMP	Child maltreatment prevention
CMPR	Child maltreatment prevention readiness
RAP-CM	Readiness Assessment for the Prevention of Child Maltreatment
CAN	Child abuse and neglect
CSA	Child sexual abuse
LMIC	Low and middle income countries
ISPCAN	International Society for Child Abuse and Neglect
GDP	Gross Domestic Product
MLSP	Ministry of Labour and Social Policy
MoH	Ministry of Health
MoE	Ministry of Education
MoI	Ministry of Interior
GO	Governmental organization
NGO	Nongovernmental organization

Country Project Team:

Marija Raleva, MD, PhD, child psychiatrist, Safe Childhood
Izabela Filov, MD, PhD, psychiatrist, Medical School, Bitola
Liljana Trpchevska, special educator, Safe Childhood
Aleksandra Coneva, MA, social worker, Safe Childhood
Dimitrinka Jordanova Peshevska, MA, psychologist, Violence Prevention Officer, WHO country office, Skopje
Rozalinda Isjanovska, MD, PhD, epidemiologist and statistician, Institute for Epidemiology and Biostatistics, Medical School, Skopje

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1. Introduction and background information

A major shift in the field of child maltreatment (CM) has, for some time now, been under way: from responding to CM after it occurs – through, for instance care, support and treatment (child protection) – to preventing it in the first place (child maltreatment prevention) which now appears to become a global health priority. Republic of Macedonia, a low income country, putting violence prevention high on the political agenda, and thus recognizing the importance of preventing child maltreatment, has joined in the efforts to address this health priority.

A review of the literature by Browne and Filkenhor (1986) shows that depression, feelings of isolation and stigma, poor self-esteem, distrust, substance abuse, and sexual maladjustment are the most frequently reported long-term effects of child abuse and neglect. Other findings include a variety of other psychopathological disorders such as suicide, panic disorder, dissociative disorders, post-traumatic stress disorder, and antisocial behaviors (De Bellis et al., 2004; Johnson & Leff, 1999; Silverman et al., 1996; Springer et al., 2007; Teicher, 2000; Zeitlen, 1994). Child abuse and neglect also result in impaired brain development with long-term consequences for cognitive, language, and academic abilities (Watts-English et al., 2006; Zolotor et al., 1999). Many retrospective and prospective studies have established that CM has strong, long-lasting effects on brain architecture, cognition and behavior leading to disruption in psychological and social functioning and mental health problems, health risk behaviours, lower life expectancy and higher health-care costs (Knudsen et al., 2006; Shonkoff et al., 2009; Perry et al., 2009; MacMillan et al., 2009).

The Readiness Assessment for the Prevention of Child Maltreatment (RAP-CM) is a method to assess how “ready” (in terms of awareness, willingness, ability and capacity) a country, province/state, or community or municipality is to implement evidence-based child maltreatment prevention programmes on a large scale. Once this has been established, the next step is to increase readiness on those dimensions where this may be necessary and then implement evidence-based child maltreatment programmes on a scale commensurate with the magnitude of the problem.

Thus recognizing the importance of prevention readiness assessments, WHO's Prevention of Violence Unit in Geneva, with the generous help of the Fetzer Institute, and research teams from six countries (Brazil, China, Malaysia, Saudi Arabia, South Africa and Republic of Macedonia) decided to launch a project on CMPR in the respected countries. This report refers to Readiness Assessment for the Prevention of Child Maltreatment (RAP-CM) in Republic of Macedonia on national and local level.

The concept of readiness for child maltreatment prevention (CMP) includes key players' attitudes towards and knowledge of child maltreatment; the availability of scientific data on child maltreatment and its prevention; willingness to take action to address the

problem; and the nonmaterial (e.g. legal, policy, human, technical, and social resources) and material (e.g. infrastructural, institutional, and financial) resources that can be brought to bear on the prevention of child maltreatment.

The definition of child maltreatment RAP-CM adopted is taken from the 2006 World Health Organization-International Society for Prevention of Child Abuse and Neglect Guide on Preventing Child Maltreatment. Child maltreatment is defined as:

"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" (WHO/ISPCAN, 2006).

For the sake of clarity, we realize that the following distinction between child protection and child maltreatment prevention does not necessarily match the way these terms have been used in R. Macedonia, but as employed by the World Health Organization (WHO) and in RAP-CM, the basic difference between these two terms is that:

- **child protection services** investigate and try to substantiate reports of suspected child abuse and either directly provide or refer to appropriate support, care, and treatment for the traumatized child. Child protection intervenes *after* the child maltreatment has taken place.
- **child maltreatment prevention** refers to measures taken to prevent child maltreatment before it occurs by addressing the underlying causes and risk and protective factors – such as teaching positive parenting skills to pregnant first-time mothers.

WHO's Prevention of Violence Unit, supported by the Fetzer Institute, and research teams from five countries decided to develop an instrument to systematically measure CMPR as a first step toward readiness assessment.

RAP-CM can serve several important purposes:

- identify major gaps in readiness and inform plans to address them;
- establish a baseline measure against which progress in increasing readiness can be tracked;
- help to allocate resources at the international, national, sub-national, and community and municipal levels to increase readiness for CMP;
- assist in matching an intervention to the existing level of readiness;
- act as a catalyst for taking action to prevent CM; and
- function as a teaching tool to introduce the concepts of CMP and CMPR to key players.

This project began in mid-2009 and country research teams gathered on three workshops which were held at WHO-HQ in Geneva in September 2009, October 2010 and June 2011. During these workshops, the evidence-base for CMP was reviewed and its applicability in LMICs was discussed; the draft conceptual model for CMP readiness was presented and discussed; and each country was prepared to help develop, pilot, and field test the instrument and completed the field trials.

1.1. Country background information

Republic of Macedonia is a land-locked country situated in the Southern Balkan Peninsula. The country gained independence in 1991. Since then the country has undergone dramatic changes to adjust itself to a new political and economic environment. The last available official census data (2002) for Macedonia puts the population total at 2,052,722 people. Macedonian society is composed of several ethnic groups: Macedonian (64,18%) Albanian (25,17%), Turks (3,85%), Roma (2,66%), and Serbs (1,78%), other (2,36%). The age structure of the population considering children age 0-14, mostly susceptible to child maltreatment, represents 17.7% (363 332) (see Annex1); The capital of Macedonia is Skopje with an estimated 467,257 citizens. The total urban population is 57,8%.

Over the last few years the inflation rate and GDP have stabilized but unemployment figures have steadily increased. GDP per capita is \$9,400 (2010 est.). Unemployment rate is 31,7%, 28,7% of population is below international poverty line of US\$1.25 per day. Health indicators are given in the table No1.

The civil and ethnic wars in the neighborhood and the armed conflict in the country in 2001 have had a major traumatic effect on the displaced population, as victims of or witness to severe violence and abuse but the conflict has also had a negative effect on a much larger part of the population and on the country in general, disrupting the social strata. Violence is thus frequently the expression of a context of social anomie, i.e. the absence of rules and standards or at least a loss of reference points and forgetfulness of the values underpinning them.

In low-income countries, such as Macedonia, that bear the brunt of the global mortality burden associated with homicide, suicide and war, have substantially elevated rates of child physical, sexual and emotional abuse. Although the region is emerging quite rapidly now from a past in which violent and humiliating punishment and treatment of children in the home was more or less universal and socially and legally accepted, still the traditional status of children as possessions rather than people exists. Also prevalence of school violence increases and we consider this phenomena to be just the outcome or extension of other forms of violence carried out and undergone within, by and outside the school, within the family, community and entire society. Growing in such an environment put children at risk of becoming victims of different types of violence, or adopting violent behavior and continuing perpetrating violence among themselves.

1.2. Legislation, programmes, and policies for child maltreatment prevention in R. of Macedonia

The Constitution of R. Macedonia guarantees the moral and physical integrity of human being, maternity and children and youth. Criminal code – defines pedophilia and all forms of sexual abuse, physical abuse of children.

Family Law and Child Protection Law regulates the relationship between parents and children, responsibility of parents, custody, and child protection measures in case of domestic violence.

The Law on Primary and Law on Secondary Education prohibit corporal punishment and psychological maltreatment of students in primary and secondary schools.

In 2004, legislative measures criminalizing domestic violence were adopted. This entailed amending the Family Law and codifying domestic violence in the Criminal Code. Following these legal changes, a joint civil society and government effort was initiated to improve protection of victims of domestic violence, including children and adolescents through establishment of temporary protection measures as prescribed under the Family Law. In the area of prevention some efforts were also made to raise awareness, and those activities are now considered to be of continuous, coordinated and sustainable nature.

Ministry of Labor and Social Policy (MLSP) as a main governmental institution in charge of children's welfare has a Sector for Child Protection with a main mandate on national policies, legislation and planning of service provision for child maltreatment prevention and child protection purposes. There is also another division with a mandate on domestic violence prevention, which also is responsible for children's wellbeing in context of the family. On the local level the Ministry of Local Self Government is in the phase of preparation of developing Sectors for Child Protection on the municipality level.

NGOs such as First Children's Embassy – Megjasi, have mandate for CMP in the country.

In the agenda of the Ministry of Health (MoH) violence has been set up as a priority in 2004 – 2005; 2006 – 2007 and as well in the biennium 2008 – 2009 as a part of the Biennium Collaborative Agreement between MoH and WHO CO Skopje. National Commission on Violence and Health was established 2005. National Strategy for Protection against Domestic Violence has been launched in April 2008, and a National Coordinative body for DV Prevention as an intersectoral body was established in collaboration with other relevant ministries and institutions as well as civil society organizations. National Action Plan on Prevention of Sexual Abuse of Children and Pedophilia was adopted in October 2008. National Action Plan on Prevention of Child Abuse and Neglect is in a preparatory phase.

Child maltreatment prevention, as it is pointed in the concept note of this project, means to reduce the frequency of new child maltreatment cases through direct efforts to remove or reduce the underlying causes and risk factors, and by harnessing the indirect effects of other policies and programmes that may contribute to reducing exposure to risk factors and underlying causes. The emphasis of child maltreatment prevention is on preventing child maltreatment before it happens. Although some preventive programmes are in place, there is a lack of coordinated and holistic approach towards the problem of CMP. Some of the preventive programmes that exist in the country are:

(1) Early childhood home visitation programme, which originally was focused on infant physical health and maternal support, consists of trained professionals (paediatric nurses and paediatricians) who visit the families of newborns during the first year of life, needs further training in CM prevention.

(2) Parenting education programmes, which are usually centre-based and aim to prevent child maltreatment by improving parents' child-rearing skills, increasing parental knowledge of child development, and encouraging positive child management strategies are delivered to parents of children in kindergartens, on a local level, mainly in Skopje.

(3) Child sexual abuse prevention programmes, which are typically delivered in schools and teach children about body ownership, the difference between good and bad touch, to recognize abusive situations, say no, and disclose abuse to a trusted adult are delivered within some communities;

(4) Media-based interventions: public awareness campaigns, performed by the NGOs mainly, and lately in collaboration with GOs should become a continuous practice.

2. Aims and objectives of the Fetzer Research Country Project

The overall aim of the Fetzer Research Country Project on child maltreatment prevention readiness in Republic of Macedonia was to contribute to the development of a single instrument to measure child maltreatment prevention readiness, to pilot, test, and apply the developed instrument to measure readiness for implementing evidence-based CMP programmes in low- and middle-income countries such as R. of Macedonia among other five countries globally (namely Brazil, China, Malaysia, Saudi Arabia and South Africa). It was decided to focus on the assessment of readiness for CMP at two levels – the national and the community level.

