Child Abuse & Neglect 37 (2013) 1237–1251

Contents lists available at ScienceDirect

Child Abuse & Neglect

The assessment of the readiness of five countries to implement child maltreatment prevention programs on a large scale☆

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ARTICLE INFO

Article history:
Received 28 December 2012
Received in revised form 16 July 2013
Accepted 17 July 2013
Available online 17 August 2013

Keywords:
Child maltreatment prevention
Capacity
Developing countries
Implementation
Policy
Readiness

ABSTRACT

This study aimed to systematically assess the readiness of five countries – Brazil, the Former Yugoslav Republic of Macedonia, Malaysia, Saudi Arabia, and South Africa – to implement evidence-based child maltreatment prevention programs on a large scale. To this end, it applied a recently developed method called *Readiness Assessment for the Prevention of Child Maltreatment* based on two parallel 100-item instruments. The first measures the knowledge, attitudes, and beliefs concerning child maltreatment prevention of key informants; the second, completed by child maltreatment prevention experts using all available data in the country, produces a more objective assessment readiness. The instruments cover all of the main aspects of readiness including, for instance, availability of scientific data on the problem, legislation and policies, will to address the problem, and material resources. Key informant scores ranged from 31.2 (Brazil) to 45.8/100 (the Former Yugoslav Republic of Macedonia) and expert scores, from 35.2 (Brazil) to 56/100 (Malaysia). Major gaps identified in almost all countries included a lack of professionals with the skills, knowledge, and expertise to implement evidence-based child maltreatment programs and of institutions to train them; inadequate funding, infrastructure, and equipment; extreme rarity of outcome evaluations of prevention programs; and lack of national prevalence surveys of child maltreatment. In sum, the five countries are in a low to moderate state of readiness to implement evidence-based child maltreatment prevention programs on a large scale. Such an assessment of readiness – the first of its kind – allows gaps to be identified and then addressed to increase the likelihood of program success.

☆ This research was funded by the Fetzer Institute, Kalamazoo, Michigan, USA (Project 2486). The Fetzer Institute played no role in the research or the preparation of the article.

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http://dx.doi.org/10.1016/j.chiabu.2013.07.009

In the last decade, a global shift has been occurring from responding to cases of child maltreatment after they have happened by providing services, support, and treatment – referred to as "child protection services" – to trying to prevent child maltreatment before it arises – referred to as "child maltreatment prevention".

The following five developments have contributed to this shift: (a) a better understanding of the far-reaching consequences of child maltreatment for mental and physical health and socio-occupational functioning (Garner et al., 2012; Mercy & Saul, 2009; Shonkoff, Boyce, & McEwen, 2009; Shonkoff & Garner, 2012); (b) findings that only a small proportion of victims of child maltreatment ever come to the attention of child protection services – e.g. 5–10% in the West, 0.3% in Hong Kong, and none in the many countries where such services do not exist (Finkelhor, Lannen, & Quayle, 2011; Gilbert et al., 2009); (c) epidemiological studies showing that child maltreatment is a global phenomenon that occurs in many low- and middle-income countries at rates that are higher than in high-income countries (Reza et al., 2009; Stoltenborgh, van Ijzendoorn, Euser, & Bakermans-Kranenburg, 2011; United Nations Children's Fund, Centers for Disease Control and Prevention, and Muhimbili University of Health and Allied Sciences, 2011; United Nations Children's Fund, Centers for Disease Control and Prevention, Together for Girls, and Kenya Vision 2030, 2012); (d) evidence suggesting that preventing maltreatment in the first place through either universal or selective prevention programs is cheaper and more effective than trying to remediate its effects later (Doyle, Harmon, Heckman, & Tremblay, 2009; Heckman, 2012; Kilburn & Karoly, 2008); and (e) reductions in rates of childhood mortality and diseases which have led to the prevention of childhood adversities – including child maltreatment – receiving more attention (Lozano et al., 2011). "Saving our children from these diseases only to let them fall victim to violence . . . would be a failure of public health" (Brundtland, 2002).

