

## Abstract

*This article reviews the global incidence and effects of child maltreatment, focusing on theories of causation and parameters of prevention. Based on this and on an analysis of the various types of abandonment that frustrate prevention, the article proposes an integrated health and human rights process for prevention. This process is based on a summary matrix that incorporates children's rights, medical evidence, relevant social sectors, and professional responsibilities for each stage of primary, secondary, and tertiary prevention. The article then looks at the ways in which the United Nations Convention on the Rights of the Child (CRC) supports this type of endeavor and explains the linked roles of WHO and CRC implementation. The stages of implementation at a country level are reviewed with attention to the needs of less-resourced countries. The potential impacts of full implementation are also explored.*

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*Cet article examine l'incidence et les effets du mauvais traitement des enfants à l'échelle mondiale, en présentant des théories sur les relations de cause à effet et des paramètres de prévention. Sur cette base, et en s'appuyant sur une analyse des divers types d'abandon qui rendent difficiles les efforts de prévention, il propose un processus d'intégration de la santé et des droits de l'homme pour la prévention. Ce processus est basé sur une matrice récapitulative qui incorpore droits des enfants, preuves médicales, secteurs sociaux appropriés et responsabilités professionnelles pour chaque étape de la prévention primaire, secondaire et tertiaire. L'article examine ensuite les façons dont la Convention des Nations Unies relative aux droits de l'enfant (CDE) soutient ce type d'effort et explique les activités complémentaires de mise en œuvre par l'OMS et la CDE. Les étapes de la mise en œuvre au niveau des pays individuels sont passées en revue en tenant compte des besoins des pays disposant de faibles niveaux de ressources. Les impacts potentiels d'une mise en œuvre complète sont également explorés.*

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*Este artículo revisa la incidencia global y los efectos del maltrato de menores, enfocándose en las teorías de causalidad y los parámetros de prevención. Con base en estas teorías y parámetros y en el análisis de varios tipos de abandono que impiden la prevención, el artículo propone un proceso que integra salud y derechos humanos para la prevención. Este proceso está basado en una matriz central que incorpora los derechos de los menores, evidencia médica, sectores sociales pertinentes y las responsabilidades profesionales para cada etapa de prevención (primaria, secundaria y terciaria). El artículo considera los modos en que el Convenio de Los Derechos del Niño (CRC por sus siglas en inglés) de las Naciones Unidas apoya este tipo de esfuerzo y explica la relación entre las funciones de la OMS y el CRC en la implementación del convenio. El artículo revisa las etapas de implementación en cada país, prestando atención a las necesidades de los países con menos recursos, y también explora el impacto potencial de una implementación completa del convenio.*

# PREVENTING CHILD MALTREATMENT: An Integrated, Multisectoral Approach

*John W. Kydd*

Unlike the wounds of war, civil conflict, and accident, child maltreatment can cripple more than the mind and the body. Maltreatment creates a legacy of injury. It reverberates through generations, hobbling the most basic human faculties of love, care, and nurture. Of all the forms of violence done to children, maltreatment is the most under-reported. When instances of abuse are reported, they are unlikely to be fully investigated since many countries lack legal and social systems that require responses to such reports.<sup>1</sup> Child maltreatment is intrinsically related to all other forms of violence. Any sustainable reduction in adult violence (civil conflict, criminal violence, or self-directed violence) requires a reduction in maltreatment of children and vice versa.

This article examines the international health and legal aspects of maltreatment prevention by analyzing the forces and factors that frustrate prevention and by proposing an integrated global approach for more effective prevention. It begins with a summary of the multicausal nature of maltreatment, its incidence, its short- and long-term health effects, and its direct and indirect costs. Examined next are the prerequisites needed by all children so that they can grow and develop to their full potential, as well as what parents and states must do to protect children from harm. The

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multicausal nature of maltreatment is analyzed from the perspective of various types of abandonment by family, community, society, culture, faith, and economic policy, thus illustrating the need for participation by all social sectors. In this context, historical health and human rights initiatives are examined and the recent effort to integrate children's global human rights within a public health framework are explained.

The concepts of "global" and "local" childhood are considered to demonstrate the interdependence of children's globally recognized rights and local needs. This then leads to a proposed, integrated multisectoral approach to prevention, which is supported by the World Health Organization (WHO) and the United Nations Committee on the Rights of the Child (the Committee). WHO/expert collaboration with the Committee has resulted in recognition of the need for global guidelines to prevent maltreatment. WHO's guidelines process could then be integrated into a matrix of maltreatment prevention for each country, which would become the basis for each country's compliance with Article 19 and other related rights as detailed in the Convention on the Rights of the Child.<sup>2</sup> The matrix would provide uniform mapping of each country's commitment to prevent maltreatment and a method for assessing and enhancing efficacy. The advantages of this process for developing countries are noted and a summary of the steps (and possible results) of implementation is provided.

### **Causes of Maltreatment**

While most laws hold only parents (or parent substitutes) responsible for maltreatment, most violence to children is multicausal. Children are mistreated by parents, siblings, families, schoolmates, communities, corporations, cultures, states, and misguided global development policies. While parents are primarily responsible for the welfare of their children, they cannot fairly be held responsible for inadequate health-care programs; underfunded, overcrowded (or nonexistent) daycare programs; decrepit school systems with underpaid and undersupported teachers; dangerous housing; easily available handguns; violent games; and

drugs and other pollutants that foul a child's internal (e.g., addiction, fetal alcohol syndrome) and external environments. When both parents work full time, and (due to low wages) still find themselves below the poverty line and without adequate daycare, it is less than reasonable to hold them solely responsible for the many harms inflicted on their children. Thus laws that find only parents and parent substitutes responsible for harm cannot adequately prevent many forms of maltreatment.

