

Handbook for the Readiness Assessment for the Prevention of Child Maltreatment (RAP-CM)



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1. INTRODUCTION

The Readiness Assessment for the Prevention of Child Maltreatment (RAP-CM) is a method to assess how “ready” a country, province, or community is to implement evidence-based child maltreatment prevention programmes on a large scale – that is programmes which seek to prevent child maltreatment (child maltreatment) before it even occurs. Readiness includes several facets including the awareness of the problem and its severity in relation to other problems (priority); the willingness or motivation to change the problem; the skills and knowledge required to address the problem; and the capacity to address the problem in terms of, for instance, financial and material resources. Once readiness to implement child maltreatment programmes on a large scale has been assessed, the next step is to increase readiness on those dimensions where this may be necessary and then implement evidence-based child maltreatment programmes on a scale commensurate with the magnitude of the problem.

RAP-CM can serve several important purposes:

- identify major gaps in readiness and inform plans to address them;
- establish a baseline measure against which progress in increasing readiness can be tracked;
- help to allocate resources to increase readiness for child maltreatment prevention;
- assist in matching an intervention to the existing level of readiness;
- act as a catalyst for taking action to prevent child maltreatment; and
- function as a teaching tool to introduce the concepts of child maltreatment prevention and child maltreatment prevention readiness to key players.

This method for assessing readiness to implement child maltreatment prevention programmes on a large scale may be of particular interest to countries just beginning to address child maltreatment. This may include countries which have, for instance, recently completely for the first time a baseline survey on child maltreatment or violence against children and which are preparing to step up activities to address the problem.

The conceptual model of readiness for child maltreatment prevention on which RAP-CM is based includes key players' attitudes towards and knowledge of child maltreatment; the availability of scientific data on child maltreatment and its prevention; willingness to take action to address the problem; and the nonmaterial (e.g. legal, policy, human, technical, and social resources) and material (e.g. infrastructural, institutional, and financial) resources available to help prevent child maltreatment.

There are two options when assessing child maltreatment prevention readiness using the RAP-CM method :

OPTION 1 – FULL ASSESSMENT: The first option results in a full and detailed assessment of child maltreatment prevention readiness and *requires a small team of two to five experienced researchers* to carry it out. It results in a list of recommended measures to increase readiness. It uses two sources of information: the views of key informants and those of a group of experts using all available data.

OPTION 2 – RAPID ASSESSMENT: The second option, which can be used if time and resources are limited, is based on a short questionnaire administered to key informants. This can be carried out by anybody familiar with administering and analyzing the results of a questionnaire survey. It does not generate any recommendations for increasing readiness, but the measures required to increase readiness can nevertheless be inferred from the gaps identified by the questionnaire. Assessment of readiness using the short questionnaire has been shown to produce results that are highly correlated with those of the full assessment (correlations of 0.9 on total scores and between 0.7 and 0.9 on scores on dimensions).

Both options are based on the same 10-dimensional model of readiness, as will be explained.

All materials required to carry out a RAP-CM assessment are available free online:

http://www.who.int/violence_injury_prevention/violence/child/en/index.html

The definition of child maltreatment RAP-CM adopted is taken from the 2006 World Health Organization – International Society for Prevention of Child Abuse and Neglect *Preventing child maltreatment: a guide to taking action and generating evidence*. Child maltreatment is defined as:

"All forms of physical and/or emotional ill-treatment, sexual abuse, neglect or negligent treatment or commercial or other exploitation, resulting in actual or potential harm to the child's health, survival, development or dignity in the context of a relationship of responsibility, trust or power" (World Health Organization/International Society for Prevention of Child Abuse and Neglect, 2006).

Child maltreatment can affect children of all ages from 0 to 18 years and can occur in many settings such as the home, schools, and the community. This project, however, focuses upon child maltreatment involving children between 0 to 12 years of age. This is the type of child maltreatment which accounts for the largest proportion of cases and which has, in most countries, been the most neglected by way of prevention efforts.

As employed by the World Health Organization (WHO) and in RAP-CM, the basic difference between child protection and child maltreatment prevention is that:

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

For further discussion of the difference between child protection and child maltreatment prevention, see Appendix 1

2. WHY THE PRIMARY PREVENTION OF CHILD MALTREATMENT IS A PRIORITY

A major shift in the field of child maltreatment has, for some time now, been under way: from responding to child maltreatment after it occurs – through, for instance care, support and treatment – to preventing it in the first place. WHO's Prevention of Violence Unit and the United States Centers for Disease Control and Prevention (CDC) have made the primary prevention of child maltreatment one of their priority violence prevention activities.

Child maltreatment now appears poised to become a global health priority for the following reasons. First, research has established that adverse childhood experiences, including child maltreatment, have life-long and far-reaching consequences for the individual. These include strong, long-lasting effects on brain architecture, psychological functioning, mental health, health risk behaviours (such as smoking, excessive drinking, physical inactivity, and unsafe sexual practices), physical health outcomes, social functioning (school, job, or relationship difficulties), life expectancy, and health-care costs (Knudsen et al., 2006; Shonkoff et al., 2009; Perry et al., 2009; Gilbert et al., 2009). Second, the full implications of these effects on human capital formation, the workforce, and, ultimately, social and economic development in low-, middle- and high-income countries are now better understood (WHO, 2008). Third, epidemiological studies have clearly established that child maltreatment is widespread. It is a global phenomenon that occurs in some low- and middle-income countries at higher rates than in wealthier countries. For instance, based on surveys in Swaziland and Tanzania almost 3 in 10 girls experience some form of sexual violence before the age of 18 and in Tanzania almost three-quarters of both females and males report experiencing serious physical violence by a relative, authority figure (such as teachers), or an intimate partner prior to the age of 18 (Reza et al., 2009; UNICEF/CDC, Muhumbili University of Health and Allied Sciences, 2011). Fourth, evidence strongly suggests that responding to, and trying to remedy the effects of child maltreatment after it occurs through care, support and treatment are both less

effective and more costly than preventing it in the first place (Kilburn and Karoly, 2008). "In the brain, as in the economy, getting it right the first time is ultimately more effective and less costly than trying to fix it later" (Heckman, 2012). Fifth, in high-income countries 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 low- and middle-income countries (LMIC) the fraction may be smaller still – when, that is, child protection services exist (Finklehor et al., 2011). Hence, given that the vast majority of victims of child maltreatment remain undetected and never benefit from child protection services, preventing child maltreatment before it occurs becomes all the more important. Finally, research has been emerging that demonstrates that child maltreatment can 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).

