**Technical report on the assessment of readiness
to implement evidence-based child maltreatment prevention programmes of
Brazil, the Former Yugoslav Republic of Macedonia,
Malaysia, Saudi Arabia, and South Africa.**

Introduction

In the last decade, a gradual shift has been occurring around the world from responding to cases of child maltreatment (CM) after they have happened by providing services, support, and treatment – often referred to as "child protection services" – to trying to prevent CM before it arises by addressing the underlying causes and risk factors – generally referred as "child maltreatment prevention" (CMP)[1].

At least five interrelated developments account for this shift from child protection to child maltreatment prevention. First, advances in disciplines such as neuroscience, molecular biology, genomics, developmental psychology, epidemiology, and economics are shedding light on the long-term and far-reaching consequences of childhood adversities – including CM – and their underlying mechanisms. Central to these advances is a better understanding of the disruptive impact of toxic stress on brain structure and functioning, on the physiological systems underlying the regulation of stress and emotions, on psychological functioning, health risk behaviours, mental and physical health, socio-occupational functioning, and on life expectancy. These advances suggest that many adult diseases should be viewed as developmental disorders that begin early in life and that persistent health disparities could be reduced by alleviating toxic stress in childhood (Shonkoff and Garner, 2012).This is leading to what has been described as a major "paradigm shift" in our understanding of health and disease across the lifespan and to rethinking basic notions of health promotion and disease prevention (Shonkoff and Garner, 2012; Shonkoff et al., 2009; Mercy and Saul, 2009; Knudsen et al., 2006). Second, recent high-quality epidemiological studies have clearly established that child maltreatment is a global phenomenon that occurs in many low- and middle-income countries (LMIC) at rates that are higher than in high-income countries (HIC; Reza et al., 2009; Stoltenborgh et al., 2011; UNICEF et al., 2011; Zimbabwe National Statistics Agency, 2012). Moreover, in HIC only a small fraction – 5-10% or less – of victims of child maltreatment come to the attention of child protection services (Gilbert et al, 2009). In Hong Kong a recent study suggests this percentage is 0.3% and in LMIC the fraction may be smaller still – when, that is, child protection services exist (Finklehor et al., 2011). Thus, the vast majority of victims of child maltreatment remain undetected and never benefit from child protection services. Third, evidence suggests that preventing maltreatment in the first place through either universal or selective prevention programmes is cheaper and more effective than trying to remediate its effects later (Heckman, 2012; Kilburn and Karoly, 2008). Fourth, emerging evidence suggest that CM can

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[1] According to UNICEF, child protection refers to 'preventing and responding to violence, exploitation and abuse against children – including commercial and sexual exploitation, trafficking, child labour and harmful traditional practices, such as female genital mutilation/cutting and child marriage' (UNICEF, 2006). Although this UNICEF definition of child protection includes prevention, in practice, child maltreatment has mainly involved providing support and treatment after child maltreatment has already occurred and protecting children from further maltreatment (e.g. Leventhal, 2005). Indeed in most countries in the world the dominant response to child maltreatment is focused upon the establishment of child protection services that are designed to identify child maltreatment cases as early as possible after they have occurred and then provide services with a view to stopping further maltreatment and mitigating its consequences.

be effectively prevented through evidence-based interventions, such as certain nurse home visitation programmes or parenting programmes (MacMillan et al., 2009; Mikton and Butchart, 2009; Prinz et al., 2009; Knerr et al., 2012). Finally, greater attention is being paid to addressing child adversities – including CM – and promoting child well-being as a result of increased child survival due to reductions in rates of childhood mortality and diseases (UNICEF, 2012; Lozano et al., 2011). In the words of the former Director-General of the World Health Organization: "[s]aving our children from these diseases only to let them fall victim to violence…would be a failure of public health" (Krug et al, 2002).

This shift of emphasis from responding to CM after it has occurred to preventing it in the first place is evidenced in the priorities and activities of international and large national organizations active in the field. For instance, WHO has made the primary prevention of child maltreatment one of its priorities in the field of interpersonal violence prevention. Likewise, the US Centers for Disease Control and Prevention (US-CDC) has made preventing child maltreatment one of the priorities of National Center for Injury Prevention and Control both nationally and globally (US-CDC, 2012) . Both WHO and CDC are part of the wider international partnership *Together for Girls* (TfG) which aims to address sexual violence and other forms of child maltreatment partly by preventing them before they occur (http://www.togetherforgirls.org/).

An increasing number of national surveys of child maltreatment in LMIC have been conducted in recent years with the explicit longer term aim of contributing to preventing child maltreatment better. For instance, US-CDC, UNICEF, and TfG have conducted national surveys of violence against children in Swaziland, Tanzania, Kenya, and Zimbabwe and will soon be conducting similar studies in Malawi and the Philippines (CDC, 2012). The UBS Optimus studies have examined the prevalence of child sexual abuse in China and Switzerland and plan to do the same in a country in Africa and another in Latin America (UBS Optimus Study, 2012) .

The UN Secretary General's *Study on Violence against Children* (UN, 2006) called for urgent action to *prevent* and respond to all forms of violence. The main role of the Special Representative of the Secretary General on Violence against Children, appointed to follow-up on the recommendations of the UN Secretary General's Study, is to advocate for the prevention and elimination of all forms of violence against children (SRSG Violence against Children, 2012).

Article 19 of the Convention on the Rights of the Child (CRC) on protection from all forms of violence states that all measures should be taken to prevent child maltreatment (Office of the United Nations High Commissioner for Human Rights, 2012). Every country in the world – except for the United States of America, Somalia and the new nation of South Sudan – have ratified, accepted, or acceded to the CRC. The Committee on the Rights of the Child, the body of independent experts that monitors the implementation of the CRC, recently published a General Comment 13 on the right of the child to freedom from all forms of violence which emphasizes the need for increased CMP (Office of the United Nations High Commissioner for Human Rights, 2012).

In HIC, it is only in the last half century that child maltreatment has become a prominent issue and this is generally dated to the publication of "The Battered-Child Syndrome" (Kempe et al., 1962) 50 years ago. Since then, in the USA, the emphasis on prevention as opposed to protection has waxed and waned to enjoy a recent resurgence (Daro and Donnelly, 2002). In four of the five countries in which this study was conducted – Brazil, the Former Yugoslav Republic (FYR) of

Macedonia, Malaysia, Saudi Arabia– the field is younger still. For instance, the first case report of child maltreatment was published in 1990 (Al-Eissa, 1991; Al-Mugeiren and Ganelin, 1990), child protection services began in the year 2000, and national efforts at prevention in 2004 (Almuneef et al., 2012). In Malaysia, the first Suspected Child Abuse and Neglect (SCAN) Team was set up in 1985. In South Africa, the fifth country this study was conducted in, child neglect was recognized as a social problem from the turn of the 20th century with the Children's Protection Act passed in 1913 and case reports of child maltreatment published as early as 1981 even though service provision was based on racial exclusion (Gannon and Hoffmann, 1996).

Many of the organizations which have supported the shift of emphasis from child protection services to CMP have at the same time promoted the implementation of evidence-based CMP programmes (e.g. Krug et al., 2002; WHO, 2006, 2009; CDC, 2012a). However, evidence-based prevention interventions alone are not enough to prevent CM. Sufficient "readiness" or "capacity" to implement the evidence-based CMP programmes on a large scale is a prerequisite. "Readiness" or "capacity" includes, for instance, adequate data on the issue; legislation; policies; financial, human, and technical resources; and leadership. Evidence-based CMP should extend beyond rigorously evaluating program effectiveness to systematically including the assessment of CMP readiness.

As a starting point, four facets of readiness were distinguished: (1) an awareness of the problem and its severity in relation to other problems (priority); (2) a willingness, or motivation, interest, desire, intention, to change the problem; (3) the ability or skills, knowledge, self-efficacy, and confidence to address the problem; and (4) the capacity to address the problem in terms of financial, material, social support, networks and institutional backing. Although readiness and capacity are largely used interchangeably, an advantage of the concept of readiness over that of capacity is that readiness includes the notions of willingness, drive, and motivation (Mikton et al., 2011).

In the last decade, capacity and readiness and their assessment and development have become central concerns in the fields of health promotion, prevention science, and public health more generally (e.g. Ebbesen et al., 2004; Laverack & Wallerstein, 2001; MacLellan-Wright et al., 2007). Building capacity is one of the five required key actions in the Bangkok Charter for Health Promotion in a Globalized World (2006) to ensure that evidence-based strategies are widely implemented. "Capacity is a necessary condition for the development, implementation, and maintenance of effective community-based health promotion and disease prevention programmes." (Goodman et al., 1998).

A review of the literature failed to identify any instrument to assess CMP readiness or any country in which CMP readiness had been systematically assessed (Mikton et al., 2011) and this in spite of the growing importance of CMP; of the initiatives to address CMP that have been multiplying, internationally and nationally; and of the growing recognition of the need to assess readiness and capacity and increase it where necessary to ensure the success of prevention programmes. Hence, the aim of this project was to develop an instrument to assess readiness to implement large-scale, evidence-based CMP programs and identify strategies to increase readiness, particularly in LMIC, and then apply this instrument. The instrument aims to provide a comprehensive assessment of a country's overall state of readiness to implement child maltreatment prevention programmes along ten dimensions of readiness (see Box 1). This report focuses the findings from applying the

instrument in five countries. See Mikton and Power (in preperation) for a description of the development and psychometric properties of the instrument.

Assessing CMP readiness can serve several important purposes, including identifying major gaps in readiness and informing plans to address them, establishing a baseline measure against which progress in increasing readiness can be tracked, helping to allocate resources to increase readiness for CMP, assisting in matching an intervention to the existing level of readiness, and acting as a catalyst for taking action to prevent CM.

This report will describe the application of the instrument in Brazil, FYR of Macedonia, Malaysia, Saudi Arabia, and South Africa[2]. These countries were selected for three reasons: first, the country research teams submitted high quality proposals to carry out this research in response to a competitive bid for proposals; second, no such assessments had been conducted before in these countries; and third, recognizing the scale of the problem of CM and the severity of its consequences, these countries are all beginning to step up CMP activities to varying degrees to complement what are usually already better developed child protection services. For instance, in FYR of Macedonia, a National Action Plan on the Prevention of Child Abuse and Neglect is under discussion and is expected to be adopted soon; in Malaysia, while there already is a National Plan for the Protection of Children, there has been a recognition that the legal and policy framework needs to be strengthened in the area of CMP and early intervention; in Saudi Arabia the National Family Safety Program which was established in 2005 has been advocating for more attention to be paid to the prevention of CM; and in South Africa, one of the aims of the Children's Act (2005) was to rectify the historical bias in the country towards child protection services and shift the emphasis towards prevention and early intervention programmes.

For more information on the development of child protection services and CMP and for detailed results of the application of the instrument in these countries, please see the full country reports for each country by Cardia et al. (2012 - Brazil), Raleva et al. (2012 – FYR of Macedonia), Cheah et al. (2012 – Malaysia), Almuneef et al. (2012 – Saudi Arabia), and Makoae et al., (2012 – South Africa). For a detailed description of the development of the model on which the instrument is based, please see Mikton et al. (2011) and of the development and psychometric properties of the instrument, see Mikton and Power, (in preperation). A handbook for the instrument is also available (Mikton C., 2012)

Method

The instrument and its development:

The Readiness Assessment for the Prevention of Child Maltreatment (RAP-CM) is a method of assessing a country's readiness to implement evidence-based CMP programmes on a large scale and of generating recommendations to increase the country's readiness that is made up of two instruments, both based on the same 10-dimensional model (Box 1): (1) the Readiness Assessment for the Prevention of Child Maltreatment – Informant version (RAP-CM-I), which is based on the views of key informants using a semi-structured interview schedule with over 100 items and which takes approximately one hour to complete; (2) the Readiness Assessment for the Prevention of Child Maltreatment based on expert opinion using all available data (RAP-CM-XD) which is a semi-structured interview schedule whose items mirror those or RAP-CM-I. RAP-CM-

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[2] The instrument was also applied in a sixth country which has chosen, however, not to publish its results.