### **Incidents of Maltreatment**

According to WHO, 40,000,000 children (0 to 14 years old) suffer from physical, sexual, and emotional abuse and neglect severe enough to require health and social-service care.<sup>3</sup> Infants and very young children are at greatest risk for both fatal and nonfatal injury. The annual fatality rate for children five years old and younger ranges from 2.2 to 17.9 per 100,000 for boys and 1.8 to 12.7 per 100,000 for girls. The range is affected by complex factors, such as local tolerance of physical punishment, family size and resources, parental personality, poverty, substance abuse, violence in the home, and lack of community resources.<sup>4</sup> Fatalities resulting from abuse are frequently under-reported because they are often attributed to accident, sudden-infant-death syndrome, and other causes. Even in high-income countries, such as the United States, failure to do routine post-mortem examinations has misclassified many homicides as accidental deaths.<sup>5</sup>

Nonfatal maltreatment is likewise under-reported with official statistics lagging far behind case reports and population surveys. A U.S.-based survey estimated that 49 of 1,000 children are physically abused.<sup>6,7</sup> Survey research conducted in other countries shows that the reported rate of abuse is rarely lower and often higher than that reported for the United States. A survey in Egypt revealed that 37% of children sustained physical injuries, such as fractures, loss of consciousness, and permanent disability from being beaten or tied up.<sup>8</sup> In the Republic of Korea, 66% of parents surveyed reported whipping their children and 45% had hit, kicked or beaten them.<sup>9</sup> Prevalence of sexual abuse varied

considerably due to variance in definition and reporting. International estimates, however, assert a mean lifetime prevalence of 20% for girls and 5% to 10% for boys.<sup>10,11</sup> The United States has been reporting a decline in child maltreatment of about 10% per year for the last several years, which has been attributed to awareness training and education.<sup>12,13</sup> The health effects and costs of maltreatment are explored below.

## **Health Effects**

No other health issue involves a child's recovery from injuries inflicted by people on whom that child should be able to trust and rely. The often-reported physical and sexual injuries obscure the unreported emotional and psychological harm inflicted. Maltreatment creates long-term physical, sexual, psychological, and behavioral effects and can delay or prevent a child's normal physical, psychological, emotional, and social development.<sup>14</sup> In 2002, WHO compiled the following list of potential health consequences of child abuse (reprinted with permission):

### **Physical**

- Abdominal/thoracic injuries
- Brain injuries
- Bruises and welts
- Burns and scalds
- Central nervous system injuries
- Physical disability
- Fractures
- Lacerations and abrasions
- Ocular damage

### **Sexual and reproductive**

- Reproductive-health problems
- Sexually transmitted diseases
- Sexual dysfunction, infertility
- Unwanted pregnancy

### **Psychological and behavioral**

- Alcohol and drug abuse
- Cognitive impairment
- Delinquent, violent, and other risk-taking behaviors
- Depression and anxiety
- Developmental delays

- Eating and sleep disorders
- Feelings of shame and guilt
- Hyperactivity
- Poor relationships
- Poor school performance
- Poor self-esteem
- Post-traumatic stress disorder
- Psychosomatic disorders
- Suicidal behavior and self-harm

**Other long-term consequences**

- Cancer
- Cardiac Ischemia
- Chronic lung disease
- Fibromyalgia
- Irritable bowel syndrome
- Liver disease

**Costs**

The global costs of maltreatment are unknown. In the United States, the annual direct health, welfare, and legal costs (for hospitalizations, chronic health problems, mental-health care, child welfare, law enforcement, and legal services) due to child maltreatment in 2001 are estimated at \$24.3 billion (U.S.).<sup>15</sup> Also in 2001, indirect costs (for special education, mental and physical health-care needs for recovery, consequent juvenile delinquency, lost productivity, and ensuing adult criminality) are estimated at \$69.6 billion. In other words, the total cost of treating the aftereffects of child maltreatment in the United States for 2001 was *\$94 billion* (U.S.).<sup>16</sup> Cost reduction requires a broader examination of the forces that create harm and frustrate its prevention.

**Denial and Disagreement**

Child maltreatment results from risk factors, context, culture, faith, law, and values. The argument that violence is endemic to humanity founders on the broad statistical variance of prevalence (e.g., the 1998 U.S. homicide rate being seven times greater than that of England and Wales).<sup>17</sup> Under-reporting of maltreatment is due to both the failure to report known maltreatment and the failure to recognize incidents as maltreatment.<sup>18</sup> We cannot prevent what we do

not acknowledge. Legal definitions vary considerably; some focus on specific proscribed behaviors, whereas others look at harm or threat of harm. Some definitions require parental intent to harm and some do not; some include maltreatment in school or institutional settings, but most focus only on the family.<sup>19</sup> This lack of consensus stems, in part, from the act of violence itself being defined (and addressed) differently by different cultures, faiths, professions (medical, social science, legal, public health, and clergy), and local laws. Variance in definition and identification of maltreatment makes comparative research between—and even within—countries very difficult.<sup>20</sup>

### **Common Needs and Obligations**

Regardless of circumstance, all children have common needs that, when met, can ensure their full physical, mental, emotional, and psychological development. Likewise, each state has a common obligation to use its institutions, cultures, and customs to protect its children from harm. An advantage of differing legal systems is that they can embody different, yet successful, methods for reducing child maltreatment. A disadvantage is that these systems can also foster denial—hiding practices and problems that should be confronted. Successful prevention demands that the rights of children and the responsibilities of parents and states are recognized fully under national and international law. The balance to be struck is a judicial system that honors local culture and tradition while incorporating internationally recognized rights and responsibilities.