Also contributing to this shift has been the much greater prominence given to child maltreatment prevention by international and large national organizations active in the field. For instance, child maltreatment prevention has been identified as a priority violence prevention activity by the World Health Organization and the U.S. Centers for Disease Control and Prevention (CDC, 2012a; WHO, 2012). The UN Secretary General's *World report on violence against children* (UN, 2006) called for urgent action to prevent and respond to all forms of violence. The Special Representative of the UN Secretary General on Violence against Children is advocating for the prevention and elimination of all forms of violence against children (SRSGVAC, 2012). In addition, Article 19 of the Convention on the Rights of the Child[19] states that all measures should be taken to prevent child maltreatment (OHCHR, 2012a). Every country in the world – except for the USA, Somalia, and the new nation of South Sudan – have ratified, accepted, or acceded to the Convention on the Rights of the Child. The Committee on the Rights of the Child, the body of independent experts that monitors the implementation of the Convention on the Rights of the Child, recently published a General Comment 13 on the right of the child to freedom from all forms of violence which emphasizes the need for increased child maltreatment prevention (OHCHR, 2012b). An increasing number of national surveys of child maltreatment in low- and middle-income countries have been conducted in recent years with the explicit longer term aim of better preventing child maltreatment (CDC, 2012b; Together for Girls, 2012; UBS Optimus Study, 2012). Child maltreatment prevention is establishing itself as a global public health and human rights priority.

The shift from response to prevention has been accompanied by an emphasis on evidence-based child maltreatment prevention programs (CDC, 2012c; Krug, Dahlberg, Mercy, Zwi, & Lozano, 2002; WHO, 2006, 2009). However, evidence-based programs alone are not enough to prevent child maltreatment. Another critical condition must be met to ensure program success: sufficient readiness or capacity within countries to implement evidence-based programs on a large scale.

In the last decade, readiness or capacity and their assessment and development have become central concerns in the fields of health promotion, prevention science, and public health more generally (Bangkok Charter for Health Promotion in a Globalized World, 2007; Ebbesen, Heath, Naylor, & Anderson, 2004; Laverack & Wallerstein, 2001; Maclellan-Wright et al., 2007). Capacity is considered a "necessary condition for the development, implementation, and maintenance of effective community-based health promotion and disease prevention programs." (Goodman et al., 1998), while "[m]atching an intervention to a community's level of readiness" is viewed as "absolutely essential for success" (Plested, Edwards, & Jumper-Thurman, 2006).

We used the following four-faceted definition of readiness as a starting point for the development of the model on which the instruments were based: (a) the group's awareness of the problem and its perception of the problem's priority; (b) its willingness to take action to address the problem; (c) the nonmaterial resources, including human, social, and technical resources, it can apply to the problem; and (d) the material resources, including infrastructure, institutional, and financial resources, it can bring to bear on the problem.

An analysis of the concept of readiness and cognate constructs – including capacity, capacity building, community readiness, community empowerment, and sustainability – indicated that definitions of these concepts often overlap and that they are often defined in terms of each other. Nonetheless, an important distinction between readiness and cognate concepts is that the notions of willingness, drive, and motivation are prominent in the former, but missing from the latter – see Mikton et al. (2011) for a more detailed analysis of these concepts.

A review of the literature found no instrument specifically designed to assess child maltreatment prevention readiness (Mikton et al., 2011). Hence, this project aimed to develop and apply such an instrument. Assessing child maltreatment prevention readiness can serve to identify major gaps in readiness with a view to address them, establish a baseline measure against which progress in increasing readiness can be tracked, help allocate resources to increase readiness for child maltreatment prevention, assist in matching an intervention to the existing level of readiness, and act as a catalyst for taking action to prevent child maltreatment.