The specific objectives of the country project were to:

1. Contribute to the development of an integrated conceptual model for CMP readiness at national and community levels on the basis of which the instrument can be developed;
2. Contribute to the development of a single instrument to measure CMP readiness at these three levels;
3. Pilot test the instrument in the country;
4. Apply the instrument, further testing it in the process (the "field trial"), in Macedonia
5. Outline strategies to increase CMP readiness in R. Macedonia
6. Produce a country report which assess – using the instrument developed – CMP readiness at national and community levels and outline strategies for increasing CMP readiness as a first step towards implementing large-scale CMP programmes;

3. Target audience/readership for this report/research

It is expected that this study will assess community and national CMP readiness in the R.

of Macedonia and further will encourage the implementation of scientifically proved interventions and their evaluation as well as for broader implementation and dissemination of proved and promising strategies for child maltreatment prevention in the sectors of health, education, social welfare and justice. "Matching an intervention to a community's level of readiness is absolutely essential for success." (Plested et al., 2006).

Policy-makers, programme planners working at national and local levels in these sectors could benefit from such a study giving priorities to some interventions which seem to be most appropriate for the country or the local region: in the health sector - strengthen the early child development programmes; health policy and planning; epidemiology and health-information systems; public health and preventive medicine; child's development and mental health; pediatrics; reproductive health; In the sector of social services: social work and child maltreatment prevention; child protection. In the legal sector, the relevant technical fields are those of: justice; law enforcement; human rights. Research is also vital for the evaluation of the effectiveness of the programmes and policies to prevent child maltreatment. It is therefore crucial to involve the broader scientific community, including: universities and medical schools; science councils; research institutes and government

4. Method

4.1. Development of the instrument on CMPR in R. Macedonia

RAP-CM-I was developed in a five stage process conducted in six countries (Brazil, China, The Former Yugoslav Republic of Macedonia, Malaysia, Saudi Arabia, and South Africa):

Stage 1: Country contribution to the development of the conceptual model underlying the instrument. The development of the conceptual model proceeded in three steps: 1. review of existing models and approaches relevant to the assessment of readiness for CMP (defining the construct of readiness and examining of the related constructs, identifying theories underlying them); evaluation of the models and approaches identified and developing an initial model; 2. consultation meeting of 17 international experts to critique the model; 3. systematically conducted 2-3-hour-long focus groups in six project countries globally.

The aim of the focus groups was in part to capture better country and culturally specific aspects of readiness for CMP. This process resulted in ten-dimensional model (See Mikton et al., 2011).

In R. of Macedonia a focus group discussion on model was organized with experts from different sectors that are in charge of prevention in our country: Ministry of Labor and Social Policy (MLSP), Institute of Social Protection, Ministry of Health (MoH), Institute of Health Protection of Mother and Child, Institute of Mental Health of Children and Youth, University Clinic of Pediatrics, WHO CO Skopje and University Clinic of Psychiatry.

The initial version of the conceptual model on CMP readiness, which consisted of 8 dimensions was translated in Macedonian and presented to the participants in the focus group. On the basis of the discussion that followed, main comments that were addressed to the each dimension of the model contributed to the development of the Version I of the questionnaire.

Stage 2: Cognitive testing of the instrument. On the basis of the 8 dimensional conceptual model for CMP readiness assessment the first draft of the questionnaire was developed, which had to be cognitively tested. The aim of the cognitive interviews was to assess whether the interview schedule was generating the information required, the quality (e.g. clarity, intelligibility) of the interview schedule, how interviewee's elaborate their answers, and how they interpreted the questions.

The recruitment of subjects, targets persons for the cognitive testing are people with specific interests in the field of child maltreatment prevention and protection, but not taking the leading positions, coming from different public domains such as: health, social work, social policy and education. The group interviewed for the cognitive testing consisted of forensic psychiatrist, general practitioner, social worker from social service; social worker in the Ministry of Labor and Social Policy, pedagogue from the Ministry of Education, clinical psychologist and child psychiatrist from the University Clinic of Psychiatry. All the interviews were conducted by one interviewer, in order to guide the subject and tailor the interchange in a way that is controlled mainly by the interviewer and minimize the possibility of bias through the explanation of the different questions using probing techniques.

During the cognitive testing it was agreed by the group of professionals that:

1. The clarity of the questions was sufficient, and they are clearly formulated. In Macedonian language there isn't clear distinction between child protection and child maltreatment prevention, although the term prevention implies that these particular practices are connected with prevention of maltreatment before it occurs. The term child protection refers to broader protective practices which also include prevention.
2. Most of the questions were applicable in our context although most of the questions had been derived from the public health approach which health professionals are familiar with, but may not be the case for professionals from the social sector.
3. There was no need of reformulating the questions, but might need shortening.
4. The interviewees didn't feel uncomfortable being asked about their knowledge for the problem of CMP and combining them with their attitudes towards the problem gives them the impression that their opinion is worth and valuable.
5. The time required was too long for an interview, but it was comprehensive.
6. The order of the questions was gradual, logical, informative at the beginning, but later with very specific and precisely defined questions, which elaborate in detail all possible aspects of the problem, which is very instructive for countries that haven't reached the level required to establish the child maltreatment prevention high on the political agenda.
7. Options for answering seemed clear.
8. The clarity of options was adequate.
9. The understanding of the question was adequate,
10. Social desirability of the answers in the beginning of the interview was higher, but as it continues there is less and less opportunity for this.
11. There were some questions that should be omitted.

12. The remarks for explanation of the questions are very clear and lead the interviewee through the process of thinking and concluding in formulating the answer.

13. The main concern was whether the respondent would devote sufficient mental effort to answer all the questions accurately and thoughtfully, and to shorten the length by half.

Stage 3: Revision of Version 1 and development and pilot testing of Version 2 on country level

Version 1 of the interview schedule was revised on the basis of the results of the cognitive interviews and then Version 2 was pilot tested on samples of 20 key informants in the country, selected from professionals working in the field of CM prevention. The semi-structured interview schedule was translated into Macedonian and was ready to be administered to obtain the informants' views of the level of readiness of Macedonia, to implement evidence-based child maltreatment prevention programmes on a large scale. Each interview took approximately two hours and more and produced both quantitative and qualitative results.

The assessment of interviewee's knowledge did not appear to cause offense, as was initially feared. On the contrary there was a general impression that the process of conducting these interviews was raising awareness of child maltreatment prevention and acting as a catalyst for the issue

Stage 4: Revision of Version 2 and development and field testing of Version 3 on country level. Through quantitative analyses of the results of the pilot study using Version 2, it was cut down by 50%, resulting in Version 3 of the instrument which was then field tested in the country on a sample of 50 key informants.

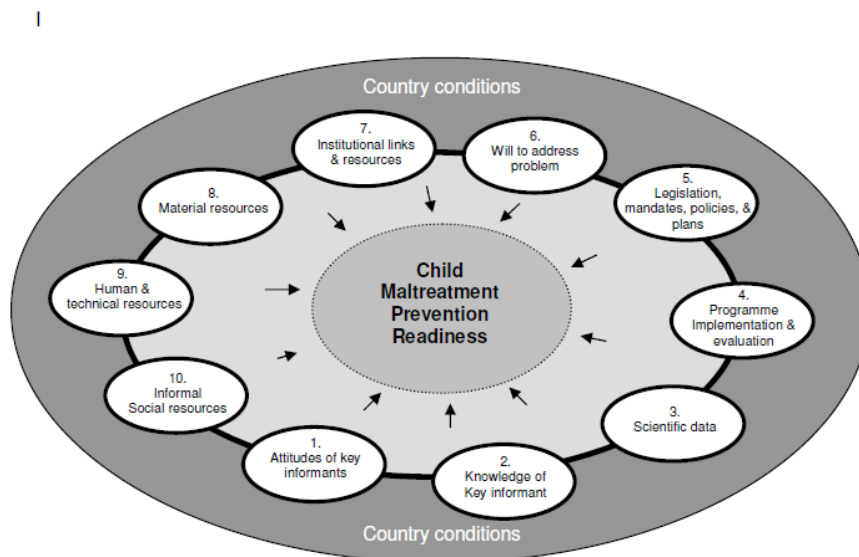


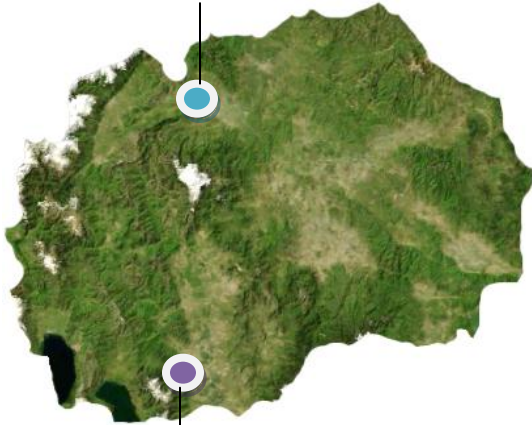
Figure No.4.1: 10 Dimensional model on child maltreatment prevention

4.2. Field testing

Our aim was to assess CMPR in general and at two levels: the national level and the community/local level, conducting 30 interviews at national level and 20 at community/local level. The community that was selected - the town of Bitola - has 122,173 inhabitants.

Interviewees were key players or potential key players in CMP. Because the field is only beginning to develop in the country, the key players that were included were people from the ministries such as policy makers, programme planners involved in the child protection services and early child development programmes, high level health and social welfare practitioners, academics and researchers. They came from governmental organizations, NGOs, community-based organizations, international organizations, university and research institutes and the media. The sample selected was, as far as possible, representative of the field nationally and locally.

Skopje (national level)



Bitola (community level)

Figure no.4.2: Map of R. Macedonia: areas in which the national and local level of the research was conducted

The response rate was satisfactory. We have approached 56 potential respondents, but only 6 of them couldn't participate because of being engaged in other activities. Most of the respondents who refused were key people from the ministries, delegating this task to their assistants and advisors.

The "objective" assessment was conducted by the team members themselves who gathered together to give consensual answers to the questions in the interview, and to review policies, legislative and programmes that were implemented on CM prevention. Data analysis was performed in two ways

- Quantitative analysis
- Qualitative analysis

5. Analysis of the results

Starting the field trial the interviewers approached the selected key informants from different backgrounds on national and local level. In total 50 participants accepted to be interviewed out of 56 that were originally asked to take part in the study. The main reason for not participating was their over-engagement in other activities mostly by key informants on national level (general elections were approaching).

Almost three fourths of respondents who took part in the interview are female -74,0% (76,6% on national level and 70% on local level respectively), versus 26,0% male respondents (23,3% on national level and 30% on local), which reflects the fact that more women are engaged in social and health care for this particular category of population, as it is globally.

Table no.5.1 Distribution of respondents according to their employment

Organization	Total	%	National level	%	Local level	%
Governmental	32	64.0	17	56,7	15	75,0
Non- governmental	15	30.0	11	36,7	4	20,0
Research institute	1	2.0	1	3,3		
university	1	2.0	1	3,3		
other	1	2.0			1	5,0

The sample of respondents consists of key informants on national and local level. The majority of them are working for government organizations-64,0% (56,7% on national level and 75% on local level), the rest are working for non-governmental organization-30,0% (36,7% on national and 20% on local level) (table.5.2). The sample is more balanced on national level, including informants coming from different backgrounds, which is logically for a country the size of Macedonia.

5.1. Dimension 1: Attitudes towards child maltreatment prevention

The majority of the key respondents (86%) perceive the problem of CM as extremely serious- and serious. Although this question is socially desirable, it also reflects the efforts on national level to establish a reliable system for CM prevention.