3. WHY AND HOW RAP-CM WAS DEVELOPED

However, evidence-based interventions alone are not sufficient to prevent child maltreatment. Other conditions must be met to ensure that these interventions can be sustainably implemented on a large-scale. These conditions are sometimes referred to as child maltreatment prevention “readiness” or “capacity” and include, for instance, adequate legislation; policies; financial, human, and institutional resources; and leadership. Evidence-based child maltreatment prevention should go beyond rigorously evaluating program effectiveness to include careful assessment of child maltreatment prevention readiness. "Matching an intervention to a community’s level of readiness is absolutely essential for success." (Plested et al., 2006).

The need for an instrument to assess readiness for child maltreatment prevention is all the more pressing in view of the increasing amount of data available on and growing awareness of child maltreatment in LMIC and the many child maltreatment prevention activities being initiated to respond to this problem. The series of national surveys on violence against children recently conducted or under way by UNICEF and CDC under the aegis of the Together for Girls partnership (Haiti, Kenya, Malawi, Philippines, Swaziland, Tanzania, Zimbabwe, and others) and by the UBS-Optimus Foundation (China and Switzerland [completed] and countries in Latin America and Africa [in preparation]) has begun to draw international attention to the problem. Many measures to respond to and prevent child maltreatment in these countries are now under discussion. But without a clear idea of the readiness and capacity of these countries, plans to prevent child maltreatment run the risk of being inappropriate and ultimately ineffective.

Given that no adequate instrument to assess readiness for child maltreatment prevention currently exists, WHO, with support from the Fetzer Foundation, decided to develop the RAP-CM method. The instrument was designed primarily, but not exclusively, for LMIC, where the prevalence of child maltreatment is often higher than in high-income countries and resources to tackle the problem are generally more limited. RAP-CM's goal is to provide a snapshot of the overall state of readiness in one setting along all main important dimensions at one point in time.

RAP-CM was developed in a rigorous multi-stage process conducted in six countries (Brazil, China, The Former Yugoslav Republic of Macedonia, Malaysia, Saudi Arabia, and South Africa). The five stages of the process were: (1) the development of a conceptual model underling RAP-CM; (2) cognitive testing of the instrument; (3) pilot testing of the instrument; (4) field testing of the instrument; (5) final revision of instrument in light of results of the field testing. For more information on the development of RAP-CM, see Appendix 2.

While the method and instruments included in this handbook are the result of a rigorous process of development, they remains a work in progress. We therefore strongly encourage all those who use this method to get in touch with us (miktonc@who.int) to discuss the possibility of collaborating to further test and refine RAP-CM. The development of RAP-CM to date has involved examining some of the

instruments' psychometric properties. However, further refinement will require testing their reliability and beginning to assess their validity.

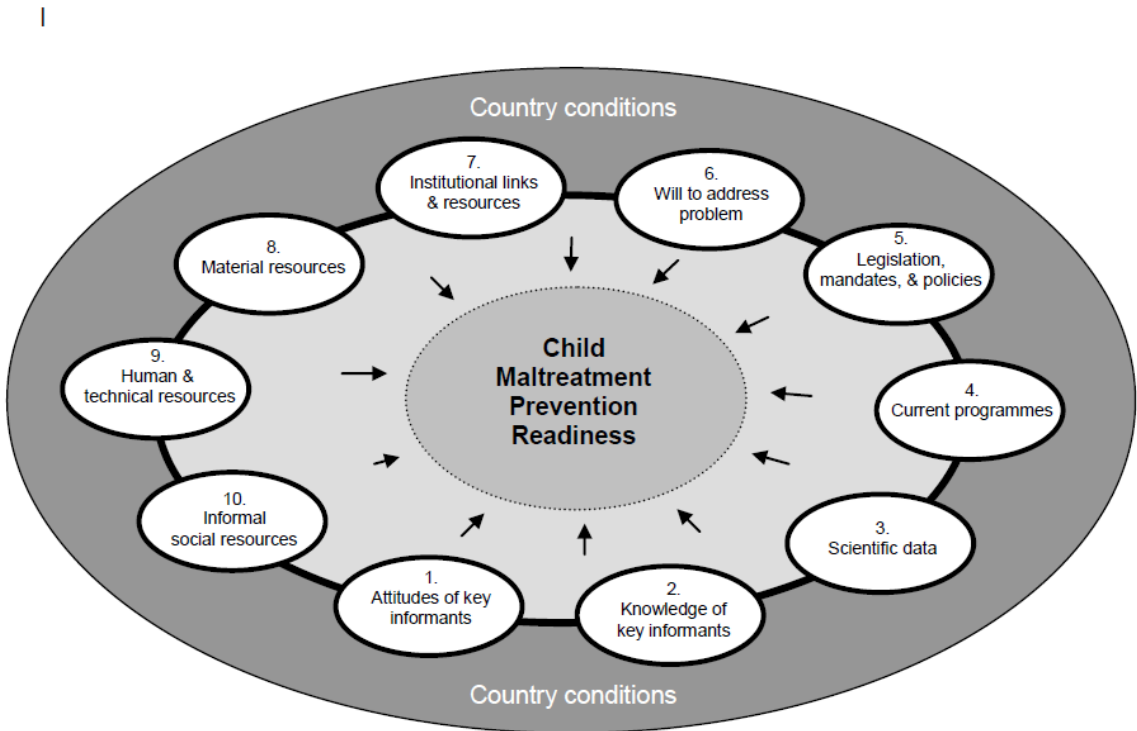
4. THE TEN DIMENSIONS OF RAP-CM

RAP-CM is based on a model of readiness for child maltreatment prevention made up of ten dimensions:

1. Key informants' attitudes towards child maltreatment and its prevention;
2. Key informants' knowledge of child maltreatment and prevention;
3. Scientific data on child maltreatment and its prevention;
4. Existing programmes and their evaluation;
5. Legislation, mandates, and policies;
6. Will to address the problem;
7. Institutional links and resources;
8. Material resources;
9. Human and technical resources; and
10. Informal social resources (see Figure 1 and Box 1).

An additional dimension, which is however not assessed by the interview schedule, is the key background country conditions.

Figure 1: The ten dimensions of the Readiness Assessment for the Prevention of Child Maltreatment



Box 1: The 10 dimensions and facets of the RAP-CM

Dimension 1. Attitudes of key informants towards child maltreatment and its prevention

Dimension 2. Knowledge of key informants about child maltreatment and its prevention

Dimension 3. Scientific data on child maltreatment and its prevention, e.g. data on magnitude & distribution of child maltreatment; short and long term consequences of child maltreatment; risk factors for child maltreatment; appropriateness of child maltreatment prevention interventions; information systems for child maltreatment, etc.

Dimension 4. Existing programmes and their evaluation

- 4.1. Existing or recent child maltreatment prevention programmes and whether their effectiveness has been evaluated
- 4.2. Existing programmes into which child maltreatment prevention components could be integrated (e.g. child protection programs; early childhood development programs; etc.)

Dimension 5. Legislation, mandates, policies, and plans relevant to child maltreatment prevention e.g. Children's Act, Child Care Act,; Ministries, government departments, NGOs with mandates for child maltreatment prevention or aspects of child maltreatment prevention such as data collection, monitoring and evaluation; international and regional resolutions, treaties, conventions, etc.

Dimension 6. Will to address the problem

- 6.1. Leadership
- 6.2. Political will
- 6.3. Public will
- 6.4. Advocacy
- 6.5. Communication

Dimension 7. Institutional links and resources

- 7.1. Institutional links and intersectoral collaboration: partnerships, coalitions, networks, and alliances between institutions and the extent to which they involve different sectors
- 7.2. Institutional resources and efficiency

Dimension 8. Material resources

- 8.1. Budgets for child maltreatment prevention
- 8.2. Infrastructure and equipment (e.g. office space, computers, etc.)

Dimension 9. Human and technical resources

- 9.1. Technical, administrative, and managerial skills, knowledge, and expertise
- 9.2. Institutions that enable the acquisition of the required skills, knowledge, and expertise in child maltreatment prevention

Dimension 10. Informal social resources (non-institutional), e.g. citizen participation, social capital, collective efficacy

5. OPTION 1 – FULL ASSESSMENT USING RAP-CM-I AND RAP-CM-XD

The full assessment process will produce the following:

- A summary of the quantitative findings on each of the 10 dimensions of readiness using a radar diagram and an overall score;
- Qualitative findings concerning the 10 dimensions of readiness;
- An integration of qualitative and quantitative findings;
- A comparison of findings from key informants with those based on expert opinion using all available data;
- A list of recommended measures to increase readiness;
- A summary of key country characteristics and how they relate to readiness for child maltreatment prevention.

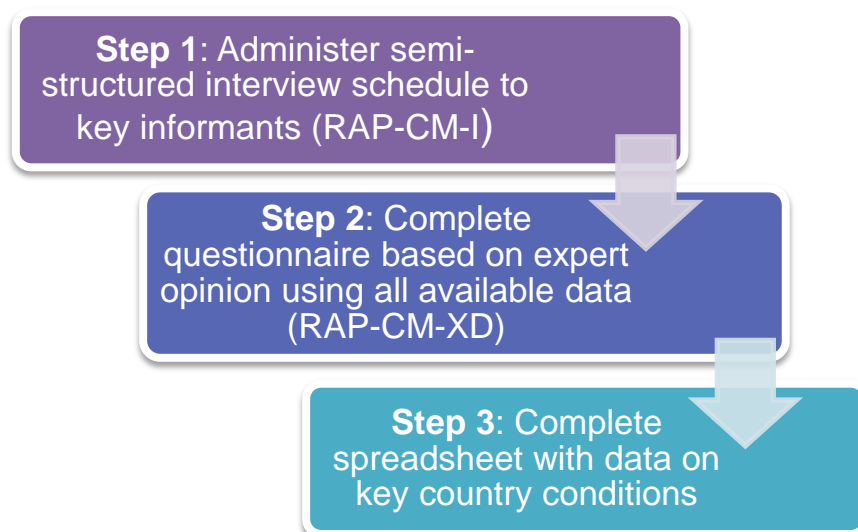
To complete the full assessment will **require a small team** of – perhaps two to five – researchers (e.g. Masters level or above in the social or behavioural sciences) with expertise in child maltreatment prevention. It is a relatively lengthy undertaking. No specific training is required of researchers other than carefully reading this handbook and familiarizing themselves with the semi-structured interview schedule, questionnaire, and respective scoring sheets.

5.A. Administering the instruments to collect the data

The full assessment using RAP-CM consists of three steps: (1) administering the semi-structured interview schedule to key informants (RAP-CM-I); (2) completing the questionnaire based on expert opinion using all available data (RAP-CM-XD); (3) and completing the spreadsheet for key country conditions – as outlined in Figure 2. The items in RAP-CM-I and RAP-CM-XD largely mirror each other and the development of RAP-CM-XD was based on RAP-CM-I.