XD is completed by the experts from the research team after conducting the interviews of key informants with RAP-CM-I using all available data relevant to CMP in the country data – both gleaned from the interviews with key informants and collected from other sources. Experts in all cases were academic researchers – who in some cases were clinicians as well – who had been specializing in CMP in their country for a number of years. In addition, data on key country conditions – such as income level, per capita GDP, Gini index, adolescent fertility rate – with a potential bearing on the country's readiness to implement child maltreatment prevention programmes are also collected.

The assessment process results in:

1. An overall score out of 100 on RAP-CM-I;
2. An overall score out of 100 on RAP-CM-XD;
3. A score out of ten on each of the ten dimensions of RAP-CM-I
4. A score out of ten on each of the ten dimensions of RAP-CM-XD
   o Scores on dimensions of RAP-CM-I and RAP-CM-XD can be represented on a radar diagram (Figure1);
5. A comparison of findings from RAP-CM-I and RAP-CM-XD; and
6. A list of proposed recommendations to increase readiness.

RAP-CM is based on the following standard definition of child maltreatment: "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"[3] . This definition was provided to all key informants on a card and it was further specified that child maltreatment can occur in many different settings and that perpetrators may be parents and other family members; caregivers; friends; acquaintances; strangers; others in authority – such as teachers, soldiers, police officers and clergy; employers; health care workers; and other children.

Box 1: the 10 dimensions of RAP-CM

Dimension 1: **Attitudes** towards child maltreatment and its prevention – including, for instance, understanding of the difference between child maltreatment prevention and child protection; perceived priority of child maltreatment prevention; and adequacy of measures taken to date to prevent child maltreatment.

Dimension 2: Knowledge about child maltreatment and its prevention – including, for instance, the nature of, prevalence of, risk factors for, and consequences of child maltreatment, and the appropriateness of different prevention programmes.

Dimension 3: Existence **of scientific data** on child maltreatment and its prevention in the country, e.g. the data on magnitude & distribution of child maltreatment; short and long term consequences of child maltreatment; risk and protective factors for and causes of child maltreatment; official definitions of child maltreatment; reporting systems.

Dimension 4: Existing child maltreatment prevention **programmes** and programmes into which child maltreatment prevention components could be integrated and outcome evaluations of these programmes.

Dimension 5: Legislation, official **mandates** of governmental or non-governmental agencies**, and policies** relevant to child maltreatment prevention.

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[3]Source: Report of the consultation on child abuse prevention, 29–31 March 1999. Geneva, World Health Organization, 1999 (document WHO/HSC/PVI/99.1) & Krug EG et al., eds. World report on violence and health. Geneva, World Health Organization, 2002.

Dimension 6: Will to address the problem including leadership, political will, public will, advocacy and communications efforts.

Dimension 7: Institutional links (e.g. coalitions, partnerships and networks dedicated to CMP) **and resources** of institutions involved in child maltreatment prevention.

Dimension 8: Material resources, including funding, infrastructure and equipment.

Dimension 9: Human and technical resources, including professionals with the required technical, administrative, and managerial skills, knowledge, and expertise and the institutions that enable the acquisition of such skills and knowledge.

Dimension 10: Informal social resources (e.g. citizen participation, social capital, collective efficacy). When assessing readiness and capacity, it is generally considered as important to focus on the quality of social interactions and social bonds within a community or society as it is on specific assets for child maltreatment prevention readiness such material resources, and legislation, and policies.

RAP-CM-I is designed to be administered to "key informants", which refers to individuals who have or are likely to have significant influence on, and decision-making power over, child maltreatment prevention in a country. These may include policy makers; programme planners, commissioners, and implementers; high level practitioners; high level civil servants and their senior technical advisers; leaders, champions, and politicians with a strong interest in the subject; and academics and researchers. They may come from many different sectors and types of organizations involved in child maltreatment prevention, including the health, social welfare/social development, education and criminal justice sectors and governmental ministries and departments, non-governmental and community-based organizations, international organizations, as well as universities and other research institutions.

RAP-CM-I has a dual aim: its primary aim is to assess the perceptions, attitudes, underlying beliefs, opinions, and knowledge concerning CMP of key informants, who are likely to be the main actors in CMP in their countries; but it also serves the secondary purpose of gleaning factual information, and references to sources of further factual information, from the key informants, which can then be followed-up by the research team and used for the assessment using RAP-CM-XD.

Rather than base the assessment on a single version of the instrument, it was decided that developing two parallel versions of the instrument – RAP-CM-XD and RAP-CM-I – to be used in combination, would be more informative. RAP-CM-XD produces an assessment that is based on all available data of those dimensions of readiness which are primarily or partly factual – Dimension 3 (scientific data), Dimension 4 (programmes), Dimension 5 (legislation, mandates, and policies), Dimension 7 (institutional links and resources), Dimension 8 (material resources) and to an extent Dimension 9 (human and institutional capacity) – and an assessment of the remaining dimensions that is informed by information that is as factually correct as possible. RAP-CM-I allows the perceptions, attitudes, underlying beliefs, knowledge, and opinions of precisely those individuals who have or are likely to have significant influence on and decision-making power over child maltreatment prevention in the country to be evaluated. The assumption is that the readiness of a country to scale up the implementation of CMP programmes is largely dependent on the perceptions, attitudes, underlying beliefs, knowledge, and opinions of the key actors in the field in the country concerning CM. Comparing RAP-CM-XD against RAP-CM-I can help reveal any gaps that might exist in key actors' knowledge – particularly on the more factual dimensions – and can help identify their perceptions, attitudes, underlying beliefs, and opinions which might facilitate or impede the implementation of CMP programmes. Thus, the full

assessment of CMP readiness using this approach depends on RAP-CM-I and RAP-CM-XD individually, but also – and just as importantly – on a comparison of RAP-CM-I and RAP-CM-XD.

RAP-CM-I was developed in a four stage process conducted in the six countries (one of which has chosen not to publish its results). These stages are: (1) development of the conceptual model underlying the instrument (see Mikton et al., 2011); (2) development of a first version of the semi-structured interview based on the conceptual model and cognitive testing of the instrument; (3) revision and development and pilot testing of a second version in six countries; (4) revision and development of a third version which was then applied in the six countries. On the basis of the results of the application of this third version in the six countries, the instrument has been further refined (see Mikton and Power [in preparation] for more on the development of the instrument and its psychometric properties, which were found to be acceptable overall). The semi-structured interview was translated from English into national languages and back-translated to ensure accuracy of the translation.

Recruitment of research teams and samples in each country

The research teams in the countries which administered RAP-CM-I and then completed RAP-CM-XD included between three and seven experts affiliated with universities or research institutes. The research teams were recruited on a competitive basis following a bid for proposals issued by the WHO which resulted in the submission of 13 full proposals.

Each of the five country research teams, whose findings are reported here, recruited at least 40, and up to 50, key informants to interview using RAP-CM-I (Table 3). To guide the selection of key informants a sample selection matrix was created to ensure that key informants from all main relevant organizations and sectors were included. Key informants who were purposively selected were generally initially contacted by e-mail or phone followed up by a letter with an information sheet describing the study. Key informants chose to remain anonymous in most countries.

Data analysis

Quantitative data analysis – including descriptive statistics, Chi-square, T-tests, and ANOVAs – was performed using SPSS Version 17. Qualitative data analysis of narrative responses of key informants focused on categorizing answers to the open-ended questions and summarizing the measures to increase readiness suggested by informants from which overall recommendations to increase readiness in the country were derived.

Ethical approval and informed consent

This research did not directly involve patients. Nor did it involve victims or perpetrators of child maltreatment. It aimed to assess countries' readiness to implement child maltreatment prevention programmes on a large scale based on interviews with key informants – defined as individuals who have or are likely to have significant influence on, and decision-making power over, child maltreatment prevention in the country (see above) – and a desk review of relevant data by research teams. Nonetheless, research teams in each country fully complied with the ethical requirements of their countries and institutions, obtaining approval from their institutional or national ethics review boards for the study as required. For instance in Malaysia ethical clearance was granted to conduct the research by the Ministry of Health Research and Ethics Committee and the University of Malaya Medical Institutional Review Board; in Saudi Arabia, the Retrospective

Research Subcommittee of the King Abdullah International Medical Research Center reviewed the research proposal and decided there was no need to obtain approval from the Institutional Review Board as there was no disclosure of identity and no risk associated with participants in the study. In South Africa, the research team from the Human Sciences Research Council obtained approval from its institution's ethics committee. Free and informed consent was obtained in writing from all key informants and experts in all countries and their relevant ethics review board also approved the study, when required.

Results

Key characteristics of countries

Although four of the five countries are classified as upper-middle-income countries by the World Bank (2012), there are nevertheless many important differences between these countries that could have a bearing on their readiness to implement child maltreatment prevention programmes (Table 1). Their populations range from two million in FYR of Macedonia to over 200 million in Brazil. The Gini indices, measuring income inequality, for these countries vary considerably – from a low of 32% in Saudi Arabia to a high of 67% in South Africa – which is the country with the second highest Gini index in the world after Namibia. By comparison, Denmark, Japan, and Sweden have the lowest rates of income inequality in the world with Gini indices of 25%. Adolescent fertility rates are 10 times higher in Brazil than in Saudi Arabia and rankings on the Human Development Index go from 56 for Saudi Arabia to 123 for South Africa, out of a total of 187 countries. Furthermore, there are also stark differences in these countries' histories, cultures, religions, languages, and political systems.

Table 1: Some key country characteristics

Key country indicator	Brazil	FYR Macedonia	Malaysia	Saudi Arabia	South Africa
Population (2012)	205,716,890	2,082,370	29,179,952	26,534,504	48,810,427
High, lower-middle, upper-middle, low-income country (2012) *	Upper-middle-income	Upper-middle-income	Upper-middle-income	High-income	Upper-middle-income
GDP per capita US$ (PPP*)"	11'210	11'162	14'731	22'713	10'565
% of population below international poverty line of US$1.25 per day (2009)*	3.8	0.3 (2008)	0	N.A.	17.4 (2006)
Gini Index (2009 World Bank (%)*	54 (2009)	44 (2008)	46 (2009)	32 (but GPI, not World Bank)	67 (2006)
Adolescent fertility rate (births per 1000 women aged 15-19)**	77	20	12	7	54
Human development index (rank) (2011)) †	0.718 (84)	0.728 (78)	0.761 (61)	0.77 (56)	0.619 (123)

*World Bank; **UNICEF); †UNDP

Samples of key informants and research experts: The number of key informant ranged between 41 and 50 per country, with the research team in the FYR of Macedonia interviewing the largest number (Table 1). Response rates for the interviews with key informants using RAP-CM-I were on the whole acceptable with three out of five of the countries having response rates in the region of 80% or more. Response rates in Brazil (22.3%) however, were much lower. Possible explanations for the lower response rate in Brazil are the fact that the research was carried out during the summer holidays; the need for and difficulty many officials experienced in getting clearance from superiors to participate in the interview; and that the research took place during a

period of political transition as a result of elections (the majority of key informants worked for governmental organizations – see Table 2). At least two research teams, such as those in Brazil and FYR of Macedonia reported having difficulties recruiting more senior key informants and, in South Africa, key informants from sectors other than child protection. There were between three and seven experts on the five country research teams.