The terminological distinction between child maltreatment prevention and child protection is well understood but not the generic distinction. Majority of the key informants, although understand the distinction don't have the opportunity to practice this difference in approaches, since there isn't a system in the country that consistently differentiates the both aspects. Child maltreatment protection activities are usually alternatively named as early intervention, secondary prevention (with population at risk), so the notions are usually mixed.

The average experience of the key respondents in child maltreatment prevention is $12 \pm 8,6$ y, in child protection is $11,5 \pm 8,6$ y. and working in both areas at the same time is $13,3 \pm 9,2$ years, which again indicates that child maltreatment prevention and child protection are fields that are overlapping and often jointly approached and thus have much more chances to be mixed with one another.

The average experience on both national and local levels are very similar: more than 10 years in each area. Working in both areas at the same time for the participants is almost equal - 13,3.

Almost all the respondents think that CM can be prevented (99% - sometimes, usually, or almost always).

Considering the political priority of CM prevention, 44% of key informants think that “low” and “extremely low” priority is given to child maltreatment prevention (both on national and local level), 22,0% think that it is given moderate priority, and 34% think that it’s given “high” and “extremely high” priority. The responses on national level are more in favor of the given political priority to CM prevention.

Comparing CM prevention and CM protection more than half of the respondents (54%) think that CM prevention is less and much less of a political priority than CM protection, and 24,0% of the respondents think that it is given more and much more of a political priority, 14,0% think they are treated about equal. The opinions do not differ much according to the level of respondents.

Table no.5.1.1. Measures to prevent CM

	Total frequency	%	National level	%	Local level	%
Adequate	16	32,0	9	30,0	7	35,0
Neither adequate nor inadequate	17	34,0	9	30,0	8	40,0
Inadequate Extremely inadequate	17	34,0	12	40,0	5	25,0

Most of the participants-34,0% think that measures taken are neither adequate nor inadequate, 32,0% think that measures are adequate, 30,0% -inadequate (tab.5.1.3). Respondents on national versus those on local level are more critical to the measures taken to prevent child maltreatment.

Table no.5.1.2: Protection of the rights of children

	Total frequency	%	National level	%	Local level	%
extremely well/well protected	37	74,0	18	60,0	19	95,0
Moderate protected	11	22,0	10	33,3	1	5,0
Inadequately protected	2	4,0	2	6,66		

Most of the participants - 74,0% have the opinion that the rights of children are well and extremely well protected in legislation, 22% think they are moderately protected, (tab.5.1.2). The opinion of the respondents on national level is more critical to the protection to the rights of the children.

But when it comes to practice, most of the participants - 38,0% have the opinion that the rights of children are moderately protected, 44,0%- think that they are inadequately protected or not at all protected, and only 18,0% - well protected (graph.5.1.5).

On national level respondents are more critical and most of them (40%) think that they are inadequately protected, than moderately protected (30%) and 16,7% think that they are not at all protected. On local level the perception is more idealized and half of the respondents (50%) think that they are moderately protected, 25% think well protected and 15% think that they are inadequately protected.

5.2.Dimension 2: Knowledge of child maltreatment prevention

All the respondents listed from 2 to 6 forms of child maltreatment. Most of them (58%) listed 2-4 forms. On national level half of the respondents have listed 2-4 forms of CM and the other half 5-6 forms of maltreatment. On local level more than two thirds of the respondents have listed 2-4 forms and 30% 5-6 forms of maltreatment.

There aren't population based research studies in Macedonia from which estimation on the percentage of the adults maltreated as children can be made. So the percentages given by respondents are their subjective estimations, mainly based on the cultural beliefs and patterns on disciplining children by corporal punishment and some forms of neglect that were very appreciated in the past. Still most of the participants - 38% have answered that they don't know the percentage of the current population of adults maltreated as children, because there isn't any evidence on that.

The respondents are familiar with immediate and long term consequences of CM but most of them indicated the long-term psychological and behavioral consequences, and very few the immediate and long-term consequences on physical health. The consequences listed by the respondents ranged from one to 11. Equal number of the respondents (24%) listed four or five types of consequences for the victim. Most of the respondents on national level (60%) listed four to five types of consequences, and 40% of respondents on local level listed 2 to 5 types of consequences.

Main costs on child maltreatment were assessed ranging from 1 up to 9 types of costs. 96% of the respondents estimated at least one type of cost and 4% estimated up to 9 types of costs. 58% estimated 1-4 types of costs and 32% estimated 5-9 types of costs. On national level 63% of the respondents estimated 5-9 types of costs, and on local level 90% of the respondents estimated 1-4 types of costs.

Different risk factors were listed by the key respondents. Main risk factors for child maltreatment are in range from one to 14 types of risk factors spread out on different levels of the ecological model. Most of the respondents (36%) have listed 5 and 6 risk factors. The distribution on national versus local level shows that the respondents on national level are more acquainted with the risk factors. 86,7% of the respondents on this level listed 5-14 risk factors. Half of the respondents on local level listed 1-4 types of risk factors and 45% listed 5-14 risk factors.

Half of the participants - 50,0% have heard of “evidence based” or “public health approach” to child maltreatment prevention, the other half haven’t heard of it.

The evidence based child maltreatment preventive programmes are appreciated as extremely appropriate and appropriate by the majority of respondents. Parent education and sexual abuse prevention programmes are mostly appreciated. But, on the other hand the majority of the respondents haven’t got sufficient information and access into scientific evaluation of those programmes.

Qualitative analysis of the Dimension 2:

Most common forms of child maltreatment according to the respondents are physical abuse, emotional abuse, sexual abuse, neglect and commercial exploitation of child labor. Two of the respondents on local level have added political abuse and early marriage as common forms of abuse in the country. The former is newly recognized form of abuse and the later is a common form of abuse which is culturally specific in certain population such as Roma community.

Respondents are familiar with the main consequences of child maltreatment for the victim – with immediate and long term consequences. All of them (100%) addressed to the long-term psychological consequences, 86% to behavioral consequences, 28% to the immediate medical and 18% to the long-term consequences on physical health. Respondents coming from police and medical professionals are those who are familiar with consequences on physical health, which is not the case with other professionals.

On National level respondents are far more acknowledged with the whole range of immediate and long term consequences especially on mental health and risk behavior (60%), but still most of them do not take into consideration long-term consequences on physical health (18% have listed those consequences). On local level only 20% referred to immediate physical health consequences and no one to long-term consequences on physical health. This shows that long-term medical consequences as a result of maltreatment are not yet integrated in the system of preventive thinking and actions taken.

Main costs on child maltreatment were assessed ranging from 1 up to 9 types of costs. Non-medical costs were mentioned by 58% of respondents, indirect by 56% and medical by 54%. On national level 65% have taken into consideration all types of costs. 67% referred to medical costs, and 63% to nonmedical and indirect costs. On local level 50% referred to nonmedical costs, 45% to indirect costs and 35% to medical costs.

A variety of risk factors were listed by the key respondents spread out through different levels of the ecological model. On national level respondents are more acquainted with the different levels of the ecological model of risk factors - 46% of them have taken into consideration all the levels of the ecological model giving at least one example for each level, 37% referred to three levels (usually jointly referring to community and societal level). Local level informants pointed out to the most frequent risk factors, not responding systematically to this question. Most frequently mentioned risk factors on individual level are: alcohol abuse and being treated violently as a child; on relationship level: lacking awareness of child development, having unrealistic expectations, and inflicting violent punishment, family break-down and violence; on community level: unemployment and poverty; and on societal level lack of social, economic, health and education policies that lead to better living standards.

5.3.Dimension 3: Scientific data on child maltreatment prevention

Most of the participants - 52,0% confirmed that data on the magnitude and distribution of child maltreatment in general exist, but 34,0% stated that such data do not exist. The distribution is very similar on national and local level.

Majority of respondents - 42,0% confirmed that data on magnitude and distribution of child physical abuse exist, 58,0% of the respondents confirmed that data on magnitude and distribution of child sexual abuse exist. For the problem of child psychological abuse and neglect - 40,0% of the participants think that data on magnitude and distribution on these forms of abuse don't exist.

Table no.5.3.1.: Magnitude and distribution of child physical, sexual, emotional abuse & neglect on national and local level

National level	Physical abuse	%	Sexual abuse	%	Emotional abuse	%	Neglect	%
Yes	13	43,33	19	63,33	8	26,66	11	36,66
no	9	30,0	8	26,66	12	40,0	11	36,66
don't know	8	26,66	3	10,0	10	33,33	8	26,66
Local level	Physical abuse	%	Sexual abuse	%	Emotional abuse	%	Neglect	%
Yes	8	40,0	10	50,0	7	35,0	7	35,0
no	7	35,0	8	40,0	8	40,0	9	45,0
don't know	5	25,0	2	10,0	4	20,0	3	15,0
missing					1	5,0	1	5,0

Evidence on magnitude and distribution of child physical, sexual, emotional abuse & neglect according to respondents on national and local level doesn't differ much. Most of them confirm that data exist for sexual abuse of children (63% on national and 50% on local level), and for physical abuse (43% on national and 40% on local level).

Most of the respondents (38%) stated that there are no data on magnitude and distribution of consequences of any or all forms of child maltreatment, 36% of them - don't know and 22% confirmed that such data exist. On national level almost half (47%) of the respondents don't know if such data exist and one third claim that there are no data. On local level 45% claim that there are no data.

Most of the participants-70,0% confirm that there are official definitions of child maltreatment. This distribution of respondents is very similar on national and local level.

No data exist on the percentage of the reported cases of child abuse to the official agencies, but most of the participants think that 5-10% of child maltreatment cases are reported to the official agencies.

Most of the participants (36,7% at national and 45% at local level) think that 5-10% of child maltreatment are reported to the official agencies, 43,3% of them at national level don't know, and 10% on national level and 35% on local level think that this percentage is less than 5%. In fact such research studies do not exist.

There is a mandatory system for reporting of cases of abuse and most of the respondents (92%) confirmed that such system exist. Most of the respondents (44%) think that existing reporting system works poorly and extremely poorly, 30,0% - fairly, 16,0%-well. On both levels, national and local, equal number of respondents assessed the work of the reporting system as "fairly" and "poorly", but there is a difference between levels for those informants who assessed the system as working "well" (30% on local level and 6,7% on national level).

Most of the respondents - 62,0% think that there aren't procedures in place for compiling these data. The same is on national and local level. At the same time majority of the respondents from both GOs and NGOs think that there aren't procedures in place for compiling these data.

Two thirds of the respondents (66%) think that scientific evidence strongly and extremely strongly shapes the thinking and decision of people in child maltreatment prevention, 24,0% think moderately, 8,0% weakly.

On national level - 60% of respondents think that scientific evidence "strongly" and "extremely strongly" shapes the thinking and decision of people in child maltreatment prevention, and on local level even 75% think that in that way; 26,7% on national and 20% on local level think it is moderately. The key informants from both levels (especially from local level) tend to idealize the way the thinking is being shaped by scientific evidence.