Administering RAP-CM-I should take approximately 1 hour per informant and between 10 and 40 key informants should be interviewed, depending on the level – i.e. national, sub-national, community/local – at which readiness is being assessed. Completing RAP-CM-XD should take the research team a total of a few hours, once all the required data have been assembled.

Figure 2: implementing RAP-CM



All the three following steps are to be completed by the research team.

Step 1: Administering the semi-structured interview schedule to key informants (RAP-CM-I)

(i) Selecting the sample

RAP-CM-I is a semi-structured interview schedule designed to be administered to key informants. "Key informants" in this context refer to individuals who have or are likely to have some influence and decision-making power over child maltreatment prevention in the country at either national, sub-national (province, state, district), or municipal or community levels. These may include policy makers; programme planners, commissioners, and implementers; high level practitioners; high level civil servants and their senior technical advisers; leaders and champions and politicians with a strong interest in the subject; and academics and researchers with a strong interest in child maltreatment. Key informants 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 (at national, state or provincial and municipal levels), non-governmental and community-based organizations, international organizations, and universities and other research institutions. Informants may include, for instance, Directors of Child Health or Welfare Departments, coordinators of child maltreatment prevention or child protection programmes, or heads of some of the main NGOs involved in child maltreatment prevention or child protection.

It is recommended that between 10 and 40 key informants be interviewed for each level at which readiness for child maltreatment prevention is being assessed. If the aim is to assess readiness for child maltreatment prevention at national level, 30 to 40 key informants should be selected who have extensive knowledge of the subject of child maltreatment prevention (and/or child protection) throughout the country. If the aim is to assess child maltreatment prevention at sub-national level, 20-30 key informants with extensive knowledge of the topic within the state, province, or district should be selected. Finally, if child maltreatment prevention is to be assessed at the municipal or community level, 10-20 key informants with in-depth knowledge of child maltreatment prevention (and/or child protection) within the municipality or community should be selected for interview. The numbers of key informants to be interviewed at each level suggested here are no more than indicative; numbers will depend on the setting and the number of people involved in the field of child maltreatment prevention or child protection within it. It is however critically important to interview a sample of informants who are representative of the key players in all sectors and all types of organization involved in the field.

(ii) Administering the interview schedule (RAP-CM-I)

RAP-CM-I should take on average one hour to administer. It is seeking both quantitative and qualitative data. More detailed instructions are included in the interview schedule which can be downloaded from: http://www.who.int/violence_injury_prevention/violence/child/en/index.html.

Interviewers should:

- let interviewees answer questions freely (and record their replies either by taking notes or with the help of a tape recorder); and then
- select one of the boxes in the scoring column that best matches the interviewee's answer (unless otherwise indicated).

Each page of this interview schedule is divided into as many as five columns:

Column 1: Question number ("No.");

Column 2: Question ("Question");

Column 3: Notes on the interviewee's answer ("Qualitative answer");

Column 4: Response options ("Response options") – to be scored by interviewer, unless otherwise indicated;

Column 5: Any additional comments, guidance, and prompts.

The text in italics is to be read aloud by interviewer. However, the interview is to be conducted in as conversational a style as possible and the interviewer is not expected to read questions word for word, but can paraphrase them in his or her own words and add prompts and follow-up questions as required. If some of the questions are politically too sensitive and likely to damage rapport or cause difficulties, the interviewer should consider omitting them, but should indicate why the question was dropped. In general, the aim is to get at the interviewee's personal perspective on child maltreatment prevention readiness, and not the official perspective of the institution they represent.

Step 2: Completing the questionnaire based on expert opinion using all available data (RAP-CM-XD)

After readiness for child maltreatment prevention has been assessed based on interviews with key informants using RAP-CM-I, it should also be assessed using RAP-CM-XD, based on expert opinion using all available data. RAP-CM-XD serves two important purposes. First, in those areas for which studies and evidence exist, the RAP-CM-XD will allow key informants' answers to be evaluated by comparing them to more objective knowledge. Secondly, for the non-factual questions, it will allow the knowledge, expertise, and experience of research teams to inform the overall assessment of readiness for child maltreatment prevention. RAP-CM-XD, which should be completed at least at the national level, includes:

(i) *An objective assessment*: research teams should complete those questions in RAP-CM-XD that call for factual answers – shaded in grey in RAP-CM-XD – drawing on all or the best available scientific data they will have collected beforehand. Studies referred to by the key informants should be included in this body of data if appropriate.

2. *Research team's consensus opinion*: for those questions – unshaded in RAP-CM-XD – that call for non-factual answers, research teams should provide answers based on a consensus reached during a discussion including all research team members and informed by team members' expertise in the field and the experience of administering RAP-CM-I to key informants.

Although RAP-CM-I and RAP-CM-XD are similar (they can be downloaded at: http://www.who.int/violence_injury_prevention/violence/child/en/index.html), a number of questions assessing key informants' basic knowledge and concepts included in the latter have been dropped from the former.

It is estimated that completing RAP-CM-XD will take a few hours, once the relevant data has been collected. It is recommended that the objective assessment be based on all available data the research team has managed to obtain and urge the research team to get copies of all the higher quality studies conducted in the country over the past decade. The consensus opinion should be reached on the basis of discussions involving all members of the research team who carried out the interviews of the key informants.

An important part of completing RAP-CM-XD consists – in question 4.2 – of drawing up a list of all the main child maltreatment prevention programmes identified in the country, state or province, or locality or municipality (and *NOT* child *protection* programmes, i.e. *not* programmes that provide care, support and treatment to victims of child maltreatment). This list should include:

- The name of the programme;
- What type of child maltreatment prevention programme it is;

- The programme's reach (i.e. implemented locally, throughout municipality, at sub-national level, at national level); and
- Whether the programme has undergone an outcome evaluation.

