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Child maltreatment prevention readiness in the United Arab Emirates

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ABSTRACT

This study aimed to evaluate the level of child maltreatment prevention (CMP) readiness in United Arab Emirates (UAE) using the Readiness Assessment for the Prevention of Child Maltreatment, which comprises 10 dimensions. The study was conducted with 45 key informants with leadership positions in different governmental and non-governmental institutions in the field of child maltreatment, who have a strong influence on CMP in UAE. There is a moderate CMP readiness level in UAE, which was shown in most dimensions, with a total score of 55.6 out of 100. The informants scored high (≥ 5) in child maltreatment legislation, mandates, and policies (8.94), followed by institutional resources and links (7.61), will to address the problem (6.33), knowledge of CMP (6.27), attitudes towards CMP (5.44), implementation of current programs (5.22), and informal social resources (5.05). However, participants scored low (< 5) in human and technical resources (2.05), scientific data on CMP (4.16), and material resources (4.61). The findings indicate that UAE need to work on capacity building in the field of CMP to coordinate and combine the efforts of all the relevant organizations to increase funding and availability of professionals and data in the child maltreatment field as well as advocates and volunteers who can help to implement better action plans and more effective large-scale prevention programs.

1. Introduction

Child maltreatment (CM) is a global public health problem with long-term negative consequences. The World Health Organization (WHO, 2016a) reported that around 1 billion children worldwide experienced all types of maltreatment in the past year and approximately 41, 000 children under the age of 15 died as a consequence of CM (WHO, 2016b). The United Nations Children's Fund (UNICEF, 2017) stated that around 300 million children (aged 2–4 years) worldwide have experienced corporal punishment and maltreatment on daily basis by their caregivers, and 250 million have suffered specifically from physical maltreatment. In the United States, in 2016, an estimated number of 1, 750 children died from CM and around 700,000 children are maltreated yearly (National Children Alliance, 2016). However, these are official numbers and the real numbers are certainly higher. Many children are abused who never get reported. In Europe, psychological maltreatment was the most common form of abuse, accounting for 29.1% of CM, followed by physical maltreatment (22.9%), and sexual abuse (9.6%) (WHO, 2013).

The annual report of the Dubai Foundation for Women and Children (DFWAC) reported receiving 62 new cases of CM in 2017 (DFWAC, 2017), of which 20 (32%) cases were male and 42 (68%) female. Approximately 86% of the cases suffered from neglect, 100% from psychological maltreatment, 59% from physical maltreatment, and 11% from sexual abuse. The number of calls received at the call center about CM was 11% in 2016, compared to 9.8% in 2015; this indicating a clear increase in the number of CM cases reported and the need to increase efforts to deliver more CMP programs in the UAE (DFWAC, 2015, 2016, 2017).

Moreover, in 2015, the DFWAC conducted the study "Child Maltreatment in the United Arab Emirates Society," with the aim to understand the magnitude of all forms of maltreatment occurring at home and schools among Emiratis and resident children. This study used the tool designed by the International Society for the Prevention of Child Abuse and Neglect (ISPCAN), UNICEF, and WHO, namely, the ISPCAN Child Abuse Screening Tool (ICAST-CH) (ISPCAN, 2017), with

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a cluster sample size of 4111 including both Emirati and resident children selected from private schools in all seven emirates. The findings of the study revealed that 6.5% of the children were maltreated in their homes, and fathers were more likely to commit the maltreatment (32.7%). In school, 12.3% experienced maltreatment, of whom 48.3% were victims of peer violence and 29.4% by teachers (DFWAC, 2015).

Mikton and Butchart (2009) reported that treating the consequences of CM is less effective and costlier than preventing it before it occurs. Preventing CM necessitates the development of safe, stable, and healthy relationships and environment between children and their parents or caregivers. The Centers for Disease Control and Prevention (CDC, 2017) reported that securing healthy relationships and environments will protect children against early adverse events and is essential to ensure their long-term physical and psychological well-being. Various studies indicate that CM could be prevented through implementing large-scale evidence-based prevention programs encouraging early interactions between children and their caregivers and promoting healthy development, as well as home visiting programs, which have been shown to reduce CM by 39% (WHO, 2014).