Approaches to this problem have thus far been fragmented. As one researcher noted:

Professionals have focused on specific forms of victimization, such as child abuse, sexual abuse, handgun violence, and kidnapping, mostly as separate problems. But the fragmentation has inhibited a comprehensive perspective on the overall victimization of children. Such a comprehensive perspective would emphasize better the true toll of violent victimization.<sup>21</sup>

A comprehensive approach demands that we recognize that social problems and child maltreatment are similar in

their causes, complexities, and cures. As noted by Halpern:

When we define the problem as neglect of children, we tend to look to solutions that seem immediately linked to the neglect—better healthcare, better childcare, more investment in education, more responsive child welfare services. These obviously are critical, *but the basic reasons for lack of well-being of many children in American society are not found in schools, or health clinics or social service agencies. They are found in the primacy of the market place in defining people's worth and entitlement, and in shaping social relations . . .*<sup>22</sup> (Emphasis added)

Moving from such complex causes to cures requires a search for common factors and comprehensive theories to explain them.

### **The Role of Abandonment in Child Maltreatment**

Prevention requires that we identify the common factors that lead parents to maltreat, communities to neglect, cultures to injure, societies and development policies to ignore, and markets to exploit children. One common thread is that many individuals who maltreat as adults grew up amid poverty, high stress, isolation, overcrowding, substance abuse, and maltreatment and became parents at an early age.<sup>23</sup> These factors suggest that victims and perpetrators alike have suffered from various types of abandonment—by individuals and institutions. Institutional abandonment can occur in families, communities, society, professions, cultures, faiths, and economies. Child abandonment has been a common practice since ancient Greece. In Rome, during the first three centuries after the common era, 20% to 40% of all free children from infancy to 18 years old were physically abandoned—that is, children were routinely left at designated places in the city to be claimed as foster children.<sup>24</sup>

*Familial abandonment* occurs when parents and other primary caregivers fail to provide the nurturing, attention, and care that are necessary for children to realize their full physical, emotional, psychological, and social development.<sup>25</sup> For example, many of the developmental difficulties that children have appear to result from emotional mal-



treatment, deprivation, and the neglect that comes from physical or sexual abuse.<sup>26</sup> Most laws and programs to prevent maltreatment focus on physical and sexual abuse, not emotional abuse.

*Communal abandonment* occurs when community (extra-familial) members decide that they can no longer assure the safety, education, and development of its children. Communal abandonment also exists when community members and political representatives do nothing to improve poor school systems or to address inadequate resources, inadequate policing, insufficient welfare systems, bias, bullying, and discrimination.

*Societal abandonment* involves social welfare systems' overlooking maltreatment and other child-related problems. In industrialized countries, the methods used to tolerate inadequate welfare systems parallel the methods used in less-developed countries to rationalize nonexistent welfare systems. Examples are acceptance of the status quo as the "best that can be done," under-reporting the problem or asserting that there are other "higher" priorities. Tolerating high levels of unemployment that put people, including parents, at risk of becoming destitute; enacting laws that fail to protect children from harm, and failing to provide sufficient resources to parents so they can adequately support their children's full development are all forms of societal abandonment.

*Professional abandonment* takes place when economic gain takes precedence over duty of service. Professional abandonment theory explores how the ethic of entrepreneurialism has displaced that of service in law and medicine.<sup>27</sup> Precious few schools of public health have comprehensive programs on preventing child maltreatment.

*Cultural abandonment* occurs when children are denied their culture and language and when harmful cultural practices, such as female-genital mutilation, are allowed to continue. While efforts to stop such practices are usually focused in lower-income countries, the cultural practices of affluent countries should also be examined. For instance, in the United States staggering numbers of young girls are at risk for developing bulimia and anorexia in an effort to

attain the cultural ideal of female beauty, and many young athletes are forced to sacrifice their childhoods for the possibility of stardom.

*Religious abandonment* takes place when a religious tradition is practiced to the detriment of a child's best interests. Such instances would include traditions that value the continuation of marriage over seeking protection from an abusive spouse.

*Economic abandonment* places more importance on market forces than on the welfare of children not only by exploiting child labor but also by instilling desires in children that result in their valuing consumption over faith or social duty as adults.

*Spousal fear of abandonment* is a significant factor in spousal and familial violence.<sup>28</sup> The relationship between external abandonment (when a society ignores the needs of children in general) and internal abandonment (when parents and providers ignore the needs of the children entrusted to them) deserves further exploration. Many of these forces are beyond the direct influence of health and legal authorities.

Problems created in all sectors of society can only be resolved by involving all sectors of society. No single model, law, or medical practice can prevent child abuse. Rather, prevention is best achieved by incorporating all causal agents, all theories, and all proven practices into systems that are systematically reviewed for their effectiveness. An integrated multisectoral approach to prevention requires an examination of prior health and legal initiatives and, based on that, new parameters for prevention can be proposed.