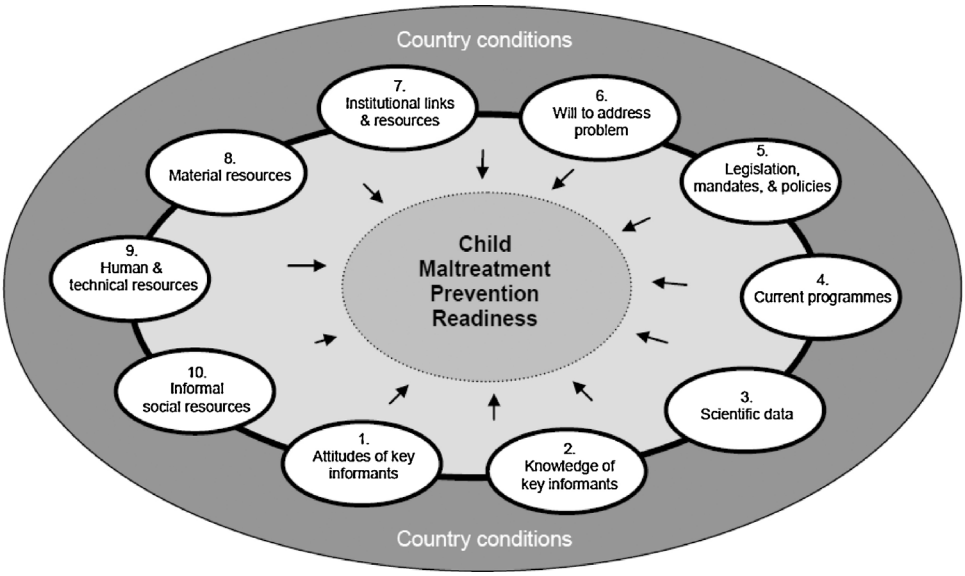

Fig. 1. The 10 dimensions of the Readiness Assessment for the Prevention of Child Maltreatment.

Here we report findings from the application of the instrument to assess the readiness of five, mostly middle-income countries – Brazil, the Former Yugoslav Republic of Macedonia, Malaysia, Saudi Arabia, and South Africa – to implement evidence-based child maltreatment prevention programs on a large scale. The research took place in early 2011. These countries were selected on the basis of a competitive bid for proposals, that no such assessments had been conducted before, and that they are all beginning to step up child maltreatment prevention activities.

For more information on the development of child protection services and on child maltreatment prevention in these five countries and for detailed results of the application of the instrument in them, please see the full country reports (Almuneef et al., 2012; Cardia, Laggata, & Affonso, 2012; Cheah, Choo, & Ramly, 2012; Makoae, 2012; Raleva, Filov, Trpchevska, Coneva, & Jordanova-Peshevska, 2012). For a description of the development and psychometric properties of the instrument, see Mikton and Power (2013). A handbook for the instrument is also available (Mikton, 2012a).

Methods

The Readiness Assessment for the Prevention of Child Maltreatment (RAP-CM) is a method of assessing a country's readiness to implement evidence-based child maltreatment prevention programs on a large scale and of generating recommendations to increase the country's readiness. It is based on a 10-dimensional model (Fig. 1 and Box 1) that was developed in a rigorous process described in Mikton et al. (2011). RAP-CM is made up of two parallel versions of an instrument with over 100 items, both based on the same 10-dimensional model.

The first instrument is the *Readiness Assessment for the Prevention of Child Maltreatment – Informant version* (RAP-Informant) which measures the knowledge, attitudes, beliefs, and opinions concerning child maltreatment prevention of key informants using a semi-structured interview and aims to capture informants' subjective assessment of readiness. "Key informants" refers to individuals who have or are likely to have significant influence on, and decision-making power over, child maltreatment prevention in a country. These may include policy makers; program planners and implementers; high level practitioners; high level civil servants and their senior technical advisers; leaders, champions, and politicians with a strong interest in the subject; and academics and researchers. They may come from many different sectors and types of organizations involved in child maltreatment prevention, including the health, social welfare/social development, education, and criminal justice sectors and governmental ministries and departments, non-governmental and community-based organizations, international organizations, as well as universities and other research institutions.

The second instrument is the Readiness Assessment for the Prevention of Child Maltreatment based on expert opinion using all available data in the country (RAP-Expert). Experts consisted of the research teams in each country who conducted the readiness assessment. In all countries, they were academic researchers – who also worked as clinicians in several cases – who had been specializing in child maltreatment prevention in their country for a number of years. RAP-Expert allows a more objective assessment of those dimensions which are primarily factual (2–4 and 7–9) and an assessment of the remaining dimensions informed by factually correct information. Comparing RAP-Expert with RAP-Informant helps identify gaps in key actors' knowledge and differences between experts and key actor's attitudes, beliefs, and opinions concerning child maltreatment prevention.

RAP-CM is based on the following definition of child maltreatment: "all forms of physical and/or emotional ill-treatment, sexual abuse, neglect or negligent treatment or commercial or other exploitation, resulting in actual or potential harm to

Box 1: The 10 dimensions of RAP-CM

Dimension 1: **Attitudes** toward child maltreatment and its prevention – e.g. understanding of the difference between child maltreatment prevention and child protection; perceived priority of child maltreatment prevention; and adequacy of measures taken to date to prevent child maltreatment.