Based on opinions of Gulf Cooperation Council (GCC) countries experts in preliminary discussions with field leaders, stakeholders, and site principal investigators, there is a lack of research on CM and its prevention is limited in the GCC countries. The National Family Safety Program (NFSP) in the Kingdom of Saudi Arabia (KSA) is collaborating with the WHO and investigators from the other GCC countries in order to assess their level of readiness, share technical support, and implement large-scale evidence-based CMP programs at a regional level, given their similar background and cultures. The purpose of this study was to assess CMP programs in UAE and the readiness level to deliver sustainable and large-scale evidence-based CMP programs, through evaluation of the awareness level; attitudes of health professionals, educators, social workers, researchers, and leaders towards implementing such programs; existence of CM data and research; availability of institutional, human and technical resources; and availability of laws and policies to ease the process of implementing prevention programs. This research with UAE policy makers and practitioners in the CMP field can generate useful insights into the identified gaps affecting the implementation of effective and sustainable large-scale CMP programs. Furthermore, policy makers will be able to develop more appropriate action plans to address problems and develop better CMP programs.

2. Methods

2.1. Participants

Key informants from 45 different institutions (governmental and non-governmental) in UAE, with strong influence and leadership positions in the field of CMP participated in the study. Almost all relevant governmental organizations and ministries took part in the study. Participants (n = 45) were selected according to a selection matrix (Table 1).

2.2. Procedures

Site investigators, who were mainly senior pediatricians or professionals from governmental agencies working with children, were selected from the GCC countries to oversee the implementation of the project in their own country. Each site investigator was responsible for the appropriate conduct of the study, obtaining local ethical approval from his/her research institutions, recruiting data collectors, and promoting the accuracy and quality of the collected data. When selecting the data collectors, site investigators recruited professionals working in the child protection area, familiar with the national and international organizations that are actively involved in combatting CM. Prior to the initiation of this study, site investigators of each country attended a 2-day training workshop at the NFSP in collaboration with WHO to understand the interview techniques, data collection tool, ethical considerations, and data transfer process. Furthermore, the principal investigator visited each country during the inception phase to train the recruited interviewers.

Table 1
Distribution of participants by type of organization.

Type of organization		Number	%
International	- International organizations (e.g., UNICEF, WHO, etc.)	2	4
Government departments or ministries	- Health, Public Health, etc. - Social welfare, development, affairs, etc. - Education - Women and Children - Justice, Criminal Justice, etc.	24	53
Civil society	- NGOs - Community-based organizations, etc.	8	18
Research	- Universities - Research institutes - Think tanks, etc.	4	9
Leaders	- Formal leaders in CM - Informal leaders in CM - CM Champions and patrons, etc.	2	4
Politicians and law-makers	- Parliamentarians - Party leaders; - Lawyers and judges, etc.	3	7
Private sector	- Donors - Media	2	4

In UAE, DFWAC researchers were assigned and trained to collect data. The study was approved by the Institutional Review Board (IRB) at the Ministry of Higher Education and Scientific Research in UAE and State Security of UAE. Face-to-face interviews were conducted usually at the participants' work place. Before the interview, the participants were asked to sign the informed consent for and endorsement letter describing the goals of the study and stating its anonymous nature. Each interview took approximately 30 min to complete. The data were handled as confidential and no one could have access to records, review, or analyze them, except for the authorized research team from King Abdullah International Medical Research Center in KSA, IRB, Research Scientific Committee, Ministry of Health auditors, NFSP, and any accreditation bodies and related personnel.

2.3. Measures

Through a five-stage process, the WHO in collaboration with five countries (Brazil, Macedonia, Malaysia, KSA, and South Africa) developed the Readiness Assessment for the Prevention of Child Maltreatment (RAP-CM) (Almuneef et al., 2012; Cardia, Laggata, & Affonso, 2012; Guat Sim & Wan Yuen, 2012; Makoae, Roberts, & Ward, 2012; Mikton et al., 2011, 2013; Raleva et al., 2012). This study utilized the modified short version of the RAP-CM, which has 10 dimensions: (1) Attitudes of key informants towards CM and its prevention; (2) Knowledge of key informants about CM and its prevention; (3) Scientific data on CM and its prevention; (4) Existing programs and their evaluation; (5) Legislation, mandates, policies, and plans relevant to CM prevention; (6) Will to address the problem; (7) Institutional links and resources; (8) Material resources; (9) Human and technical resources; and (10) Informal social resources (Mikton, 2013).