Table 2: Size of samples of key informants in each country, response rate, number of experts on country research teams

Country	Number of key informants approached	Number of RAP-Informant interviews completed	Response rate	Number of experts on research team
Brazil	184	41	22.3%	7
Macedonia	56	50	89.3%	6
Malaysia	66	42	63.6%	5
Saudi Arabia	50	41	82.0%	6
South Africa	52	41	78.8%	3

There were several noteworthy and statistically significant differences between countries in the sample characteristics that were measured (Table 2). The majority of key informants in all countries except Saudi Arabia were female, with the highest proportion of females in South Africa (82.9%). There were large differences in the mean number of years key informants had worked in child maltreatment prevention – up to 15 years of difference between Malaysia (17.2) and Brazil (2.2). In most countries, key informants working for governmental organizations made up the largest single group, over half in Brazil, FYR Macedonia, and Saudi Arabia. Other than in South Africa, where 22% of key informants worked for universities and research institutes, much smaller proportions of key informants worked for international organizations, universities and research institutions, and other types of organizations. Implications of these differences in sample characteristics are explored below through an analysis of possible associations between them and scores on RAP-CM-I and RAP-CM-XD.

Table 3: Characteristics of key informants – gender, years of experience in child maltreatment prevention, type of organization for which they work

Country	N	Gender (% female)	Mean number of years of experience in child maltreatment prevention (SD)	Type of organization (%)							
				GO	NGO/ CBO	IO	Univ/ RI	Other	Missing	GO	All others
Brazil	41	61	2.2 (4.5)	58.5	22	4.9	7.3	7.3	0	58.5	41.5
Macedonia	50	74	12.2 (8.7)	64	30	0	4	2	0	64	36
Malaysia	42	76.2	17.2 (13.8)	47.6	45.2	2.4	4.8	0	0	47.6	52.4
Saudi Arabia	41	43.9	8.9 (7.1)	73.1	19.5	4.9	0	2.4	0	73.1	26.9
South Africa	41	82.9	9.3 (0.9)	39	29.3	4.9	22	2.4	2.4	39	61
		$X^2=18.16$, df=4; p<0.001	F=12.12 P<0.001 Scheffe post hoc test (p<.05): B<Mc, Ml, SAr Ml>SAr	$X^2=55.00$, df=24, p<0.001							

SD: standard deviation; GO: Government organization;NGO/CBO: Non-Governmental Organization or Community-Based Organization; IO: International Organization; Univ/RI: University or Research Institute; B=Brazil; Mc=TFYR of Macedonia; Ml= Malaysia; SAr=Saudi Arabia; SAf = South Africa

Scores on RAP-CM-I

Total scores on RAP-CM-I ranged from 31.2 (Brazil) to 45.8/100 (FRY of Macedonia – Table 4), indicating that on the basis of interviews with key informants Brazil has the lowest level of readiness to implement CMP programmes on a large scale and FYR of Macedonia, the highest level.

The total scores of FYR Macedonia , Malaysia, Saudi Arabia, and South Africa are closely clustered in the lower and mid-forties with only small and non-significant differences between them. The dimension with the lowest score for almost all countries is Dimension 4 (existing programmes) – except for Malaysia where this dimensions was the third lowest. Dimensions 8 (material resources) and 9 (human and technical resources) were also consistently low. The dimension with the highest score in three out of five of the countries (Brazil, Saudi Arabia, and South Africa) is Dimension 2 (knowledge). Countries also tended to score high on Dimensions 3 (scientific data) and 5 (legislation – Table 4 and Figure 1) .

The ranking of total scores for each country is broadly reflected in the ranking of scores on each dimension. Some of the more noteworthy exceptions to this are FYR of Macedonia's score on Dimension 2 (knowledge), which is the lowest, significantly lower than several of the other countries, even though it has the highest overall score; South Africa's score on Dimension 2 (knowledge), which is the highest even though overall South Africa is ranked fourth; Malaysia's score on Dimension 9 (human and institutional capacity) which is very low even though Malaysia had the second highest score overall (however this difference is not significant); and Saudi Arabia's score on Dimension 6 (will to address problem) and 8 (material resources) which are the highest score of any country even though Saudi Arabia has the third highest score overall. Scores across the five countries on Dimension 2 (knowledge), Dimension 5 (programmes), Dimensions 8 (material resources), and Dimension 10 (informal social resources) are particularly tightly clustered with standard deviations of 0.6 or less – though there were some significant differences between countries (Table 4).

Scores on RAP-CM-XD

Total scores on RAP-CM-XD ranged from 35.2 (Brazil) to 56.0/100 (Malaysia). The ranking of countries (Table 5) indicate that based on the expert opinion of the research teams using all available relevant data Brazil had the lowest level of readiness and Malaysia the highest. The dimensions on which countries scored high tended to be Dimension 2 (knowledge), Dimension 4 (programmes), and Dimension 5 (legislation) – as reflected in the means on these dimensions. Country rankings on scores on dimensions reflected the country rankings on total score less well than in the case of RAP-CM-I (Table 5). Already low in the ranking of total scores, Saudi Arabia scored particularly low on Dimension 1 (attitudes). Brazil, ranked last on the overall score, scored particularly low on Dimensions 3 (scientific data), 6 (will to address the problem) and 9 (human and institutional resources); and South Africa on Dimension 8 (material resources). FYR of Macedonia scored low on Dimension 7 (institutional resources) in spite of its high total score. South Africa scored particularly high on Dimensions 2 (knowledge) and 4 (legislation) and Saudi Arabia on Dimension 10 (informal social resources). There was greater variation of scores on dimensions between countries with only Dimension 2 (knowledge) having a standard deviation of less than 1.

Comparison of scores between RAP-CM-I and RAP-CM-XD

Scores on RAP-CM-XD were higher than scores on RAP-CM-I for all countries except for Saudi Arabia (Table 6). The biggest difference was in the case of Malaysia (12.3[4] points difference). Other differences ranged between 3 and 5 points. Rankings of countries based on RAP-CM-XD and RAP-CM-I changed in all cases except for Brazil which was ranked last on both.

The most consistent differences between RAP-CM-I and RAP-CM-XD were found on Dimension 4 (programmes), where all countries scored between 3.3 and 6 points higher on RAP-CM-XD and where there was a difference of 4.4 in the overall mean scores of all five countries on each instrument (Tables 6). The only other consistent difference was on Dimension 3 (scientific data), where all countries scored higher on RAP-CM-I than on RAP-CM-XD, by between 0.3 and 1.5 points, and where there a difference of 0.9 in overall mean scores. On Dimension 6 (will to address the problem), scores in all countries other than Brazil were higher on RAP-CM-XD and there was a difference of 1.0 in the overall mean scores of all five countries on each instrument. On Dimensions 5 (legislation) and 6 (will to address problem) scores on RAP-CM-XD were generally higher and on Dimension 7 (institutional links) scored on RAP-CM-I were generally higher. Several other large differences (>2 points) occurred, but were not consistently found on any particular dimension (Table 6).

Dimension 2 (knowledge), Dimension 3 (scientific data), Dimension 4 (programmes), Dimension 7 (institutional links and resources), and Dimension 8 (material resources) concerned either predominantly or exclusively factual information, while the remaining dimensions where to a much greater extent matters of opinion. Other than on Dimensions 3 (scientific data) and 4 (programmes), differences between RAP-CM-XD and RAP-CM-I on the other more factual dimensions were generally smaller than on the non-factual dimensions (see Table 6).

In 42% of cases (i.e. 21/50), the differences between scores on the 10 dimensions of RAP-CM-XD and RAP-CM-I across the five countries were of less than 1 point, indicating that the results of the two assessments of readiness very often converged. This was particularly the case with Dimensions 2 (knowledge), 3 (scientific data), 6 (will to address the problem), and 10 (informal social resources) where differences of less than 1 point were found in at least 3/5 countries. Further convergence was found on a number of dimensions where the same countries scored either highest or lowest on both versions of the instrument. South Africa scored the highest on Dimension 2 (knowledge) on both versions of the instruments. Malaysia scored the highest on Dimension 3 (scientific data) and 4 (programmes) on both versions; Macedonia scored the highest on Dimensions 5 (legislation). Brazil scores the lowest on Dimensions 3 (scientific data), 4 (programmes), 6 (will to address problem), 9 (human and institutional resources), and 10 (informal social resources).

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[4]Positive differences indicate that the scores on RAP-CM-XD>RAP-CM-I; negative differences that score on RAP-CM-XD<RAP-CM-I

Table 4: RAP-CM-I – mean total scores and mean scores on each dimension

Country		Dim 1	Dim 2	Dim 3	Dim 4	Dim 5	Dim 6	Dim 7	Dim 8	Dim 9	Dim 10		
		Attitudes (SD)	Knowledge	Scientific data	Programmes	Legislation	Will to address	Institutional links	Material	H and I capacity	Informal social resources	Total score (max.100)	Rank
Brazil		3.6 (1.3)	6.1 (1.4)	3.7 (2.5)	1.1 (1.2)	5.0 (2.0)	2.9 (2.1)	2.8 (2.1)	1.93 (2.0)	1.4 (2.0)	2.7 (2.0)	**31.2 (10.9)**	**5**
Macedonia		5.8 (2.2)	6.0 (2.0)	6.3 (1.7)	1.7 (1.4)	6.3 (2.6)	4.5 (2.4)	4.2 (2.5)	3.0 (2.4)	3.9 (2.4)	4.1 (2.1)	**45.8 (12.7)**	**1**
Malaysia		4.0 (2.0)	6.9 ((1.3)	7.0 (2.0)	3.2 (1.9)	5.2 (2.5)	4.3 (2.1)	4.6 (1.9)	3.1 (2.4)	1.7 (2.2)	3.8 (2.3)	**43.7 (12.2)**	**2**
Saudi Arabia		4.1 (1.1)	7.1 (1.4)	5.9 (1.8)	2.0 (1.7)	5.2 (2.0)	5.3 (1.7)	4.54 (2.1)	3.6 (2.6)	2.1 (2.8)	4 (1.8)	**43.7 (9.7)**	**3**
South Africa		4.0 (1.6)	7.2 (0.7)	5.9 (1.1)	2.0 (1.4)	5.6 (1.7)	4.1 (2.1)	3.9 (1.4)	3.5 (1.9)	2.3 (1.3)	3 (1.8)	**41.4 (7.2)**	**4**
Mean		4.3 (0.9)	6.7 (0.6)	5.8 (1.2)	2.0 (0.8)	5.4 (0.5)	4.2 (0.9)	4.0 (0.7)	3.0 (0.6)	2.3 (1.0)	3.5 (0.6)		
ANOVA	F	12.47	7.16	18.34	10.28	2.81	7.03	5.21	3.24	10.99	4.15	12.00	
	p	p<0.001	p<0.001	p<0.001	p<0.001	p<0.05	p<0.001	p<0.001	p<0.05	p<0.001	p<0.01	p<0.001	
Scheffe post hoc test (p<.05)		Mc> all others	SAf>B,,Mc SAr>Mc Ml>Mc	B<All	Ml>All	--	B<Mc,SAr	B<Mc,Ml,SAr	SAr>B	Mc>All	Mc>B	B>All	

SD = standard deviation; B=Brazil; Mc=TFYR of Macedonia; Ml= Malaysia; SAr=Saudi Arabia; SAf = South Africa

Table 5: Scores on RAP-CM-XD – total and on each dimension

Country	Dim 1	Dim 2	Dim 3	Dim 4	Dim 5	Dim 6	Dim 7	Dim 8	Dim 9	Dim 10		
	Attitudes	Knowledge	Scientific data	Programmes	Legislation	Will to address	Institutional links	Material	H and I capacity	Informal social resources	Total score (max.100)	Rank
Brazil	2.5	6.7	2.5	5	5	2.1	5	3.6	0.8	2	**35.2**	**5**
Macedonia	3.3	6.7	4.8	7.7	7.5	5.4	2.2	5.7	2.5	3	**48.8**	**2**
Malaysia	4.2	6.7	6.4	8.3	7.5	6.7	3.3	5.7	3.3	4	**56.0**	**1**
Saudi Arabia	1.7	5	5	5.3	3.3	5.9	3.6	2.9	1.7	6	**40.4**	**4**
South Africa	4.2	7.5	5.7	5.7	7.5	5.8	3.3	0.7	3.3	3	**46.7**	**3**
Mean	3.2 (1.1)	6.5 (0.9)	4.9 (1.5)	6.4 (1.5)	6.2 (1.9)	5.2 (1.8)	3.5 (1.0)	3.7 (2.1)	2.3 (1.1)	3.6 (1.5)		

NB: no statistical test were conducted as these scores were based on expert consensus of research teams and not on samples of informants.