## **Health Initiatives to Prevent Maltreatment**

The lack of a comprehensive health approach reflects, in part, the lack of a unifying theory of causality of maltreatment. In the 40 years since the term "battered-child syndrome" was coined, child maltreatment has been analyzed using a number of theoretical perspectives, such as attachment theory, behaviorism, social ecology, sociobiology, and sociology.<sup>29-34</sup> These analyses led to theories based on cognitive, behavioral, and developmental systems; com-

munication, attachment, social ecology, and family systems; and ecological transactional perspectives.<sup>35-37</sup> These attempts at integrated theory progressively acknowledged the complexity of preventing child maltreatment but failed to explain its occurrence.

As noted previously, violence was only recently considered a public health issue. In 1997, WHO adopted a plan of action for violence prevention, and its 1999 *Consultation on Child Abuse Prevention* drafted the following definition of maltreatment:

Child abuse or maltreatment constitutes all forms of physical and/or emotional ill treatment, sexual abuse, neglect or negligent treatment or commercial or other exploitation resulting in actual or potential harm to the child's health, survival, development or dignity in the context of a relationship a responsibility, trust or power.<sup>38</sup>

WHO's collaborative work with the International Society for Prevention of Child Abuse and Neglect (ISPCAN) on the matrix and its *World Report on Violence and Health* are groundbreaking efforts to create a comprehensive approach to preventing violence against children.<sup>39,40</sup> Comprehensive prevention is impossible without the active involvement of all sectors of society—including health, legal, and social—at all three levels of prevention:

- **Primary prevention** focuses on preventing child abuse in the general population.
- **Secondary prevention** aims at reducing the risk of maltreatment to specific populations.
- **Tertiary prevention** works toward rehabilitating victims of maltreatment so they can be reintegrated into society. This process should involve the child and the child's family, as well as the perpetrator.

Children's rights to development and protection from harm are derived from human rights initiatives. Comprehensive prevention requires determining which rights most effectively support each stage of prevention.

Table 1 lists the rights in the Convention on the Rights of the Child (CRC) that are relevant to preventing maltreatment.

### Human Rights Initiatives to Prevent Maltreatment

Although the UN long ago articulated rights for adults in the Universal Declaration of Human Rights, as well as for children in the Declaration on the Rights of the Child, those rights were not fully recognized until the CRC was adopted in 1989.<sup>41</sup> The specific rights contained in the CRC are supported by other international legal documents, including the Covenant on Civil and Political Rights; the Covenant on Economic, Social, and Cultural Rights; the Convention on

Articles 1, 3, 4, 12–15, 19, 23, 24	The right to child-centric services that promote child participation, children's perspective and protection of child development as a central measure of best interests instead of services focusing on the acts most offensive to adults. Children's views should be solicited and given due weight in accordance with the age and maturity of the child.
Articles 2, 4, 18, 24, 27, 28, 30	States' duty to implement and assist without discrimination programs to the maximum extent of their available resources and, where resources are lacking, to seek technical and financial assistance from other countries and entities; to provide appropriate assistance to parents; to provide the highest attainable standard of health; and to provide children with an education and a standard of living sufficient for their full development.
Articles 6, 18, 24, 29, 31,	Parents' and states' duty to ensure a child's right to development, including complete physical, mental, moral, and social development that respects the environment, parental culture, community, language, and religion and that provides children with what they need to live a responsible life in a free society.
Articles 9, 16, 17, 18, 19, 20, 24(3), 28(2), 32–40	The right to protection from all forms of violence, including physical and mental violence, injury, abuse, neglect, and negligent treatment both within and outside of the home, as well as to be protected from sexual and economic exploitation and abuse, from media violence and other harmful information and materials, and from being separated from parents without a finding of necessity by competent authorities subject to judicial review.
Articles 24, 25, 39	The right to recover from violence that includes physical, psychological, and social reintegration into an environment that fosters a child's health, dignity, and self-respect.

**Table 1.** *CRC Rights Relevant to Preventing Maltreatment.*

Torture and Other Cruel, Inhuman, or Degrading Treatment or Punishment; and the Convention on the Elimination of all Forms of Discrimination Against Women, as well as by regional (African and European) conventions for children.<sup>42,43</sup> The rights within these instruments can be enforced through the CRC review process described below.

Article 19, section 1, of the CRC provides the most direct right to protection from maltreatment:

States parties shall take all appropriate legislative, administrative, social and educational measures to protect the child from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse, while in the care of parent(s), legal guardian(s) and any other person who has the care of the child.<sup>44</sup>

This broad and comprehensive mandate creates the need for child-protection legislation that would use an integrated, multisectoral approach, combining legislative, administrative, social, and educational “measures to protect the child.”<sup>45</sup> Article 19, section 2 defines more specifically states’ responsibilities for assisting providers who are caring for children who have been harmed:

Such protective measures should, as appropriate, include effective procedures for the establishment of social programs to provide necessary support for the child and for those who have the care of the child, as well as for other forms of prevention and for identification, reporting, referral, investigation, treatment and follow-up of instances of child maltreatment described heretofore and, as appropriate, for judicial involvement.<sup>46</sup>

In this context, the CRC functions as a constitution for child development, identifying rights that should be accessible to all children, including the rights to family life, culture, care, and play; to participate in framing their current lives as well as their futures (e.g., referred to as *protagonismo infantil*, or child protagonism, in Latin America); to sustenance and resources necessary for full intellectual, physical, and emotional development; and to full recovery from maltreatment.<sup>47,48</sup> According to the CRC, local and regional laws should include the “laws” of child development. The CRC

also specifies rights that protect children from all forms of maltreatment and assist them in making a full recovery from abuse. These rights also extend to family members and other caregivers in their efforts to protect children from maltreatment. An analysis of a complex web of rights creates a need for basic concepts that embody a realization of these rights. This leads to the notion of global and local childhood.