Dimension 2: Knowledge about child maltreatment and its prevention – e.g. the nature of, prevalence of, risk factors for and consequences of child maltreatment, and the appropriateness of different prevention programs.

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

Dimension 4. Existing programs and their evaluation

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

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

Dimension 6. Will to address the problem

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

Dimension 7. Institutional links and resources

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

Dimension 8. Material resources

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

Dimension 9. Human and technical resources

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

Dimension 10: Informal social resources (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, legislation, and policies.

the child's health, survival, development or dignity in the context of a relationship of responsibility, trust or power" (Krug et al., 2002).

The RAP-CM assessment process results in:

(a) An overall score out of 100 on RAP-Informant and on RAP-Expert:
   - A score out of ten on each of the ten dimensions of RAP-Informant and RAP-Expert – which can be represented on a radar diagram (Fig. 2).

(b) A comparison of findings from RAP-Informant and RAP-Expert.

(c) A list of proposed recommendations to increase readiness.

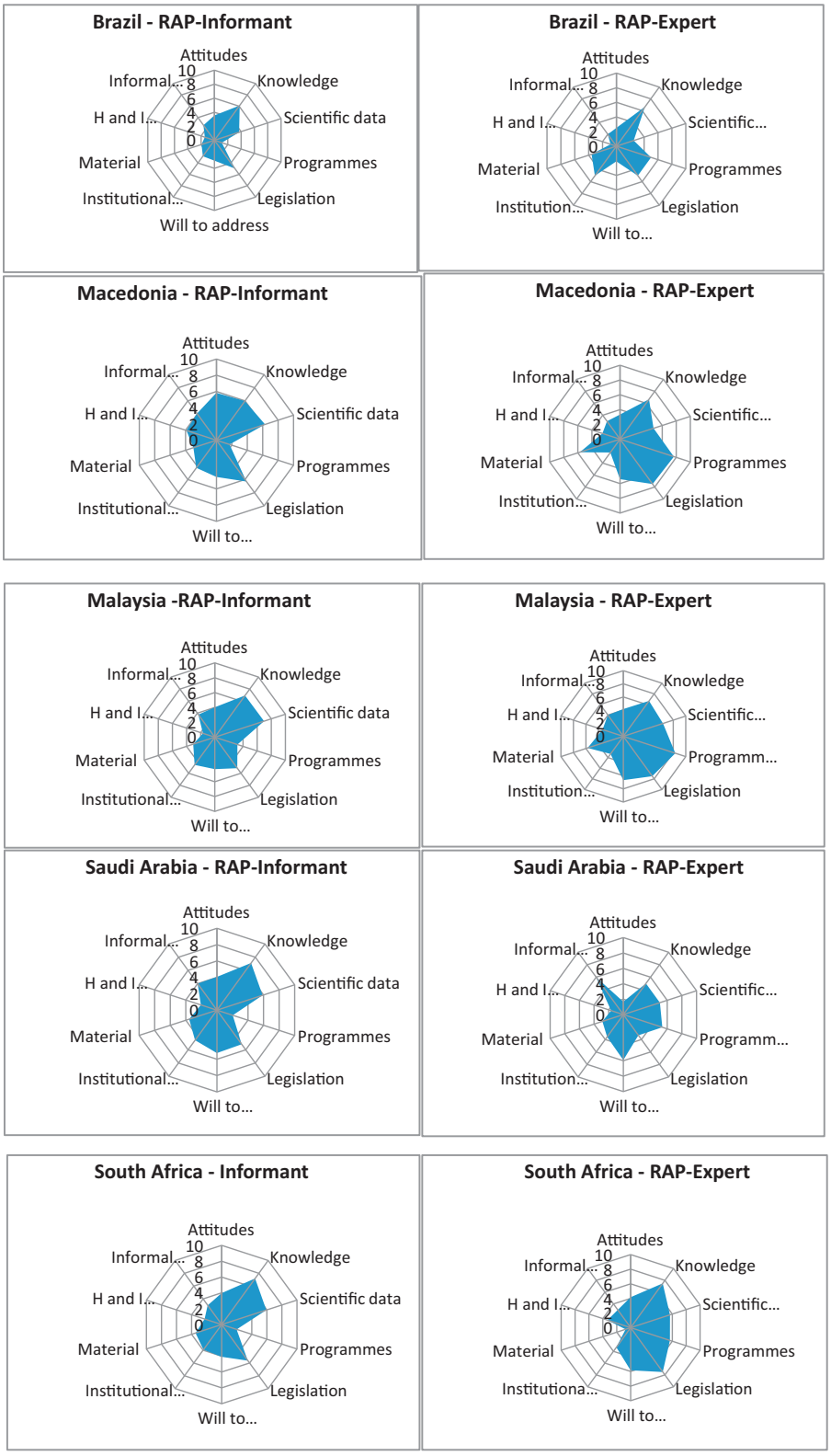

Fig. 2. Scores on the 10 dimensions for each country on RAP-Informant and RAP-Expert represented on radar diagram.

Table 1
Size of samples of key informants in each country, response rate, number of experts on country research teams.

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

Table 2
Characteristics of key informants – gender, years of experience in child maltreatment prevention, type of organization for which they work.

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

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

The number of key informants ranged between 41 and 50 per country and response rates in most countries other than Brazil were acceptable. To guide the selection of key informants a sample selection matrix was created to ensure that key informants from all main relevant organizations and sectors were included. The number of experts completing RAP-Expert in each country varied between 3 and 7 (Table 1).