Table 6: Differences between scores on RAP-CM-XD and RAP-CM-I (RAP-CM- XD –- RAP-CM-I)

|	Dim 1	Dim 2	Dim 3	Dim 4	Dim 5	Dim 6	Dim 7	Dim 8	Dim 9	Dim 10	
	Attitudes	Knowledge	Scientific data	Programmes	Legislation	Will to address	Institutional links	Material	H and I capacity	Informal social resources	**Difference in total scores**
Brazil	-1.0*	0.5	-1.2	3.9	0.04	-0.8	2.2	1.6	-0.6	-0.7	**3.9**
Macedonia	-2.5	0.7	-1.5	6.0	1.2	0.9	-2.0	2.7	-1.4	-1.1	**3.0**
Malaysia	0.1	-0.3	-0.6	5.1	2.3	2.4	-1.3	2.7	1.7	0.2	**12.3**
Saudi Arabia	-2.4	-2.1	-0.9	3.3	-1.8	0.7	-1.0	-0.7	-0.4	2	**-3.3**
South Africa	0.2	0.3	-0.3	3.7	1.9	1.7	-0.6	-2.8	1.1	0	**5.3**
Mean (SD)	-1.1 (1.2)	-0.2 (1.0)	-0.9 (0.4)	4.4 (1.0)	0.7 (1.5)	1.0 (1.1)	-0.5 (1.4)	0.7 (2.1)	0.07 (1.1.)	0.1 (1.1)	4.2 (5)

*Positive differences indicate that the scores on RAP-CM-XD>RAP-CM-I; negative differences that score on RAP-CM-XD<RAP-CM-I;

Table 7: Mean of scores on RAP-CM-I and RAP-CM-XD

	Dim 1	Dim 2	Dim 3	Dim 4	Dim 5	Dim 6	Dim 7	Dim 8	Dim 9	Dim 10	
	Attitudes	Knowledge	Scientific data	Programmes	Legislation	Will to address	Institutional links	Material	H and I capacity	Informal social resources	**Total score**
Brazil	3.0	6.4	3.1	3.1	5.0	2.5	3.9	2.8	1.1	2.3	**33.2**
Macedonia	4.6	6.3	5.5	4.7	6.9	5.0	3.2	4.4	3.2	3.5	**47.3**
Malaysia	4.1	6.8	6.7	5.8	6.3	5.5	4.0	4.4	2.5	3.9	**49.9**
Saudi Arabia	2.9	6.1	5.4	3.7	4.2	5.6	4.1	3.2	1.9	5	**42.0**
South Africa	4.1	7.4	5.8	3.8	6.6	5.0	3.6	2.1	2.8	3	**44.1**
Overall mean	3.7 (0.7)	6.6 (0.5)	5.3 (1.3)	4.2 (1.1)	5.8 (1.1)	4.7 (1.3)	3.8 (0.3)	3.4 (1.0)	2.3 (0.8)	3.6 (1.0)	**43.3 (6.4)**

Figure 1: Scores for each country on RAP-CM-I and RAP-CM-XD represented on radar diagram
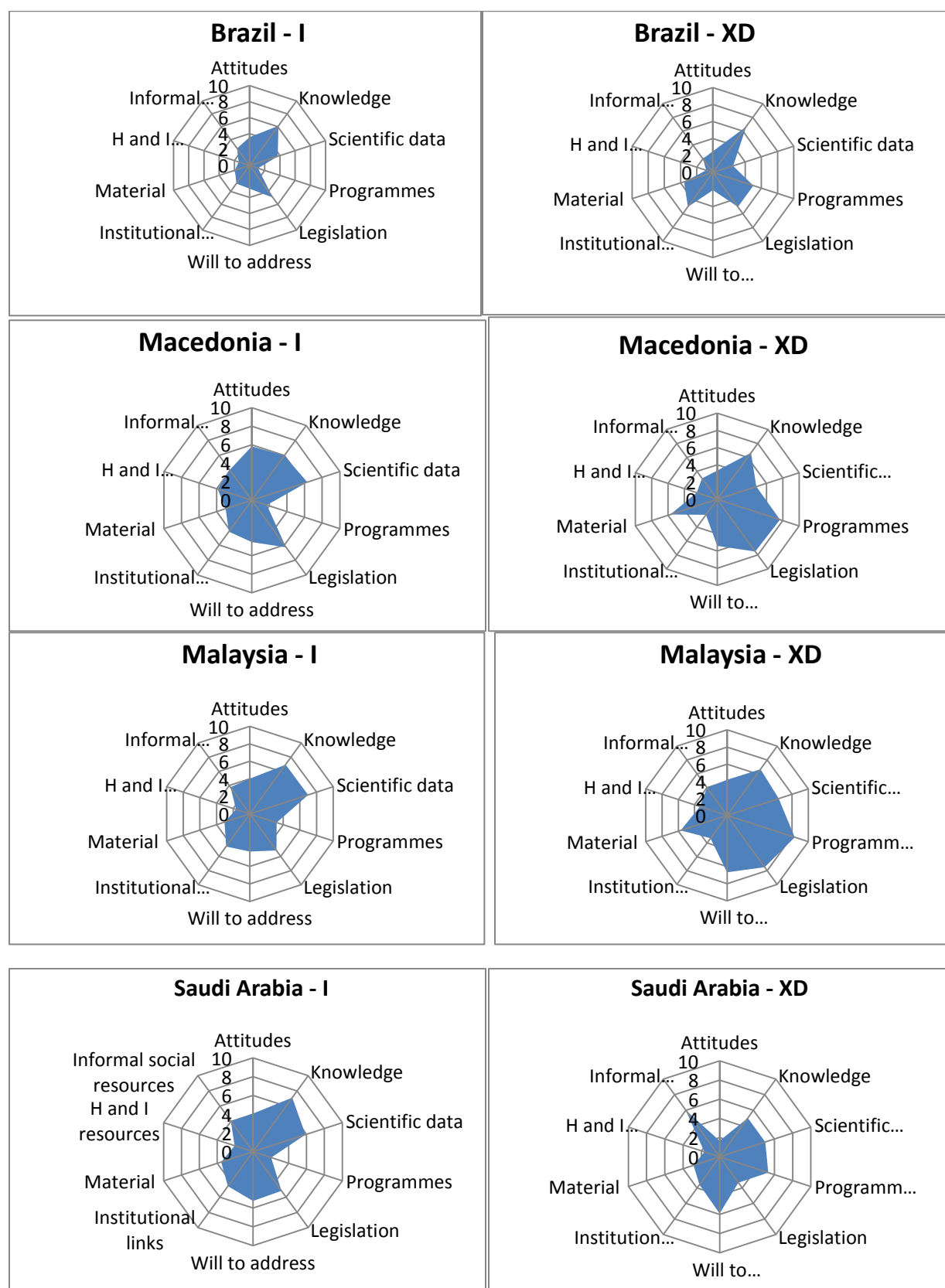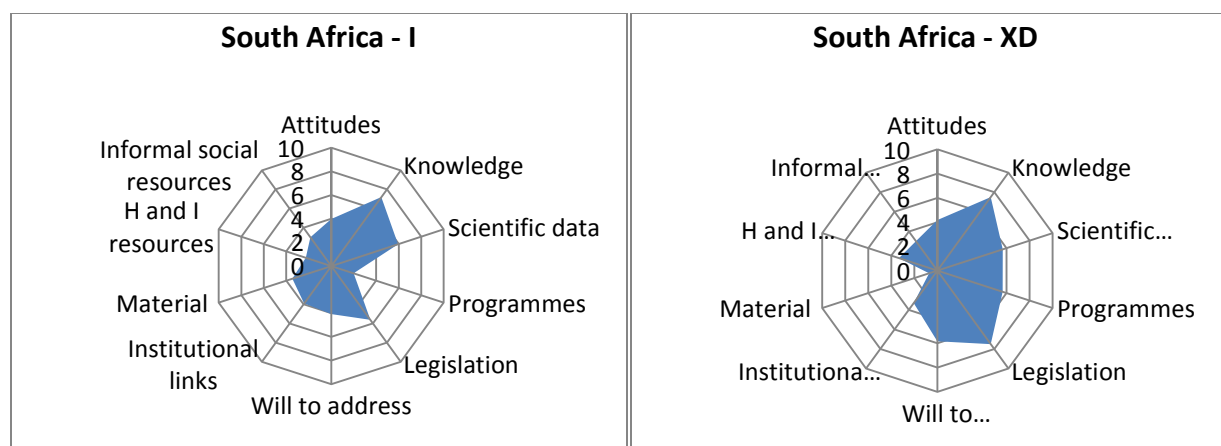
Scores on selected individual items of RAP-CM-I and RAP-CM-XD

To get a better sense of the type of information generated by the items included in the ten dimensions of RAP-CM, this section examines scores on a number of individual items. These have been selected either because of their intrinsic interest or because countries scored particularly high or low on these items.

Dimension 1 (attitudes): Key informants, but not research teams, were asked if there was a difference between child protection and child maltreatment prevention and, if in their opinion such a difference existed, to explain what it consisted of. Results suggest that this difference is widely understood: at least 65% of informants in all countries were able to explain the difference and this proportion increased to 100% in Saudi Arabia and the FYR of Macedonia. While key informants appeared to be aware of this distinction when directly asked about it, research teams in most countries remarked that the distinction very often became blurred in answers to other questions, in spite of repeated reminders that RAP-CM-I exclusively concerned CMP, i.e. preventing child maltreatment before it arises.

There was a consensus across all countries and among key informants and research teams that CMP was a low priority in the country compared to other social problems and to child protection. A maximum of 36% of key informants, in South Africa and Saudi Arabia, thought it was a high priority compared to other social problems and only 4.9% in Brazil. A minimum of 58.5% – in Saudi Arabia – thought CMP was less of a priority than child protection and this increased to 92.7% in Brazil. All research teams judged child maltreatment to be less of a priority than other social problems (except for South Africa, which considered it to be of about equal priority) and child protection.

Key informants in Malaysia, Saudi Arabia, and South Africa all considered that measures taken so far to prevent child maltreatment had been inadequate (76.2%, 85.4%, and 68.35, respectively). In Brazil and Macedonia, 48.8% and 34% considered such measures to be inadequate and ANOVA tests with Scheffe post-hoc tests (p<0.5) showed that Macedonia's mean score on this item was significantly different from all other countries but Brazil. The view of research teams was similar with only FYR of Macedonia judging that measures taken so far to prevent child maltreatment were "neither adequate or inadequate", rather than "inadequate".

In most countries, both key informants and research teams judged children's rights to be much better protected in terms of legislation than in practice.

Dimension 2 (knowledge): Half or more of key informants in all countries had heard of the "evidence-based" or "public health" approach to CMP and this proportion rose to 95.1% in South Africa.

Dimension 3 (scientific data): None of the countries had conducted nationally representative population-based studies on the prevalence of child maltreatment.

