Child Maltreatment Prevention Readiness Assessment Country Report: Saudi Arabia

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Executive summary

The Child Maltreatment Prevention Readiness (CMPR) study aims to assess how ready a country is to implement large scale evidence based child maltreatment prevention programs. The CMPR instruments used in this study was developed by the World Health Organization (WHO) and conducted in five countries in collaboration with organizations in each respective country. These countries are: Saudi Arabia, Macedonia, Malaysia, Brazil and South Africa.

In Saudi Arabia, the National Family Safety Program (NFSP) performed the study using two parallel versions of the instrument, both based on the same 10-dimensional model and including over 100 items. The CMPR-key informants is more subjective and measures the knowledge, attitudes, beliefs and opinions concerning CMP of key informants, and the other one based on expert opinion using all available data in the country which allows a more objective assessment of those dimensions . The 10 dimensions applied are : 1) attitudes towards child maltreatment, 2) knowledge 3) scientific data on child maltreatment prevention, 4) current program implementation and evaluation, 5) legislations, mandates and policies on child maltreatment prevention, 6) assessment of the strength of the will to address child maltreatment problem in Saudi Arabia, 7) institutional links and resources, 8) material resources, 9) human and technical resources, 10) informal social resources (non-institutional). A score of ten given to each of the ten dimensions with a total score of 100 for CMPR- key informants and CMPR- experts. Comparisons between the two were performed.

Out of the 10 dimensions, Key Informants scored high on (2) Knowledge, (3) Scientific data, (5) Legislations and mandates and (6) Will to address child maltreatment. Key Informants scored low on (1) Attitudes toward child maltreatment, (4) Current programs, (7) Institutional links (8) Material resources (9) Human resources and (10) informal social resources.

As for the experts they scored high on (2) Knowledge on child maltreatment, (3) Scientific data on child maltreatment (4) Current programs (6) Will to address child maltreatment (10) Informal social resources. Experts scored low on (1) Attitudes towards CAN, (5) Legislations, mandates, (7) Institutional links, (8) Material resources and (9) Human resources.

Key informants and experts gave an overall score of 43/100 and 40/100 readiness in Saudi Arabia to implement large-scale child maltreatment prevention programs, respectively indicating a low level of readiness. The slightly higher readiness scores of key informants compared to experts could be related to their background employment where the majorities were from the government sector who have high poised their institution, though the expert readiness assessment is more objective and close to the reality of the situation.

Key informants and experts agree 70% on the scores of the ten dimensions. Both experts and key informants agreed that (1, 7, 8, 9) attitude, institutional link, material and human resources dimensions need improvement in the country.
Both key informants and experts agreed that (2, 3, 6,), knowledge, scientific data, and the will to address the problem were strong in the country.
The major discrepancies between key informants and experts were in dimensions (4, 5, and 10), current programs, legislations, and informal resources. Although the key informants affirmed the existence of legislations and special agency mandated for protecting children from maltreatment in Saudi Arabia, although ineffective, experts believed that the current legislations and agencies are neither specific nor effective.

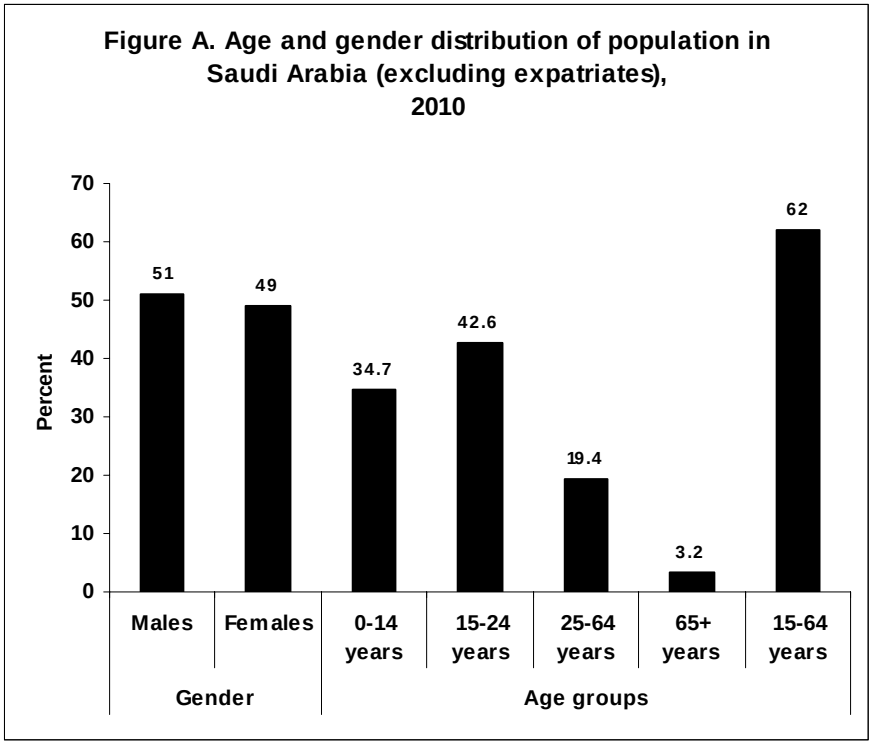
Key informants were not aware of existing prevention programs that have been implemented in the country, while experts believe that these programs were not evaluated and their sustainability is unknown.

The findings of this survey have far reaching implications. It paves the way for the development of large-scale child maltreatment prevention programs in Saudi Arabia, which could protect millions of children from maltreatment and empower parents and other sectors of the society to prevent such actions from happening and recurring. Such prevention programs could be initiated as small-scale pilot projects in several areas of a province or a whole community before spreading all over the country.

Recommendations include: improving attitude to child maltreatment by raising awareness across all sectors of society, unanimous official definition of child maltreatment. To develop human resources in the field through training programs, curriculum development, scholarships amongst others. Develop material and technical resources by allocating a specific fund for prevention programs. In addition, to strengthen links between concerned agencies and to create an agency focused on prevention and review old legislations and issue new ones, mandate reporting to all concerned agencies.

Chapter 1: Country Background Information

Saudi Arabia occupies much of the Arabian Peninsula. It has an area of approximately 2,149,690 square kilometers and is home to 27,136,977 persons (1). Of these, Saudi nationals constitute 69% (18,707,576) and expatriates constitute 31% (8,429,401), with males being the predominant expatriate population (70%). The age and gender distributions of the total excluding expatriates (2) are shown in figure A. In comparison to other countries, Saudi Arabia's population ranks 46 in the world (2). It is the largest and most populated country amongst the Arabian Gulf states (Kuwait, United Arab Emirates, Bahrain, Oman and Qatar).



Saudi Arabia consists of 13 provinces that have cities divided into category (A) and category (B) depending on the size and population density (Appendix B). The urban population accounts for 82% of the country's population. The total fertility rate in Saudi Arabia is 2.31 children born per woman (2). As for adolescent fertility rate, there are 7 births per 1000 girls aged 15-19 years (3).

Economy

The Gross Domestic Product (GDP) per capita is $24,200 (2) ranking Saudi Arabia at 55 compared to the world. The unemployment rate is 10.8% (4), which ranks the Kingdom at 118th compared to the world (2), and the Gross Net Income (GNI) per capita is $17,700 (5). It is important to note that Saudi Arabia recently joined the G-20 countries because of its strong economy.

Health

The annual number of live births is 593,000 (5). The infant mortality rate is 17.3 per 1000 live births in 2009 (6). Saudi Arabia ranks 111 compared to the world. The annual number of deaths for children under 5 years of age is 12,000 (5), with a mortality rate of 21 per 1000 live births (5). The percent of children less than 5 years of age that are underweight (either severe or moderate) is 14% (8). Life expectancy at birth for both males and females is 73.5 years (6), with the Kingdom ranking 109 compared to the world. The maternal mortality ratio is 14.3 per 100,000 live births. (9)

The general governmental expenditure on health as a percentage of total government expenditure is 5.6% (10). The total expenditure on health as a percentage of GDP is 5.0% (10), which ranks Saudi Arabia as 139th compared to the world. The prevalence of HIV/AIDS in adults in Saudi Arabia is 0.01% (11).

Education

The total adult literacy rate in Saudi Arabia is 86% (13). The primary school net enrollment is 85% (14). The survival rate to last primary grade (primary to tertiary) is 96 % (14). The total government appropriation for education in 2009 was 116,882 million Saudi Riyals, 5.6% of the GDP, (16). However, there is no data, currently, on the public expenditure on primary education per pupil.

Equality of Access to Healthcare and Education and Social Protection

There is no information on the density of community health workers in the Kingdom of Saudi Arabia (KSA). However, the physician-population ratio is 9.4 per 10,000 populations (9). Of the overall spending on health, 67% is from the government (10).

Childhood education is available in Saudi Arabia; primary education is both compulsory and free (public schools) for both males and females. Secondary education is compulsory as well and is free in public schools. There are benefits for children with disabilities in the Kingdom.

Welfare and/or food supplements are available to the needy and the unemployed are entitled to unemployment benefits. All families are entitled to some kind of allowance/benefits regardless of family income. There is a statutory paid maternity leave, which ranges between 40-60 days based on sector of employment, but no statutory paid paternity leave in Saudi Arabia.

Government of Saudi Arabia:

The Head of the State and the government is His Royal Highness - Custodian of the Two Holy Mosques, King Abdullah Bin Abdulaziz Al Saud. The Cabinet consists of the

Council of Ministers appointed by the king every four years. The legislative branch consists of the Saudi Parliament known as the Consultative Council, *Majlis al Shura*- comprised of 150 members and a chairman appointed by the king to serve a four years term. An elected local legislation, known as the Municipality Council, which is elected every four years for every region in the Kingdom, is responsible for passing laws that serve the local community. Both males and females are appointed in the legislative council and both can be elected in the Municipality council. (Appendix C)

The constitution is governed according to Islamic law- *Shariah*. The Basic Law that articulates the government's rights and responsibilities was propagated by a Royal Decree in 1992. The legal system is Islamic legal system with some elements from foreign countries and customary laws.