### **Global and Local Childhood**

The CRC endows all children worldwide with the same rights, support for developmental needs, and protection from maltreatment. These are core rights that do not vary by culture or country. Each child has a unique local childhood based on a range of factors, including family, community, culture, and economic context. The attainment of global and local childhoods are interdependent: Each flourishes in the presence (or fails in the absence) of the other. Global childhood requires local support just as local communities and cultures often require global support.

To prevent child maltreatment globally, initiatives must be implemented locally that establish guidelines for fostering healthy child development and for recognizing incidents of maltreatment. In this context, the “best interests of the child” requires programs that ensure full child development, prevent maltreatment, assure recovery from physical and emotional injury and that are regularly monitored and improved on accordingly. Success in applying rights requires identifying a framework that can most likely realize them. The public health framework provides the best fit for applying global rights in unique local circumstances.

### **Applying the CRC Within a Public Health Framework**

A public health model to prevent child maltreatment uses the following stages:

- **Definition** (parameters of child development, maltreatment, and recovery from maltreatment).
- **Prevention** (primary prevention for the entire population).
- **Response and Intervention** (secondary and tertiary pre-

- **Training** (sectoral and cross-sectoral of all relevant personnel).
- **Data Collection** (standardized reporting of type, prevalence and context of maltreatment).
- **Monitoring** (delivery and cost effectiveness of services, assessment of outcome).
- **Evaluation** (analysis to improve problem identification, policy and prevention services).

Integrating this public health model with the rights contained in the CRC would result in the matrix illustrated in Table 2.

### Parameters for Prevention: WHO/Expert Standards

A public health model uses an epidemiological approach to reach a common medical understanding of the problem while taking into account a diversity of effective prevention measures. Without establishment of a common understanding, each nation is likely to rely on its own definitions and descriptors of maltreatment and to invest scarce resources in national programs that are difficult to monitor and compare.

Stages of a public health framework	Corresponding Articles in the CRC
Defining	6, 9, 19, 24(3), 28(2), 32-38,
Preventing	1-4, 6, 12, 17-19,23, 27, 29, 32-40
Responding and Intervening	2, 4, 9, 10, 16, 18-21, 24, 25, 39
Training	12, 16, 29, 42, other articles identified above
Collecting data	24, 25
Monitoring	19, 24, 25, 39
Evaluating	4, 19, 24, 39

**Table 2.** *Integrating the CRC into a Public Health Framework.*

Comparisons allow for learning from others' successes and failures. The preeminent legal authority to provide us with a consistent definition of "best interests" is the Committee on the Rights of the Child, the treaty monitoring body set up to monitor state party compliance under the CRC. The CRC Committee is not equipped to articulate public health standards. The "best interests of the child" in this context needs input from other sources.

WHO, in consultation with appropriate experts, is the most logical entity to develop and maintain the standards for identification and prevention of child maltreatment. Per Article 2 of its Constitution, one of WHO's core functions is setting, validating, monitoring, and pursuing the proper implementation of norms and standards.<sup>49</sup> Successful prevention depends on identifying all causal agents, understanding their roles, and then determining the best practices for identifying, diagnosing, and treating immediate harm while preventing the likelihood of future occurrences. WHO is collaborating with IPSCAN and other experts to develop global guidelines for child maltreatment prevention.

### **Monitoring by the Committee on the Rights of the Child**

The CRC requires that each nation submit a written report every five years detailing its compliance with the obligations under the Convention. The reports are distributed to Committee members and available to interested members of the public. Local interest groups and NGOs often provide alternative reports that include rebuttals and challenges. Countries are invited to meet with the Committee and to engage in constructive dialogue. After review, the Committee drafts its findings, which offer encouragement for innovative laws, policies, and practices, along with suggestions for improvement in a range of areas. This mechanism could be better used for the prevention of child maltreatment if nations were systematically requested to report on their commitments for resource allocation, goals for prevention, and methods for interim oversight to confirm that their commitments are being met. The guidelines articulated through the WHO process, coupled with the framework for prevention (presented earlier), could



become both a blueprint for resource allocation and a report card for achievement of each state's responsibility for child maltreatment prevention under the CRC. Under-resourced countries that commit to this process could use their commitments to leverage needed funds and technical assistance from other states and entities.<sup>50</sup> Thus, the CRC in this process would help create new global expectations and concrete local commitments and monitor outcomes. In this context, the CRC would become a global engine for all states to implement practices to prevent child maltreatment.

Regional human rights bodies could also become increasingly active in protecting children from maltreatment. The European Court of Human Rights recently sanctioned British authorities for failing to protect children from an abuser.<sup>51</sup> Global models based on protection of rights can often conflict with those based on preservation of health. A common process recognizing both models is required and recent actions by the CRC and WHO suggest there is opportunity for major progress in this area.