The majority of key informants in all but one country replied that there were official definitions of CM that were used to record cases – 85.4% in South Africa and 70% in Macedonia, for instance. The only exception to this was Saudi Arabia, where 39% replied that such definitions existed and were used and 51.2% thought no such official definitions were used. ANOVA tests with Scheffe post-hoc tests ($p<0.05$) showed that Saudi Arabia's mean score was lower than both South Africa and Malaysia. According to the research teams, basing themselves on all available data, such definitions exist and are used in all countries, except Macedonia (contradicting the view of key informants).

While the overwhelming majority of key informants from all countries replied on RAP-CM-I that an official reporting system for cases of CM exists in their country, only a minority thought that the reporting system worked well – as low as 0% in Macedonia and a maximum of 43.9% in Saudi Arabia. poorly. On RAP-CM-XD, all research teams stated that official reporting systems existed in their countries and three out of five thought that the reporting system worked "poorly"; in FYR of Macedonia and Malaysia research teams thought it worked "fairly".

FYR of Macedonia was the only country in which most key informants – 66% – thought that scientific evidence on CM and its prevention strongly shaped the thinking and decisions in the field. This difference was confirmed by ANOVA tests with Scheffe post-hoc tests ($p<0.05$) which indicated that Macedonia's mean score on this item was significantly higher than Brazil, Saudi Arabia, and South Africa's. Research teams from most countries – other than FYR of Macedonia and South Africa – replied that scientific evidence only had a weak role in shaping thinking and decisions in the field. In South Africa, the research team believed it had a strong influence and in Macedonia a moderate influence.

Dimension 4 (programmes): Out of a possible maximum of six points on RAP-CM-I concerning whether CMP programmes had undergone outcome evaluations, the highest score was 0.7/6 for FYR of Macedonia; four countries scored less than 0.2/6. Outcome evaluations appear to be exceedingly rare in these countries. This picture was corroborated by the research teams, except in the case of FYR of Macedonia, which scored 4/5 points on the question concerning outcome evaluations.

Dimension 5 (legislation, mandates, and policies): According to RAP-CM-XD, in all countries legislation relevant to child maltreatment and its prevention was in force. Almost 90% or more of key informants in all countries, except Saudi Arabia, were aware such legislation existed. In Saudi Arabia 39% believed there was no such legislation in force. ANOVA tests with Scheffe post-hoc tests ($p<0.5$) indicated that Saudi Arabia's score on this item was lower than all other countires. The legislation of two of these countries – Brazil's Statute on Children and

Adolescents 1990 and South Africa's recent Children's Act 2005 – is often held up as being among the most advanced in the world.

There was a marked and consistent pattern across countries in findings from both RAP-CM-I and RAP-CM-XD indicating that while legislation, agencies mandated with CMP, and CMP policies existed, none was considered to contribute to preventing CM particularly effectively. Another finding on both RAP-CM-I and RAP-CM-XD was that official policies specifically addressing CM existed less often than legislation or agencies officially mandated with CM. For instance, the research teams in Brazil and Saudi Arabia replied that no such policies exist in their countries.

Dimension 6 (will to address problem): Less than half of key informants in all countries considered that political leaders were willing, in spite of the pressure of electoral cycles, to invest in long-term CMP programmes – and this figure shrank to 26.2% in Malaysia. Research teams in three out of five of the countries (FYR of Macedonia, Malaysia, and South Africa) rated political leaders willingness to invest in long-term CMP programmes as "unclear", rather than judging political leaders to be unwilling to invest in long-term CMP programmes.

Less than half of informants in all countries thought that the general public perceives CMP to be a serious problem in the country – with the highest percentage in Saudi Arabia (43.9%) and the lowest in Brazil (17.1%). Research teams' views contrasted with this: South Africa and FYR of Macedonia judged it to be perceived as a serious problem by the general public, Malaysia and Saudi Arabia as "neither serious nor not serious", and Brazil as "not serious".

Dimension 8 (material resources): In all five countries, only about a third of key informants (range 31.7-39%) thought there were any dedicated budgets for CMP in government departments or ministries. The research teams from Brazil, FYR of Macedonia, and Malaysia confirmed that such budgets existed in these three countries, suggesting that the existence of dedicated budgets in these countries is not widely known among the key informants. Attitudes of potential funders were generally judged to be more positive by the research teams than by the key informants , but were viewed as particularly unsupportive in Brazil by both key informants and research teams.

Dimension 9 (human and technical resources): Key informants and especially research teams in most countries scored this dimension the lowest. Less than 8% of key informants in Malaysia, Saudi Arabia, and South Africa thought the number of professionals specializing in CMP was adequate for large-scale implementation of CMP programmes – with this percentage going down to 2.4% in South Africa. In Brazil this percentage went up to 19.5% and in FYR of Macedonia to 30%. ANOVA tests with Scheffe post-hoc tests ($p<0.05$) showed that only in Macedonia's case was the score significantly different from Malaysia, Saudi Arabia, and South Africa, but not Brazil. None of the research teams judged the number of professionals specializing in CMP to be adequate for large-scale implementation of CMP programme.

Similarly, in three out of five countries, less than 10% of key informants thought that the number of institutions providing training and education in CMP was adequate for large-scale implementation of CMP programmes – as low as 4.9% in Saudi Arabia. The two exceptions were South Africa, where 53.7% of key informants thought the number of such institutions was adequate and, to a lesser extent, FYR Macedonia, where 22% of key informants thought they were adequate. But ANOVA tests with Scheffe post-hoc tests ($p<0.05$) showed that only in

South Africa's case was the score significantly different (from all other countries). Confirming this, the South African research team was the only one which judged the number of institutions providing training and education in CMP to be adequate for large-scale implementation of CMP programmes.

Association between scores and key informant characteristics measured

Given the differences found among key informant characteristics in the five countries on gender, years of experience working in child maltreatment prevention, and type of organization they were working for (Table 3), possible associations between these characteristics and total scores and scores on the ten dimensions of RAP-CM-I were explored.

Association between gender and total scores and dimensional scores: Based on the point biserial correlation (for nominal and interval level variables), gender and total score on RAP-CM-I were not significantly correlated in the full sample aggregated across the five countries. T-test (with alpha adjusted to 0.001 due to the large number of tests run) did not identify any significant differences between male and female key informants on either total scores or scores on the ten dimensions.

Association between years of experience in child maltreatment prevention and total scores and dimensional scores: In the full sample, aggregating the five country samples of key informants, a weak but significant correlation was found between years of experience in CMP and total scores on RAP-CM-I (r= 0.253, p<0.01 – 2-tailed; R^2 = 0.0.64). Weak but significant correlations were also found between years of experience in CMP and scores on Dimensions 1 (attitudes [r= 0.277, p=0.001 – 2-tailed]), 3 (scientific data [r= 0.166, p=0.043 – 2-tailed]), 4 (programmes [r= 0.259, p=0.002 – 2-tailed]) and 7 (institutional links and resources [r=0.228, p=0.004 – 2-tailed]). None of the correlations between years of experience in CMP and total scores or scores on individual dimensions reached significance within countries (with alpha adjusted to 0.001 due to the large number of tests run).

Type of organization informants work for: A dichotomous variable made up of two values, governmental and all other types of organization was created and, based on the point biserial correlation, type of organization and total score on RAP-CM-I was found to be weakly correlated in the full aggregated sample (r= 0.2, p<0.01, R^2 = 0.04) with informants from governmental organizations scoring higher than those from all other types of organizations.

T-test (with alpha adjusted to 0.001 due to the large number of tests conducted) identified a number of significant differences in total scores and scores on the ten dimensions between key informants from governmental and all other types of organizations. In the full aggregated sample of all key informants from all countries, in cases where significant differences (p>0.001) were found, key informants from governmental organizations consistently scored higher: Dimension 1 (attitudes, 4.8 vs. 3.8/10); Dimension 6 (will to address problem, 4.7 vs. 3.6), Dimension 8 (material resources, 3.5 vs. 2.3).

No significant (p<0.001) differences were found between scores on dimensions and overall scores and type of organization key informants worked for within countries.

Correlations between the background characteristics of the five countries and total scores on RAP-CM-I were explored but none reached significance, due probably to the small sample of only five countries. A few of these relationships were nonetheless suggestive with, for instance, countries with a higher GDP per capita and a higher score on the human development index (except for South Africa) appearing to have higher total scores on RAP-CM-I.

Table 8: Summary of countries' readiness to implement evidence-based child maltreatment prevention programmes on a large scale and conclusions and key recommendations of country reports

(Total scores out of 100; scores on dimension out of 10; rank out of 5 countries)

Brazil	TFYR of Macedonia	Malaysia
RAP-CM-I: Total score: 31.2, rank: 5th; lowest* scores of any country on all dimensions but Dimension 2 (knowledge).	**RAP-CM-I:** Total score: 45.8; rank: 1st; scores highest of any country on Dimensions 1 (attitudes), 5 (legislation), 9 (human and technical resources), and 10 (informal social resources), but lowest on Dimension 2 (knowledge).	**RAP-CM-I:** Total score: 43.7; rank: 2nd; scored highest of any country on Dimensions 3 (scientific data), 4 (programmes), and 7 (institutional links and resources.
RAP-CM-XD: Total score: 35.2; rank: 5th; lowest score of any country on Dimensions 3 (scientific data), 4 (programmes), 6 (will to address problem), 9 (human and institutional resources), and 10 (informal social resources).	**RAP-CM-XD:** Total score: 48.8; rank: 2nd; scored highest of any country on Dimensions 5 (legislation), 8 (material resources) and lowest on Dimension 7 (institutional links and resources).	**RAP-CM-XD:** Total score: 56.0; rank: 1st; scored highest of any country on Dimension 3 (scientific data), 4 (programmes), 6 (will to address problem), 8 (material resources), and 9 (human and institutional resources).
Comparison RAP-CM-XD and I: Small difference of 3.94 between total scores; differences of 3.89 and 2.2 points on Dimensions 4 (programmes), and 7 (institutional links and resources) respectively – with score on RAP-CM-XD higher; lowest scores on both RAP-CM-I and RAP-CM-XD on Dimensions 3(scientific data), 4 (programmes), 6 (will to address problem), 9 (human and institutional resources), and 10 (informal social resources).	**Comparison RAP-CM-XD and I:** Small difference of 3.01 between total scores; difference of almost 6 points on Dimension 4 (programmes) and of 2.73 on Dimension 8 (material resources) – with scores on RAP-CM-XD higher.	**Comparison RAP-CM-XD and I:** largest different on total scores of 12.31; difference of 5.12 on Dimension 4 (programmes), and differences of between 2 and 3 on Dimensions 5 (legislation), 6 (will to address problem) and 8 (material resources) – with scores on RAP-CM-XD higher. Scores on Dimensions 3 (scientific data) and 4 (programmes) highest on both RAP-CM-I and RAP-CM-XD.
Conclusion: Child maltreatment prevention readiness is very low in Brazil and, thus, the country is ill-prepared to implement child maltreatment programmes on a large scale. In particular, scientific data on, and the will to address the problem appear weak, existing CMP programmes are rare, human and institutional capacity are extremely inadequate, and informal social resources in Brazil are very low.	**Conclusion:** FYR of Macedonia's readiness to implement CMP programmes on a large scale is higher than most other countries, but still doesn't reach an overall scores of 50%. The political priority of child maltreatment prevention has been growing and it is starting to be recognized as equally important as child protection. A particular strength appears to be the legislation, mandates, and policies relevant to CMP; and area of particular weakness appears to be links between institution working in the field.	**Conclusion:** Malaysia appears to be roughly at the half-way mark in terms of readiness to implement large-scale CMP programmes. Two areas of particular strength, relative to the other countries, are the availability of scientific data on CM (but not of a national prevalence study) and the greater number of existing CMP programmes. Nevertheless, greater political will and public support needs to be fostered to change attitudes towards child maltreatment and to promote children's rights and individuality.
Main recommendations: (1) collect better data on the nature, magnitude, and distribution of child maltreatment, with priority given to conducting regular nationally representative surveys on violence against children; (2) increase knowledge exchange between researchers and with policy-makers to increase the will to address the problem; and (3) the top-most priority is to foster professional education and training in child development – including child maltreatment prevention.	**Main recommendations:** (1) increase the political priority of CMP by emphasizing its long-term benefits; (2) strengthen data collection on CM and its prevention, disseminate data widely, and increase the influence of scientific evidence by establishing a centre for data and research on CMP; (3) increase current programme implementation and evaluation, particularly through dedicated budgets; (4) media campaigns to increase public and professional awareness of issue; (5) establish national council/body for CMP to strengthen links between institutions working in the area; (6) increase funds available for CMP by created separate budget in government and by fundraising; and (7) increase human and technical resources by closer collaboration with international organization on technical support, by increasing availability of university training on CMP, and creating posts in the area of CMP.	**Main recommendations:** (1) improve attitudes towards child maltreatment, by increasing awareness of its long-term consequences and the importance of healthy early child development; (2) increase knowledge of CMP, through, for instance, a sustained media campaign about all aspects of the issue; (3) increase availability of scientific data by creating a national data collection system and national clearing house on the issue to strengthen political will and public support for the issue; (4) implement evidence-based prevention programme and monitor and evaluate them; (5) improve human and technical resources by, for example, enhancing collaboration between academic institutions and professionals and increasing funding for training; and (6) ensure systematic collaboration between NGOs, religious organizations, and the corporate sector in CMP.