The highest court is the Supreme Council of Justice. There are special courts that address specific disputes; for example commercial disputes are handled by the special courts. It is important to note that in Saudi Arabia there are no political parties or political leaders.

Legal framework:

In Saudi Arabia, the establishment of laws and regulations related to domestic violence are in progress; the Child Protection Act was released recently in May 2011 from Al Shura Council and is awaiting the final approval and distribution from the Cabinet. Below are the established regulations:

1. *Child Protection Regulations*. The implementation of this regulation for the time being depends on the overall criminal justice law. This will change once the Child Protection Act is approved

2. *Regulation of Children in Need of Care*: This regulation protects children in need of care, meaning children of unknown parents and children who have been deprived of parental/guardian care due to death, divorce, imprisonment, mental illness, physical incapability or any other similar reason to the discretion of the judge. The regulation also includes children with disabilities or children with incurable disease whose parents are unable to provide treatment or care for them.

3. *The Regulation on Protection from Abuse*: This regulation aims to ensure protection from abuse in various forms through assistance and treatment, providing shelter and social welfare, psychological, health and regulatory requirements, and taking the necessary legal procedures to question and punish the offending.

It is important to note that in *Shariah,* there are laws that take into account the child's best interest in terms of welfare, respect and rights. Such rights include: the child's right to life, breast feeding, custody, guardianship, appropriate name choice, education, etc.

A committee in the Kingdom's Human Rights Commission has been formed to examine the extent to which Saudi legislation is compatible with human rights instruments as a first

step towards harmonization of the Kingdom's existing laws with its obligations under international treaties and conventions according to Shariah laws.

International Conventions Ratified by Saudi Arabia Specific to Children

Saudi Arabia has joined the most relevant international conventions related to children and women's rights. However, a general reservation was included, whereby, "in case of contradiction between any term of the convention and the norms of Islamic Law, the Kingdom is not under any obligation to observe the contradictory terms of the Convention". The following are conventions ratified by Saudi Arabia:

1. *The United Nations (UN) Convention on the Rights of the Child* (CRC) ratified in 1996
   Saudi Arabia ratified this convention and considers it to be a valid source of domestic law. The CRC underlies a range of rights to which children everywhere are entitled. It sets basic standards for children's well being at different stages of their development and is the first universal, legally binding code of child rights in history. It states that everyone under the age of 18 regardless of gender, origin, disability, religion, etc., needs special care and protection because children are often the most vulnerable group. The 54 articles in this convention are guided by the following main principles: the best interests of the child, survival, development, protection and participation.

2. *Arab Charter on Human Rights*
   This charter is set to achieve the following aims: to place human rights at the centre of key national concerns of the Arab States and to teach people to have pride, loyalty and attachment to his/her identity and country. The charter sets to entrench the principle that all humans are universal, indivisible, inter-dependent and interrelated.

3. *The Covenant on the Rights of Children in Islam* ratified in 2008
   The covenant emphasizes children's rights in Islamic law and its provisions taking into account the domestic legislation of states, as well as the rights of children of minorities and non-Muslim communities.

4. *Gulf Country Cooperation (GCC) Unified Code on Protection of Minors' Wealth*
   This code entails dealing with funds of minors, public authority for minors care funds and guardianship, backbiting and loss.

5. *Optional Protocol on the Sale of Children, Child Prostitution and Child Pornography* ratified in 2010
   This is a protocol to the convention on the Rights of the Child and requires states to prohibit the sale of children, child pornography and prostitution.

History of Child Maltreatment in Saudi Arabia

Although child maltreatment (CM) practices in the Arabian Peninsula were described in historical anecdotes and Islamic literature, it was not until 1990 that the first case report from Saudi Arabia was published in the medical literature (17, 18). In 1996, Saudi Arabia signed and ratified the United Nations Convention on the Rights of the Child (CRC), and toward the end of the decade CM was already recognized at major health facilities throughout the country. While hospitals continued to receive increased CM cases, the magnitude of the problem in Saudi Arabia, even in these settings, was not known due to the lack of accurate statistics on its occurrence. One consequence of the lack of information was that risk factors, indicators, categories, definitions, and the nature of the problem of child maltreatment were not well identified and therefore, multidisciplinary services for the victims of abuse and their families were not well informed and developed in the country.

Historically, CM was initially recognized in Saudi Arabia by health-care professionals as a rare problem affecting the well-being of few children in the country. Therefore, from 1990 to 2000 there were only 11 reports published in the medical literature and all were case studies (18, 19, 20, 21, 22, 23, 25, 26, 27). The official development of child protection started in the year 2000 when CM was recognized as a public issue by the national media focusing on the lack of legislation and services. It was not until 2004 that national efforts were geared towards preservation of children's rights and the prevention of child maltreatment. During this first stage of development (2000–2004) various governmental agencies and NGOs were created and directed towards those goals and the first Child Protection Act was drafted. Most noticeable was the role played by national media in raising the public awareness of CM practices in Saudi Arabia. During this stage, many multidisciplinary teams were also formed in major hospitals to serve abused children (28, 29)

The second stage of development was from 2005 to 2010 and was characterized by the initiation of additional governmental and non-governmental agencies specialized in child abuse and neglect prevention and treatment. Among the many positive programs and initiatives developed in the country during this stage (30, 31), the foremost was the formation of the National Family Safety Program (NFSP) in November 2005, by the royal decree of the king, as an example of a specialized quasi-governmental agency dedicated to the prevention of child maltreatment and domestic violence. Furthermore, the Human Rights Commission (HRC) and the Human Rights Society (HRS) were also initiated in 2005 and were very active in the promotion of human rights issues, especially the implementation of the CRC in different governmental agencies.

In 2007, the National Family Safety Program (NFSP) submitted a national project to establish Child Protection Centers (CPCs) in major hospitals throughout the country. The project received full approval and support by the National Health Council (NHC), which is the highest health service authority in the kingdom. The strong recommendation to the project was primarily derived from the NHC legislatives and health-care decision makers, who believed in supporting basic rights of the children declared in the CRC (UNHCHR-

CRC, 1989). Consequently, the council accredited 40 hospitals across the country as CPCs. The population densities and geographical breadth of these provinces were taken into account in the establishment of these centers to enable better service coverage. CM cases are now evaluated on a 24-hour basis by on-call multidisciplinary Child Protection Teams (CPT). Advanced training is provided to the teams' staff members by the International Society for the Prevention of Child Abuse and Neglect (ISPCAN) and NFSP joint training programs. According to the hospital-based child protection system, any suspected CM case shall be referred to the nearest CPC where urgent evaluation by CPT to substantiate abuse allegation takes place. Appropriate interventions are made for substantiated cases utilizing the regional social services resources. Cases of confirmed physical or sexual assaults are referred to law enforcement officials for investigation where criminal cases are to be prosecuted in court.

The CPC project also included drafting and issuance of health care professionals' and school professionals' mandatory reporting laws and establishing a National Family Safety Registry (NFSR). Currently, only healthcare professionals and school professionals are mandated to report all suspected cases of CM to CPCs. The law of mandatory reporting of CM cases undoubtedly protects the identity of the reporter and preserves the confidentiality of information. Negligence to report any case would subject the worker to penalties, according to the Saudi Health Practice Act (2006). In 2009, CPCs were mandated to report all substantiated cases to NFSR. The web-based registry enables trained CPT members to register any substantiated case into a web-based registry to determine prevalence, demographics, and recurrence of CM, in addition to short term services provided. Data on registered cases are entered into the registry from all CPCs from major hospitals in the country. The case registration form adapted the World Health Organization (WHO) definitions for various forms of CM (32). The electronic form has bilingual (Arabic and English) entries to enable English speaking physicians and nurses to report CM cases. It contains general information on the victim and perpetrator, form of abuse, risk factors, investigation, disposition, consequences, notifications and follow-up plan.

In conclusion, the outcomes of the last decade 2000-2010 were notable for child protection services with little emphasis on child maltreatment prevention programs. However, CM prevention is currently poised to become a global health priority with emphasis on evidence-based interventions and prevention programs.

Child Maltreatment Prevention

Most of the efforts on CM in Saudi Arabia thus far have been focused on child maltreatment protection with little emphasis on child maltreatment prevention. Child maltreatment protection, as defined by the World Health Organization (WHO), are measures taken *after* child maltreatment has occurred, such as support and care for the victim; while child maltreatment prevention refer to measures taken to prevent child maltreatment *before* it occurs by addressing the underlying causes and risk factors, such as teaching positive parenting skills to pregnant first-time mothers (33).

Prevention is a systematic process that promotes safe, healthy environments and behaviors by reducing the likelihood of an incident, injury or condition occurring (34). Prevention initiatives can address more than one level of prevention by integrating strategies that intervene in cases of child maltreatment at various stages or points in time. **Primary prevention** are activities that take place before the violence has occurred to prevent initial victimization—in other words prevent the abuse from happening in the first place. It focuses on action before the condition or situation of concerns develops. **Secondary prevention** is the immediate responses after violence has occurred to address short term consequences of violence. **Tertiary prevention** is the long-term responses after violence has occurred that deal with lasting consequences of violence to ameliorate and/or prevent further negative health consequences (34).

The efforts thus far in Saudi Arabia have focused on providing national awareness on domestic violence and child maltreatment through organizing local, regional and international human rights' conferences, by issuing publications, brochures and books on the subject and educating adults and children about their rights. There have been various lectures given at schools and universities addressing topics of domestic violence and child abuse, in addition to various media campaigns, events, conferences and expert meetings. For a complete list of programs, refer to Appendix D. Most noted programs are early parenting programs and child sex education programs; however, the majority of these programs were not evaluated in terms of impact and sustainability.