### **Multisectoral Commitment**

An integrated multisectoral approach to preventing child maltreatment has long been supported by the public health community. In September 2001, the CRC endorsed this approach in its report *Violence Against Children Within the Family and the Schools*. In the report, the Committee recommended the following:

The Committee urges agencies and bodies of the UN system to adopt a more *integrated multisectoral approach to prevention of violence against children, including, inter alia, through public health and epidemiological approaches*, consideration of poverty and socio-economic marginalization, and the impact of multiple forms of discrimination.<sup>52</sup> (Emphasis added.)

This explicit endorsement provides important new avenues in which human rights norms and standards could be used to implement and enforce a specific public health program. The matrix presented in Table 3 is intended to serve as a map of feasible commitment, and is not a mandate for unrealistic pledges. Countries with fewer resources will be able to invest in only a few modules of implementa-

tion within the matrix, whereas more affluent countries should be able to invest in all modules.

### Advantages for Developing Countries

The preventive power of integrating health and human rights to address child maltreatment is immense and until recently has been largely underutilized. It can provide a powerful way to elevate both the political status of the problem and the feasibility of its prevention. As a public health

		PUBLIC HEALTH STAGES						
		Definition	Prevention	Response Intervention	Training	Data Collection	Monitoring	Evaluation
S E C T O R S	Policy-makers	consult w/CRC	consult w/CRC	consult w/CRC	consult w/CRC	consult w/CRC	consult w/CRC	consult w/CRC
	Health Care (physical & mental health)	medical definitions	general public	at risk & injured services	separate & cross-sectoral	standard & shared	actual services	assess & improve
	Social Services (family welfare, etc)	social definitions	general public	at risk & injured services	separate & cross-sectoral	standard & shared	actual services	assess & improve
	Education (formal and informal)	definitions for education	general public	at risk & injured services	separate & cross-sectoral	standard & shared	actual services	assess & improve
	Mass Media	media definitions	general public	at risk & injured services	awareness	oversight & review	oversight & review	analyze & publicize
	Legal Services	legal definitions	general public	at risk & injured services	separate & cross sectoral	standard & shared	actual services	assess & improve
	NGOs & Faith-Based & Private Orgs.	advocacy definitions	all	at risk & injured services	awareness	oversight & review	oversight & review	analyze & publicize
	Community	local definitions	all	at risk & injured services	awareness	oversight & review	oversight & review	analyze & publicize

**Table 3.** *A Multisectoral Matrix for Maltreatment Prevention: Integrating a Public Health Methodology with Sector Involvement.*

Note: Each square in the matrix is a module of implementation.

issue, it can be pursued within an ethos of scientific rigor, standards, and evaluation. This approach can demonstrate the linkage between child maltreatment, impaired child development, and consequent compromising of adult relational capacity and lifetime economic productivity. Linking harm to both child development and economic development (and thereby state development) can also help frame the debate over resources within wealthier countries, making the issue not one of whether a country can afford to address maltreatment, but whether it can afford to ignore it. The legal framework for the rights of the child has little protective value in countries that do not honor such rights or that have little trust in their police and legal systems. By recognizing the rights issues involved in each stage of the public health model, the rights framework can assist those who work in health and other social sectors in their efforts to protect children.

Use of the reporting process under the CRC can more effectively broker economic and political commitments to prevention than national or international interest groups could. This is particularly true for countries with weak economies and limited or nonexistent social welfare systems. Such countries may believe they are unable to afford a professional prevention program but could, through the CRC process, both seek and secure technical assistance and direct funding for such programs from wealthier countries.<sup>53</sup> This gives the lowest-income countries the opportunity to make great progress in preventing maltreatment and may help to put limits on media, marketing, and other structural forces that are harmful to child development—that may be difficult to achieve in higher-income countries.

### **Factors for Successful Global Guidelines**

Global guidelines that impose uniformity rarely succeed. Successful guidelines must lead, not point. Thus the guidelines proposed here function more as guidelines *for* guidelines to allow each country to craft its own model for prevention. The above considerations suggest that the following factors are central:

1. The guidelines must be rights- and evidence-based (both legal and medical) and provide evidence linking children's rights, health, and development.<sup>54</sup>
2. They must be inclusive, incorporating the concerns of all sectors of a nation.
3. They must be adaptive, i.e., they are sensitive to culture and context while being sufficiently flexible to find globally effective methods of protective the rights of all children so that each can have a full social, emotional, physical, and mental development free from maltreatment. This is a "top-down, bottom-up" approach to implementation in which global evidence of best practices is balanced with local evidence of needs and resources.<sup>55</sup>
4. They must be feasible. Many guidelines focus only on practitioner-patient relationships, seeking the best-possible practice within this context. This is consistent with the approach of the U.S. Task Force on Preventive Services and *CDC Guide to Community Preventive Health Services*, whose recommendations are based only on "efficacy."<sup>56,57</sup> Such standards miss sizeable populations who have no access to best practices, let alone to practitioners. Guidelines must also consider cost-effectiveness within different economic contexts.
5. They must be inquisitive, not directive. Dialogue must precede programs. Thus, the guidelines are introduced as "guidelines for guidelines"—vehicles used to ask critical questions about all aspects of child maltreatment and then to answer them within a local context. The dialogue will involve all sectors within a society that affect the health and well-being of children.

### **Successful Implementation**

Successful guideline creation must consider requirements for successful implementation. While the full scope of implementation cannot be explored here, key points can. Implementation should focus on the feasible and the practical and provide basic measures of success that are understandable to the public.