2.4. Data analysis

Quantitative data was managed and analyzed using the Statistical Package for the Social Sciences (SPSS) version 23. Frequency distributions were calculated for all characteristics of the sample, including

socio-economic data and responses to various interview items. According to the scoring system provided by the WHO, the responses to all questions except for dimension 4 were scored on a scale from 0 to 2, with 0 corresponding to a negative evaluation of a situation, 1 to a low level of an attribute, and 2 to the highest possible level of an attribute. In dimension 4, the question was scored from 0 to 4, with 0 corresponding to no names of programs listed and 4 to more than five names of programs listed. Similarly, in dimension 7, the question was scored from 0 to 2, with 0 corresponding to no names of institutions listed and 2 to more than five names of institutions listed. Scores for each respondent were first calculated, followed by mean scores for all respondents on each dimension and mean total scores. Overall total scores were then compared across countries. The scores for each dimension on a scale of 1–10 were categorized into two groups: a mean score ≥ 5 represented high readiness, and a mean score < 5 represented low readiness (Almuneef et al., 2014).

3. Results

3.1. Demographic characteristics

Fifty key informants were approached and 45 consented and completed the interview (90% response rate). In terms of gender distribution, about three-quarters (71.1%) of the participants were female. As for the organization affiliation of the participants, over half (64.4%) worked in governmental organizations and less than a quarter (17.8%) in non-governmental organizations. Regarding the scope of work of the organization, slightly over half (51.1%) of the participants were at the federal level and over one-third (37.8%) were at non-federal level (Fig. 1).

3.2. Scores of different dimensions

The overall score of the 10 dimensions of all participants was 55.6 (Table 2); 7 of the dimensions (attitudes towards CMP; knowledge of CMP; current program implementation and evaluation; legislation, mandates, and policies; will to address problem; institutional links and resources; and informal social resources) had high readiness scores (≥5) and 3 of the dimensions (scientific data on CMP; material resources; and human and technical resources) had low readiness scores (< 5) (Fig. 2).

3.3. Participants' responses to readiness assessment for the prevention of child maltreatment

Most of the participants (91.1%) considered CMP as high/moderate priority compared to other health and social problems, and 68.9% stated that the measurements taken so far to prevent CM were neither adequate nor inadequate. When asked about the main types of consequences and risk factors for CM, 100% and 97.8% of participants were able to mention 1–5 different consequences and risk factors, respectively. More than three-quarters (80%) reported that data on the magnitude and distribution of CM existed but their quality was either poor or fair. In terms of current program implementation and evaluation, more than half (64.4%) were able to list maximum 1–3 programs when asked to list names of CM programs that were currently active or had been implemented in the past. The majority of the participants stated that there were governmental or non-governmental agencies (84.4%) and official policies (86.7%) specific for CMP. Three-quarters (75.6%) revealed that there were political leaders who expressed strong commitment to CMP and were taking effective measures to address the problem. When asked to list the names of institutions currently involved in CMP, more than half (64.4%) listed five or more institutions and 55.6% listed more than three partnerships, alliances, coalitions, or networks wholly or in a large part dedicated to CMP. A total of 87% reported that either they did not know or there was no dedicated budget in the ministry of social welfare for CMP. However, three-quarters (71.1%) reported that there were dedicated budgets in other parts of the government. When asked if the number of professionals specializing in CMP were adequate for a large-scale implementation of CMP programs, most participants (95.6%) believed that these resources were neither adequate nor inadequate, or did not know about them. Two-thirds (66.7%) revealed that there was a moderate to high level of citizens' participation to address various health and social problems; 68.9% reported a moderate to high level of joint efforts.