Training of professionals dealing with children has also been active in Saudi Arabia by offering courses for medical professionals, social workers, law enforcement officials and multidisciplinary courses on how to deal with cases of child abuse and neglect. The aim of these training courses is to build the capacity of professionals from different disciplines and increase their knowledge and skills in this field.

The National Family Safety Program established the Saudi Child Helpline (116-111) in 2010 that provides children (until the age of 18) and their care givers with counseling and referral services. The helpline was established with the help of 14 various governmental, non-governmental and international agencies (UNICEF and Arab Gulf Program for Development [AGFUND]). Having such a wide network allows the helpline to adequately assist the child/caregiver's needs if the problem is beyond counseling and requires more severe action. Such entities include: Ministry of Social Affairs, Ministry of Education,

Police, Human Rights Commission, National Society for Human Rights, National Childhood Council, and others.

The Saudi Child Helpline operates 12 hours per day and will be launched officially in 2012. The line will operate 24 hours a day, throughout the whole week with a specialized team of agents ready to take calls and offer counseling and referral.

Shaken Baby Syndrome Prevention Program for New Mothers

Recent statistics gathered from pediatrics ER cases have shown an alarmingly high number in cases of Shaken Baby Syndrome (SBS) in Saudi Arabia. Looking at the statistics from just one hospital, King Abdulaziz Medical City Riyadh- The Suspected Child Abuse (SCAN) team indicated that out of the 248 substantiated child maltreatment cases, 36 were shaken baby syndrome. 80% of these cases led to permanent disabilities and19.4% were fatal. The average period of time the patient stayed in the hospital was 8 days, and the age of the children were between four days to two years.

The need to educate new mothers on SBS became evident and a prevention program was devised and recently implemented at King Abdulaziz Medical City Riyadh as phase I. This was a one year project (year 2012) to assess the effectiveness of educating mothers on preventing SBS.

The Goal:
To educate new mothers on SBS and how to adequately handle crying babies by highlighting the dangers of shaking their newborns and infants violently and the lifelong impact it may have on their lives.

Phase I:
To educate 6,000 new mothers on shaken baby syndrome and provide them with coping strategies and advice on how to deal with crying babies in King Abdulaziz Medical City- Riyadh. There are 9,000 births per year in this hospital.

Results:
This prevention program proved to be highly effective. By the end of 2012, cases of SBS have been significantly reduced. Only two cases were reported and both were from outside Riyadh, and mothers had not undergone the prevention program.

Phase II:
The program will be adopted by the Ministry of Health to be implemented nationally in various hospitals in the 13 regions of the country.

Ethical Consideration for CMPR

The Child Maltreatment Prevention Readiness study was conducted through the NFSP. The NFSP is under the umbrella of the National Guard Health Affairs and has built its reputation over the years to be one of the leading entities for combating child maltreatment

nationally. The research protocol was reviewed and approved by the Research Committee at King Abdullah International Medical Research Center,. A proposal for the study was sent to the research center which was reviewed by the research committee headed by the Chairman of Retrospective Research Subcommittee and was provisionally approved. The committee had some questions regarding the sample size and selection, but the approval was obtained swiftly. There was no need to obtain approval from the IRB as there was no disclosure of identity and no risk associated to participants in the study. In addition, mentioning that the study was being conducted in collaboration with the WHO, gave it more legitimacy. There is great need for Saudi Arabia to be part of international studies being conducted worldwide as it helps shed light on the Kingdom's current standing in comparison to other nations.

In terms of ethical problems encountered while carrying out the study, there were none. Prior to beginning the interview, participants were briefed about the subject matter and asked to sign a consent form indicating their understanding of the study and their right to stop the interview at any given time. In addition, participants were given the option of disclosing their identities or remaining anonymous.

Rationale for CMPR

There needs to be a shift from a reactive approach to a proactive approach in child maltreatment. As mentioned, most efforts have been focused on protection, and although the problem is being dealt with as it arises, there needs to be more efforts placed on educating people to avoid CM from happening in the first place. The first annual report produced by the National Family Safety Registry in 2011 showed 292 substantiated cases of abuse. The victims were from all over Saudi Arabia, (52.4%) male and (47.6%) female. The forms of CM included physical abuse (60%), sexual abuse (15.4%) and neglect (41.3%). Other categories were Munchausen Syndrome by Proxy and Shaken Baby Syndrome, (2.6%) and (4.6%) respectively. Although these statistics only show data from late 2009 until September 2010, and represent the tip of the iceberg, it is an important indicator that CM exists in Saudi Arabia and needs to be prevented.

The consequences of child maltreatment are vast stretching from short term consequences to long term consequences both emotionally and physically. In fact, in many cases it becomes the cycle of abuse, in which the abused child becomes the perpetrator. Some of the most known consequences of CM on the victim include depression, low self-esteem, personality and conduct disorder, poor problem solving and social skills, difficulties with relationships, educational problems, violent and aggressive behavior, sexuality problems, unwanted pregnancies, developmental delays, withdrawal and isolation, identity problems, divorce and others. In addition, recent studies have linked CM to risky health behaviors and subsequently development of chronic physical diseases, as a long term consequences, such as lung disease, coronary heart disease, diabetes, sexually transmitted diseases.

CM can be very costly to governments because it has a major effect on productivity, performance and health in general. These factors can lead to poor economic growth due to unemployment and a weak community structure. In addition, CM can cause criminal

behavior and delinquency and encourage drug and alcohol abuse. Furthermore, the cost of rehabilitation (both establishment of rehabilitation facilities and treatment for victims) and legal costs can be a burden to countries.

For these reasons, it is clear that there is a need for prevention programs. However, prior to establishing such, it is necessary to determine how ready Saudi Arabia is to do so. Before that it is vital to understand some of the main risk factors of child maltreatment in Saudi Arabia that these prevention programs can address. Some of the risk factors include: poverty, economic and financial strains, family violence and dysfunction, parental level of education, addiction to drugs and alcohol, misinterpretation and misunderstanding of religion, child health issues and disabilities, low levels of awareness, young parents, large families, divorce or single parent, unemployment amongst others.

Aim of this Project in Saudi Arabia

Although child maltreatment protection services have been progressing well in Saudi Arabia in the last decades, there is little emphasis on child maltreatment prevention programs. The aim of the study was to assess the readiness of Saudi Arabia in implementing large-scale evidence-based child maltreatment prevention programs in Saudi Arabia.

Target Audience/Readership for this Report

The target audiences for this report are the policy makers, general public, researchers, program managers and others involved in child maltreatment prevention activities. This report is expected to raise the awareness of the issue on all levels of the society, which could lead to better national support to all facets of child maltreatment prevention programs.

Chapter 2: Methodology

Development of Instrument- WHO Headquarters

The method used for data collection was in-depth personal interviews. The instrument, The Child Maltreatment Prevention Readiness (CMPR) questionnaire, was initially comprised of 8 dimensions: (1) problem assessment; (2) legislation, mandates, policies and plans; (3) will to address the problem; (4) institutional links and intersectoral collaboration; (5) institutional resources and efficiency; (6) material resources; (7) human and technical resources; (8) current program implementation and evaluation. In the final version of the questionnaire, the dimensions were further broken, resulting in a total of 10 dimensions: 1) attitudes towards child maltreatment, 2) knowledge and 3) scientific data on child maltreatment prevention, 4) current program implementation and evaluation, 5) legislations, mandates and policies on child maltreatment prevention, 6) assessment of the strength of the will to address child maltreatment problem in Saudi Arabia, 7) institutional links and resources, 8) material resources, 9) human and technical resources, 10) informal social resources (non-institutional). The scoring system and the resulting scores are based on the 10 dimensions and are reported below. Appendix A contains a brief description of each dimension.

After the questionnaire was compiled and ready for testing, a core group of researchers were identified and selected to be part of this research project. The team consisted of four main researchers. The questionnaire was cognitively tested on a focus group, which mainly consisted of employees working at the National Family Safety Program (NFSP). At this point, none of the researchers felt it was necessary to translate the questionnaire into Arabic, as English is considered the second language in Saudi Arabia. The CMPR instrument can be accessed through the WHO website at the following address: http://www.who.int/violence_injury_prevention/violence/child/cmp_readiness/en/index.html

Pilot Phase in Saudi Arabia

The pilot phase took place in Saudi Arabia in 2010, in which 20 individuals were interviewed. All interviews were scheduled by phone by the researchers. The participants were physicians, social workers and teachers. The goal of the pilot phase was to determine the difficulties with the questionnaire and gain a better understanding of how well the questionnaire would be culturally accepted.

The main problem identified during the pilot phase was the length of the interview. Secondly, a lot of time was spent translating the questionnaire during the interview if the interviewee did not speak English. Some interviews lasted up to 3 hours or longer.

After the completion of the pilot phase, each country gathered the information, voiced concerns and added suggestions in an excel sheet provided by WHO. The results were assembled and discussed in a meeting held at the WHO headquarters where some adjustments were made. However, not much was changed in order to preserve the content

and ideally test for the above mentioned categories. In addition, two versions of the questionnaire were produced: one for the interviewer that contains cues and provides some instruction and another version for the interviewee, which contained the questions only. Providing the interviewee with the questions during the interview made it easier for the participant to choose from the options as well as reread the question on his/her own time if necessary.

Translation and Adaptation of Instrument:

The 'interviewee' version of the questionnaire was translated by a professional translating agency into Arabic. The questionnaire was then validated by bilingual researchers at the National Family Safety Program (NFSP) to ensure no information had been lost during translation, that the wording in Arabic was suitable and correct, as well as to ensure consistency in wording and explanation.

Field Testing in Saudi Arabia:

The field testing was conducted in 2011, in Riyadh, the capital city of Saudi Arabia . Participants were recruited through convenience sampling and were selected from professional organizations, governmental, non-governmental agencies and international organizations in Saudi Arabia.
The participants are key stakeholders who have or are likely to have significant influence and decision-making power on child maltreatment prevention in the country. These participants will be referred to as "key informants" in this report.