Dimension 3: Qualitative analysis

Main measures that the respondents recommended in order to improve the collection of scientific data on child maltreatment and its prevention ranged from one to 6 measures. All respondents recommended at least one measure, 70% recommended at least 2 measures, 32% recommended at least 3 measures, 14% at least 4 measures etc.

a) Improvement of collection of scientific data:

Although most of the respondents think that scientific evidence strongly shapes the thinking and decision of people in child maltreatment prevention, (tab.30) they suggested a list of basic key recommendations to improve the collection of scientific data. 66% of them propose establishing a resource center for data collection on CM which would offer access to data, (90% of key respondents on national level and 30% on local level); 46% propose support of researches on CM (43,3% on national level and 50% on local level); 62% propose intersectoral collaboration and coordination for better collection and sharing of methodology and data (83,3% on national level and 30% on local level); 16% propose training on research methodology etc. One third of respondents on national level propose establishing a national council/body for prevention encompassing professionals from all sectors working on the problem.

b) Increase the influence of the scientific evidence:

The ideas to increase the influence of the scientific evidence concentrate on access to scientific data and evidence, dissemination and updating professionals in the field on recent scientific data, intensifying publishing of the research data and offering access to the ministries and sectors in charge to scientific evidence on CM prevention (46% of the informants agree on this issue on both levels). Half of the informants on national level think that promotion of good practices on CM prevention as well as evaluation of programmes is very important for intensifying the influence of scientific evidence. 33% of informants on national level also support the idea of inclusion of scientific data in public campaigns which will be informative for professionals, leaders and wider public. 30% on national level think that it is crucial to create policy /strategy on CM prevention based on evidence and data.

5.4.Dimension 4: Programme implementation and evaluation

More than half of the participants know at least one preventive programme that has been or is actually being implemented on CM prevention. But this percentage of key respondents differs significantly between the both levels of assessment – national and local ($p < 0,05$). On national level respondents are far more familiar with current or past preventive programmes on CM prevention (70% on national level versus 30% on local level). This representation is understandable having in mind that programme implementation mainly happens on national level.

More than half of the participants (54,0%) can name at least one current or past programme on child maltreatment prevention, 18,0% can name two programmes, 12,% can name up to three programmes, and only one participant can name up to 4 programmes. Among the most frequently mentioned preventive programmes are: “Childhood without violence” (14% of respondents reported on this programme on child maltreatment prevention); “Have you hug your child” and “Ten steps towards better parenting” (14% of respondents); The “Action plan on child sexual abuse prevention” (8%) was also included in this list although it’s not a preventive programme, but a plan that enables development of such programmes; preventive programmes on child trafficking (6% of respondents); SOS programme for empowering families at risk (Roma Families); early home visitation programmes; violence prevention programmes in schools; early childhood development programmes etc. On national 32 programmes were listed and on local level only 12 programmes.

Most of the participants at national level who know the type of the implemented programmes think that most of them (13) were preventive, 6 programmes were preventive and protective and 5 programmes were capacity building programmes. Most of the known programmes (24) by type were listed on national level and 2 on local. There are a lot of missing answers in this category (64%-94%).

Participants think that 64% of programmes are performed on national level, 12% on community level and just 8% on subnational level. National level respondents think that 80% of the programmes are at national level, and only 17% are at local level. Local level respondents listed 40% of programmes that were on national level, 10% on subnational and 5% at community level. (tab.5.4.3). This distribution of answers reflects the actual situation: national level is the most important level in the country after which comes the community level. The notion of the sub-national in macedonian context is unclear. There are a lot of missing answers (ranging from 48% to 98%).

Most of the participants at national level (83.3%) think that the programs have undergone an outcome evaluation and less than half (40%) at local level.

More than half of the participants (52,0%) gave information of current or past child maltreatment programmes into which child maltreatment prevention components could be integrated, and 48% don’t know, haven’t answered or said that there weren’t such programmes.

In total 28 current or past child maltreatment programmes into which child maltreatment prevention components could be integrated were listed – 19 on national level and 9 on local level. They were presented by 56% of key respondents among which 38% of the respondents mentioned at least one such programme, 12% mentioned 2 programmes and 6% mentioned three programmes. Those programmes do not differ much from the previous list of programmes, contributing to the confusion on the type of the programme in terms of prevention and protection.

26% of the listed programmes according to the participants were preventive, 10% preventive and protective and 14% were capacity building programmes. But most of the respondents obviously didn't know the type of the programmes they had listed. (70%-96%).

Most of the informants at national level who know the type of the programmes think that 9 of them were preventive, 4 both preventive and protective; at local level 5 programmes were preventive school programmes and 2 were capacity building programmes.

Most of the listed programmes (14) on both levels are national programmes, 4 are sub-national programmes and 2 are community programmes. For most of the programmes there isn't information on which level they have been implemented. The percentage of missing answers ranged from 74% up to 96% for some of the programmes.

Dimension 4: Quality analysis

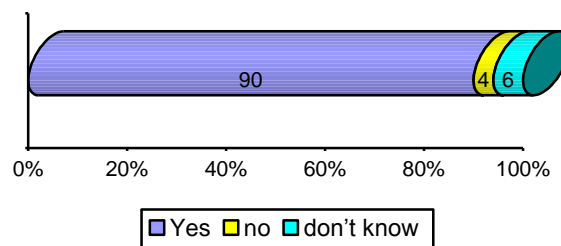
Majority of the respondents (76%) recommended one to four measures in order to increase programme implementation and evaluation and 24% recommended 5-7 measures.

42% of the key informants on both levels recommended implementation of evidence-based preventive programmes in CM prevention, 34% of the key informants recommend mandatory monitoring and evaluation of programmes implemented by NGOs and GOs and availability of results (40% on national level and 25% on local level). On national level it was also suggested providing sustainability of programmes (17%), allocation of budget for external evaluation of programmes (17%), and better partnership among NGOs and GOs (13%).

5.5.Dimension 5 - Legislation, mandates, and policies

Most of the respondents - 90,0% confirm that there is legislation in force relevant to child maltreatment and its prevention (graph.5.5.1).

Graf no.5.5.1: Legislation in force relevant to child maltreatment and its prevention



The distribution of the responses on national and local level is very similar, most of the respondents (96,7% on national level and 80% on local level) think that there is legislation in force.

One third of the respondents - 32,0% think that the legislation is “neither effective nor ineffective”, and exactly the same percentage (32%) think it is “ineffective” and “extremely ineffective”, nearly one third (30%) think it is “effective” (tab.5.5.2).

On national level one third of the key informants (33,3%) think that the legislation is “neither effective nor ineffective” and even 43,3% think that it is “ineffective” or “extremely ineffective”. On the other hand most of the respondents on local level (40,%) think that the legislation is effective, and only 15% think it’s “ineffective” and “extremely ineffective”. It is paradoxical that national level informants who are in a position of decision making or advising the decision makers have more negative attitude towards effectiveness of legislation than local informants who overestimate it.

Most of the respondents (66%) confirm that there is officially mandated agency for child maltreatment prevention, 26% think that there isn’t such agency or don’t know (6%).

On national level almost two thirds of the respondents (73,33%) confirm that such agency exist and on local level only 55% of the respondents think so.

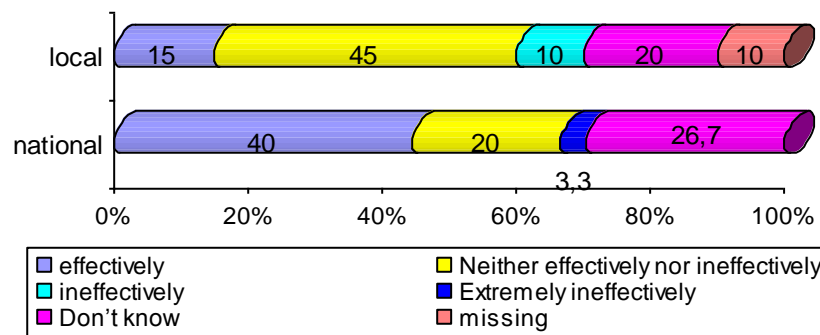
Equal number of the respondents (26%) think that agencies “effectively” or “Neither effectively nor ineffectively” contribute to preventing child maltreatment, and 18% have negative attitude towards it. 30,0% either don’t know or haven’t answered. On national level most of the respondents (30%) think that mandated agencies are “effective”, and more than one fourth (26,7%) think that they are “Neither effective nor ineffective”. On local level this pattern is opposite – equal percentage (25%) think that these agencies are “Neither effective nor ineffective”, and “ineffective”, and only 20% think that they are effective.

Most of the respondents (28%) coming from GOs think that agencies effectively contribute to preventing child maltreatment. On the contrary most of the respondents (33%) coming from NGOs think that agencies contribute “ineffectively” and “extremely ineffectively” to CM prevention. 25% of the respondents from GOs versus 13,3% from NGOs think that organizations neither effectively nor ineffectively contribute to preventing child maltreatment.

Most of the respondents (72,0%) know that there are official policies addressing child maltreatment prevention, 10,0% think there aren’t and 18,0% don’t know (tab.36). Similar distribution of answers is on national and local level.

Equal number of the respondents – 30% think that policies contribute “effectively” and “neither effectively nor ineffectively” to preventing child maltreatment, and cumulatively 40% think “ineffectively”, “extremely ineffectively”, “don’t know” or missing answers.

Graph. 5.5.2: Effectiveness of policies addressing child maltreatment prevention on national and local level



Most of the respondents on national level (40%) think that policies effectively contribute to preventing child maltreatment, versus 15% at local level; 45% at local level think that policies contribute “neither effectively nor ineffectively” versus 20% at national level; The same percentage of respondents on national and local level (40%) think “ineffectively”, “extremely ineffectively”, “don’t know” or have missing answers (graph.5.5.2). Local level informants criticize policies addressing child maltreatment prevention which is opposite to the previous overestimation of legislation.

Most of the respondents - 54% think that national level is the most important for child maltreatment prevention, 8% sub-national and 30% - community/municipal level. This opinion differs according to the level of respondents. On national level almost two thirds (60%) of the respondents think that national level is the most important versus 45% at local level. 26,7% on national level and 35% on local level think that community level is the most important.

Dimension 5: Qualitative analysis

The main measures that were recommend by the respondents to improve the legislation, mandates, and policies for child maltreatment prevention ranged from 1 to 7 measures. Most of the respondents recommended 1-4 measures (77% on national level and 100% on local level). On national level 23% of the respondents recommended 5 to 7 measures

Main measures recommended by the key informants for this dimension are: developing National Strategy and Action Plan on CM prevention (the existing one is on Child Sexual Abuse Prevention) by 42%, law enforcement and improvement of existing laws also by 42% of respondents. On national level it was also recommended to involve wider group of professionals in the legislative process and initiate debates and discussions on the strengths and weaknesses of the current legislation, mandates and policies by 23% of respondents.

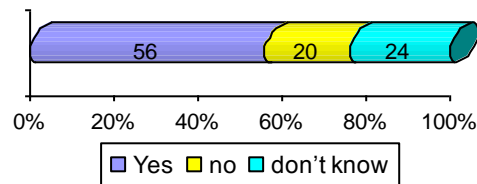
5.6.Dimension 6: Will to address the problem

Table no.5.6.1: Political, religious and other leaders concern with child maltreatment

	Total frequency	%	National level	%	Local level	%
extremely & somewhat concerned	19	38,0	12	40.0	7	35.0
neither concerned nor un concerned	19	38,0	10	33.3	9	45.0
somewhat & extremely unconcerned	12	24,0	8	26.7	4	20.0

Equal number of the respondents - 38,0% think that political, religious and other leaders are “neither concerned nor unconcerned” with child maltreatment, or that they are “somewhat and extremely concerned”, and 24% think that they are “somewhat unconcerned” and “extremely unconcerned”. On both levels there is a similar distribution of answers (tab.5.6.1).