Quantitative data analysis – including descriptive statistics, Chi-square, *T*-tests, and ANOVAs – was performed using SPSS Version 17. Qualitative data analysis focused on summarizing the suggested measures to increase readiness from which recommendations were derived.

This research did not directly involve victims or perpetrators of child maltreatment or patients of any sort. Instead, key informants – as defined above – were interviewed and a desk review of relevant data was conducted by the country research teams. All countries obtained ethical approval from their institutional or national ethics review boards as required. Free and informed consent was obtained in writing from all key informants and experts.

Results

Characteristics of key informants

There were several statistically significant differences between countries in the sample characteristics measured (Table 2): in most countries, the majority of informants were female; the mean number of years key informants had worked in child maltreatment prevention varied considerably; and in most countries, key informants working for governmental organizations made up the largest single group. Only in the case of years key informants had worked in child maltreatment and type of organization were significant associations with total scores on RAP-Informant found. These, however were weak and only applied to the whole sample aggregated across all five countries and not within individual countries (see Mikton (2012b) for further details and interpretation of this analysis).

Scores on RAP-Informant

Total scores on RAP-Informant indicated that key informants thought that Brazil has the lowest level of readiness (31.2/100) to implement child maltreatment prevention programs on a large scale and the Former Yugoslav Republic of Macedonia, the highest (45.8/100 – Table 3).

The total scores of the Former Yugoslav Republic Macedonia, Malaysia, Saudi Arabia, and South Africa were closely clustered in the low to mid-forties with non-significant differences between them. The dimension with the lowest score in almost all countries was Dimension 4 (existing programs) – except for Malaysia where it was the third lowest. Dimensions

Table 3
RAP-Informant – mean total scores, mean scores on each dimension, and rankings.