The researchers selected the key informants by initially listing all of the various concerned ministries, such as the Ministry of Health, Ministry of Social Affairs, Ministry of Interior, and the Ministry of Education, other governmental entities such as the National Childhood Council and the National Society for Human Rights, non-governmental organizations (NGOs) that are concerned with child maltreatment and international agencies such as UNICEF and the Arab Gulf Program for Development (AGFUND) which also have local concerns with child maltreatment. After the major organizations were selected, representatives from each one were chosen to be interviewed. The selection was made so that there would be representation from national, regional (provincial), and local levels. Interviews were scheduled either by phone directly by one of the four researchers or through the research coordinator. If requested, formal information letters were sent inviting the eligible participant to take part in the study. Box1 below portrays the list of institutions participated in the study and the corresponding number of participants interviewed from each entity.

Box 1: Agencies and corresponding participants interviewed	
Agency	Number of Participants
Governmental	
Ministry of Social Affairs	8
Ministry of Education	4
Ministry of Health	8
Ministry of Justice	2
Ministry of Interior	3
Al Shura Council	2
Human Rights Commission	1
Academic Institutions	3
Total	**31**
Non-Governmental	
Human Rights Society	2
Saudi Pediatrics Society	1
National Childhood Council	1
Family Protection Society	1
Other NGOs (Hayat and Al Riyadh Newspapers)	2
Total	**7**
International Organizations	
Unicef	2
AGFUND	1
Total	**3**

Response Rate:

Fifty key informants were selected from the stakeholders and 41(82% response rate) agreed to participate in the study and completed the lengthy interview (Box 1). Thirty one (76%) were from the government sector and 10 (24%) from non-governmental organizations, including regional and international agencies. Twenty three (56%) were males and 18 (44%) were females.
The four lead researchers conducted the interviews; 3 researchers conducted 10 interviews each and 1 researcher conducted 11 interviews. Twenty participants were key informants at a national level, 10 at a regional level and 11 at a local (Riyadh) level.

Justification for national readiness assessment

The Child maltreatment prevention readiness survey in Saudi Arabia was intended to provide a national picture on the readiness of the country and not at a regional or community level to implement large-scale child maltreatment prevention programs. This approach was adapted because of the following reasons:

1. The awareness of child maltreatment in Saudi Arabia is in its early stages and most of the campaigns are focused on urban areas, mostly in the capital – Riyadh. The regions or rural communities are less aware of the issue and may provide less concrete information about the readiness situation in their regions and the country.
2. There were only few experts representing other regions, which we interviewed them, but were not adequate to provide a regional picture on its readiness.
3. The central government is based in Riyadh and attracts the most qualified personnel. Regional branches of the government are mostly staffed by less qualified personnel who can give a comprehensive assessment of the readiness situations in the country.
4. Infrastructures for child maltreatment prevention are mostly in Riyadh-The Capital City, and other regions have less developed infrastructures. Thus, information collected could be incomplete and may not provide useful information to assess the situation.

Process of Carrying out the Interview:

The interview was conducted either in English or Arabic depending on the interviewee's language of preference. If the interview was conducted in Arabic, the interviewer thereafter translated the responses into English. The location for the interview was determined by the participants; some elected to carry out the interview at their work place and others at the NFSP or other venues.

Challenges:

There were many challenges that were faced during the field testing of the interview. Some of the challenges were related to the questionnaire itself and/or with the sample.

Scheduling the interviews was also difficult, especially if done so by a coordinator or a junior. There was some skepticism about taking part in the interview and some requested a formal letter to be sent to their organization.

Finally, the interviewers faced difficulties with some questions like listing specific prevention programs. Many participants mentioned prevention programs that were not specific to child maltreatment. In addition, questions that asked for specific answers, such as the number of people working in organizations were left unanswered or were guesses.

The major concern with the sample was that it had only a good national representation, but had sub-optimal representation for the regions (3 regions out of 13) and local areas (only Riyadh).

Process of Conducting Objective Assessment:

Once all of the interviews were completed, the four lead researchers met and filled out the questionnaire together based on their opinion and using all available data in the country. The expert assessment allows a more objective assessment of those dimensions which are primarily factual (2, 3, 4, 7, 8, and 9). This assessment will be referred to as 'experts' assessment in the rest of the document. The CMPR expert assessment instrument can be accessed through the WHO website at the following address: http://www.who.int/violence_injury_prevention/violence/child/cmp_readiness/en/index.html

Data analysis:

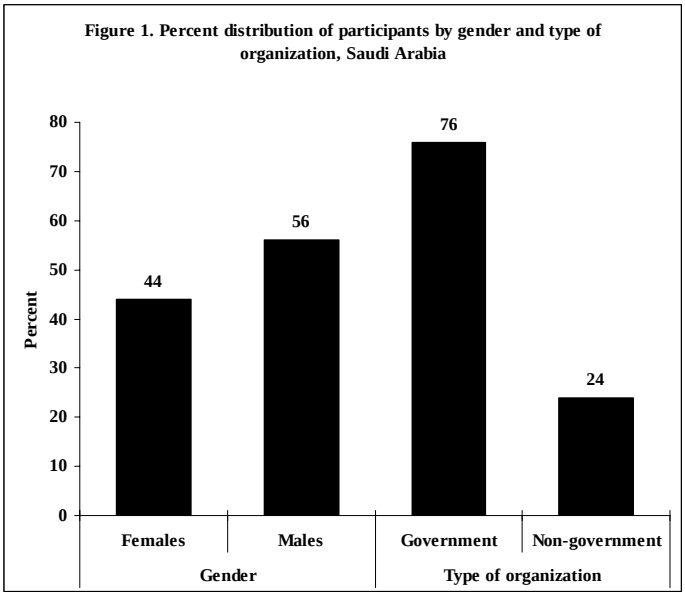
SPSS was used for data analysis. For questions with likert-scale type responses, some of the response categories were collapsed. The number and percent of the collapsed response categories were reported. For questions with "yes", "no" or "don't know" type responses, we reported the frequency and the percent of these categories. The percent of respondents who responded in each question was cross-tabulated with type of organization and gender. The selection of the cross-tabulations was based on conceptual judgment about possible response variations between genders and/or organizations. Significance test was not performed to compare the percentage differences between government and non-governmental organizations or between genders, as the sample was too small and was not selected through a random process. Thus, only descriptive statistics will be presented.

As for scoring the responses, the score of each question in the ten dimensions was calculated for the experts and key informants. Each dimension was scored on a scale from 1-10 with a total score of 100 for CMPR- key informants and CMPR- experts. The overall score of the ten dimensions and the score for each dimension was also calculated. To assess the agreement between the key informants and experts, the mean scores for each dimension were categorized into two categories: 5 or higher and below 5. The percent agreement between the key informants and experts on these two categories on the dimensions was calculated.

For open-end responses (qualitative information), we listed the responses of each question and counted the number of key informants who gave these responses. Responses that belong to the same theme were collapsed. Tables showing the number and percent of responses for each question were generated. The top responses are summarized in Box 7.

Chapter 3: Findings

There were 41 key informants that participated in the survey. Fifty six percent were males and 44% were females, Thirty one (76%) were from the government sector and 10 (24%) from non-governmental organizations, including regional and international agencies (Figure 1).



Box 2 below shows key informants professional background within their organizations:

Box 2. Position in the organization	Number of Persons
1. Healthcare providers	6
2. Senior managers	14
3. Mid-level managers	8
4. Policy makers/legislators	2
5. Judges and legal advisors	3
6. Media and communication specialists	2
7. Social workers & volunteers	5
9. Treasurers	1
Total	**41**

The majority of key informants, 42%, had 1-5 years experience in child maltreatment prevention, 27% had 6-10 years and 32% had 11 years or more experiences in child maltreatment prevention. The percent of key informants who had 1-5 years, 6-10 years and 11 years or more experience in protection were comparable to that of prevention.

Psychometric characteristics of the survey instrument in Saudi Arabia

The overall score of the ten dimensions from the key informants and experts were 43.7/100 and 40/100 respectively. Out of the 10 dimensions, Key Informants scored high (≥5) on (2) Knowledge, (3) Scientific data, (5) Legislations and mandates and (6) Will to address child maltreatment. Key Informants scored low (<5) on (1) Attitudes toward child maltreatment, (4) Current programs, (7) Institutional links (8) Material resources (9) Human resources and (10) informal social resources.

As for the experts they scored high on (2) Knowledge on child maltreatment, (3) Scientific data on child maltreatment (4) Current programs (6) Will to address child maltreatment (10) Informal social resources. Experts scored low on (1) Attitudes towards CAN, (5) Legislations, mandates, (7) Institutional links, (8) Material resources and (9) Human resources.

The overall agreement of the scores between the key informants and experts on the ten dimensions was 70%, indicating a moderate reliability of the instrument in measuring the opinions of the key informants and experts. Both experts and key informants agreed that dimensions (1, 7, 8, 9) attitude, institutional link, material and human resources dimensions need improvement in the country (where both gave scores less than 5). Both key informants and experts agreed that dimensions (2, 3, 6,), knowledge, scientific data, and the will to address the problem were strong in the country with scores above 5 (Box 3). Using the mean score of the experts as the gold standard, the key informants agreed 60% with the experts on dimensions with scores of 5 or above, and 80% on dimensions with scores below 5 (Box 3). This shows that the key informants' assessment has a sensitivity of 60% and a specificity of 80% which is a good level of accuracy.

Key informants and experts gave an overall score of 43/100 and 40/100 readiness in Saudi Arabia to implement large-scale child maltreatment prevention programs, respectively, which indicate a low level of readiness. The fact that key informants scored slightly higher than experts is concerning. This may be due to the fact that the majority of the key informants are government employee where they see their organization is doing well. Although the experts assessment is more objective and close to reality of the situation, the difference in the scores between key informants and experts were minimal and does not move the country to a higher or lower level of readiness.