Graph no.5.6.2: Leading agency in child maltreatment prevention



Most of the respondents - 56,0% confirm that there is an official agency, specialist officer or unit that takes the lead in child maltreatment prevention, 20,0% - think that there isn't such agency, and 24,0% don't know (graph.5.6.2). On national level two thirds of the respondents claim that there is such an agency and 40% on local level do so, the same percentage of respondents on both levels think that there isn't such an agency.

Table no.5.6.3: The leadership on the issue of child maltreatment prevention

	Total frequency	%	National level	%	Local level	%
Extremely good	13	26,0	10	33.3	3	15.0
Good						
Fair	23	46,0	11	36.7	12	60.0
Poor/	11	22,0	9	30.0	2	10.0
Extremely poor						
Don't know	2	4,0			2	10.0
missing	1	2,0			1	5.0

Assessing the leadership in CM prevention most of the respondents - 46% think that the leadership is fair, 26% think it is “good/extremely good”, 22% think it is “poor and extremely poor”. (tab.5.6.3).

On both levels most of the respondents (36,7% at national level and 60% at local level) think that the leadership is fair, 33,3% on national and 15% on local level think it is good, 30% on national and 10% on local think it's poor (tab.5.6.3).

Table no.5.6.4: Commitment to the issue of child maltreatment prevention by political leaders

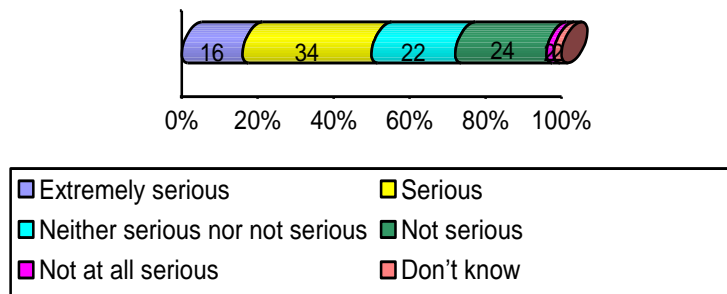
	frequency	%	National level	%	Local level	%
Yes, definitely	28	56,0	20	66.66	8	40.0
Yes, to an extent						
Not clear	4	8,0	1	3.33	3	15.0
No, not really	16	32,0	7	23.33	9	45.0
No, definitely not						
Don't know	2	4,0	2	6.66		

Most of the participants (56%) think that there are political leaders who express strong commitment to the issue of child maltreatment prevention. 32% are doubtful about such leaders (tab.43). The distribution of the answers differs between levels. On national level most of the respondents (66,7%) think that there are political leaders who express strong commitment to CM prevention versus 40% on local level who think the same. On local level 45% think that there aren't really such leaders versus 23% on national level. (tab.5.6.4). Key respondents on national level are significantly more affirmative towards the commitment of political leaders.

Most of the respondents - 66% think that there isn't really enough resources for the prevention of child maltreatment (“not clear”, “no not really” “no, definitely not”) 28,0% think that there are such resources to an extent (“yes to an extent” and “yes definitely”). The same pattern of distributions of answers is on national and local level, where most of the respondents think that there isn't really enough resources for CMP.

Most of the participants (60%) think that there is not enough willingness of political leaders to invest in long-term child maltreatment prevention programmes (not clear/not really, definitely not), 32,0% think that there is willingness (to an extent and definitely yes). The same pattern can be followed on national and local level – where most of the participants-53% on national and 70% on local think that there is not really willingness of political leaders, 26,7% on national and 15% on local – “yes, to an extent”.

Graph.no.5.6.5: Perception of the general public towards CM



Half of the respondents (50%) think that the general public perceives the problem of CM as serious and extremely serious, 22,0% - neither serious nor not serious, and one fourth (24%) perceives the problem as not serious. (graph.5.6.5). Most of the participants on local level-50,0% think that the general public perceive the problem as serious and 30% at national level think not serious.

Most of the respondents think that child maltreatment can be prevented (72%) – usually, sometimes and always), but 24,0 don't share this opinion and think usually it is not possible.

Table no.5.6.6: Public support, advocacy efforts & communication efforts for child maltreatment prevention

Total	Public support frequency	%	Advocacy efforts frequency	%	Communication efforts frequency	%
Extremely intensive	15	30,0	6	12.0	4	8,0
Moderate	19	38,0	23	46.0	22	44,0
Weak/ Extremely weak	15	30,0	21	42.0	23	46,0
don't know	1	2,0			1	2,0
National level						
Extremely intensive	13	43.33	3	10.0	1	3.33
Moderate	8	26.66	12	40.0	14	46.66
Weak/ Extremely weak	8	26.66	15	50.00	15	50.00
don't know	1	3.33				
Local level						
Extremely intensive	2	10.0	3	15.0	3	15.0
Moderate	11	55.0	11	55.0	8	40.0
Weak/ Extremely weak	7	35.0	6	30.0	8	40.0
don't know					1	5.0

Majority of the respondents (68%) think that the public support of CM prevention is at a certain degree strong (moderately strong-38%, extremely strong 18% and strong 12%) versus 30% who think that it is weak (26,0% -weak, 4% extremely weak) (tab.5.6.6).

Most of the respondents - 46,0% think that advocacy efforts for child maltreatment prevention are moderate, 32% -weak and extremely weak, 10,0% -intensive and etc. (tab.5.6.6).

The opinion of the respondents towards communication efforts concerning CM prevention are divided between moderate and weak (44,0% think that communication efforts were moderate, 46% weak and extremely weak) (tab.5.6.6).

Public support, advocacy efforts and communication efforts perceived on national and local level differ significantly, with majority of respondents on national level whose opinion is that public support is moderate to intensive, but advocacy efforts and communication efforts are moderate to weak. On local level is the opposite, advocacy efforts and communication efforts are moderate to extremely intensive.

Most of the participants (46,0%) think that information on CM prevention were neither accessible nor inaccessible, 36,0% - inaccessible, 18,0%-accessible.

The same is on national and local level: most of the respondents think that the information were neither accessible nor inaccessible (40% on national and 55% on local), inaccessible (43% on national and 25% on local).

Dimension 6: Quality analysis

Main measures that were recommended to strengthen the will to address the prevention of child maltreatment ranged from one to 5 measures offered by the respondents. On both levels most of the respondents (33% on national and 40% on local level) recommended 2 measures, 20% on national and 35% on local level recommended one measure, and 16,7% on national and 15% on local level recommended 3 measures etc.

Most of the recommended measures (72%) referred to increasing the public awareness and informing the public and the professional community using public health objectives (such as the magnitude, risk factors and consequences of this phenomena), and benefits of prevention through media advocacy (campaigns and other forms of dissemination of information and knowledge).

5.7. Dimension 7: Institutional links and resources

Most of the respondents - 60,0% can list partnership coalitions dedicated to child maltreatment prevention. Representatives from GOs are much more acquainted with such partnerships, while more than half of the representatives from NGOs are not informed on their existence.

The respondents obtained variety of answers for the existing partnerships, coalitions, alliances, or networks in the country. Ministry of Social Affairs (specifically Department for Social inclusion) and Centers for Social Work are the leading partnerships mandated for CM prevention in the country. Newly established National Coordinating Body for Prevention of Child Sexual Abuse and Pedophilia is an intersectoral partnership between different governmental institutions and nongovernmental institutions mandated for prevention of CSA (not including other forms of CM).

The number of sectors involved differs from 1-8 but most of the respondents refer to 1-3 sectors. In fact one sector doesn't represent a coalition or partnership. There are lot of missing answers in this group of questions, either referring to the name of the coalition/partnership, or the number of sectors involved.

The respondents (86%) confirm that there are institutions involved in CM prevention, 14% don't know any such institution. The leading institutions in this area according to them are also the Ministry of Labor and Social Welfare and the Centers for Social Work (78%). The problem is that although these social services led by the Ministry are mandated for preventive work in CM as well as for protective, in practice they deal mainly with child protection. National and local NGOs (52%) are the leading institutions for CM prevention, namely First Children Embassy – Megjasi, Safe Childhood on national level and on local level Preda, Amos etc. Also international organizations such as UNICEF, WHO, (and some others mentioned by 38%) are also involved in CM prevention.

The number of people involved in CM prevention in the referred organizations is not defined and most of them don't know the exact number. This might be due to the fact that both roles – working in child maltreatment prevention and in child protection are not well differentiated not only by the respondents but also by the organizations as well.

Most of the leading institutions in CM prevention are assessed as efficient, and to a lesser extent “Neither efficient nor inefficient”, but there are also a lot of missing answers, up to 84%, because there isn't any transparent evaluation of their work.

Dimension 7: Qualitative analysis

The majority of the respondents (98%) recommended at least one main measure to strengthen links between institutions and increase the resources and improve efficiency of the main institutions involved in child maltreatment prevention. Most of them recommended 2 measures (36%), 16% recommended 3 measures.

48% of the key informants (43% on national level and 55% on local level) recommended coordinated activities between institutions, and also between GOs and NGOs, shared responsibilities between the sectors and exchange of information, joint programmes and campaigns. Also continuous education and trainings of professionals in multidisciplinary approach as well as joint funds for preventive programmes and trainings were proposed by 30% of respondents

5.8. Dimension 8: Material resources

Coming to budgets dedicated to child maltreatment prevention it becomes obvious that the respondents (48,0%) don't know about any dedicated budget, 36,0% think that there are such budgets and 12,0% think that there aren't. The distribution is similar on national and local level.

Budgets dedicated to child maltreatment prevention within different sectors/departments are allocated in health (according to 67% of respondents), social welfare (89%), early childhood development (72,2%) , and 39% in education and in local government.

Respondents on national level are far less informed on dedicated budgets to child maltreatment prevention in different sectors than respondents on local level.

Most of the respondents (38,0%) think that the attitude of potential funders were neither supportive nor unsupportive, 34,0% -supportive, 14,0% - don't know, and 10,0%- think it's unsupportive.

On national and local level the opinions differ – respondents on local level are more positive toward potential funders - 40% versus 30% on national level, possibly due to the experience they already have. On national level the opinions are that they are neither supportive nor unsupportive.

Table no. 5.8.1: Sufficiency of facilities, equipments and materials within child maltreatment prevention organizations

	frequency	%	National	%	Local	%
Somewhat adequate	8	16.0	5	16.7	3	15.0
Neither adequate nor inadequate	9	18.0	5	16.7	4	20.0
Somewhat inadequate Extremely inadequate	25	50.0	17	56.7	8	40.0
Don't know	8	16.0	3	10.0	5	25.0

Half of the respondents - 50% think that facilities, equipments and materials within child maltreatment prevention organizations are inadequate (34% “somewhat inadequate” and 16% “extremely inadequate”). 18,0% are neutral in their assessment of facilities, equipment and materials, and only 16,0% think that they are somewhat adequate (tab.5.8.1). The opinions on national and local level do not differ much.

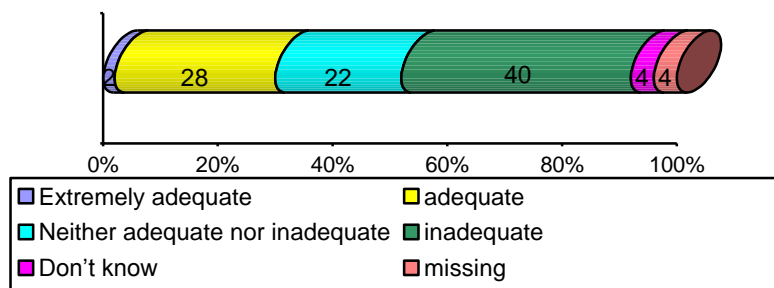
Dimension 8: Qualitative analysis

Main measures that were recommended to improve funding and infrastructure and equipment for child maltreatment prevention were one to 5. Most of the respondents proposed at least one measure – 98%. 58% recommended at least 2 measures, 26% recommended at least 3 measures etc.