4. Discussion

UAE readiness level of CMP was moderate (55.6%) according to key informants' perceptions and the questionnaire results, and readiness level to implement CMP programs was higher than that of other GCC countries (Table 3). The study has two key findings: a) 7 of the 10 dimensions showed high readiness scores (≥5), and UAE had the highest scores on 4 of these compared to all GCC countries; and b) 3 dimensions had low readiness scores (< 5).

4.1. Dimensions with overall high scores

Compared to all GCC countries, UAE scored the highest in dimension 1 (attitudes towards CM), dimension 4 (current programs implementation), dimension 6 (will to address the problem), and dimension 7 (institutional resources and links) (Table 3). This may be due to

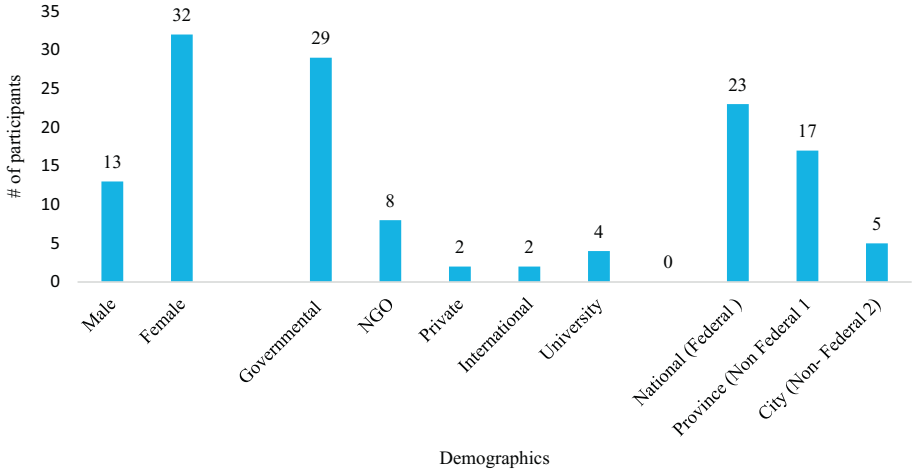

Fig. 1. Demographics of the participants.

Table 2
Scores on the 10 dimensions and mean total scores.

Dimensions	Raw score	UAE (n = 45) score on a scale of 1–10
Dimension 1: Attitudes towards child maltreatment prevention	2.17/4	5.44
Dimension 2: Knowledge of child maltreatment prevention	2.51/4	6.27
Dimension 3: Scientific data on child maltreatment prevention	1.66/4	4.16
Dimension 4: Current program implementation and evaluation	2.08/4	5.22
Dimension 5: Legislation, mandates, and policies	3.57/4	8.94
Dimension 6: Will to address the problem	2.53/4	6.33
Dimension 7: Institutional resources and links	3.04/4	7.61
Dimension 8: Material resources	1.84/4	4.61
Dimension 9: Human and technical resources	0.82/4	2.05
Dimension 10: Informal social resources (non-institutional)	2.02/4	5.05
Mean	22.24/40	55.60

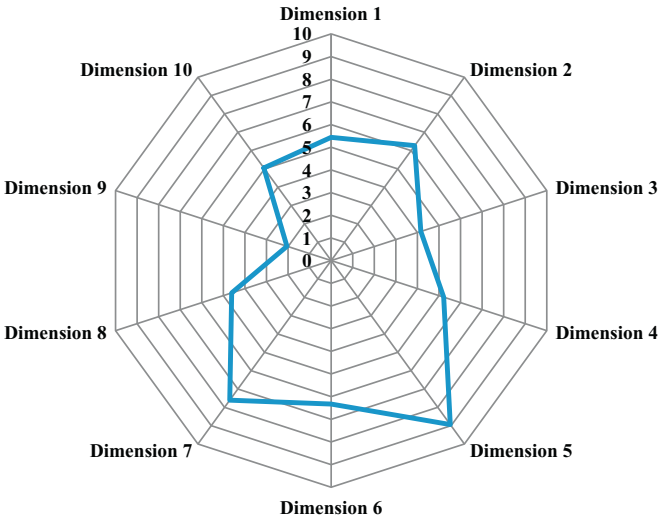

Fig. 2. Mean scores of participants on a scale of 1–10 on the 10 dimensions.

availability of budget and development of partnerships and programs to tackle this issue. This, in turn, has affected the attitudes of individuals towards addressing CM, becoming a priority compared to other health issues. Slightly over half (51.7%) of the UAE government's yearly budget is allocated to the sectors that directly serve citizens and community development, whereas 8.6% goes for health care and community prevention services and 6.6% for social development (Ministry of Finance, 2016). Although dimension 1 had high score (5.44), it might be improved by increasing awareness of long-term consequences of CM and the importance of healthy early child development (Mikton et al., 2013).