Step 3: Completing the spreadsheet with data on key country conditions

To record data on key country conditions, please go to the following link and use the Excel spreadsheet provided for the "Key country conditions":

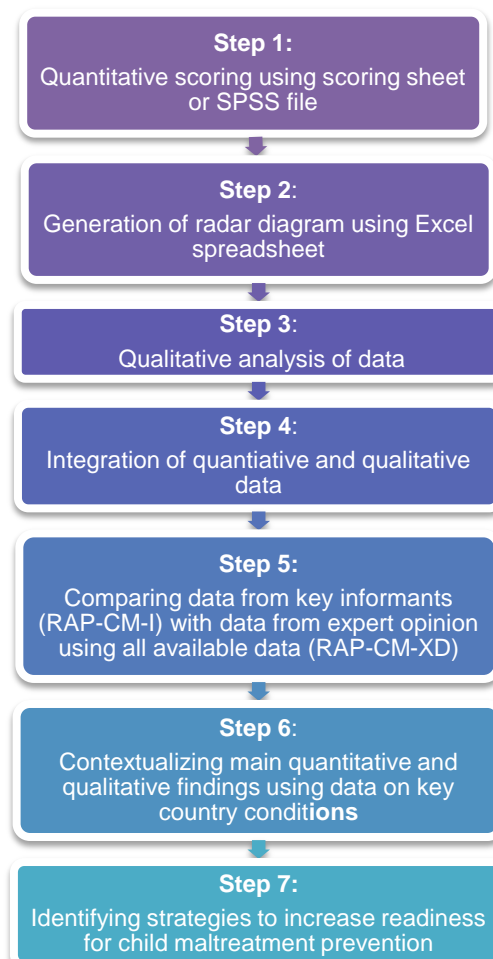
http://www.who.int/violence_injury_prevention/violence/child/en/index.html.

5.B. Generating the results

Generating results based on RAP-CM involves a six-stage process (see Figure 2) made up of (1) quantitative scoring, (2) generation of visual representation of scores on radar diagram, (3) qualitative analysis, (4) integration of quantitative and qualitative data, (5) comparison of the findings from the administration of the semi-structured interview and those based on expert opinion using all available data, (6) contextualizing main findings using data on key country conditions, and (7) identifying strategies to increase readiness for child maltreatment prevention.

It is important to go through this process of generating results separately for each of the levels at which child maltreatment prevention readiness is being assessed.

Figure 2: process of generating results



Step 1. Quantitative scoring of RAP-CM-I and RAP-CM-XD

The system for scoring RAP-CM-I and RAP-CM-XD is almost identical. The first step is to complete the scoring sheets available for each at:

http://www.who.int/violence_injury_prevention/violence/child/en/index.html. Once the scoring sheet for RAP-CM-I has been completed, to calculate scores, SPSS data and syntax files are available upon request from miktonc@who.int. Although the SPSS files will calculate scores for RAP-CM-I automatically, RAP-CM-I can also be scored by hand with the help of the scoring sheet and the table below included in the scoring sheet using the following procedure:

1. Following the scoring key in the middle column of the scoring sheet, score each question from 0 to 2 (unless otherwise indicated) and write the score in the box in the right-hand column.
2. Sum up all the scores for each dimension and write the total raw score for the dimension in the box with the thick black frame at the end of each section of the scoring sheet.
3. Enter raw scores for each dimension into table in the column "raw score".
4. Divide the total raw score for each dimension by the maximum possible score for that dimension and then multiply result by 10, to obtain a total score for that dimension on a scale of 1-10. For instance in RAP-CM-I, if the total score for Dimension 3 is 18 out of maximum possible score of 24:

$$18/24 = 0.75 \times 10 = 7.5$$

5. Enter scores on the scale of 1-10 for each dimension into table provided and then sum up to get total score on child maltreatment prevention readiness.

Table 1: Summarizing quantitative score for RAP-CM-I for each key informant

Dimension	Raw score	Score on a scale of 1-10
Dimension 1: Attitudes towards child maltreatment prevention	/16	
Dimension 2: Knowledge of child maltreatment prevention	/17	
Dimension 3: Scientific data on child maltreatment prevention	/24	
Dimension 4: Current programme implementation and evaluation	/30	
Dimension 5: Legislation, mandates, and policies	/12	
Dimension 6: Will to address the problem	/24	
Dimension 7: Institutional links and resources	/19	
Dimension 8: Material resources	/13	
Dimension 9: Human and technical resources	/12	
Dimension 10: Informal social resources (non-institutional)	/10	
Total child maltreatment prevention readiness score		/100

Step 2: Calculating mean scores of all key informants for each dimension and mean total score for RAP-CM-I

For RAP-CM-I, once scores have been calculated for each key informant following instructions in Step 1:

- Calculate the mean score for all key informants on each dimension using score on scale from 1-10;
- Calculate the mean total scores all ten dimensions for all key informants.