There were wide differences and discrepancies between the experts and key informants on dimensions (4, 5, and 10), current prevention programs, legislations and policies, and informal social resources. Key informants were not aware of existing prevention programs that have been implemented in the country by different institutions, while experts are often involved with almost all aspects of child maltreatment programs and are more aware of current programs and resources than key informants, which could explain such differences. In spite of existence of such programs, experts believe that these programs were not evaluated and their sustainability is unknown.

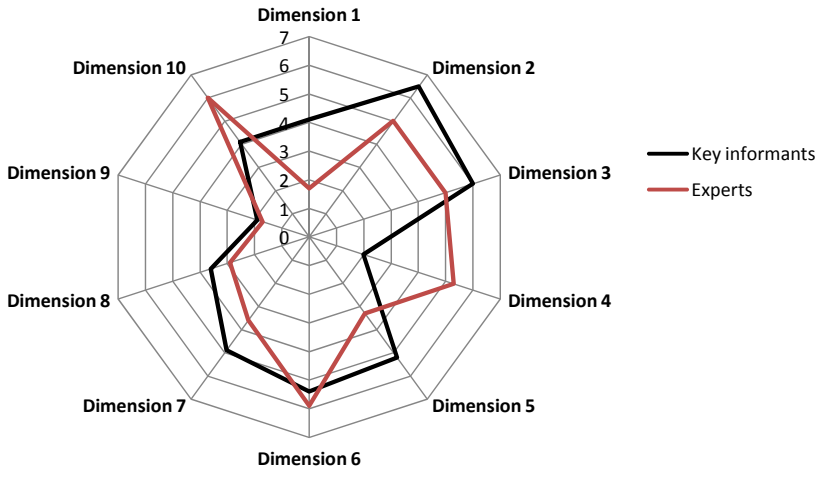
The key informants affirmed the existence of legislations and special agency mandated for protecting children from maltreatment in Saudi Arabia, although ineffective. Experts believed that the current legislations and agencies are neither specific nor effective.

Both key informants and experts are highly educated individuals and cultural norms may rarely influence their responses on child maltreatment issue. Thus, their assessment may be close to the actual status of the issue in Saudi Arabia.

Box 3 . Experts and key informant raw scores and scores on a scale of 1-10 in the ten dimensions.

	Key informants		Experts	
Dimensions	**Raw Score**	**Score on a scale of 1-10**	**Raw Score**	**Score on a scale of 1-10**
Dimension 1: Attitudes towards child maltreatment prevention	5.7/14	4.1	2.0/12	1.7
Dimension 2: Knowledge of child maltreatment prevention	9.8/15	6.5	3.0/6	5
Dimension 3: Scientific data on child maltreatment prevention	13.2/15	6	11.0/22	5
Dimension 4: Current programme implementation and evaluation	5.96/30	2	16/30	5.3
Dimension 5: Legislation, mandates, and policies	6.2/12	5.2	4.0/12	3.3
Dimension 6: Will to address the problem	13/24	5.4	13/22	5.9
Dimension 7: Institutional links and resources	9.25/19	4.9	26.5/74	3.6
Dimension 8: Material resources	4.7/13	3.6	4.0/14	2.9
Dimension 9: Human and technical resources	2.3/12	1.9	2.0/12	1.7
Dimension 10: Informal social resources (non-institutional)	4.1/10	4.1	6.0/10	6
Total		**43.7**		**40.4**

Figure 2. Key informants and experts scores on ten dimensions, Saudi Arabia



I. Attitudes towards child maltreatment prevention:

The overall mean score for this dimension was 4.1/10. Compared to other health and social problems, only 37% of the key informants believed that child maltreatment prevention has higher priority, while 42% believed that it has lower priority in Saudi Arabia (Table 1). On the other hand, 10% of the key informants believed that child maltreatment prevention has more political priority over child maltreatment protection, whereas the majority, 54%, believed that prevention has lesser political priority. Eighty five percent (85%) of the key informants also believed that the measures taken so far to prevent child maltreatment were inadequate, and none of the key informants believed that the measures were adequate. On the issue of children's rights, 22% believed that they are well protected and 27% moderately protected, whereas 49%, the majority, believed that they are inadequately protected or not protected at all in legislations. Similarly, 81% believed that children's rights are inadequately or not protected at all in practice (Table 1). Both key informants and research teams judged children's rights to be much better protected in terms of legislation than in practice.

II. Knowledge of child maltreatment prevention

The overall mean score for this dimension was 6.5/10. Sixty six percent (66%) of the key informants believed that the percent of adults maltreated in childhood is at least 25% (Table 2). The percentage for males and females were 52% and 83% respectively, Also, 59% of the key informants were aware of the existence of evidence-based or public health approaches to child maltreatment prevention, whereas 41% were not aware.

Appropriateness of several intervention programs to prevent child maltreatment was asked to the key informants. Fifty four percent (54%) and 88% of the key informants viewed that home visitation and parenting education was appropriate in Saudi Arabia respectively, (Table 3). For child sexual abuse prevention, abusive head trauma prevention and media campaign interventions, the percentage that viewed as appropriate was 90% or higher and was approximately similar in government and non-governmental organizations and in both females and males. The percent who believed that these three interventions were inappropriate were negligible.

III. Scientific data on child maltreatment prevention

The overall mean score for this dimension was 6.0/10. The majority (51%) of respondents reported the lack of an official definition of child maltreatment cases, and 39% replied that such definitions existed and were used.

The majority of key informants, 59%-85%, believed that scientific data to assess the magnitude and distribution of child maltreatment problems, in general and on specific types is not available (Table 4). The data that was viewed as the least available was the one to assess the consequences of child maltreatment (85%). This shows the scarcity of scientific data to assess general and specific child maltreatment problems in Saudi Arabia.

In addition, 49% of the key informants believed that a mandatory reporting system for child maltreatment exists in Saudi Arabia; only 39% believed that the existing reporting systems were fairly effective. Only 29% of the key informants believe that scientific evidence strongly influences their decisions on child maltreatment, whereas 44% believe that it has weak influence on such decisions.

IV. Current Program Implementation and Evaluation

The overall mean score for this dimension was 2.0/10. Among the key informants who knew child maltreatment programs that are currently being or had in the past been implemented in Saudi Arabia, mentioned several programs. The most frequently mentioned programs that had been evaluated are shown in Box 4. The programs were implemented at national or community levels. The way these programs were evaluated is not known. The research team listed more prevention programs in the country however they were concerned about their evaluations.

Box 4. Child maltreament programs that are currently being or have in the past been implemented and evaluated, Saudi Arabia.

No.	Name of the program	Type of program	Level	Evaluation
1	Awareness and Training	Awarenes	National	Yes
2	Parent Education	Education	Community	Yes
3	Dialogue with Youth	Teenage parenting Program	National	Yes
4	Multidisciplinary Training on Prevention of Child Abuse and Neglect	Training	National	Yes
5	Family Education Program	Home Visitation Program	Community	Yes
6	MAWSEEB	Parenting Proram for Mothers with Preschool Children	Community	Yes

The key informants also reported current or past child maltreatment programs that are not expressly aimed at preventing child maltreatment but to which child maltreatment prevention components could be integrated. These are shown in Box 5. Also the list consists of programs that are implemented at national or community levels. These programs are the most frequently mentioned.

Box 5. Current or Past child maltreatment programs in Saudi Arabia, that are not expressly aimed at preventing child maltreament but into which child maltreament prevention component could be integrated.

No.	Name of the program	Type of the program	Level of implementation
1	Child helpline	Counselling	National
2	Child protection center	Health	National
3	Pre-marriage counselling	Educational	Community
4	STEP	Community parenting	Community
5	Student advisory guidelines	Counselling	National
6	Immunization Programs	Health	National
7	PORTAGE	Education of mothers with disabled children	Community
8	Social Welfare Programs	School bag to the poor with parenting information	National

V. Legislation, mandates, and policies

The overall mean score for this dimension was 5.2/10. Fifty six percent (56%) of the respondents stated that there are legislations for child maltreatment prevention and are in force, but a substantial percentage, 39%, stated that there are no legislations (Table 5). Of those who stated the existence of legislation, only 22% believed that such legislations are effective; whereas the majority, 43%, believed that these legislations are ineffective (Table 5).

The majority of key informants, 85%, affirmed the existence of officially mandated agencies for child maltreatment prevention (Table 5), but only 37% believed that such agencies are effective, whereas 26% believed that they are ineffective. There was a marked and consistent pattern in findings between key informants and experts indicating that while legislation, agencies mandated with CMP, and CMP policies existed, none was considered to contribute to preventing CM particularly effectively.

VI. Assessment of the strength of the will to address child maltreatment problem in Saudi Arabia

The overall mean score for this dimension was 5.4/10. Approximately 83% of the key informants believed that the leadership is concerned with the child maltreatment problem (Table 6). However 34% of key informants believed that the quality of leadership in child maltreatment issue is good and 26% believed that they are poor.

On the political will, 76% of the key informants responded that there are definitely political leaders with strong political commitment that can take effective measures to child

maltreatment prevention. Non-governmental organizations and females had higher percentage relative to governmental organizations and males, respectively.

On the general public perception of child maltreatment prevention, 44% of the key informants stated that the general public perceives the problem as serious and 29% believe that the advocacy efforts are intensive. Twenty percent (20%) of the key informants believed that information on child maltreatment prevention is accessible to the public, whereas 44% believed as inaccessible (Table 6).

VII. Institutional links and resources

The overall mean score for this dimension was 4.9/10. There were many coalitions, partnerships or alliances reported by the key informants that have two or more sectors collaborating among each other. A subset of partnerships or alliances is shown in Box 6.

BOX 6. Names of partnerships, coalitions, alliance, and etc, Saudi Arabia.