Most of the key informants (74%) have agreed on the need for developing separate programmes on prevention allocating separate budget from the government and also by fund raising. On the local level 45% of respondents think that it is necessary to obtain political priority to CM prevention as a basis for funding, and on national level 23,3% think that it is also necessary to improve the infrastructure, and adapt it in a child friendly manner. 13,3% on national level have put an emphasis on collaboration with international organizations on technical support and fund raising.

5.9. Dimension 9: Human and technical resources

Graph no.5.9.1: Number of professionals involved in CM prevention



Most of the participants-40,0% think that the number of professionals involved in CM prevention is inadequate, 30,0% think that they are adequate and extremely adequate, 22,0% are neutral in their assessment of number of professionals and think they are neither adequate nor inadequate and etc. (graph.5.9.1). The answers on national and local level don't differ.

Table no.5.9.2: Programmes allowed by the current human and technical resources at national level, sub-national level and local level

Total	National level	%	Sub national level	%	Local level	%
Programmes in all or most states	8	16.0	1	2.0	6	12.0
Programmes in less than half of states	8	16.0	5	10.0	3	6.0
Small-scale pilot programmes in several areas	11	22.0	2	4.0	6	12.0
Small-scale pilot programme in one area	4	8.0	5	10.0	8	16.0
Don't know	2	4.0	2	4.0	2	4.0
missing	17	34.0	35	70.0	25	50.0

Macedonia is a small country and practically most of the activities are either on national level or on local level. The sub-national level is not the concept that is applicable for the country. On the other hand it is not quite clear what is the notion of “Small-scale pilot programme in one area” on national level, and the same on local level. This might be the fact that there are a lot of missing answers to this question. Majority of respondents referred to the national level, recognizing it as the most important level for CM prevention in Macedonia. 22,0% think that small-scale pilot programmes in several areas are allowed by current human and technical resources.

The local level is better perceived by the respondents, but again most of them (54%) haven’t either answered this question or said explicitly that they didn’t know, 16,0% think that “Small-scale pilot programme in one area” are allowed by the current human and technical resources, 12,0% think programmes covering most of Community and Small-scale pilot programmes in several areas, and etc. (tab.5.9.2).

National level respondents focused on national level of importance for the CM prevention activities in the country, 23,3% referring to “Programmes in all country” and 20% for “Small-scale pilot programmes in several areas”. Similarly local level respondents focused on local level of importance, 40% referring to “Small-scale pilot programme in one area”, and 25% of them also referring to national level both to “Programmes in less than half of country” and “Small-scale pilot programmes in several areas”

Table no.5.9.3: Adequacy of the number of institutions for CM prevention

	frequency	%	National level	%	Local level	%
Extremely adequate/adequate	11	22.0	7	23.33	4	20.0
neither adequate nor inadequate	12	24.0	8	26.66	4	20.00
inadequate	20	40.0	13	43.33	7	35.0
Don't know	7	14.0	2	6.66	5	25.0

Most of the respondents - 40,0% think that number of institutions is inadequate, 24,0% “neither adequate nor inadequate”, 22,0% - adequate (tab.5.9.3). Both on national and local level this distribution of answers is the same.

Table no.5.9.4: Availability of undergraduate or postgraduate educational institutions which provide training in child maltreatment prevention

Educational institutions	frequency	%	National level	%	Local level	%	Score
Widely available/ Available	11	22.0	5	16.7	6	30.0	2
Several	16	32.0	11	36.7	5	25.0	1
Almost none/ None	11	22.0	8	26.7	3	15.0	0
Don't know	12	24.0	6	20.0	6	30.0	0

Most of the respondents - 32,0% think that there are several institutions which provide training in child maltreatment prevention are available, 22,0%- think that they are available and widely available and 22,0% think that there are almost none or none such institutions (tab.5.9.4). National and local level of assessment differ in some way. On local level the perception is that institutions which provide training in child maltreatment prevention are available and widely available (30%).

Table no.5.9.5: Availability of non-university institutions which provide training in child maltreatment prevention

Non university institutions	frequency	%	National level	%	Local level	%
Available	14	28.0	9	30.0	5	25.0
Several	15	30.0	7	23.33	8	40.0
Almost none/none	11	22.0	8	26.66	3	15.0
Don't know	10	20.0	6	20.0	4	20.0

Most of the respondents - 58% think that there are “several” and “available” non-university institutions which provide training in child maltreatment prevention, 22,0% think that there are almost none or none (tab.5.9.5).

Table no.5.9.6: Opportunities for continuing professional development

Opportunities for continuing professional development	frequency	%	National level	%	Local level	%
Widely available/available	12	24.0	10	33.3	2	10.0
Several	17	34.0	8	26.7	9	45.0
Almost none/none	11	22.0	6	20.0	5	25.0
Don't know	10	20.0	6	20.0	4	20.0

Most of the respondents - 58,0% think that the opportunities for continuing professional development are “several”, “available” or “widely available”, 22,0% think that there are “almost none” or “none” such institutions and 20,0% - don’t know (tab.5.9.6). On both levels the distribution of answers is similar.

Dimension 9: Qualitative analysis

Main measures that were recommended to increase technical and human resources for child maltreatment prevention ranged from 1 to 5 measures. 88% of respondents gave at least one measure. 40% recommended two measures, 18% recommended 3 measures and 10% four measures.

Continuous education of professionals on different levels of education (undergraduate and postgraduate) was proposed by 48% of respondents (76,6% on national level and 55% on local level); Budget support and investment in training in CM prevention was proposed by 44% (60% on local level and 33% on national level). 20% of respondents on national level recommended employment of new personnel in prevention.

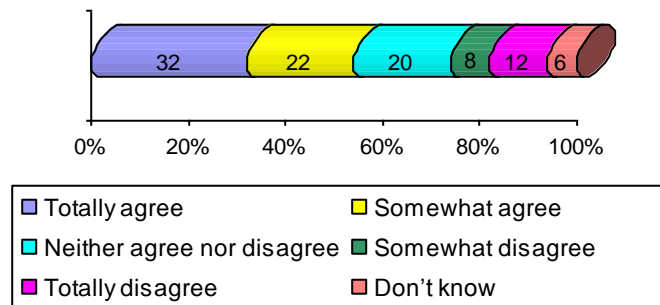
5.10. Dimension 10: Informal Social Resources

Table no.5.10.1: Citizens' participation in efforts to address various health and social problems

	frequency	%	National level	%	Local Level	%
Extremely high/high	5	10.0	4	13.3	1	5.0
Moderate	28	56.0	18	60.0	10	50.0
Low/extremely low	15	30.0	7	23.3	8	40.0
Don't know	1	2.0			1	5.0
missing	1	2.0	1	3.3		

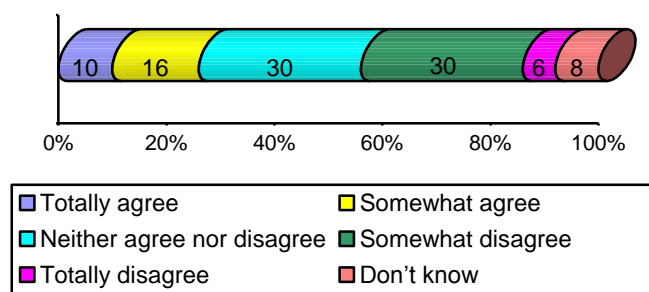
Most of the respondents - 56,0% think that citizens' participation in efforts to address various health and social problems is moderate, 30,0% think it's low/very low, and 10% think it's high and extremely high (tab.71). On both levels the distribution of answers is similar.

Graphic no.5.10.2: “People are generally dishonest and they want to take advantage of others”



Most of the respondents - 54% “totally” or “somewhat agree” with the statement that people are generally dishonest and they want to take advantage of others, 20,0%- “neither agree” nor “disagree”, and 20,0% “somewhat” or “totally disagree” (graph.5.10.2). On national level most of the respondents 63% agree, 27% are neutral, and 20% disagree. On local level 40% agree, 10 are neutral and 35% disagree.

Graphic no: 5.10.3: “If I help someone, I can anticipate that they will.....

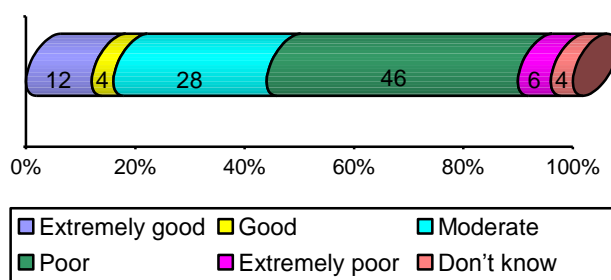


30,0% of the respondents “neither agree nor disagree” with the statement “If I help someone, I can anticipate that they will treat me just as well as I treat them”, 26,0% “somewhat” or “totally agree”, and 36% “somewhat” or “totally disagree” (graph.5.10.3). On local level respondents perceive the social bonds more positively than on national level.

The perceptions of these two statements among respondents grasp the quality of social interactions and social bonds within the Macedonian society, which are perceived as disrupted during the process of long societal transitions.

Most of the participants-50,0% perceive that the proportion of people that belong to some civic group is just few, 28,0% think some, 16% - most, and etc. The distribution of answers is similar on both levels.

Graphic no.5.10.4: “How good at getting things done through their joint efforts are the people in Macedonia?”



Most of the participants-52% think that people are “poor”/”extremely poor” at getting things done through people’s joint efforts , 28,0% moderate and only 16% “extremely good/good” (graph.5.10.4). Both informants on national and local level share that opinion (poor, moderate, good).

Dimension 10: Qualitative analysis

Main measures recommended to increase what is called "informal social resources" range from one to 8 measures. 92% gave 1-4 recommendations, and 6% gave 5-8.

Almost all the key informants recommended at least one measure (98%) to increase what is called "informal social resources". 48% of them think that collective efficacy can be enhanced through raising awareness and disseminating information through media campaigns (70% on local level and 33,3% on national level). On national level some of the informants also proposed engaging media celebrities in public campaigns, and also using campaigns to enhance citizen's cohesion instead of blaming and hatred.

Nearly half of the informants (48%) think that the way to greater citizen participation can be reached by encouraging and funding NGOs, support groups, local professionals and local leaders on advocacy and enabling their participation in decision making process (60% on national level and 30% on local level).

On national level there are opinions that regular information on the current situation of CM in the country would be productive.

5.11. Single most important problem facing child maltreatment prevention in Republic of Macedonia

All the key informants interviewed in this research listed at least one problem up to four facing child maltreatment prevention in the country. Majority of them listed two main problems (34%).

They all gave their opinion on the most important problem facing child maltreatment prevention in Republic of Macedonia. They stressed the lack of:

- joint action for prevention of CM and insufficient information on prevention and its benefit (26% both on national and local level)
- lack of coordination of the existing institutions and insufficiency of institutions in terms of CM prevention (46% both on national and local level)
- lack of financial support for strategies, action plans and programmes, as well as for human resources in the field of CM prevention (38%).

Majority of respondents (86%) expressed their satisfaction with the 10 Dimensional Model of Child Maltreatment Prevention Readiness and thought it is comprehensive, educational, 14% of respondents thought that one or two dimensions could be added to the model, such as NGO involvement in CM prevention. The proposed dimensions were already incorporated in the present model.