## Assessment

The first step is assessment. Countries without an established program to prevent child maltreatment should be assessed to determine which sectors within their societies have the greatest moral authority. Ideally, those sectors should be the primary agents of promoting implementation. For example, in states that function under Islamic law, a major effort should be made to recognize how prevention of child maltreatment is a fundamental aspect of Islam. Work in this regard within each *ulama* may precede the adoption of legislation by state authorities.<sup>58</sup>

Health services assessment must include all respected healing systems, including traditional or indigenous health systems.<sup>59</sup> In Mozambique, for example, there is one physician per 50,000 people and one traditional healer for every 200 people; therefore, converting only members of the medical establishment to the cause may do little to prevent child maltreatment.<sup>60,61</sup> The goal is integrated health care involving all respected practitioners and an assessment of the capacity of all systems for the prevention of child maltreatment.<sup>62</sup>

The next issue is to determine the form of health-service delivery that would most effectively prevent child maltreatment within a particular context.<sup>63</sup> Without access to medical services, maltreatment is difficult for service providers to identify. Child maltreatment programs cannot simply be tacked onto overburdened health services without considerable loss of efficacy. Social-medicine models that integrate health-services delivery with community-development initiatives may have the greatest success. Community-oriented primary care (COPC) is a tested practical model that uses community-based diagnosis, assessment, prevention planning, implementation, evaluation, and reassessment, and may be easily connected to prevention efforts.<sup>64</sup>

## Communication

Once an assessment is completed, a dialogue should take place between all relevant sectors, including child representatives and appropriate experts, to identify the most beneficial programs within each locality. To reduce the costs of the deliberative process, an NGO, such as ISPCAN,

in collaboration with local authorities, could host a virtual country conference that would allow more interested parties to participate in the process. Countries should be supported to make their deliberations public through a variety of channels so countries with similar economic circumstances can learn from one another. In this same manner, nations that share similar cultures may collectively be able to consider ways to better protect their children's development.

Awareness of children's rights and needs should be promoted not just as problems to prevent or rights to be recognized but rather as a *literacy* that no society can afford to do without. Literacy in child rights, child development, and child trauma is a vital precondition for creating *global localities*—regions that integrate their “global” and “local” goals for a safe childhood into all major policy decisions.

The “global locality” dialogue process should yield specific commitments from each sector for primary, secondary, and tertiary prevention (including evaluative methods) scaled to available resources. All countries are capable of some commitment, particularly as their future economic development may in some cases depend on their capacity to ensure child development. The World Bank and other multilateral and bilateral donors should integrate the WHO parameters for child development into their funding for economic/civil society development of global localities.

Distilling commitments into the multisectoral matrix format presented previously may be useful for both efficient oversight and country-by-country comparison of program efficacy. Then as part of its five-year review, the Committee on the Rights of the Child could use this matrix in its dialogue with governments, including those that receive funds from other sources as well as those that provide resources outside of their borders.

### **Possible Results of Implementation**

Implementation of this integrated, multisectoral process could create important changes toward preventing child maltreatment globally. Although these projected results are at best speculative, it is reasonable to anticipate that some changes for the better will occur.

1. Definitions of maltreatment and best prevention practices based on the latest scientific evidence. The myriad laws defining maltreatment differently would then yield to the norms and standards that protect child development.
2. More consistent reporting, more cost-effective training, and more analyses of cross-cultural efficacy of different interventions.
3. Systematic national attention to the challenge of protecting children, their families, and their cultures as maltreatment prevention becomes more than a local matter but one of national identity and accountability.
4. Meaningful comparisons between all countries bound by the CRC that focus on the efficacy of investment of limited resources in specific areas. Every country, regardless of economic circumstance, would then be able to point to some salient achievement in maltreatment prevention.
5. Meaningful comparison would also allow donor agencies to better determine what programs can be successfully replicated in what contexts and to encourage, by selective funding, the development of areas of global expertise on specific issues.
6. Colleges and universities will be able to collaborate and compete to develop model curricula for child development and maltreatment "literacy" for all relevant professional schools, colleges, and in primary and secondary education. The multisectoral approach to prevention at the state level will foster multidisciplinary collaboration and training of students in public health, medicine, law, nursing, public administration, social work, psychology, law enforcement, and anthropology, among others.
7. Systematic collaboration between religious organizations, NGOs, and businesses that have the shared goal of supporting future fully functional adults who are unimpaired by childhood maltreatment.
8. Recognition of full child development as an essential precondition for effective economic development.
9. Stimulation of religious and faith-based groups to create

support services for children and their parents. This in turn may spur interest in reanalyzing religious texts in a way that would sustain better institutional and individual support for preventing maltreatment and protecting the well-being of children. Faiths would then receive the support to become more involved in assisting the maltreated in their recovery and their reintegration into the community.

## **Conclusion**

Child maltreatment is preventable. It is a product not of the human condition but of human attitude. Public health has only recently begun to recognize that violence has worldwide public health consequences.<sup>65</sup> Legal efforts at preventing child maltreatment have also missed the mark by focusing largely on prosecution of perpetrators and treatment of victims instead of on primary and secondary prevention. The draft WHO guidelines will hopefully be completed in 2003 and then implemented on a pilot-project basis. If successful, this methodology could be extended to other forms of violence to children, such as civil conflict, structural inequality, and environmental degradation. Implementing the guidelines would place the development of children at the center of social concern and at the center of important decisions in the marketplace. Within this matrix, no decision regarding economic development or environmental development could be taken without carefully assessing the impact on child development.