	Name of coalitions/partners	Number of sectors
1	SAUDI Child helpline	14
2	National Executive Committee on Child abuse and neglect	13
3	Social protection committees	8
4	National family safety program and Human rights society	2
5	National family safety program and National council of childhood	2
6	AGFUND and Ministry of Education	2
7	AGFUND and NGO's	2

There were also many institutions currently involved in child maltreatment prevention, as stated by the key informants. The list of institutions are: ministry of social affairs, national family safety program, and ministry of health, human rights society, and national childhood council. .

VIII. Material Resources

The overall mean score for this dimension was 3.6/10. Out of the 41 key informants in the survey, less than half, 16 (39%), reported that they know some government ministries with a dedicated budget for child maltreatment prevention (Table 7). On the attitudes of potential funders towards child maltreatment prevention, 34% of the key informants believed that they are at least supportive. Only 27% of the key informants deemed that the infrastructure for child maltreatment prevention as adequate, whereas the majority, 46%, believe as inadequate (Table 7). Both key informants and experts agreed that there is no dedicated budget for CMP and material resources are generally inadequate. Attitudes of potential funders were generally judged to be more positive by the research teams than by the key informants.

IX. Human and Technical Resources

The overall mean score for this dimension was 1.9/10. Only 5% of the key informants believed that the number of professionals specialized in child maltreatment prevention is adequate for the implementation of large-scale programs on child maltreatment prevention in Saudi Arabia while 81% believe it is inadequate (Table 7). When followed up with what kind of programs that the current human and technical resources allow to be implemented at a national level, the largest percent (71%) stated that it allows small-scale pilot programs in several areas or in one area of the country.

On the assessment of the adequacy of institutions that can provide training and education for a large-scale implementation of child maltreatment prevention programs, 88% considered as inadequate or non-existent (Table 8). Similarly, 66% considered as none or almost none of the undergraduate and graduate academic institutions are available to devote part of the curriculum to child maltreatment prevention. Also 41.4% of the key informants considered that at least several non-university institutions are available (Table 8). A similar picture was observed in institutions that can provide opportunities for continuing professional development, where 66% stated that such opportunities are non-existent. The team was in agreement with the key informants in the number of professionals specializing in CMP and the training institutions to be extremely inadequate for large-scale implementation of CMP program.

X. Informal Social Resources (non-institutional):

The overall mean score for this dimension was 4.1/10. Nearly 61% of the key informants believed that there is a low participation of the citizens in addressing health and social problems. The majority of the key informants, 78%, agreed in reciprocity of good deeds among the people in Saudi Arabia. Sixty six (66%) of the key informants also believe that the proportion of the population who belong to some civic group is few , also, 24% of the key informants considered that Saudis are good in doing things jointly, while 37% considered it as poor. The experts scored higher in this dimension compared to key informants. .

Relationship between dimensions:

The ten dimensions provide a comprehensive assessment of the readiness of the country in implementing child maltreatment prevention programs and are interconnected. Given the differences found among key informant characteristics on gender, years of experience working in child maltreatment prevention, and type of organization they were working for, possible associations between these characteristics and total scores and scores on the ten dimensions were explored.

1. Association between the 10 dimensions scores: Some dimensions could be related more closely to each other in assessing a common theme, for example the relationship between resources and programs that use such resources, political will and its impact on legislations, etc. Knowing the common forms of child maltreatment, risk factors, consequences and cost to the victims need scientific data that guides the development of appropriate programs for child maltreatment prevention. Thus, dimensions 2 (knowledge), 3 (scientific data) are factual and closely linked. Therefore, both key informants and experts give these two dimensions a high score above 5, indicating similarities in their opinions and logic. Similarly, the human and material resources scores were closely related for both the key informants and the expert because they are interconnected. .

2. Association between gender and dimension scores: Gender and different dimension scores did not identify any significant differences between male and female key informants on either total scores or scores on the ten dimensions.

3. Association between types of organizations key informants work for: There were some differences between key informants working in governments and key informants working in non-governmental sector. The key informants from governmental organizations scored higher than those from all other types of organizations. It is important to note that the majority (76%) of key informants were working in governments and therefore scored higher (43.4%) than the experts (40%) who are mainly from academic institutions.

Comparison between key informants and experts

Key informants and experts gave an overall score of 43.4/100 and 40/100 readiness in Saudi Arabia to implement large-scale child maltreatment prevention programs, respectively. This could be explained by the fact that key informants were mainly government employee with a high confidence rate in their institution, while experts were academics and working in non-governmental institutions and therefore were more critical. In addition there were differences in knowledge and experiences in child maltreatment issues among the two groups. Experts may have broader involvement in the issue, while key informants could have a limited role in the spectrum of child maltreatment prevention activities.

Key informants and experts agree 70% on the scores of the ten dimensions. Both experts and key informants agreed that (1, 7, 8, 9) attitude, institutional link, material and human resources dimensions need improvement in the country.

Both key informants and experts agreed that (2, 3, 6,), knowledge, scientific data, and the will to address the problem were strong in the country.
The major discrepancies between key informants and experts were in dimensions (4, and 5,), current programs and legislations. Although the key informants affirmed the existence of general legislations and special agency mandated for protecting children from maltreatment in Saudi Arabia, experts believed that the current legislations and agencies are general and an emphasis on development of more specific legislations dictating all elements of child maltreatment protection and prevention is needed.
Key informants were not aware of existing prevention programs that have been implemented in the country, while experts

Qualitative findings

This section pertains to 15 open-ended questions on nine dimensions: Four questions on dimension 2; two on dimension 3; one on each of dimension 4, 5, 6, 7, 8, 9 and 10, and two questions, as concluding remarks, on the most important problem facing child maltreatment prevention and if anything is missing in the readiness assessment model.

On dimension 2 (knowledge of child maltreatment), key informants were asked about the common forms of child maltreatment; consequences on the victim; main cost other than health on the victim and main risk factors for child maltreatment. The most common forms of child maltreatment reported in Saudi Arabia were: Psychological; physical; sexual; neglect and verbal abuse, in that order. The main consequences for the victim were psychological, educational problems, violence and aggressive behavior and personality disorders; become child abuser in the future; poor health and injuries and low self-esteem. The cost of child maltreatment on the victim (non-health) are financial, access to rehabilitation facilities; legal; social and educational cost. The key informants reported that the main risk factors for child maltreatment were: poverty and financial strains; family violence and dysfunction; education; drug and alcohol addiction, and misinterpreting and misunderstanding of religion.

On the rest of the dimensions, the questions focus on recommending measures to improve or increase the themes that these dimensions are assessing. The main measures recommended by the key informants to improve the ten dimensions are summarized in Box 7. Also, the key informants listed several problems facing child maltreatment prevention, which include lack of awareness, effective laws, financial support, specific agency responsible for child maltreatment prevention and poor collaboration between sectors.

Box 7. Key Informants recommendations to improve the readiness in all dimensions:

1. Centralize data collection and establish national registry
2. Conduct population-based studies, surveys and surveillances
3. Raising awareness across all sectors of the society
4. Mandate reporting of child maltreatment cases to all concerned agencies
5. Conduct workshops to publicize data findings and use evidence-based interventions
6. Issuing new legislations and reviewing old ones
7. Increase child maltreatment prevention programs
8. Collaboration between agencies in child maltreatment prevention activities
9. Create independent agency for prevention and protection of children from maltreatment
10. Increase funding and fundraising activities
11. Development of special training programs and/or curriculum on child maltreatment prevention in universities and other training institutions
12. Setup scholarships for training needed professionals

The key informants listed several problems facing child maltreatment prevention, which include lack of awareness, effective laws, financial support, specific agency responsible for child maltreatment prevention and poor collaboration between sectors.

These recommendations address the weaknesses of the dimensions where key informants considered that the country is less than 50% ready, based on their mean scores. These dimensions were 1, 4, 7, 8, 9. To improve the support of the pubic, policy-makers and legislators on child maltreatment prevention programs, protection of children's rights and increase the involvement of citizens in health and social issues, key informants recommended in raising the awareness of all sectors of the society on child maltreatment prevention; conducting workshops and publicize data findings and use of evidence-based interventions. These activities would raise the level of priority given to child maltreatment prevention programs and decisions on the allocation of resources.

Also, increasing child maltreatment prevention programs, strengthening the collaboration between agencies involved in child maltreatment activities and creating independent agency for the prevention and protection of children from maltreatment were recommended to improve current child maltreatment prevention programs and institutional links and resources.

To improve the deficiencies in material, human and technical resources, key informants recommended in increasing funds and fundraising activities, development of special training programs and/or curriculum on child maltreatment prevention in universities and other training institutions, and setting up scholarship programs for training needed professionals. This would ensure availability of adequate human and material capacities to implement large-scale child maltreatment prevention programs.

In addition, to improve the collection and dissemination of scientific data, key informants give several recommendations: centralizing data collection, collecting population-based surveys and mandating reporting of child abuse cases. This ensures the availability of scientific data to monitor child maltreatment and evaluate the effectiveness of intervention programs against child maltreatment.

Strategies from the findings

The implementation of large-scale child maltreatment prevention programs in Saudi Arabia will use strategies suitable to cultural norms, legislations and resource capacities of the nation. Child maltreatment prevention programs will be implemented as pilot programs in several areas of a province to refine its components before implemented throughout the nation. This builds experiences that will be an asset to successful implementation of child maltreatment prevention programs.

The human and material resources needed for the implementation of large-scale evidence-based child maltreatment prevention programs should be ensured before its implementations. The programs also should ensure the acquisition of appropriate knowledge and skills for the human resources that are responsible for its implementation, monitoring and evaluation. Continuous monitoring and evaluation of planned activities of the prevention programs will be documented, summarized and reported regularly, depending on the nature of the activities implemented. Process and impact evaluations are executed after the completion of planned activities.

The location and initiation of large-scale child maltreatment prevention programs will be consulted with the concerned ministries, government agencies and non-governmental organizations. Child maltreatment prevention partners will fully participate in the development, planning and implementation of the programs. Their contributions, resources or otherwise, will be solicited before the initiation of the implementation of the programs. Their collaboration and working as a team is highly needed.