Country	Dim 1 Attitudes (SD)	Dim 2 Knowledge	Dim 3 Scientific data	Dim 4 Programs	Dim 5 Legislation	Dim 6 Will to address	Dim 7 Institutional links	Dim 8 Material	Dim 9 Human and institutional capacity	Dim 10 Informal social resources	Total score (max. 100)	Rank
Brazil	3.6 (1.3)	6.1 (1.4)	3.7 (2.5)	1.1 (1.2)	5.0 (2.0)	2.9 (2.1)	2.8 (2.1)	1.93 (2.0)	1.4 (2.0)	2.7 (2.0)	31.2 (10.9)	5
Macedonia	5.8 (2.2)	6.0 (2.0)	6.3 (1.7)	1.7 (1.4)	6.3 (2.6)	4.5 (2.4)	4.2 (2.5)	3.0 (2.4)	3.9 (2.4)	4.1 (2.1)	45.8 (12.7)	1
Malaysia	4.0 (2.0)	6.9 ((1.3)	7.0 (2.0)	3.2 (1.9)	5.2 (2.5)	4.3 (2.1)	4.6 (1.9)	3.1 (2.4)	1.7 (2.2)	3.8 (2.3)	43.73 (12.2)	2
Saudi Arabia	4.1 (1.1)	7.1 (1.4)	5.9 (1.8)	2.0 (1.7)	5.2 (2.0)	5.3 (1.7)	4.54 (2.1)	3.6 (2.6)	2.1 (2.8)	4 (1.8)	43.66 (9.7)	3
South Africa	4.0 (1.6)	7.2 (0.7)	5.9 (1.1)	2.0 (1.4)	5.6 (1.7)	4.1 (2.1)	3.9 (1.4)	3.5 (1.9)	2.3 (1.3)	3 (1.8)	41.4 (7.2)	4
Mean	4.3 (0.9)	6.7 (0.6)	5.8 (1.2)	2.0 (0.8)	5.4 (0.5)	4.2 (0.9)	4.0 (0.7)	3.0 (0.6)	2.3 (1.0)	3.5 (0.6)		
ANOVA												
F	12.47	7.16	18.34	10.28	2.81	7.03	5.21	3.24	10.99	4.15	12.00	
P	$p < 0.001$	$p < 0.001$	$p < 0.001$	$p < 0.001$	$p < 0.05$	$p < 0.001$	$p < 0.001$	$p < 0.05$	$p < 0.001$	$p < 0.01$	$p < 0.001$	
Scheffe post hoc test ($p < .05$)	Mc > all others	SAf > B, Mc SAr > Mc Ml > Mc	B < All	Ml > All	–	B < Mc, SAr	B < Mc, Ml, SAr	SAr > B	Mc > All	Mc > B	B > All	

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

8 (material resources) and 9 (human and technical resources) were also consistently low. The dimension with the highest score in three out of five of the countries (Brazil, Saudi Arabia, and South Africa) was Dimension 2 (knowledge). Countries also tended to score high on Dimensions 3 (scientific data) and 5 (legislation – Table 3 and Fig. 2).

Scores on RAP-Expert

The ranking of countries (Table 4) indicates that, based on the expert opinion of the research teams using all available relevant data, Brazil had the lowest level of readiness (35.2/100) and Malaysia, the highest (56.0/100). The dimensions on which countries tended to score high were Dimensions 2 (knowledge), 4 (programs), and 5 (legislation).

Comparison of scores between RAP-Informant and RAP-Expert

Differences between scores on RAP-Expert and RAP-Informant were slight in the case of most countries, other than Malaysia. Scores in all countries other than Saudi Arabia were higher on RAP-Expert than on RAP-Informant (Table 5). The biggest difference – of 12.3 points – was in the case of Malaysia. Rankings of countries based on RAP-Expert and RAP-Informant changed in all cases except for Brazil which was ranked last on both.

The largest and most consistent difference between RAP-Informant and RAP-Expert was found on Dimension 4 (programs), where all countries scored between 3.3 and 6 points higher on RAP-Expert (Table 5). The only other consistent difference was on Dimension 3 (scientific data). On Dimension 6 (will to address the problem), scores in all countries other than Brazil were higher on RAP-Expert. On Dimensions 5 (legislation) and 6 (will to address problem) scores on RAP-Expert were generally higher and on Dimension 7 (institutional links) scores on RAP-Informant were generally higher.

Other than on Dimension 4 (programs), differences between RAP-Expert and RAP-Informant on the other more factual dimensions – 2, 3, 7–9 – were not appreciably larger than on the non-factual dimensions (see Table 5). In 42% of cases (i.e. 21/50), the differences between scores on the 10 dimensions of RAP-Expert and RAP-Informant across the five countries were of less than 1 point, indicating some convergence between the two.

Scores on selected individual items of RAP-Informant and RAP-Expert

To get a richer sense of the information RAP-CM produced, we present replies to a few of its over 100 items.

Dimension 1 (attitudes). Most key informants in Malaysia, Saudi Arabia, and South Africa considered that measures taken so far to prevent child maltreatment had been inadequate (76.2%, 85.4%, and 68.4%, respectively). In Brazil and Macedonia, 48.8% and 34% considered such measures to be inadequate and ANOVA tests with Scheffe post hoc tests ($p < 0.05$) showed that Macedonia's mean score on this item was significantly different from all other countries but Brazil. Scores on this item on RAP-Expert were similar to those on RAP-Informant.