*Lowest and highest scores refer to lowest and highest scores on the dimension relative to the scores other countries obtained on the same dimension.

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Saudi Arabia	South Africa
RAP-CM-I: Total score: 43.7; rank: 3rd; score very close to that of Malaysia (47.73); highest score of any country on Dimensions 6 (will to address problem) and 8 (material resources).	**RAP-CM-I:** Total score: 41.4; rank: 4th; highest score of any country on Dimensions 2 (knowledge).
RAP-CM-XD: Total score: 40.4; rank: 4th; scored highest of any country on Dimension 10 (informal social resources), but lowest on Dimension 1 (attitudes), 2 (knowledge), 5 (legislation, mandates, and policies).	**RAP-CM-XD:** Total score: 46.7; rank: 3rd; highest scores of any country on Dimensions 1 (attitudes), 2 (knowledge), but lowest on Dimension 8 (material resources).
Comparison RAP-CM-XD and I: Small difference of -3.31, but Saudi Arabia is the only country where scores on RAP-CM-I exceed those on RAP-CM-XD; difference of 3.29 on Dimension 4 (programmes) with scores on RAP-CM-XD higher; and differences of 2.39 and 2.12 on Dimensions 1 (attitudes) and 2 (knowledge), with score on RAP-CM-I higher.	**Comparison RAP-CM-XD and I:** Moderate difference of 5.27; difference of 3.68 on Dimension 4 (programmes) with scores on RAP-CM-XD higher; and differences of 2.75 on Dimensions 8 (material resources) with score on RAP-CM-I higher. Scores on Dimension 2 (knowledge) highest for both RAP-CM-I and RAP-CM-XD.
Conclusion: Saudi Arabia readiness to implement large-scale evidence-based child maltreatment prevention programs is low. A particular area of weakness is human and technical resources, while the country's strengths lie in its informal social resources and will to address the problem.	**Conclusion:** Overall South Africa shows a low level of readiness. While legislation and policies on paper were generally judged to be good, their implementation remains inadequate. A particular strength of the country is the knowledge of key players about issue. Two areas of particular weakness are links between, and resources of, institutions involved in CMP and material resources.
Main recommendations: (1) implement small-scale evidence-based child maltreatment prevention programmes as pilot projects in several areas; (2) increase human and material resources to ensure smooth implementation of the programmes; (3) launch public education campaign to raise the awareness about the severity of child maltreatment and of its consequences and its preventability; (4) conduct a national survey to assess the magnitude of child maltreatment in the country; (5) develop standard definitions and procedures for recording child maltreatment cases; (6) setup a system for data collection and dissemination with clear protocols; (7) train adequate staff to collect, manage, and analyze data and information on child maltreatment and its prevention; (8) advocate for children's rights and CMP among legislators and law enforcement personnel; and (9) conduct evaluations on child maltreatment prevention programmes regularly.	**Main recommendations:** (1) Place CMP high on the political agenda; (2) recognize that prevention works best when integrated into broader programmes, such as maternal health, child immunization, and early childhood development; (3) improve the knowledge of key players about the immediate and long-term consequences of child maltreatment as a means of advocating for more attention to CMP in government departments; (4) increase funding for data collection to understand the magnitude of the problem, in particular for a national prevalence study; (5) advocate for increased political priority and more funds for CMP; and (6) integrate child maltreatment prevention programmes in health services already in place for families, e.g. family planning and reproductive health programmes

Discussion

The assessment of the state of readiness of Brazil, FYR of Macedonia, Malaysia, Saudi Arabia, and South Africa using RAP-CM indicates that these countries range from being in a very low to a moderate state of readiness to implement evidence-based child maltreatment prevention programmes on a large scale. The only score above 50% was that of the assessment by the research team in Malaysia using all available data (RAP-CM-XD), which reached 56.0%. Countries' rankings and scores on RAP-CM-I (based on interviews with key informants) were as follows: FYR of Macedonia (1st, 45.8); Malaysia (2nd, 43.7); Saudi Arabia (3rd, 43.7); South Africa (4th, 41.4); and Brazil (5th, 31.2). The differences between countries' total scores were not, however, always significant. Their rankings and scores on RAP-CM-XD were: Malaysia (1st, 56.0), FYR of Macedonia (2nd, 48.8), South Africa (3rd, 46.7), Saudi Arabia (4th, 40.4) and Brazil (5th, 35.2).

The mean resulting from combining the scores on each dimension of RAP-CM-XD and RAP-CM-I (Table 7) was highest on Dimension 2 (knowledge, 6.6 [SD: 0.5]), Dimension 5 (legislation, mandates, and policies, 5.5 [SD: 1.1]), and lowest on Dimension 9 (human and technical resources, 2.4 [SD: 0.8]) and Dimension 8 (material resources, 3.4 [SD: 1.1]).

Overall differences between scores on RAP-CM-XD and RAP-CM-I were slight in the case of most countries, other than Malaysia, where differences were somewhat more marked. Scores in all countries other than Saudi Arabia were higher on RAP-CM-XD than on RAP-CM-I. The only dimension on which differences were large and consistent was Dimension 4 (programmes), with scores on RAP-CM-XD considerably higher. On Dimension 3 (scientific data) scores on RAP-CM-I were consistently higher than on RAP-CM-XD but the differences were smaller.

A weak positive correlation was found between the number of years key informants had worked in child maltreatment and scores on RAP-CM-I, and a similarly weak correlation was found between whether or not a key informant worked for a government organization and scores on RAP-CM-I, with those working for governmental organizations scoring somewhat higher.

A high degree of consistency was found among the recommendation made by the country research teams to increase readiness (Table 8). All countries included the following among their recommendations (1) increase human and technical resources in the country better to address the problem, (2) improving data collection on child maltreatment and its prevention, and (3) further raising awareness of the issue to increase the will to address it.

To our knowledge, this is the first time that the readiness of any country to implement evidence-based child maltreatment programmes on a large scale has been systematically assessed. While these results have potentially important implications, the absence of normative and validation data for the instrument means interpretations of these findings must remain somewhat tentative. The instrument, the development of which has followed the standard stages of instrument development, remains nonetheless, as in the case of most such instruments, a work in progress. Measuring a country's readiness to implement CMP programmes on a large scale is a particularly complex exercise in sociometrics which tries to capture a multi-dimensional construct distributed throughout a society. In the absence of normative data, we have deliberately placed as much emphasis on countries' relative positions to each other on RAP-CM (i.e. rankings) as on scores. Although some of the psychometric properties of RAP-CM-I, such as its factor

structure and the internal consistency reliability of the 10 scales underlying the 10 dimensions, have been explored (see Mikton and Power, in preparation) and found to be acceptable, data on the construct validity of the instrument – such as its predictive, concurrent, discriminant, and convergent validity – is still missing. Applying the instrument in a HIC in which CMP programmes are known to have been implemented on a large scale and confirming that the country achieves a high or very high score on RAP-CM would be straightforward way of generating some initial data validating the instrument.

RAP-CM has identified several major consistent gaps in the readiness of all five of the included countries. These gaps should be given serious consideration when setting priorities, allocating funds in this field, and deciding on the scale of CMP programmes that can be implemented in these countries. One of the most important of these gaps was on Dimension 9 (human and technical resources) which received consistently very low scores across most countries on both RAP-CM-I and RAP-CM-XD. This dimension concerned the availability of sufficient professionals with the skills, knowledge and expertise to implement CMP programmes on a large scale and institutions to train these professionals. The vast majority – and up to 97% in South Africa – did not think that the number of professionals specializing in CMP was adequate for large-scale implemention of CMP programmes. The view among experts responding to RAP-CM-XD was that the number of professionals specializing in CMP would only allow small-scale pilot programmes in one or several areas of the country. Other significant gaps identified were on Dimension 8 (material resources) which includes the availability of sufficient funding, infrastructure, and equipment; and to some extent on Dimension 1 (attitudes) which assess key actors perceptions, understanding, and attitudes related to child maltreatment. Another weakness revealed by this assessment is that informants appeared not to be aware of child maltreatment programmes that had been implemented in their countries – as indicated by low scores on Dimension 4 (programmes) on RAP-CM-I and higher scores on this dimension on RAP-CM-XD. Furthermore, the extreme rarity of outcome evaluations of CMP programmes identified in this assessment is a cause for concern. The knowledge of key informants appeared adequate, as did the legislation in most countries, though not its implementation. In spite of the somewhat higher scores on the dimension related to the availability of scientific data in most countries (Dimension 3), none of these countries had carried out a nationally representative survey of child maltreatment at the time this readiness assessment was carried out. In sum, this assessment of readiness clearly suggests that these countries are by no means ready for a large-scale roll out of CMP programmes.

Similarly, in three out of five countries, less than 10% of key informants thought that the number of institutions providing training and education in CMP was adequate for large-scale implementation of CMP programmes – as low as 4.9% in Saudi Arabia. The two exceptions were South Africa, where 53.7% of key informants thought the number of such institutions was adequate and, to a lesser extent, FYR Macedonia, where 22% of key informants thought they were adequate. But ANOVA tests with Scheffe post-hoc tests ($p<0.05$) showed that only in South Africa's case was the score significantly different (from all other countries). Confirming this, the South African research team was the only one which judged the number of institutions providing training and education in CMP to be adequate for large-scale implementation of CMP programmes.

The main recommendations made by the research teams for increasing readiness – increase human and technical resources, improve scientific data, and raise awareness – broadly coincided with the gaps identified on RAP-CM-I. One possible reason recommendations and gaps did not match more closely may be that most countries scored low – five points or less – on many or most of the dimensions of RAP-CM, making it difficult to single out the most important gaps. In fact, little is known about exactly which of these dimensions or combination of dimensions of readiness is most important for the effective and sustainable large-scale implementation of child maltreatment prevention programmes – as is the case of other similar approaches to assessing capacity or readiness in other areas (Baker and Teaser-Polk, 1998; Brown et al., 2001; Ebbesen et al., 2004; Laverack, 2001). Ascertaining the optimal weighting of the 10 dimensions of RAP-CM-I and RAP-CM-XD would require longitudinal studies with long follow-up periods to see which dimensions are most predictive of successful implementation of effective programmes.