More than half (64.4%) of the informants listed over five agencies, and 55.6% over three partnerships or alliances dedicated to CMP. For instance, “Aqdar” program is an exceptional example of an effective partnerships, since it was implemented by the Ministry of Interior (MOI) on a large scale with many partnerships, such as Ministry of Education (MOE), Family Empowerment Foundation, Police stations, Islamic Authority, and other organizations. The program focuses on developing children's personal skills, preventing crimes, raising awareness of families about health and safety issues like cyber bullying and threats to children through exposure to inappropriate content, and national awareness about identity (Aqdar, 2015). Furthermore, the Supreme Council for Motherhood and Childhood developed a program with UNICEF in collaboration with the MOE for protecting children from bullying. Another example is the “Protect Childhood, It's Precious” awareness campaign developed by DFWAC with partnership of many organizations such as the MOE, KHDA, and Ministry of Community Development (DFWAC, 2016). Existing intervention programs need to be evaluated and provide information about their strengths and limitations. Regional and international evidence-based CMP programs need to be identified for the purpose of collaboration, adaptation, and adoption of such services in UAE.

In addition to the financial support that the UAE government provides for social issues, UAE scored high on dimension 6 for having many influential national figures and political leaders who express a commitment to face the problem of CM, such as approving the Child Protection Law, promoting human development by investing in education and building knowledge capacity in the region to cultivate future leaders in both public and private sectors (UAE Cabinet, 2016a), and by establishing Social Support Centers, Centers for Rehabilitation and Employment of People with Special Needs, and MOI's Child Protection Center (UAE Cabinet, 2016b).

Dimension 2 had high scores in all GCC countries, indicating that they have good knowledge about the problem of CMP (Table 3). High scores are most likely to be the result of increased awareness about CM among professionals as a result of various formal and informal educational activities. UAE scored high on this dimension compared to other countries, which might be due to the fact that government and leaders

Table 3
Scores the 10 dimensions and mean total scores by individual country (gulf cooperation council).

Dimensions (score on a scale of 1–10)	Bahrain (n = 45)	Kuwait (n = 45)	Oman (n = 49)	KSA (n = 60)	UAE (n = 45)
Dimension 1: Attitudes towards child maltreatment prevention	3.27	1.94	2.90	2.83	5.44
Dimension 2: Knowledge of child maltreatment prevention	7.22	6.22	7.55	7.04	6.27
Dimension 3: Scientific data on child maltreatment prevention	4.50	2.44	3.06	3.75	4.16
Dimension 4: Current program implementation and evaluation	4.50	2.44	5.10	5.16	5.22
Dimension 5: Legislation, mandates, and policies	7.88	6.61	9.08	8.29	8.94
Dimension 6: Will to address the problem	3.83	3.00	5.35	4.37	6.33
Dimension 7: Institutional resources and links	5.22	4.94	6.12	5.79	7.61
Dimension 8: Material resources	3.83	3.94	3.46	4.83	4.61
Dimension 9: Human and technical resources	1.22	2.05	2.44	1.66	2.05
Dimension 10: Informal social resources (non-institutional)	5.16	5.72	5.15	3.75	5.05
Mean total score	46.55	39.17	50.17	47.40	55.60

strongly believe in the importance of supporting social issues and CMP, and the resulting change in public opinion.