6. Discussion

6.1.Discussion of the main findings among the key respondents on national and local level of assessment of CMPR

Table 6.1. and radar diagrams (given in graphics.6.1.a and 6.2.b) present the scores based on the results achieved on national and local level of interviewing key informants on the

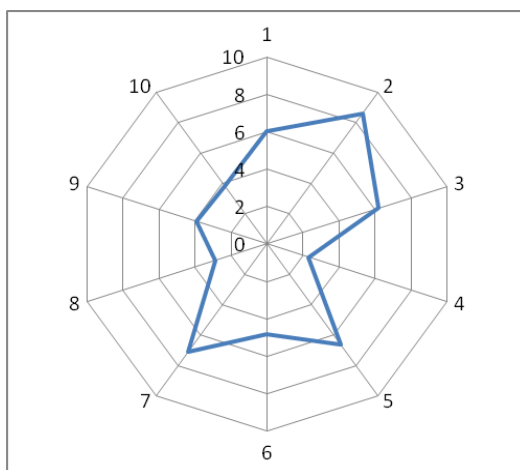
situation of the assessment of CMPR. On the basis of the quantitative and qualitative analysis presented in part 5, the main findings will be discussed in this chapter.

The total score on national level achieved by the key informants is 52 comparing to the total score on local level which is 47. This 5 score difference is distributed within the model on different dimensions which will be discussed in the analysis that follows.

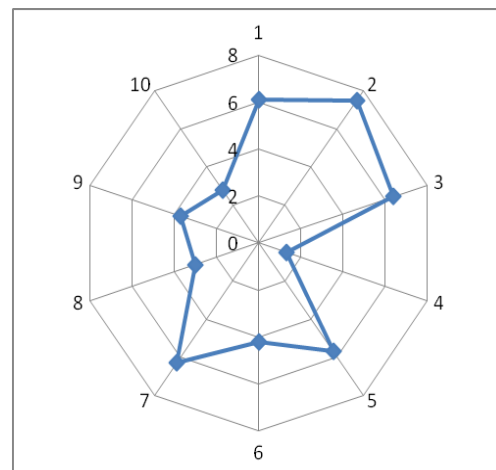
Tab. no.6.1: CMPR scores on national and local level

Dimension	Score National level	Score Local level	Total scor
Dimension 1: Attitudes towards child maltreatment prevention	5.78	6.0	5.83
Dimension 2: Knowledge of child maltreatment prevention	6.6	5.4	5.97
Dimension 3: Scientific data on child maltreatment prevention	6.2	6.4	6.3
Dimension 4: Current programme implementation and evaluation	2.3	1.2	1.71
Dimension 5: Legislation, mandates, and policies	6.6	5.7	6.3
Dimension 6: Will to address the problem	4.8	4.2	4.53
Dimension 7: Institutional links and resources	4.8	3.6	4.21
Dimension 8: Material resources	2.9	3.0	2.98
Dimension 9: Human and technical resources	3.9	3.7	3.88
Dimension 10: Informal social resources (non-institutional)	4.8	3.4	4.06
Total child maltreatment prevention readiness score	48.68/100	42.7/100	45.77/100

Graph.No.6.1.a:National level



Graph.No.6.1.b: Local level



Dimension 1: Attitudes towards child maltreatment prevention. In general, the awareness and understanding of child maltreatment as a problem is articulated among key informants. The total score on this dimension is 5.83 (5.78 on national level and 6.0 on local level). Key informants' do not differ on this dimension, their attitudes towards child maltreatment and its prevention are very affirmative in terms of its preventability. They seem to be more critical towards political priority comparing to other health and social problems and especially comparing to child protection. Measures taken are perceived as neither adequate nor inadequate. Key respondents on national level although are more in favor of the given political priority to CM prevention, seem to be more critical to the measures taken to prevent child maltreatment and especially to the protection of the rights of children in practice.

Dimension 2: Knowledge of child maltreatment prevention. Knowledge of the key informants is reflected in the total score on this dimension which is 5.97 (6.6 on national level and 5.4 on local level). The nature and different types of child maltreatment are well distinguished and understood by almost all respondents. Key informants on both levels have limited knowledge about the nature, risk and protective factors and causes. On the local level respondents are less familiar with the ecological model of risk and protective factors. The consequences of child maltreatment are known to them, short and especially the long-term psychological consequences, but again on local level they lack information on the long term consequences, and especially on physical health. The true economic costs of CM are not taken into consideration, especially on local level. They have some information on the effectiveness of evidence based prevention interventions, but concerning the programmes implemented in practice there is little evidence on both levels (see Dimension 4).

Dimension 3. Scientific data on child maltreatment prevention. The total score on this dimension is 6.3 (6.2 on national level and 6.4 on local level) The scores on both levels doesn't differ and the key informants agree for most of the issues tackled through this dimension. The overestimation of the scientific evidence by the key respondents and its impact on thinking and decision making of professionals involved in CM, on both levels is both subjective and socially desirable because it involves their competency as professionals.

Considering their recommended measures for improving this dimension establishing a resource center for data collection on CM with access for the professionals would improve collection on scientific data and would strengthen the impact of scientific data on CM prevention in the country. Support of researches on CM (which also encompass training in methodology, intersectoral collaboration and sharing of data, evaluation of programmes) will also contribute to this purpose.

Dimension 4: Current programme implementation and evaluation. The total score on this dimension achieved by key informants is 1.71 (2.3 on national level and 1.2 on local level) which indicates in general that they are very little informed and acknowledged with the existing or recent CMP programs or existing programs into which CMP components could be integrated. These information for the key informants on local level are lacking, which might be explained with the very low degree of implementation of such programmes when it comes to certain communities and the activities taken so far are not

disseminated with other professionals within the community. In general on both levels this low score is a result of very low level of dissemination of information on programmes implemented in the field locally and nationally, without providing information on evaluation and outcomes, nor publishing of results. It is evident that these results are in contradiction with the results from the previous dimension on collection and influence of scientific data on child maltreatment prevention in the country which seem to be overestimated and exaggerated both on national and especially on local level. In addition to this, key informants on both levels being aware of such lack of shared information on programmes recommended implementation of preventive programmes that are evidence-based in CM prevention, their monitoring and evaluation and availability of results.

Dimension 5: Legislation, mandates, and policies. Total score on this dimension achieved by the key informants is 6.3 (6.6 on national level and 5.7 on local level). This difference between scores is due to the fact that national level informants are more likely to assess the effectiveness higher than local level informants, being much more involved in development of legislation, policies and also are part of mandated agencies. Still among national level key informants there is inconsistency in the assessment of legislation in force, policies and mandates for CM prevention and their effectiveness. Main measures recommended by the key informants for this dimension refer to developing national policy and action plan on CM prevention and improvement of existing laws, mandates and policies .

Dimension 6: Will to address the problem. The total score on this dimension by key respondents is 4.5 (4.8 on national level and 4.2 on local level) which is slightly different. The situation in the country considering the leadership in CM prevention is perceived as fair. The perception of the political will appears to be different and depends on the level of assessment: key respondents on national level are more positive to existing and potential political leaders than their colleagues on local level, although their commitment is not particularly aimed to prevention, seems to be more general. But on the other hand key informants agree that the willingness of political leaders to invest in long-term child maltreatment prevention programmes is not clear at all. Individual, collective or organizational support, advocacy and communication efforts are assessed as moderate to weak and provided resources are far from being enough.

Dimension 7: Institutional links and resources. Total score on this dimension is 4.21 (4.8 on national level and 3.6 on local level). On national level the key informants are scarcely familiar with the existing networks and alliances in CMP, but still more than informants on local level, and their opinion is much more affirmative towards the networks, pointing primarily to the Ministries and services hierarchically linked to them (especially Ministry of Labor and Social Policy and Centers for Social Work). Similarly they assess their effectiveness slightly higher than respondents on local level. The recommended coordinated activities, shared responsibilities and exchange of information between institutions, joint programmes and campaigns support the opposite situation – lack of institutional links and resources.

Dimension 8: Material resources. The total score on this dimension is 2.9 (2.9 on national level and 3.0 on local level). Budgets for child maltreatment prevention are few and scarce, and not well recognized and distributed among the sectors. Infrastructure and equipment is lacking and this is the biggest problem articulated by the majority of key informants. Comparing both levels (national and local) it is evident that the situation is almost equal in terms of infrastructure and facilities.

Most of the key informants have agreed on the need for developing separate programmes on prevention, allocating separate budgets on regular basis and by fund raising and improving the infrastructure for this purpose.

Dimension 9: Human and technical resources. Total score on this dimension achieved by key informants is 2.98 (2.9 on national level and 3.0 on local level). Although this dimension of CMPR is also lower comparing to the other dimensions, key informants on both levels are critical towards the adequacy of current technical and human resources and number of institutions as well as the availability of continuous education and availability of programmes aimed for CM prevention. Among respondents themselves there is some inconsistency in the assessment of several related issues such as the adequacy of the number of institutions for CMP which is perceived as low, but on the other hand the availability of educational institutions and possibilities for continuing professional development are more appreciated. The question of human resources is a very sensitive one when it comes to key respondents. Most of them tend to recognize themselves as competent and well informed professionals, and in majority of cases they give socially desirable answers. But on the other hand all these points were addressed as lacking and highlighted in the key informants' main recommendations such as continuous education of professionals, investment in training in CM prevention, and employment of new personnel in prevention.

Dimension 10: Informal social resources. The total score on this dimension by key respondents is 4.06 (4.8 on national level and 3.4 on local level). Citizen participation, social capital, collective efficacy are differently captured by the key respondents on both levels due to the fact that those aspects are not equally represented on national and local level. On national level there is evidently more citizen participation and collective efficacy than on local level, due to more capacity, more NGOs involved in CMP, more opportunities for joint action.

Key respondents in their recommendations stressed that the greater citizen participation can be reached by encouraging and funding NGOs, support groups, local professionals and local leaders on advocacy and enabling their participation in decision making process.

6.2. Discussion on main differences found on the basis of informants' interview (RAP-CM-I) and experts (RAP-CM-XD)

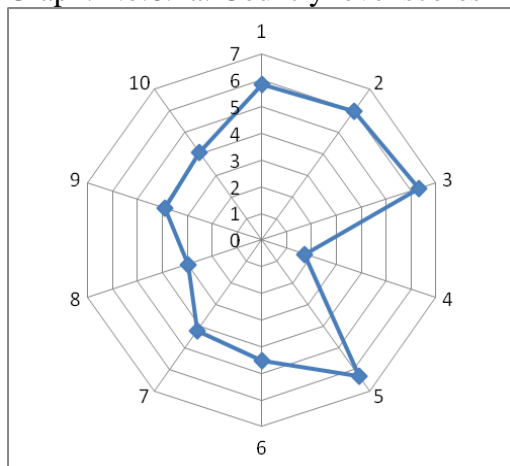
Table 6.1 and graphics 6.1a and 6.1.b show the 10 dimensional scores of the Child maltreatment prevention readiness on country level and the objective assessment made by experts. The total child maltreatment prevention readiness score is very similar between

those two groups of informants, being 50.2 on country level and 49 on expert level. But however the scores achieved by the key informants on country level and experts differ significantly within the model on different dimensions. This difference will be discussed in the following analysis.