The higher total scores on RAP-CM-XD than RAP-CM-I in all countries, except Saudi Arabia, was anticipated as key informants were expected to be in possession of less accurate factual knowledge than the research team completing RAP-CM-XD on the basis of all available data. Over 70, of key informants in Saudi Arabia were from government organizations (Table 2) and the it was found that in the aggregate sample – see section on associations between type of organization and scores – that key informant working for government organizations scored higher on RAP-CM-I. That the main consistent contributor to the higher scores on RAP-CM-XD was Dimension 4 (programmes) confirms this hypothesis. To achieve higher scores on this dimension requires detailed knowledge of specific programmes that have been implemented. Likewise, the more detailed factual knowledge of legislation, mandates, and policies of research teams using all available data probably also accounts for the generally higher scores on Dimension 5 on RAP-CM-XD. The consistently – though only slightly – higher scores on Dimension 3 (scientific data) on RAP-CM-I is not surprising since items for this dimension only asked whether or not different types of scientific data existed and did not ask for specific data or details of studies to be provided. The slightly higher scores on Dimension 3 (scientific data) on RAP-CM-I would indicate that key informants somewhat overestimate the availability of scientific data in the country due perhaps to their limited factual knowledge. The generally higher scores – by up to 2.5 points (Table 6) – on Dimension 6 (will to address problem) on RAP-CM-XD than on RAP-CM-I are difficult to interpret. Is it that being in possession of all or at least more of the available data leads experts to form a more accurate assessment of the will to address the problem than informants? Or is that experts are so deeply immersed in the field that their assessment of the will to address the problem of child maltreatment prevention in their countries ends up being slightly over-optimistic?

Comparing the results of RAP-CM-I and RAP-CM-XD provides useful insights. Important knowledge fails, it appears, to reach key actors in the field in most of these countries: for instance, knowledge about CMP programmes that have been implemented in the country; knowledge about existing scientific data (informants slightly overestimate the availability of such data); knowledge about the existence of dedicated budgets for CMP; and, to a lesser extent, knowledge about legislation, mandates, and policies relevant to CM, where, for instance, key informants were not always aware of the existence of legislation. Addressing these gaps and ensuring that those key actors with significant decision-making power over formulating policy and commissioning programmes or research know about existing programmes, data, legislation, mandates, and policies is critical. This would be comparatively easy to address through, for

instance, training and awareness raising sessions for key actors, and the creation of a national clearinghouse for data on CMP.

A comparison of findings on RAP-CM-XD and RAP-CM-I also highlights the similarity in scores on many dimension: some 42 % of differences on scores on dimension across the five countries were of less than 1 point – particularly on Dimensions 2 (knowledge), 3 (scientific data), 6 (will to address problem), and 10 (informal social resources). This suggests that when very specific factual knowledge is not required (e.g. about the implementation of specific programmes in specific parts of the country), key informants and experts using all available data reach very similar conclusions. The relatively high scores on Dimension 2 (knowledge) by both informants (mean across countries of 6.7 – the highest mean score – and standard deviation 0.6) and experts (mean 6.5 and standard deviation 0.9) is one somewhat brighter spot in an otherwise overall very negative assessment of child maltreatment prevention readiness in these countries.

The correlations – albeit weak – between key informants' years of experience working in child maltreatment and scores on RAP-CM-I and between the type of organization they work for and scores on RAP-CM-I indicate that scores on RAP-CM-I are partly dependent on these – and perhaps other unmeasured – sample characteristics. In the case of years of experience working in CMP of key informants, it is likely that those informants with more years of experience scored higher on RAP-CM-I because of the greater knowledge and expertise of the field they have acquired over time. However, as explained in the *Methods* section, RAP-CM-I has a dual aim: (1) to assess the readiness of the key actors in the field in the country by ascertaining their perceptions, underlying beliefs, attitudes, and knowledge concerning CMP; and (2) to collect "objective" information to evaluate the readiness of the country to implement CMP programmes. Determining that most of the key actors in CMP in a country have on average fewer years of experience in the field of CMP and are therefore – as indicated by the correlation between years of experience and scores on CMP – slightly less ready, is itself an important finding. Its validity, however, depends on the sample of key informants being representative of the population of key actors in the field of CMP in the country. The difficulties research teams reported in recruiting more senior key informants in Brazil and FYR of Macedonia suggest that the samples of key informants in these countries may not have been representative of the full population of key actors and sectors in the field and may contain an over-representation of more junior actors and, in the case of South Africa, of informants from the child protection services.

A possible explanation for the somewhat higher scores of key informants working for government organizations compared to key informants working for other types of organizations (for instance, non-governmental organization, community-based organizations, university and research institutes) may be that their position in the national government provides them with a vantage point from which they can build up a more comprehensive and accurate picture of the readiness of the country to implement CMP programmes on a large scale.

The regularities across countries in scores on a number of dimension on both RAP-CM-I – for instance, low scores on Dimensions 4 (progammes), 8 (material resources) and 9 (human and institutional capacity) – and RAP-CM-XD – for instance, high scores on Dimensions 2 (knowledge), 4 (programmes), and 5 (legislation, mandates, and policies) – raise a number of questions. Do they reflect real similarities in the countries' state of readiness, due perhaps to some common characteristics of the countries such as all the being upper-middle-income

countries? Or are they the result of a measurement artefact, perhaps scales that discriminate poorly on these dimensions and result in scores that are too tightly clustered together producing a false impression of similarity?

Since this is the first attempt to assess the readiness or capacity to implement CMP programmes on a large scale in any country, there are few data with which to compare the findings. The Special Representative of the UN Secretary General on Violence against Children will soon publish a global survey to help map and assess progress in the implementation of the 2006 recommendations of *United Nations Secretary-General's Study on Violence against Children* (UN, 2006). The aim of the survey is to "assess progress in the prevention and elimination of violence against children, to gain perspective on achievements made, to reflect on good practices and factors of success, and to boost efforts to overcome persisting challenges and consolidate the prevention and elimination of violence" (UN 2012). Results of the survey, to which over 100 governments submitted contributions, will be published in late 2012. Based on the analysis conducted so far the survey notes that violence against children is gaining visibility on the national agenda, with increasing legislative action, policy interventions and information campaigns on the topic, and with some promising efforts aimed to capture the prevalence of this phenomenon. However, in its summing up the preliminary conclusions of the survey, the Annual Report of the Special Representative of the Secretary-General on Violence against Children to the UN General Assembly echoes many of the conclusions of the assessment of child maltreatment prevention readiness in the five countries presented in this report This Annual Report concludes that "progress remains uneven, with insufficient efforts to develop a cohesive and well-resourced national strategy on violence against children; uncoordinated policy interventions; dispersed and ill-enforced legislation; insufficient investment in family support, in capacity-building for professionals, and in safe and child-sensitive mechanisms to address incidents of violence; and overall, with scarce data and research to break the invisibility of this phenomenon and promote evidence-based decision-making. A closer examination of data from this global survey, however, indicated that the methodology and focus of this survey does not allow are closer comparison with the ten dimensions of readiness of RAP-MC. Nor are the reports submitted to the Committee on the Rights of the Child by states party to the Convention on the Rights of the Child easily comparable with these findings using RAP-CM.

The study has several limitations. First, normative and validation data on the instruments are lacking. In a review of some 26 existing models and approaches relevant to the assessment of child maltreatment prevention readiness identified through a comprehensive review of the literature, less than a third of the models examined were found to have undergone any form of empirical validation, even though some of them have been widely applied (Mikton et al., 2011).

Second, research teams were initially asked to assess readiness at both the national level and the sub-national level (e.g. province or state). However, the samples on which RAP-CM-I findings presented here are based combine key informants from both national and sub-national levels to assess countries' overall level of readiness. RAP-CM-XD was only used to assess readiness at national level. It is unlikely that merging these two samples to assess the countries' overall readiness affected results in any important way, given that the majority of key informants were from the national level and analyses of differences in scores between national and sub-national level key informants identified no significant differences.

Third, for RAP-CM-I, purposive samples of key informants were selected the representativeness of which is not known. Assessing the representativeness of samples would require defining the population of all "key informants" in the country, which this study did not do. A possible bias in the selection of the sample in some countries may have been introduced due to senior key informants being reluctant to participate in the study resulting in an overrepresentation of key informants with fewer years of experience in CMP.

Fourth, the focus of this report on the findings from all five countries precluded providing a richer and more differentiated analysis of the findings for each individual country. For more detail on each country, readers are referred to the individual reports by Cardia et al. (2012 - Brazil), Raleva et al. (2012 – TFYR of Macedonia), Chea et al. (2012 – Malaysia), Almuneef et al. (2012 – Saudi Arabia), and Makoae et al., (2012 – South Africa) – available on the WHO web-site.

Fifth, we decided to develop two parallel versions of the instrument – RAP-CM-I and RAP-CM-XD – rather than a single one on the grounds that the differences and similarities between them would be more informative than an assessment based only on key informants or only on experts using all available data. The differences in scores found on RAP-CM-I and RAP-CM-XD and their implications – described above – seem to have justified this choice to an extent. Yet the relative weight that should be attributed to the findings from these two parallel versions of the instrument in an overall assessment of readiness of the country is unclear and could probably only be determined through a series of prospective studies. However, the many convergences in the scores on RAP-CM-I and RAP-CM-XD and the considerable time and work required to administer these two parallel versions of these semi-structured interviews has led us to develop a short version of RAP-CM-I – RAP-CM-SV, which takes approximately 15 minutes – administered solely to informants as a rapid assessment of child maltreatment prevention readiness (available on the WHO web-site). Overall and dimensional scores on RAP-CM-SV are very highly correlated with RAP-CM-I.

Conclusion

According to this assessment using RAP-CM – the first of its kind – the readiness of Brazil, FYR of Macedonia, Malaysia, Saudi Arabia, and South Africa to implement evidence-based CMP programmes on a large-scale ranges from a very low in Brazil and moderate in FYR of Macedonia and Malaysia.

Daro and Donnelly (2002), in a paper entitled "Charting the waves of prevention: two steps forward, one step back" warn that proponents of CMP in the USA have repeatedly overstated prevention's potential and have allowed rhetoric to outpace research and empirical support. The weak evidence-base for the effectiveness of programmes to prevent CM, particularly in LMIC, as indicated by the almost total absence of outcome evaluation studies in almost all of the countries included in this assessment of readiness, is one reason to heed this warning internationally[5] (MacMillan et al., 2009; Mikton and Butchart, 2009; Knerr et al., 2011). But these findings suggest an equally compelling reason to be cautious. Even if a full armamentarium

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[5] The evidence-base for the effectiveness of child protection is, however, no stronger (e.g. MacMillan et al., 2009)

of CMP programmes proven to be effective in LMIC was available, the low state of readiness of these five countries – and probably of many other LMIC countries – to implement evidence-based CMP programmes on a large scale is cause for serious concern. It should act as an incentive to make concerted efforts to increase the readiness of countries so that rhetoric concerning CMP in LMIC, where most of the world's children live, does not outpace real possibilities for change. The shift from child protection services to CMP that is occurring nationally in many countries and globally represents a major opportunity to reduce significantly the high rates of child maltreatment in many part of the world and its severe and far-reaching life-long consequences. Conducting a careful assessment of a country's readiness to implement evidence-based CMP programmes and then, more importantly, taking effective measures to address the gaps identified to ensure the success of programmes implemented is a critical element in any strategy that claims to be evidence-based or evidence-informed. There is a risk that the field is setting itself up for disappointment by over-stating the case of CMP in LMIC and that the momentum that has been generated in recent years peters out without reducing the prevalence of child maltreatment in any way. The method of assessing the readiness of countries to take evidence-based CMP programmes to scale used in this study will, it is hoped, contribute to narrowing what appears to be a widening gap between rhetoric and reality.