The nature and number of programs, list of adequate resources and infrastructures, list of partners, timetable for the activities to be implemented, management structure of the programs and roles and responsibilities of the staff, evaluation of the impact of the programs and its dissemination, and other pertinent activities to the program will be developed and carefully delineated before initiating the program. This ensures a good plan for the operation of the programs.

Implications

The findings of the readiness assessment survey will have important public health implications on the quality of lives of millions of children, their families and other members of the society engaged in raising children to have healthy lives physically, psychologically and socially. The results build the basic foundations and guidance for the development, planning and implementation of large-scale child maltreatment prevention programs in Saudi Arabia. It is expected to raise the public awareness of the severity of the

problem and their actions, and influence policy makers to take appropriate and immediate actions against all forms of child maltreatments.

In addition, the findings of the survey guide the development of appropriate plans based on the ten (10) dimensions that influence child maltreatment prevention. The activities to be included in the national, sub-national and community level plans and operations of child maltreatment prevention programs will be derived from the results of the survey. It is worthy to note that such programs will give due consideration to the culture, norms and other societal values to ensure over-arching implications.

Chapter 4: Discussion

Saudi Arabia assessed its readiness for the implementation of large-scale evidence-based child maltreatment prevention programs. Both experts and key informants indicate that the country's readiness is weak. The Key informants give a slightly higher level of readiness, 43%, than the experts, 40%.

The experts and key informants give five and four dimensions, out of ten, a score of 5 or higher, respectively, showing differences in their opinion on the level of readiness in the ten dimensions. This variation could be explained by differences in their knowledge, experiences and level of involvement on child maltreatment prevention activities in the country. The slightly higher level of readiness from the key informants' assessment could be related to their employment background. The key informants who participated in the assessment were mostly from the government sector and may give a better level of readiness than the expert, though the experts' readiness assessment is more objective and close to the reality of the situation.

The experts and key informants agree on the level of readiness on seven dimensions (1, 2, 3, 6, 7, 8 and 9) and disagree on the other three dimensions (4, 5, and 10), showing a good level of agreement (70%). The seven dimensions that both agree upon relate to information about the availability of resources and data, perceptions and the level of willingness and knowledge to address child maltreatment prevention issues in the country. This indicates that both key informants and experts are involved or have vested interest in this issue. However, the public may have different understanding of the issue and how to prevent it.

The dimensions that key informants and experts disagree require specific knowledge on the existence of specific institutions, partners and programs, informal social resources and laws protecting children from maltreatment. These aspects are expected to vary between experts and key informants. Experts have broad knowledge and experiences on the issue and may appraise from many facets, such as health, social, legal and etc., whereas key informants who might be responsible for specific aspects of the program or manage specific programs may have programmatic perspective, which could be limited to certain components of the program. Thus, the disagreement may reflect such varied responsibilities and lack of awareness and/or knowledge of other components of child maltreatment prevention programs that is beyond their domains. It is also expected that the

majority of the Saudi society may not be aware or have a sketchy understanding of the purposes of developing such programs or issuing legislations protecting children from maltreatment, as the findings indicate. Although the country has a high literacy rate, understanding child maltreatment prevention requires higher level of specific education and understanding of the complexity of the cultural norms. Thus, future child maltreatment prevention programs should address the awareness issues in the society.

The survey also assessed the readiness, using quantitative analysis of the data. This component employed percent distribution of the responses. Based on the findings of the majority of the items in each of the ten dimensions, the response of five dimensions (2, 3, 5, 6 and 7) reached 50% or higher. This shows that the country is at least 50% (5 out of 10 dimensions) ready to implement large-scale evidence-based child maltreatment prevention programs, which is a medium level of readiness. Both the key informants and experts agreed that the country is strong in knowledge and the availability of data on the subject, in addition to the political will to improve the situation and the good will of the people. This is considered to be a good start since the subject of child maltreatment is young in Saudi Arabia and most of the works in the last decades were focusing on protection services. .

The readiness assessment indicated some weaknesses in the ten dimensions, as illustrated by the overall mean scores of the dimensions and the scores of the items within each dimension. The key informants give dimensions 1, 4, 7, 8, 9, and 10 a low score on readiness, indicating the need for substantial improvements before implementing large-scale child maltreatment prevention programs.

The attitudes towards child maltreatment prevention were not conducive to the implementation of large-scale child maltreatment prevention programs. This was agreed upon by the experts and key informants. Media campaigns highlighting the seriousness of the problem and urgency of its interventions should be targeted to policymakers and law enforcement agencies. This could influence their attitudes towards the problem. The National Family Safety Program (NFSP) offered two courses to social and law enforcement agencies on the issue.

Although some programs on child maltreatment prevention and others not specifically aimed at child maltreatment prevention were implemented in Saudi Arabia, their coverage is low and mostly limited to community levels. Development and implementation of programs with large coverage is needed to demonstrate tangible improvement in child maltreatment prevention. Also, adequate staff should be trained for the 13 provinces of the country, coupled with provision of adequate resources, which key informants considered as inadequate for the implementation of large-scale child maltreatment prevention programs.

The information collected from the key informants has to be interpreted and acted upon cautiously. The information comes from 41 key informants who were conveniently chosen because of their expertise and involvement in child maltreatment prevention activities. In

spite of the valuable information given by these experts, a different picture could be found if the same survey is given to the general public. Since the issue requires knowledgeable individuals that could provide a comprehensive assessment of the situation of child maltreatment prevention, the general public are not, generally, appropriate to derive such information. Thus, balanced and comprehensive information could be gathered in this way. The information gathered from each of the dimensions assessed was evaluated, giving equal value on each of the dimensions in the analysis that use percent distribution to assess the readiness. Therefore, an expert in the field of child maltreatment prevention could give different weights to the different dimensions and come up with different conclusions. Also, the opinion given by the key informants is subjective, which needs due consideration in interpreting the results. The scores assigned to each response from the key informants and experts are also chosen arbitrarily.

The findings of the survey have far reaching implications. It paves the way for the development of large-scale evidence-based child maltreatment prevention programs in Saudi Arabia, which could protect millions of children from maltreatment and empower parents and other sectors of the society to prevent such actions from happening and its recurrence.

Chapter 5: Conclusions and Recommendations

Conclusion

Saudi Arabia is moderately ready to implement large-scale evidence-based child maltreatment prevention programs because it is strong in the infrastructure of knowledge, political will, scientific data and the informal resources. Several dimensions need to be strengthened before such programs are implemented. Attitude towards the problem needs improvement, human and material resources need to be directed to prevention programs and strategies, and finally new specific, comprehensive legislations need to be drafted and approved.

Recommendations

1. Implement evidence-based child maltreatment prevention programs as a small-scale pilot project in several areas of a province.
2. Generate adequate human and material resources to ensure smooth implementation of the programs.
3. Launch public education campaign to raise the awareness about the seriousness of child maltreatment problem and its prevention.
4. Conduct national surveys 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 with clear protocols for collecting and disseminating.

7. Train adequate staff to collect, manage, and analyze data and information on child maltreatment and its prevention.
8. Collaborate and develop joint advocacy with other organizations on children's rights and prevention of child maltreatment among legislators and law enforcement.
9. Conduct evaluation on child maltreatment prevention programs regularly.

Appendix A: Definition of Dimensions

Box 1: the 10 dimensions of Readiness Assessment for Prevention of Child Maltreatment (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, 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 CM, and the appropriateness of different prevention programmes.

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

Dimension 4: Existing child maltreatment prevention **programmes** and programmes into which CMP 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 CMP.

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 CMP.

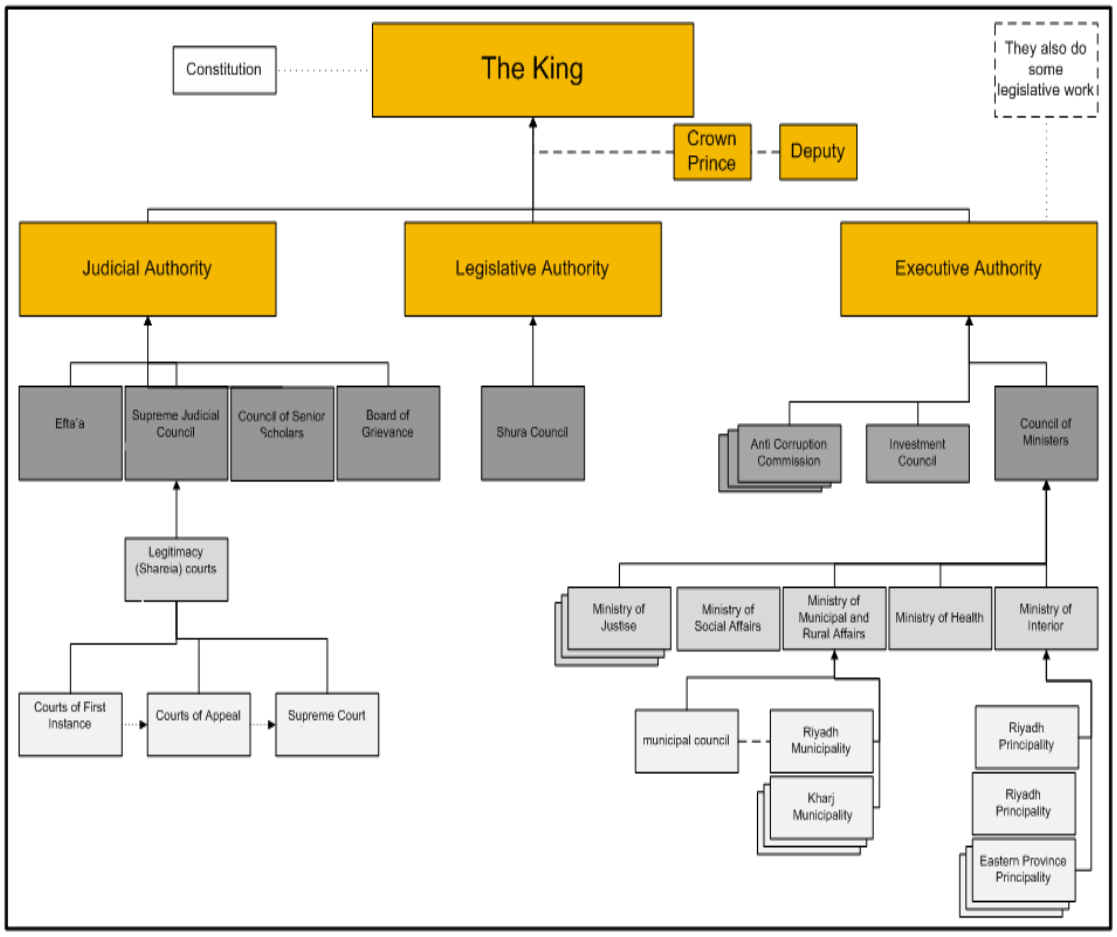
Dimension 8: Material resources, including funding, infrastructure and equipment.