Table 2: Mean score on each dimension and mean total score on RAP-CM-I

Dimension	Mean score on a scale of 1-10
Dimension 1: Attitudes towards child maltreatment prevention	
Dimension 2: Knowledge of child maltreatment prevention	
Dimension 3: Scientific data on child maltreatment prevention	
Dimension 4: Current programme implementation and evaluation	
Dimension 5: Legislation, mandates, and policies	
Dimension 6: Will to address the problem	
Dimension 7: Institutional links and resources	
Dimension 8: Material resources	
Dimension 9: Human and technical resources	
Dimension 10: Informal social resources (non-institutional)	
Total child maltreatment prevention readiness score	/100

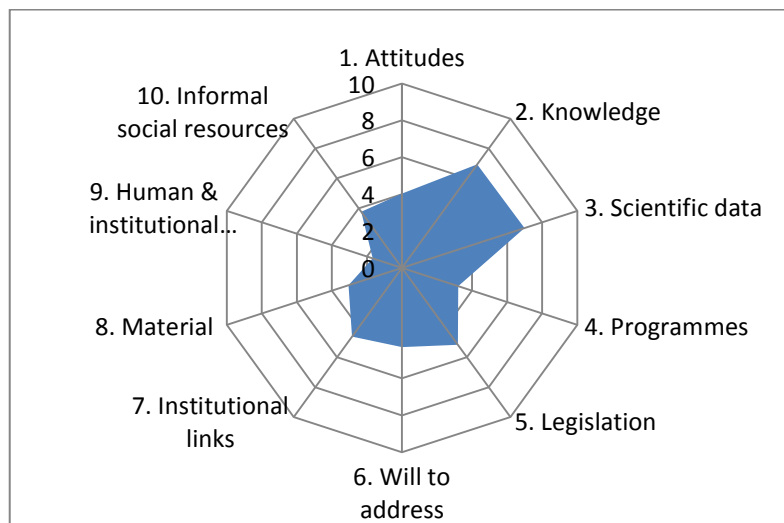
No mean scores are required to be calculated for RAP-CM-XD as only one set of scores is generated by the research team through consensus during its discussion.

Step 2: Generation of radar diagram using Excel spreadsheet for RAP-CM-I and RAP-CM-XD

An Excel spreadsheet entitled "Radar diagram for RAP-CM-I" can be downloaded at http://www.who.int/violence_injury_prevention/violence/child/en/index.html. Enter scores for each dimension of RAP-CM-I into the Excel spreadsheet to produce radar diagram. Click on Chart Wizard and select "radar" to produce diagram (Figure 2).

For RAP-CM-I, a separate radar diagram should be produced for every level at which readiness for child maltreatment prevention is being assessment, i.e. national, sub-national, and/or community or municipal levels and for RAP-CM-I. For RAP-CM-XD, which only assesses readiness for child maltreatment prevention at the country level, only one radar diagram should be produced.

Figure 3: Example of a radar diagram visually representing scores on RAP-CM-I



Step 3. Qualitative analysis of data

Qualitative analysis refers to a number of procedures by which textual, rather than numerical data, can be analyzed. It varies from the very basic to the highly sophisticated using qualitative software programs such as N-VIVO. Outlined here are some suggestions for straightforward analyses of the qualitative answers to some of the open-ended questions in RAP-CM-I.

1) Direct quotations from individual questionnaire responses: for example, for question 1.1 “Is there a difference between child protection and child maltreatment prevention”, the quantitative variable simply records whether or not the answer is correct or not. However, you might wish to give a direct quotation of the actual definition used by the key informant. The main point with direct quotations is that they are both simple and informative and can bring to life the quantified data.

2) Content analysis: Content analysis has been defined as a research method “for the subjective interpretation of the content of text data through the systematic classification process of coding and identifying themes or patterns” (Hsieh & Shannon, 2005, p.1278) or “any qualitative data reduction and sense-making effort that takes a volume of qualitative material and attempts to identify core consistencies and meanings” (Patton, 2002, p.453). Methods of content analysis range from very simple to much more complex, using specialist software. Standards textbooks on social research methods should be consulted for more information on this topic¹.

However, some of the open-ended answers in RAP-CM-I allow a much simpler form of content analysis to be used – e.g. questions 2.3; 2.4; 2.5; or C2. A set of categories can be iteratively generated that covers the possible responses and then the total number of responses in each of the possible categories can be totaled. This type of content analysis therefore permits a quantification of the open-ended answers.

To give some examples:

2.3 “What are the main consequences of child maltreatment for the victim”

- Review the possible categories (e.g. physical health consequences, mental health consequences, intergenerational transmission of violence, etc.) across all

¹ e.g. H. Russell Bernard (2000) Social research methods: qualitative and quantitative approaches. Thousand Oaks: Sage.

respondents then summarize number of responses received in each category. This can then be compared by, for instance, respondent characteristic (e.g. male, female)

C. “What are the main measures you would recommend.....”

- Again, review the possible categories then summarize number of responses in each category.

Step 4: Integration of quantitative and qualitative data

Qualitative and quantitative data generated by this interview schedule can be used in various ways. For instance, numbers can be used to add precision to narrative and qualitative data by:

- Contextualizing and qualifying the quantitative data;
- Explaining complex or contradictory responses;
- Revealing emergent and unexpected issues (e.g. dimensions or facets that may be missing from the model or that are country-specific);
- Providing greater understanding and description of people’s personal experiences of phenomena; the last section of the interview schedule, entitled "Interviewer's impression" may be particularly useful in this respect;
- Determining how participants interpret some of the key constructs used to generate the quantitative data (e.g. "child maltreatment prevention" vs. "child protection", or "evidence-based approaches").

Use of such mixed-methods can provide stronger evidence for a conclusion through convergence of findings, add insights and understanding that might be missed when only a single method is used, be used to increase the generalizability of the results, and produce more complete knowledge necessary to inform practice.

Step 5: Comparing data from key informants (RAP-CM-I) with data based on expert opinion using all available data (RAP-CM-XD)

Comparison of data from key informants with the objective assessment for those questions – shaded in light-grey in RAP-CM-XD – that call for factual answers will allow key informants' answers to be evaluated by comparing them to more objective knowledge.

Step 6: Contextualizing main quantitative and qualitative findings using data on key country conditions

The aim of the data on key country conditions is to provide important background information relevant to the readiness of countries to implement child maltreatment prevention on a large scale. Characteristics of countries captured by this dimension (e.g. age structure of population, adolescent fertility rate, GDP per capita, income inequality, literacy rate, primary school enrolment, etc.) are likely to have a significant influence on a country's readiness and capacity to implement child maltreatment prevention programmes.