References

Al-Eissa, Y. (1991). The battered child syndrome: Does it exist in Saudi Arabia? Saudi Medical Journal, 12, 129–133.

Al-Mugeiren, M., & Ganelin, R. (1990). A suspected case of Munchausen syndrome by proxy in a Saudi child. Annals of Saudi Medicine, 10, 662–665.

Almuneef, M., Qayad, M., Al-Eissa, M., AlBuhairan, F., Noor, I., & Inam, S. (2012). Readiness Assessment of Child maltreatment Prevention in Saudi Arabia.   Retrieved 8 December 2012, 2012, from http://www.who.int/violence_injury_prevention/violence/child/en/index.html

Bangkok Charter for health Promotion in a Globalized World. (2007). Bangkok Charter for health Promotion in a Globalized World. Health Promotion International, 21(S1), 10-14.

Brundtland, G. H. (2002). Preface. In E. Krug, L. Dahlberg, J. Mercy, A. Zwi & R. Lozano (Eds.), World Report on Violence and Health Geneva: World Health Institution.

Cardia, N., Laggata, P., & Affonso, C. (2012). Readiness Assessment of Child maltreatment Prevention in Brazil.   Retrieved 8 December 2012, 2012, from http://www.who.int/violence_injury_prevention/violence/child/en/index.html

CDC – US Centers for Disease Control and Prevention (2012). Stepping in for Child Abuse Prevention.   Retrieved 8 December 2012, 2012, from http://blogs.cdc.gov/ncipc/2012/04/20/stepping-in-for-child-abuse-prevention/

Cheah, I., Choo, W., & Ramly, R. (2012). Readiness Assessment of Child maltreatment Prevention in Malaysia.   Retrieved 8 December 2012, 2012, from http://www.who.int/violence_injury_prevention/violence/child/en/index.html

Children Band Violence Evaluation Challenge Fund. (2012). Children and Violence Evaluation Challenge Fund.   Retrieved 8 December 2012, 2012, from http://www.evaluationchallenge.org/

Daro, D., & Donnelly, A. C. (2002). Charting the waves of prevention: two steps forward, one step back. Child Abuse & Neglect, 26(6-7), 731-742.

Doyle, O., Harmon, C. P., Heckman, J. J., & Tremblay, R. E. (2009). Investing in early human development: Timing and economic efficiency. Economics & Human Biology, 7(1), 1-6.

Ebbesen, L. S., Heath, S., Naylor, P. J., & Anderson, D. (2004). Issues in measuring health promotion capacity in Canada: a multi-province perspective. Health Promotion International, 19(1), 85-94.

Finkelhor, D., Lannen, P., & Quayle, E. (2011). Optimus Study: A cross-national research initiative on protecting children and youth. Synthesis. Zürich: UBS Optimus Study.

Gannon, B., & Hoffmann, W. (1996). A History of Child and Youth Care. In K. B. B & B. Gannon (Eds.), An Orientation to Child and Youth Care (Second Edition, revised 1999). Cape Town: National Association of Child Care Workers

Garner, A. S., Shonkoff, J. P., Siegel, B. S., Dobbins, M. I., Earls, M. F., McGuinn, L., et al. (2012). Early Childhood Adversity, Toxic Stress, and the Role of the Pediatrician: Translating Developmental Science Into Lifelong Health. Pediatrics, 129(1), E224-E231.

Gilbert, R., Kemp, A., Thoburn, J., Sidebotham, P., Radford, L., Glaser, D., et al. (2009). Child Maltreatment 2 Recognising and responding to child maltreatment. Lancet, 373(9658), 167-180.

Goodman, R. M., Speers, M. A., McLeroy, K., Fawcett, S., Kegler, M., Parker, E., et al. (1998). Identifying and defining the dimensions of community capacity to provide a basis for measurement. Health Education & Behavior, 25(3), 258-278.

Heckman, J. J. (2012). The developmental origins of health. Health Economics, 21(1), 24-29.

Kempe, C. H., Silver, H. K., Silverman, F. N., Droegemu.W, & Steele, B. F. (1962). Battered-child syndrome. JAMA-Journal of the American Medical Association, 181(1), 17-&.

Kilburn, M., & Karoly, L. (2008). The economics of early childhood policy: what the dismal science has to say about investing in children. Santa Monica, CA: Rand Corporation.

Knerr, W., Gardner, F., & Cluver, L. (2011). Parenting and the prevention of child maltreatment in low- and middle-income countries: a systematic review of interventions and a discussion of prevention of the risks of future violent behaviour among boys. Pretoria: Sexual Violence Research Initiative.

Knudsen, E. I., Heckman, J. J., Cameron, J. L., & Shonkoff, J. P. (2006). Economic, neurobiological, and behavioral perspectives on building America's future workforce. Proceedings of the National Academy of Sciences of the United States of America, 103(27), 10155-10162.

Krug, E., Dahlberg, L., Mercy, J., Zwi, A., & Lozano, R. (2002). World Report on Violence and Health Geneva: World Health Institution.

Laverack, G., & Wallerstein, N. (2001). Measuring community empowerment: a fresh look at organizational domains. Health Promotion International, 16(2), 179-185.

Leventhal, J. M. (2005). Getting prevention right: maintaining the status quo is not an option. Child Abuse & Neglect, 29(3), 209-213.

Lozano, R., Wang, H. D., Foreman, K. J., Rajaratnam, J. K., Naghavi, M., Marcus, J. R., et al. (2011). Progress towards Millennium Development Goals 4 and 5 on maternal and child mortality: an updated systematic analysis. Lancet, 378(9797), 1139-1165.

MacLellan-Wright, M. F., Anderson, D., Barber, S., Smith, N., Cantin, B., Felix, R., et al. (2007). The development of measures of community capacity for community-based funding programs in Canada. Health Promotion International, 22, 299-306.

MacMillan, H. L., Wathen, C. N., Barlow, J., Fergusson, D. M., Leventhal, J. M., & Taussig, H. N. (2009). Child Maltreatment 3 Interventions to prevent child maltreatment and associated impairment. Lancet, 373(9659), 250-266.

Makoae, M. (2012). Readiness Assessment of Child maltreatment Prevention in South Africa. Retrieved 8 December 2012, 2012, from http://www.who.int/violence_injury_prevention/violence/child/en/index.html

Mercy, J. A., & Saul, J. (2009). Creating a Healthier Future Through Early Interventions for Children. Jama-Journal of the American Medical Association, 301(21), 2262-2264.

Mikton, C. (2012a). Handbook for the Readiness Assessment for the Prevention of Child Maltreatment (RAP-CM). Geneva: World Health Organization

Mikton, C. (2012b). Technical report on the assessment of readiness to implement evidence-based child maltreatment prevention programmes of Brazil, the Former Yoguslav Republic of Macedonia, Malaysia, Saudi Arabia, and South Africa. Geneva: World Health Organization.

Mikton, C., & Butchart, A. (2009). Child maltreatment prevention: a systematic review of reviews. Bulletin of the World Health Organization, 87(5), 353-361.

Mikton, C., Mehra, R., Butchart, A., Addiss, D., Almuneef, M., Cardia, N., et al. (2011). A Mulitdimensional model for child maltreatment prevention readiness in low- and middle-income countries. Journal of Community Psychology, 39(7), 826-843.

Mikton, C., & Power, M. (in preperation). The development and psychometric properties of the Readiness Assessment for Child Maltreatment Prevention.

Office/UNICEF, Z. N. S. (2012). National baseline survey of life experiences of adolescents - prelimary report. Harare, : Zimbabwe National Statistics Office/UNICEF.

OHCHR, (2012). Convention on the Rights of the Child Retrieved 8 December 2012, 2012, from http://www2.ohchr.org/english/law/crc.htm

OHCHR, (2012). General Comment 13 - The right of the child to freedom from all forms of violence Retrieved 8 December 2012, 2012, from http://www2.ohchr.org/english/bodies/crc/comments.htm

Prinz, R. J., Sanders, M. R., Shapiro, C. J., Whitaker, D. J., & Lutzker, J. R. (2009). Population-Based Prevention of Child Maltreatment: The US Triple P System Population Trial. Prevention Science, 10(1), 1-12.

Raleva, M., Filov, I., Trpchevska, L., Coneva, A., & Jordanova-Peshevska, D. (2012). Readiness Assessment of Child maltreatment Prevention in the Former Yugoslav Republic of Macedonia. Retrieved 8 December 2012, 2012, from http://www.who.int/violence_injury_prevention/violence/child/en/index.html

Reza, A., Breiding, M. J., Gulaid, J., Mercy, J. A., Blanton, C., Mthethwa, Z., et al. (2009). Sexual violence and its health consequences for female children in Swaziland: a cluster survey study. Lancet, 373(9679), 1966-1972.

Shonkoff, J. P., Boyce, W. T., & McEwen, B. S. (2009). Neuroscience, Molecular Biology, and the Childhood Roots of Health Disparities Building a New Framework for Health Promotion and Disease Prevention. Jama-Journal of the American Medical Association, 301(21), 2252-2259.

Shonkoff, J. P., Garner, A. S., Comm Psychosocial Aspects Child, F., Comm Early Childhood Adoption, D., & Sect Dev Behav, P. (2012). The Lifelong Effects of Early Childhood Adversity and Toxic Stress. Pediatrics, 129(1), E232-E246.

SRSG-VAC – Special Representative of the Secretary General on Violence against Children (2012). Mandate of Special Representative of the Secretary General on Violence against Children. Retrieved 8 December, 2012, from http://srsg.violenceagainstchildren.org/srsg/mandate

Stoltenborgh, M., van Ijzendoorn, M. H., Euser, E. M., & Bakermans-Kranenburg, M. J. (2011). A Global Perspective on Child Sexual Abuse: Meta-Analysis of Prevalence Around the World. Child Maltreatment, 16(2), 79-101.

UBS Optimus Study. (2012). UBS Optimus Study.   Retrieved 8 December 2012, 2012, from http://www.optimusstudy.org/

TfG. (2012). Together for Girls.   Retrieved 8 December, 2012, from Together for Girls

UN. (2006). World report on violence against children. New York: United Nations

UN. (2012). Annual report of the Special Representative of the Secretary-General on Violence against Children to the UN General Assembly. New York: United Nations Organization.

UNICEF. (2006). Africa's Orphaned and Vulnerable Generations: Children Affected by AIDS New York: UNICEF.

UNICEF, US-CDC., and Muhimbili University of Health and Allied Sciences. (2011). Violence Against Children in Tanzania Findings from a National Survey 2009: United Nations Children's Fund, U.S. Centers for Disease Control and Prevention, and Muhimbili University of Health and Allied Sciences.

UNICEF, US-CDC, Together for Girls, and Kenya Vision 2030. (2012). Violence against Children in Kenya: Findings from a 2010 National Survey: United Nations Children's Fund, U.S. Centers for Disease Control and Prevention, Together for Girls, and Kenya Vision 2030.

World Bank. (2012). How we Classify Countries from http://data.worldbank.org/about/country-classifications

WHO. (2012). Child maltreatment.   Retrieved 8 December, 2012, from http://www.who.int/violence_injury_prevention/violence/child/en/index.html

WHO. (2006). Preventing child maltreatment: a guide to taking action and generating evidence. Geneva: World Health Organization. Retrieved 8 December, 2012, from http://whqlibdoc.who.int/publications/2006/9241594365_eng.pdf

WHO. (2009). Violence prevention: the evidence. Geneva: World Health Organization. Retrieved 8 December, 2012, from http://www.who.int/entity/violence_injury_prevention/violence/4th_milestones_meeting/publications/en/index.html