UAE scored high in legislation, mandates, and policies (dimension 5) because of the enactment and passing of the new Child Protection Law No. 3/2016, which was considered a milestone in the CM field (Table 3). Furthermore, UAE have recently approved two strategies, "National Motherhood and Childhood Strategy" and "National Strategic Plan for the Rights of Children with Disabilities 2017-2021," to guarantee high-quality services for children living in UAE and meet UAE's Vision of 2021 (SCMC, 2017). In comparison to other GCC countries, UAE ranked second after Oman, since Oman passed its law in 2014 before UAE. However, the enforcement of these laws is considered low and challenging in all Middle Eastern countries (WHO, 2014).

Regarding dimension 10 (informal social resources), most of the GCC countries scored high, since almost half of the informants reported that volunteers/citizens could be more involved in supporting social services programs and campaigns and could advocate for improving programs and policies to prevent CM in the community (Table 3). The level of citizens' participation can be improved by providing them with training and non-financial and motivational rewards for volunteering in the community. Furthermore, promoting volunteerism and community work among enthusiastic youth might also increase the score of this dimension.

4.2. Dimensions with overall low scores

All GCC countries scored low on dimension 3 (scientific data on CMP), dimension 8 (material resources), and dimension 9 (human and technical resources) (Table 3). Lack of data on CM is a problem in all GCC countries and globally (WHO, 2016a). In the current study, UAE ranked second after Bahrain on dimension 3, since 13.3% of the informants in Bahrain were aware of available data on CM, compared to only 6.7% in UAE. It is anticipated that available data is either unstructured or not organized in a national database. This type of data is not collected to be analyzed and published, which explains the UAE score low in this dimension. There is a pressing need for national surveys to identify the prevalence of all forms of CM and to assess its risk factors and consequences. A unified nationwide registry needs to be established for data collection including the use of valid and reliable instruments for the measurement of CM and to ensure the dissemination of results to decision makers, researchers, and the public. Such information would be vital for developing an effective national CMP programs. The DFWAC develops statistical reports on CM annually and conducts studies in this field. However, other organizations should make a substantial contribution. Therefore, it is important to develop a national database for CM and research connected to the database of the Federal Competitiveness and Statistics Authority of UAE and other national statistic centers in different emirates.

Regarding dimension 8 (material resources), although the UAE score was low compared to other dimensions, it ranked second after KSA when compared to other GCC countries (Table 3). In UAE, the majority of the informants were not aware of the material resources and funds available specifically in the Ministry of Community Development, although they were aware of the availability of funds in other ministries. This can be due to the fact that many organizations do not depend on the Ministry of Community Development to finance and fund their programs and projects. Scores on this dimension can be improved by liaising with the government to allocate a fixed and specific budget for preventing and combatting CM. In addition, training can be provided for non-governmental organizations (NGOs) to write justification to apply for funding for CMP activities from corporate and government sectors (Guat Sim & Wan Yuen, 2012).

The vast majority of the participants reported that the number of professionals specializing in CM was inadequate/there are none/do not know and few described it as neither adequate nor inadequate. Furthermore, most of them were either unaware of any programs or though there were no undergraduate or postgraduate educational institutions devoting some of their curriculum to CMP. Specialized expertise can be developed through interdisciplinary training programs that can provide in-service continuous development training, graduate and post-graduate education in the identification and management of CM cases, and encouraging young scientists to do their research on CM. However, in UAE, modest efforts have been made since the CM curriculum has been introduced in some of the local universities. According to ISPCAN (2011) and WHO (2005), capacity development is essential to achieve CMP success. Human capacity development needs to be strengthened in UAE and should maximize the use of evidence-based training resources and programs. Score of this dimension can also be increased by a) collaboration with international organizations on technical supports; b) collaboration between academic institutions and professionals and increasing funding for training; and c) creating post in the area of CMP (Mikton et al., 2013).

5. Conclusion

UAE have a moderate readiness to implement large-scale evidence-based CMP programs. Strengthening several dimensions is required to improve the country's readiness to implement such programs. Working on capacity building in the field of CMP; combining efforts of relevant organizations in all areas, especially in CMP; developing a national database of CM statistics; and conducting research connected to the database of the Federal Competitiveness and Statistics Authority of UAE and other national statistic centers in different emirates were measures recommended by the study participants to improve the UAE readiness level in CMP. Moreover, mass media has a vital role in preventing CM in the community.

Conflict of interest

This is to declare that all authors have no conflict of interest.

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