Associations between the data on these country characteristics captured in the spreadsheet and the outcomes on the 10 dimensions of the RAP-CM should be analyzed qualitatively, to contextualize and explain findings on the 10 dimensions of the RAP-CM-I and RAP-CM-XD. For instance, the priority of child maltreatment prevention (question 1.3 and 1.4) and the will to address the problem (dimension 6) will to a large extent depend on the magnitude and severity of other health and social problems the country has to contend with. The appropriateness of child sexual abuse prevention programmes delivered in schools (question 2.7.) will be influenced by the primary school net enrollment, the survival rate to last primary grade, and whether or not primary school is compulsory and free in the country. Material

resources available for child maltreatment prevention (dimension 8) and institutional resources for child maltreatment prevention (dimension 7) will be a function of the country's wealth and its expenditure on health and social welfare. The human and technical resources the country has to devote to child maltreatment prevention (dimension 9) will be correlated with density of health care workers and physicians. A careful consideration of these key country conditions is important to gain a complete understanding of a country's readiness for child maltreatment prevention and the challenges it may face in its efforts to increase its readiness and capacity.

Step 7: Identifying strategies to increase readiness for child maltreatment prevention

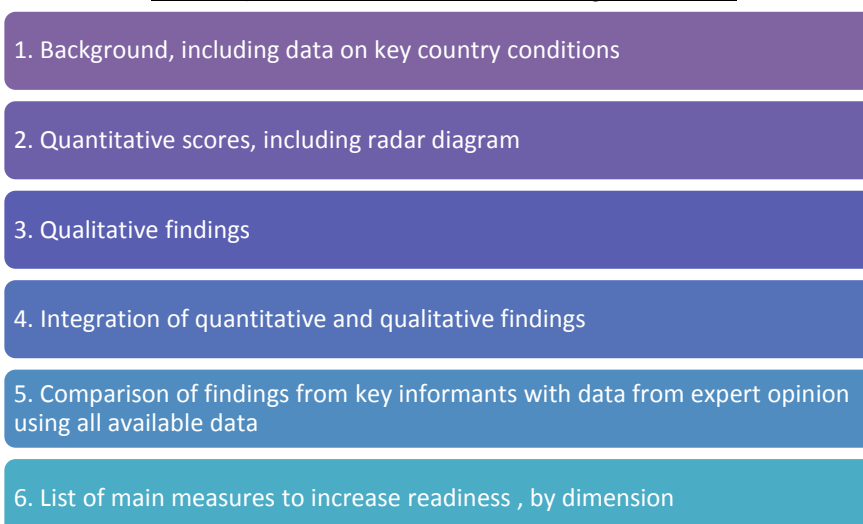
Information relevant to strategies to increase readiness in the country can come from three sources within the RAP-CM assessment process:

- From RAP-CM-I: Section C.2. in the concluding part of the interview schedule specifically asks:
 - "For each of the following dimensions of child maltreatment prevention readiness, can you tell me what are the main measures you would recommend to improve your *Country/Province/ Community's* score on the dimension?"
 - Although these questions come at the end of the interview schedule, it is critically important to make every effort to elicit recommendations for measures to improve readiness on each one of the dimensions listed here.
- From RAP-CM-I: During the interview, the interviewee should write down any suggestions for increasing readiness the interviewer may have made.
- RAP-CM-XD: When the research team complete RAP-CM-XD, they are asked to recommend measures to improve

5.C. Presenting the findings

Key findings for each level at which readiness for child maltreatment prevention have been assessed (i.e. national, sub-national, and/or local and municipal) should be presented separately under the headings outlined in Figure 3. Heading 1, "Background, including data on key country conditions", however, only applies to the national level.

Figure 4: Presentation of summary findings for each level (i.e. national, sub-national, municipal or local) at which RAP-CM is being assessed



6. OPTION 2 – RAPID ASSESSMENT USING RAP-CM-SV

The rapid assessment consists of administering the **Short Version Questionnaire of RAP-CM (RAP-CM-SV)** to key informants and produces summary scores on each of the 10 dimensions of readiness and an overall score based on key informants' views. While it does not generate recommendations for increasing readiness, the measures needed to increase readiness can nevertheless be inferred from the gaps identified by the questionnaire.

6.A. Administering RAP-CM-SV

RAP-CM-SV consists of 19 questions and is designed to assess the same 10 dimensions of readiness as RAP-CM-I and RAP-CM-XD. It was derived from RAP-CM-I and scores on dimensions of RAP-CM-SV and overall total scores have been shown to be highly correlated with RAP-CM-I. It is a self-administered questionnaire and should take about 10-15 minutes to complete.

The RAP-CM-SV questionnaire and the scoring system can be downloaded at:
http://www.who.int/violence_injury_prevention/violence/child/en/index.html

Like RAP-CM-I, RAP-CM-SV should be administered to key informants (see Section 7.A for a definition of key informant). Again, as in the case of RAP-CM-I, it is recommended that between 10 and 40 key informants be interviewed for each level at which readiness is being assessed. If the aim is to assess readiness at national level, 30 to 40 key informants should be selected who have extensive knowledge of the subject of child maltreatment prevention throughout the country. If the aim is to assess child maltreatment prevention readiness at sub-national level, 20-30 key informants with extensive knowledge of the topic within the state, province, or district should be selected. Finally, if child maltreatment prevention readiness is to be assessed at the municipal or community level, 10-20 key informants with in-depth knowledge of child maltreatment prevention within the municipality or community should be selected for interview. The numbers of key informants to be interviewed at each level suggested here are no more than indicative; numbers will depend on the size of the country, province or state, community of municipality and the number of people involved in the field of child maltreatment prevention or child protection within it. It is however critically important to administer the questionnaire to a sample of informants who are representative of the key players in all sectors and all types of organization involved in the field.