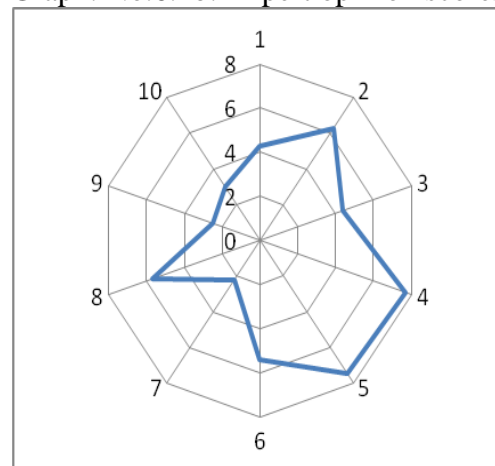
Tab. no.6.2: Comparison of key informants CMPR scores and experts scores

Dimension	Key informants Score	Experts Score
Dimension 1: Attitudes towards child maltreatment prevention	5.83	4.3
Dimension 2: Knowledge of child maltreatment prevention	5.97	6.25
Dimension 3: Scientific data on child maltreatment prevention	6.3	4.4
Dimension 4: Current programme implementation and evaluation	1.71	7.7
Dimension 5: Legislation, mandates, and policies	6.3	7.5
Dimension 6: Will to address the problem	4.53	5.4
Dimension 7: Institutional links and resources	4.21	2.2
Dimension 8: Material resources	2.98	5.7
Dimension 9: Human and technical resources	3.88	2.5
Dimension 10: Informal social resources (non-institutional)	4.06	3.0
Total child maltreatment prevention readiness score	45.77/100	49 /100

Graph. No.6.2a: Country level scores



Graph. No.6.2b: Expert opinion scores



Dimension 1: Attitudes towards child maltreatment prevention. The total score of the key informants is 5.83 versus experts' assessment which is 4.3. The key informants' opinion differs from the one of the experts' mainly in overestimation of the given political priority to CM prevention in comparison to other health and social problems as

well as to the priority of prevention versus protection. Experts think that although there is a growing political priority in promotion of CM prevention and protection in the country, prevention is only starting to be recognized as equally important as protection and needs establishing further necessary conditions for its evidence based implementation.

Dimension 2: Knowledge of child maltreatment prevention. Knowledge of the key informants is reflected in the total score on this dimension 5.97, which is the second highest score achieved on the 10 dimensional model of the assessment of CMPR and is similar to the total score of the experts assessment - 6,25. Most of the informants are familiar with the nature, types, risk and protective factors and cause, but based on information gathered from literature, not from original research in this field. The ecological model of risk and protective factors is less known. The long-term physical health consequences of child maltreatment are not so familiar to them as psychological consequences. The true economic costs of CM are underestimated, maybe due to the fact that up to now in the country there isn't any study that estimates any real costs of health and social problems, including child maltreatment.

Dimension 3: Scientific data on child maltreatment prevention. The total score on this dimension is 6.3 which differs significantly from the experts score which is 4.4. The key informants tend to present more "idealized" situation when it comes to the existence of data on magnitude & distribution of different types of CM, data on consequences of CM. Some of these data exist but their quality is not good and accessibility is problematic. There is an overestimation of the scientific evidence by the key respondents and its impact on thinking and decision making of professionals involved in CM, on both levels.

Dimension 4: Current programme implementation and evaluation. The total score on this dimension achieved by key informants is 1.71 which indicates that they are very little informed and acknowledged with the existing or recent CMP programs or existing programs into which CMP components could be integrated and differs significantly from the experts score which is 7.7. This is a result of very low level of dissemination of information on type of programmes implemented in the field locally and nationally, providing no information on their evaluation and outcomes, no publishing of results (arguments that are complementary to the recommended measures). Mainly NGOs started to implement such programmes almost a decade ago and official institution became involved in this problem only recently, so most of the respondents are not informed, or have some very scarce information on the whole process. There is also lack of sharing information and insight into projects between sectors, which results in overlapping or leaving areas totally uncovered with CMP activities.

Dimension 5: Legislation, mandates, and policies. Total score of this dimension achieved by the key informants is 6.3 which differs from experts score of 7.5. This difference is due to the fact that there isn't enough information among respondents about legislation, mandates and policies (especially those informants coming from educational and health institutions). Ministries, government departments, NGOs with mandates for CMP are not well recognized by the key informants as being in charge for CMP which is due to the fact that these two areas, prevention and protection, are not distinguished

enough. It is also evident that there is inconsistency among key informants on the assessment of legislation in force, policies and mandates for CM prevention and their effectiveness. Legislation, policies and mandates encompass both prevention and protection, explaining their overlapping in practice.

Dimension 6: Will to address the problem. The total score on this dimension by key respondents is 4.5 which doesn't differ much from the experts opinion score of 5.4. The leadership and political will to address the problem of CM are almost equally assessed by the key respondents and the experts, but there is a slight difference in the assessment of advocacy and communication efforts and public support of the issue of CM prevention. Key informants are more critical to those aspects than experts. In fact during the last 10-15 years advocacy and communication efforts and public support were mainly initiated and undertaken by NGOs, leaving governmental institutions far away in that process. The situation today is different, the GO are taking the lead but lack information on the work that had been done before.

Dimension 7: Institutional links and resources. Total score on this dimension is 4.21 versus experts opinion which is 2.2. Overall, key informants tend to overestimate institutional links and resources. In fact inter-institutional collaboration in regard to partnerships, coalitions, networks, and alliances between institutions are very few and poorly recognized by the key informants. They are not exclusively aimed for CM prevention but involving protection as well. The extent to which they involve different sectors is problematic, since most of the respondents refer to "network" within one sector (MLSP and CSW). There is also inconsistency in assessing institutional resources and their efficiency – resources are weak and not defined (number of people involved is not known) but on the other hand they are perceived as efficient and "neither efficient nor inefficient". The assessment of this dimension by the key informants is also in contradiction with the Dimension 4, which shows evident lack of information (by the key informants) on programmes due to weak inter-institutional links and collaboration.

Dimension 8: Material resources. The total score on this dimension is 2.98. The experts score on this dimension is 5.7. Although material resources are very limited and the difference is due to the fact that the key informants are not familiar with existing budgets within different sectors because most of them are not transparent and sometimes not used for CMP purposes. This is a serious problem because resources that exist are not used for their purposes. On the other hand both experts and key informants agree that sufficiency of facilities, equipments and materials is far from being adequate, causing a serious problem for preventive activities (as it is with most of the addressed social and health issues).

Dimension 9: Human and technical resources. Total score on this dimension achieved by key informants is 3.88. The experts rating of this dimension is 2.5 which differs significantly from the key informants rating. Macedonia is a small country and practically most of the activities are either on national or on local level. The sub-national level is not the concept that is applicable for the country. The notion of "Small-scale pilot

programme in one area” on national and on local level hasn’t been well understood. In addition to this there are a lot of missing answers to this question.

The assessment of the dimension 9 is obviously in contradiction to the previous dimension in which key respondents criticized much more the budgets and infrastructure, being more subjective in assessing the technical, administrative, and managerial skills, knowledge, and expertise of the professionals in the field (mainly referring to themselves) and the availability of institutions that enable the acquisition of the required expertise in child maltreatment prevention. But again all these points were addressed as lacking and highlighted in the key informants’ main recommendations.

Dimension 10: Informal social resources. The total score on this dimension by key respondents is 4.06. The experts score is 3.0. Citizen participation, social capital, collective efficacy are better captured by the key respondents, and the experts tend to be more critical in the assessment of these aspects of the development of the civil society. But still the score is low which reflects the quality of the informal social resources such as social cohesion and social bonds within the Macedonian society perceived as exhausted and disrupted during the process of long societal transitions.

6.3.Limitations of findings according to the 10 dimensional model on CMPR

The results of this study are subject to certain limitations. These limitations involve issues listed here:

- Responses were based on self-reports and they might be subjective to a certain level.
- 10% of the key respondents refused to participate in the study mainly those coming from the decision making level, (members of parliament, deputy ministers and advisors) because of their engagement in the parliamentary elections, taking place in the same period.
- There is an evident gender misbalance in this study. Most of the interviewees were women, because these problems in general involve more women as professionals.
- Initial length of the interview was almost 2 hours and contained slight redundancy of the questions, which was the major cause why many interviewees haven’t gone through the whole interview. In the beginning most of them were much more focused and productive than by the end of it, when they became tired, impatient, giving repetitive answers to different questions.
- A potential weakness of studies reporting key informants’ opinion on certain issues might result in the likelihood of giving socially desirable answers and overestimating the actions and measures taken. This might be the case with state officials who give apologetic answers to questions concerning politics, political leaders and activities undertaken on political level.

- Interviewing key informants on different levels, such as the national and the local level, put the informants in unequal position and the results are predictable. Very often on local level human and material resources and initiatives are much more limited, not only in the field of CMP but in social issues in general.
- Overemphasizing of CM prevention as a separate area from protection in a very small country like Macedonia might result in situation in which preventive activities can't be supported because of limited resources and limited number of professionals, in order to meet the needs of prevention.

7. Implications of findings for large-scale implementation of CMP programmes in Macedonia

The Readiness Assessment for the Prevention of Child Maltreatment (RAP-CM) as a method to assess how “ready” Republic of Macedonia on national and local level is to implement evidence-based child maltreatment prevention programmes on a large scale is shown through the previous analysis. The next step is to increase readiness on those dimensions where this may be necessary and then implement evidence-based child maltreatment programmes on a scale commensurate with the magnitude of the problem. This can be immediately captured by taking the radar diagram as an indicator of it. It is evident that in the Republic of Macedonia there is a growing political priority for CM prevention, starting to be recognized as equally important as protection. Based on the overall assessment of the child maltreatment prevention readiness through interviewing key informants on national and local level in the country and the objective assessment provided by the experts opinion there is a strong need to increase measures to prevent child maltreatment before it occurs through strengthening the dimensions that are lacking: according to the key informants those dimensions are 4, 6, 7, 8, 9 and 10, and according to the experts those are the dimensions are 1, 3, 7, 9, 10. We will take into consideration both levels as well.

- **Dimension 1:** Strengthening Political priority of CM prevention and its evidence based long-term effectiveness as a starting point for any other further activity;
- **Dimension 3:** Strengthening collection of scientific data on child maltreatment and its prevention on the ground, and increase the influence of the scientific evidence by establishing a resource center for data collection on CM with access to data; Spreading wide the information on magnitude, types, consequences, costs and risk factors of child maltreatment; Supporting the research on CM with training on research methodology, evaluation of effectiveness; Supporting the inter-institutional and intersectoral collaboration in research;
- **Dimension 4:** Increasing current programme implementation and evaluation: Implementation of evidence-based preventive programmes in schools, kindergartens, providing training in CM prevention for home visiting professionals, providing monitoring and external evaluation of programmes, availability of results; Providing sustainability of programmes with allocation of budget for prevention;

- **Dimension 6:** Strengthening the will to address the problem by increasing public and professional awareness engaging media celebrities in public campaigns, and also using campaigns to enhance citizen's cohesion and participation in CMP;
- **Dimension 7:** Strengthening institutional links and resources by supporting coordinated activities, shared responsibilities and information exchange between sectors, institutions, GOs and NGOs; Establishing a national council/body for prevention encompassing professionals from all sectors working on the problem;
- **Dimension 8:** Enabling material resources by allocation of separate budget for prevention from government and by fund raising; by improving the infrastructure, and adapt it in a child friendly manner;
- **Dimension 9:** Strengthening human and technical resources through supporting the collaboration with international organizations on technical support and fund raising. Provide widely available undergraduate and postgraduate education of students in CMP; Support the employment of new personnel for prevention;
- **Dimension 10:** Strengthening the informal social resources by supporting the funding of NGOs, support groups, local professionals and local leaders on advocacy and enabling their participation in decision making process;

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