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.

Appendix B: Map of Saudi Arabia Showing the 13 Provinces (Regions)

Appendix C Diagram of Legal Framework



Appendix D- List of Prevention Programs in Saudi Arabia:

Lectures and Seminars:

On average these lectures/seminars are carried out twice a month at different schools around the central region. The target is usually 100-200 students and mothers. The preparations are made by the hosting school; the social workers attend to give lectures, depending on the target (child or mother)

- "It's my Body" lectures that teaches primary school children the difference between safe and unsafe touch
- Lectures on Child Rights and Domestic Violence
- Lectures on sexual harassment to middle school students
- Lecture of persecution against children entitled "Thank you for protecting me"
- Sexual Harassment and Exploitation towards Children Lectures
    - For primary caregivers
    - For school personnel (teachers, advisors, administrative staff, school nurse, etc)
- A Seminar on the "Basic Rules in Communicating with Children" for school personnel
- Seminar on domestic violence "My Life is in your hands"

Workshops

- "Child Maltreatment and Methodologies of Prevention and Intervention" for social workers, psychologists and health care practitioners
- Workshop on sexual harassment, within the first training event "Keep your hands off me"
- Workshop to introduce the concepts and types of child abuse "Authority, not responsibility"

Awareness Campaigns

- Awareness campaign on domestic violence "My Life is in your hands"
- Awareness Campaign to stop violence against women and children
- Awareness campaign on violence against children (Ghusoun Al Rahma)
- Awareness campaign against bullying

List of Manuals:

Manuals are distributed at all events that are carried out, there are booths in malls and educational/cultural centers, and book fairs

- It is my body
- Turning Point
- Children's Rights
- When the Child Draws
- We have the Right to Life
- My Child is violent, why?
- Causes of child Abuse
- Stop… don't hurt your children
- Psychological impact of child abuse
- Child Helpline 116-111 manual
- Domestic violence, a word from the Grand Mufti of Saudi Arabia

Appendix E- List of Tables

Table 1 .Priority of child maltreatment prevention and child rights in protection, Saudi Arabia.			
		N=41	
		No.	%*
Priority of child maltreatment prevention over other health and social problems	High priority	15	36.6
	moderate priority	9	22.0
	low priority	17	41.5
Priority of child maltreatment prevention over protection	More of political priority	4	9.7
	about equal	13	31.7
	Less of a political priority	22	53.6
	the two are not usually distinguished	2	4.9
Adequacy of measures taken so far to prevent child maltreatment	Neither adequate nor inadequate	6	14.6
	inadequate	35	85.4
Level of protection of the rights of children in legislation	Well protected	9	22
	moderately protected	11	26.8
	inadequately/not all protected	20	48.8
Level of protection of the rights of children in practice	well protected	1	2.4
	moderately protected	6	14.6
	Inadequately/not all protected	33	80.5
* percentages do not add up to 100% due to missing values			

Table 2. Percentage of the adults mistreated in childhood by gender, Saudi Arabia

percentage of the adults mistreated in childhood		Total	
		No.	**%**
	<10%	1	2.4
	10%-24%	7	17.1
	25%-49%	12	29.3
	50%-74%	12	29.3
	75%-100%	3	7.3
	don't know	6	14.6
	Total	**41**	**100.0**

Table 3. Appropriateness of Intervention Programs in Saudi Arabia.

		N=41	
		No.	%*
Appropriateness of early home visitation	Appropriate	22	53.7
	Not clear	6	14.6
	Inappropriate	12	29.3
Appropriateness of parenting education	Appropriate	36	87.8
	Not clear	2	4.9
	Inappropriate	3	7.3
Appropriateness of child sexual abuse prevention	Appropriate	37	90.2
	Not clear	2	4.9
	Inappropriate	1	2.4
	Don't know	1	2.4
Appropriateness of prevention of abusive head trauma	Appropriate	41	100.0
Appropriateness of media campaigns	Extremely appropriate	39	95.1
	Not clear	2	4.9

*** Precentages do not add up to 100% due to missing values**

Table 4. Availability of scientific data about child maltreatment, Saudi Arabia.				
	N=41			
	Yes		No	
Type of scientific data available	**No.**	**%**	**No.**	**%**
Magnitude and distribution of child maltreatment in general	14	34.1	24	58.5
Magnitude and distribution of child physical abuse	14	34.1	24	58.5
Magnitude and distribution of child sexual abuse	11	26.8	28	68.3
Magnitude and distribution of child psychological or emotional abuse	11	26.8	28	68.3
Magnitude and distribution of child neglect	11	26.8	27	65.9
Consequences of any or all forms of child maltreatment	3	7.3	35	85.4
***% percentages do not add up to 100% due to missing**				

Table 5. Existence of legislations, officially mandated agencies and policies, and their effectiveness Saudi Arabia.			
		N=41	
		No.	%*
Legislation on child maltreatment and prevention	Yes	23	56.1
	No	16	39
Any agencies officially mandated with child maltreatment prevention	Yes	35	85.4
	No	5	12.2
Official policies addressing child maltreatment prevention	Yes	11	26.8
	No	27	65.9
Effectiveness of existing legislations	Extremely effective	1	4.3
	Effective	4	17.4
	Neither effective nor ineffective	5	21.7
	Ineffective	9	39.1
	Extremely ineffective	1	4.3
Effectiveness of mandated organizations in contributing to preventing child maltreatment	Extremely effective	3	8.6
	Effective	10	28.6
	Neither effective nor ineffective	12	34.3
	Ineffective	9	25.7
Effectiveness of policies in preventing child maltreatment	Effective	4	40.0
	Neither effective nor ineffective	3	30.0
	Ineffective	2	20.0
	Extremely ineffective	1	10.0
*** percentages do not add up to 100% due to missing**			

Table 6. Level of concern of the leadership, existence of special agency that leads and quality of leadership, resources, advocacy and accessibility of information, Saudi Arabia.

		N=41 No.	%*
Level of concern of the political, religious, business, traditional, civil society and others leaders in child maltreatment	Concerned	34	82.9
	Neither concerned nor unconcerned	2	4.9
	Unconcerned	5	12.2
Quality of the leadership on child maltreatment prevention	Good	15	36.6
	Fair	13	31.7
	Poor	11	26.8
Any political leaders who express strong commitment and take effective measures	Yes, definitely	2	4.9
	Yes, to an extent	19	46
	Not clear	7	17
	No, not really	3	7
Enough resources that the organizations headed by these leaders provide	Yes, definitely	3	8
	Yes, to an extent	19	48
	Not clear	13	33
	No, not really	4	10
	No, definitely not	1	3
Perception of the general public on the serious of the problem	Extremely serious	2	5
	Serious	16	39
	Neither serious nor not serious	15	37
	Not serious	7	17
	Not at all serious	1	2
Intensiveness of advocacy efforts for child maltreatment	extremely intensive	2	4.9
	intensive	10	24.4
	moderate	19	46.3
	weak	7	17.1
	extremely weak	2	4.9
Accessibility of information on child maltreatment prevention	accessible	8	19.5
	neither accessible nor inaccessible	14	34.1
	inaccessible	12	29.3
	extremely inaccessible	6	14.6

*** Percentages do not add up 100% due to missing**

Table 7. Dedicated budgets in government minitries and attitudes of funders for child maltreatment prevention			
		No.	**%***
Total Budget for Child Maltreatment prevention	Yes	16	39.0
	No	17	41.5
Attitude of potential funders	Extremely supportive	2	4.9
	Supportive	12	29.3
	Neither supportive nor unsupportive	12	29.3
	Unsupportive	3	7.3
	Extremely unsupportive	4	9.8
Facilities, equipments and materials within child maltreatment prevention organizations	Extremely adequate	4	9.8
	Somewhat adequate	7	17.1
	Neither adequate nor inadequate	7	17.1
	Somewhat inadequate	9	22.0
	Extremely inadequate	10	24.4
Number of professionals specialized in child maltreatment	Adequate	2	4.9
	Neither adequate nor inadequate	3	7.3
	Inadequate	33	80.5

*** percentages do not add up to 100% due to missing**

Table 8. Adequacy of number of institutions providing training for large-scale implementation of programs and their availability, Saudi Arabia			
		No.	**%***
Adequacy of number of institutions providing training for large-scale implementation of prog	Adequate	2	4.9
	Neither adequate nor inadequate	3	7.3
	Inadequate	30	73.2
	None	6	14.6
Availability of the undergraduate or postgraduate institutions to devote some of the curriculum to child maltreatment prevention	Available	4	9.8
	Several	1	2.4
	Almost none	8	19.5
	None	19	46.3
Availability of non-university institutions that offer training in related skills	Available	11	26.8
	Several	6	14.6
	Almost none	14	34.1
	None	7	17.1
Opportunities for continuing professional development	Available	4	9.8
	Several	4	9.8
	Almost none	9	22.0
	None	18	43.9
*** Percentages do not add up to 100% due to missing**			

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