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

Dimension 3 (scientific data). None of the countries had conducted nationally representative surveys of child maltreatment prevalence. While the overwhelming majority of key informants from all countries replied that an official reporting system for cases of child maltreatment existed in their country, only a minority thought that the reporting system worked well – 0% in Macedonia to 43.9% in Saudi Arabia. On RAP-Expert, all countries stated that official reporting systems existed in their countries and three out of five countries thought that the reporting system worked "poorly"; in the Former Yugoslav Republic of Macedonia and Malaysia experts thought it worked "fairly".

Dimension 4 (programs). Out of a possible maximum of six points on RAP-Informant on outcome evaluations of child maltreatment prevention, the highest score was 0.7/6 for the Former Yugoslav Republic of Macedonia; four countries scored less than 0.2/6. Outcome evaluations appear to be exceedingly rare in these countries. This was corroborated by replies on RAP-Expert, except for Macedonia, which scored 4/5 points on the question concerning outcome evaluations in RAP-Expert.

Dimension 5 (legislation, mandates, and policies). Based on replies to RAP-Expert, legislation relevant to child maltreatment prevention was in force in all countries. Almost 90% or more of key informants in all countries, except Saudi Arabia, were aware such legislation existed. In Saudi Arabia 39% believed there was no such legislation in force. There was a marked and consistent pattern across countries on both RAP-Informant and RAP-Expert indicating that while legislation existed, implementation was poor and that policies specifically addressing child maltreatment existed less often than legislation or agencies officially mandated with child maltreatment.

Dimension 6 (will to address problem). Less than half of key informants in all countries considered that political leaders were willing, in spite of the pressure of electoral cycles, to invest in long-term child maltreatment prevention programs – and this figure shrank to 26.2% in Malaysia.

Dimension 7 (institutional links and resources). The majority of key informants knew of at least one partnership, coalition, network, or alliance dedicated to child maltreatment prevention in their country. This varied from 56% of key informants in Brazil to 78.6% in Malaysia. However, in several countries the percentage of key informants that did not know whether or not such partnerships, coalitions, networks, or alliances existed was high: 36% in the Former Yugoslav Republic of Macedonia and 24.5% in both Brazil and South Africa.

Table 4
Scores on RAP-Expert–total scores, scores on each dimension, and rankings.

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

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

Table 5
Differences between scores on RAP-Expert and RAP-Informant.

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

[a] Positive differences indicate that the scores on RAP-Expert > RAP-Informant; negative differences that score on RAP-Expert < RAP-Informant.

Dimension 8 (material resources). In all five countries, only about a third of key informants (31.7–39%) thought there were any dedicated budgets for child maltreatment prevention in government departments or ministries. In Brazil, the Former Yugoslav Republic of Macedonia, and Malaysia this was contradicted by replies on RAP-Expert which indicated that such budgets existed.

Dimension 9 (human and technical resources). Key informants and experts in most countries scored this dimension among the lowest. For instance, less than 8% of key informants in Malaysia, Saudi Arabia, and South Africa thought the number of professionals specializing in child maltreatment prevention was adequate for large-scale implementation of child maltreatment prevention programs.

Dimension 10 (informal social resources). Typical levels of citizens' participation to address various health and social problems, one of the items of this dimension, was judged to be high by between 7% (Brazil) and 19.5% (South Africa) of key informants on RAP-Informant (with no statistically significant differences in mean scores on this item) and by none of the experts on RAP-Expert.

Discussion

This application of RAP-CM indicates that Brazil, the Former Yugoslav Republic of Macedonia, Malaysia, Saudi Arabia, and South Africa are in a low to moderate state of readiness to implement evidence-based child maltreatment prevention programs on a large scale.

It identified several major and consistent gaps in all five countries: lack of professionals with the skills, knowledge and expertise to implement child maltreatment prevention programs on a large scale and of institutions to train these professionals (Dimension 9); inadequate funding, infrastructure, and equipment (Dimension 8); extreme rarity of outcome evaluations of child maltreatment prevention programs; and an absence of nationally representative surveys of the prevalence of child maltreatment (Dimension 3). These gaps should be given serious consideration when setting priorities, allocating funds in this field, and deciding on the scale of child maltreatment prevention programs that can be implemented in these countries.