6.B. Generating results with RAP-CM-SV

Start by completing the scoring sheet for RAP-CM-SV. SPSS data and syntax files are available upon request to score RAP-CM-SV (contact miktonc@who.int). To score by hand, after you have scored each of the individual questions on the scoring sheet, enter total scores for each dimension into the table provided and calculate the overall total score. For each dimension, to get a score out of 10, multiply the score out of 4 by 2.5; and to get the overall score in percentage points, multiply the total score out of 40 by 2.5.

Once scores have been calculated for each key informant, calculate mean scores for all respondents on each dimension and mean total scores.

An Excel spreadsheet entitled "Radar diagram for RAP-CM-SV" can be downloaded at http://www.who.int/violence_injury_prevention/violence/child/en/index.html. Enter scores for each dimension of RAP-CM-SV into the Excel spreadsheet to produce radar diagram. Click on Chart Wizard and select "radar" to produce diagram.

As for RAP-CM-SV, a separate radar diagram should be produced for every level at which readiness for child maltreatment prevention is being assessed, i.e. national, sub-national, and/or community or municipal levels and for RAP-CM-I.

7. APPENDICES

Appendix 1: The distinction between child protection and child maltreatment

It is important to differentiate as clearly as possible between child maltreatment prevention and child protection, two terms which partly overlap and are, hence, easily – and often – confused. **Child maltreatment prevention**, the focus of RAP-CM, means to reduce the frequency of new child maltreatment cases through direct efforts to remove or reduce the underlying causes and risk factors, and by harnessing the indirect effects of other policies and programmes that may contribute to reducing exposure to risk factors and underlying causes. The emphasis of child maltreatment prevention is on preventing child maltreatment before it happens. Effective child maltreatment prevention programmes usually address specific sub-types of child maltreatment – such as abusive head trauma, physical abuse, or sexual abuse – that can be clearly defined and reliably measured at the level of the population.

Child protection refers, according to UNICEF, to preventing and responding to violence, exploitation and abuse against children – including commercial sexual exploitation, trafficking, child labour and harmful traditional practices, such as female genital mutilation/cutting and child marriage. Although this UNICEF definition of child protection includes prevention, in practice, it has mainly involved investigating and substantiating suspected cases of child maltreatment, and directly providing, or referring to appropriate, support and treatment services after child maltreatment has already occurred and protecting children from further maltreatment. Indeed in most countries in the world the dominant response to child maltreatment is focused upon the establishment of child protection services and systems 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. And this in spite of the fact that trying to remedy the effects of child maltreatment after it occurs through care, support and treatment are often less effective and more costly than preventing it in the first place.

Appendix 2: The process of development of RAP-CM-I

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

- Stage 1: Development of the conceptual model underlying RAP-CM;
- Stage 2: Development of a Version 1 of the RAP-CM-I based on the conceptual model and cognitive testing of Version 1 in six countries;
- Stage 3: Revision of Version 1 and development and pilot testing of Version 2 in six countries;
- Stage 4: Revision of Version 2 and development & field testing of Version 3 in six countries;
- Stage 5: Revision & development of Version 4 – the final version presented in this handbook.

Stage 1: Development of the conceptual model underlying the instrument : The development of the conceptual model proceeded in three steps. The first step consisted of a comprehensive review of existing models and approaches relevant to the assessment of readiness for child maltreatment prevention. To define the content domain and dimensions, the construct of readiness was defined and constructs related to readiness for child maltreatment prevention examined, and theories underlying them identified (Clark & Watson, 1995; Netemeyer, Bearden, & Sharma, 2003). Next, the models and approaches identified were evaluated on the basis of a set of criteria and an initial model was derived. The second step involved a consultation meeting of 17 international experts to critique the model, and the third step consisted of six systematically conducted 2-3-hour-long focus groups in Brazil, China, Malaysia, Saudi Arabia, South Africa, and The former Yugoslav Republic of Macedonia with local experts. The aim of the focus groups was in part to capture better country and culturally specific aspects of readiness for child maltreatment prevention. This process resulted in an initial ten-dimensional model (See Mikton et al., 2011).

Stage 2: Development of a Version 1 of the questionnaire based on the conceptual model and cognitive testing in six countries. On the basis of the conceptual model, items were generated to tap each of the ten dimensions and a first draft of the interview schedule was developed. This was subjected to an evaluation by each of the six country teams, which resulted in an eight-dimensional instrument after merging of some of the dimensions. This Version 1 of the instrument was translated into local languages (and back-translated to check for equivalence and then adjusted) and cognitive interviews with five to ten subjects were conducted in each of the six countries. The aim of the cognitive interviews was to assess whether the interview schedule was generating the information required, the quality (e.g. clarity, intelligibility) of the interview schedule, how interviewee's elaborated their answers, and how they interpreted the questions.

Stage 3: Revision of Version 1 and development and pilot testing of Version 2 in six countries. Version 1 of the interview schedule was revised on the basis of the results of the cognitive interviews and then Version 2 was pilot tested on samples of approximately 20 key informants in each country.

Stage 4: Revision of Version 2 and development and field testing of Version 3 in six countries. Through quantitative analyses of the results of the pilot study using Version 2, missing values were identified, response category distribution problems (e.g. skewness and kurtosis) and floor and ceiling effects detected, internal reliability assessed, possible scales and sub-scales determined, and the performance of questions across countries were examined. On the basis of these analyses and a meeting of research teams from each of the countries, Version 2 was made 50% shorter, resulting in Version 3 of the instrument which was then field tested in the six countries on samples of between 40-70 key informants.

Stage 5: Revision of Version 3 and development of Version 4 – the final version presented in this handbook. On the basis of quantitative analyses of the results of the field testing similar to those conducted for Version 2 and consultations with the research teams, the version of the instrument included in this handbook was developed.

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