This endeavor's ultimate goal is to make the full physical, emotional, and intellectual development of each child a central priority of civil society at both the local and global levels. The change called for is immense, but the process begins with affirming values long held in our oldest, indigenous cultures and best summed up by Chief Sitting Bull:

Let us put our minds together and see what kind of life we can make for our children.<sup>66</sup>

## **Acknowledgment**

The author wishes to thank Dr. Marcellina Mian for her unfailing support and helpful commentary.



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43. See, for example, European Convention on the Exercise of Children's Rights, ETS 160, Strausbourg, 25.01.1996; African Charter on the Rights and Welfare of the Child, OAU Doc. CAB/LEG/24.9/49 (1990).

44. See note 2.

45. See note 43.

46. See note 43, art. 19, sect. 2.

47. The feasibility and necessity of child participation is well-demonstrated globally in the UN Special Session on Children and its outcome document, UNICEF, *A World Fit for Children* (2002). Feasibility has been demonstrated regionally: e.g., South America (Cussianovich, A and Marquez, A (2002) *Towards protagonist participation of boys, girls and teenagers*, Save the Children Sweden, Lima Peru); Asia (ECPAT International Secretariat/UNICEF (1999) *A Study on the concepts and practices of young peoples rights to participation*, Philippines); Africa, (Children's Consortium of Zimbabwe (2002) CRIN #16, Oct 2002), Canada (CIDA, *Meaningful Youth Participation in International Conferences: A case Study in War affected Children*, (2000) [www.acdi-cisa.gc.ca/publications-e.htm](http://www.acdi-cisa.gc.ca/publications-e.htm)). A good theoretical overview of the why and how of child/youth participation can be found in Roger Hart's *Children's Participation: The theory and practice of involving young citizens in community development and environmental care*, Earthscan Publications, London (1997) and Gerison Lansdowne's *Promoting Children's Participation in Democratic Decision-making*, Innocenti Insight #6, UNICEF (2001) Innocenti Center, Florence.

48. The most recent clarification to the CRC (see note 2) is on protecting

children from violence, which can be found in the Committee's 28 Sept. 2001 special discussion (CRC/C/111) on protecting children from violence within the family and at school.

49. Constitution of the World Health Organization, (22 July 1946), art.2 (a,b,o).

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51. In *E and Others v. United Kingdom*, Application No. 33218/96, 4 Dec. 2002, four individuals were awarded \$80,000 in damages and \$64,000 in costs and expenses.

52. See note 48 (CRC/C/111), p. 11.

53. Through the process of "international cooperation" noted in numerous articles of the CRC. (See note 48)

54. As noted above, no single psychological theory adequately explains the causes of maltreatment. The preferred epidemiological framework at this time is ecological: including individual, familial, communal, societal, and environmental theories of trauma, causation, and prevention. See, for example, notes 35 and 36. Abandonment theory could also be used to explore the internal and external forces that influence individuals and institutions to maltreat children. This should help identify risk factors for individual and institutional abandonment and therefore offer effective measures to prevent abandonment.

55. Since the process involves systemic change, great care should be taken in gathering evidence in a systematic fashion to avoid and minimize bias. Consideration should be given to following the *Cochrane* method of systemic reviews because of the need to improve the basis for making revisions on generalized ability of the interventions. In case there is not enough evidence on which to base the guidelines, hence the statements based on expert opinion should be secured provided that these statements are issued with a limited lifespan during which the necessary research will be done to provide evidence needed in the longer term.

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58. *Ulama* is a term that refers to the community of learned men. The direct translation is "the ones possessing knowledge." The ulama has considerable power in many Muslim countries, but its influence on the society often depends on the strength of the secular authorities. *Encyclopedia of the Orient*, accessed 15 Feb. 2003 at <http://i-cias.com/e.o/>.

59. WHO's global strategy on traditional and alternative medical practices is available at [www.who.int/inf/en/pr/2002/38](http://www.who.int/inf/en/pr/2002/38). The report notes that 80% of people in Africa used traditional medicine, and that in developed countries, such as France, 75% of the population have used complementary medicine at least once. The focus of the initiative is to develop methods to test the efficacy of these healing methods to assure

their safety and reliability.

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62. This includes both T/CAM (traditional, complementary, and alternative medicine) and mainstream biomedical practitioners. WHO's Traditional Medicine Initiative ([www.who.int/medicines/organizations/trm/orgtrmmain.shtml](http://www.who.int/medicines/organizations/trm/orgtrmmain.shtml)) provides useful examples of integrating traditional healers into the public health infrastructure. This study notes that in both AFRO and WPRO, member states consider traditional medicine to be a priority for health care in their regions.

63. See note 62.

64. See *American Journal of Public Health* 92/11 (2002): 1717, 1722, 1740. The COPC movement has been successful in underserved areas of developed countries as well as in developing and less-developed countries.

65. The U.S. Surgeon General, in his 1979 report, first recognized this, asserting that the consequences of violent behavior could not be ignored in the effort to improve the nation's health. *Healthy People: The Surgeon General's Report on Health Promotion and Disease Prevention*, Washington, DC, United States Department of Health, Education, and Welfare, Public Health Service, Office of the Assistant Secretary for Health and Surgeon General, 1979 (Pub. 79-55071). The issue was generally noted in the ICD-9 (1985) and given more recognition in the ICD-10 (1992) but was not acted on internationally until WHO's 1996 resolution declaring violence a leading worldwide public health problem (WHO/EHA/SPI. POA. 2).

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