Consistency was found among the recommendation made by country research teams to increase readiness (Table 6). These largely flow from the gaps identified. All countries recommended (a) increasing human and technical resources in the country, (b) improving data collection on child maltreatment and its prevention, and (c) further raising awareness of the issue to increase the will to address it. A comparison of RAP-Informant and RAP-Expert shows that important knowledge fails to reach key actors in the field in most of these countries, specifically knowledge about child maltreatment prevention programs implemented, existing scientific data, and, to a lesser extent, the existence of legislation and dedicated budgets.

The higher total scores on RAP-Expert than RAP-Informant in all countries, except Saudi Arabia, was anticipated as key informants were expected to be in possession of less accurate factual knowledge than the research team completing RAP-Expert on the basis of all available data. That the main consistent contributor to the higher scores on RAP-Expert was Dimension 4 (programs) confirms this hypothesis. To achieve higher scores on this dimension requires detailed knowledge of specific programs that have been implemented. The higher scores on Dimension 3 (scientific data) on RAP-Informant is also not surprising since items for this dimension asked whether or not different types of scientific data existed and not for specific findings from the studies. The higher scores suggest that informants somewhat overestimate the availability of scientific data in the country.

Since this is the first systematic assessment of the readiness to implement child maltreatment prevention programs on a large scale in any country, few data are available with which to compare the findings. However, the recent Annual Report of the Special Representative of the Secretary-General on Violence against Children to the UN General Assembly echoes some of the findings of this assessment. Based on a global survey, it concludes that "progress remains uneven, with insufficient efforts to develop a cohesive and well-resourced national strategy on violence against children; uncoordinated policy interventions; dispersed and ill-enforced legislation; insufficient investment in family support, in capacity-building for professionals, and in safe and child-sensitive mechanisms to address incidents of violence; and overall, with scarce data and research to break the invisibility of this phenomenon and promote evidence-based decision-making" (UN, 2012). A closer examination of data from this global survey, however, indicated that they do not allow close comparison with the ten dimensions of readiness of RAP-CM. The methodology of this survey was less rigorous than RAP-CM and its aim was not an assessment of readiness or capacity.

This study has several limitations. First, the absence of normative and validation data and data on test–retest and inter-rater reliability for the instruments means interpretation of findings must remain somewhat tentative. However, an examination of some of the instrument's other psychometric properties, including internal consistency reliability, showed they were adequate (for more on the development and psychometric properties of the instrument, see Mikton & Power, 2013). Second, the samples on which RAP-Informant findings presented here are based combine key informants from national and sub-national levels (e.g. province or state). It is unlikely that merging these two samples to assess the countries' overall readiness affected results in any significant way, given that the majority of key informants were from the national level in most countries and no significant differences in their scores were found. RAP-Expert was only used to assess readiness at national level. Third, for RAP-Informant, purposive samples of key informants were selected the representativeness of which is not known. However, a sample selection matrix was used to increase the chance that key informants from all main

Table 6
Summary of countries' readiness to implement evidence-based child maltreatment prevention programs on a large scale and conclusions and key recommendations of country reports (total scores out of 100; scores on dimensions out of 10; rank out of 5 countries).

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

Table 6 (*continued*)

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

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

relevant organizations and sectors were included. Fourth, this report, which summarizes the findings from all five countries, provides few details on the assessment of individual countries. For more detail on individual countries, readers are referred to the individual country reports.

Conclusion

Daro and Donnelly (2002) warn that proponents of child maltreatment prevention in the USA have repeatedly overstated prevention's potential and have allowed rhetoric to outpace research and empirical support. In view of the global prominence child maltreatment prevention has achieved in recent years, there are at least two sound reasons to heed this warning internationally. The first is the weak evidence-base for the effectiveness of programs to prevent child maltreatment in low- and middle income countries – concerted efforts, however, are being made to address this (Children & Violence Evaluation Challenge Fund, 2012; Knerr, Gardner, & Cluver, 2011; Mikton & Butchart, 2009). The second is the low state of readiness of the mostly upper middle-income countries included in this study – and probably of many other low- and middle income countries countries – to implement evidence-based child maltreatment prevention programs. RAP-CM, it is hoped, will contribute to addressing this.

The shift from protection to prevention globally represents a major opportunity to reduce the high rates of child maltreatment in low- and middle income countries where most of the world's children live. Conducting systematic assessments of countries' readiness to implement evidence-based child maltreatment prevention programs with a view to taking measures to address the gaps identified to ensure the success of programs can help ensure this opportunity is not missed.

Declaration of interest

None declared.

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