PROFESSIONALS’ PERCEPTIONS OF THE IMPLEMENTATION OF THE MULTIDISCIPLINARY NATIONAL FAMILY SAFETY TRAINING PROGRAMME IN THE KINGDOM OF SAUDI ARABIA

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ABSTRACT

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EJALAL JALAL

Background: Despite the global increase in public awareness of child safeguarding issues, there is significant variation in policy, service systems and practice internationally. Professional training is an essential component of child protection services, usually in an inter-agency context. A number of high profile cases of child abuse in Saudi Arabia resulted in a growing number of initiatives, with the goal of preventing and managing child maltreatment. However, there is still a lack of an evidence-base on systematic evidence on the profile of children at risk, those attending services, and the impact of interventions, including training programmes.

Aim: To explore professionals’ perceptions of factors promoting or hindering the implementation of an inter-agency child protection training programme.

Methodology: The National Family Safety Programme (NFSP) was established in 2005, and has established child protection centres and inter-agency training courses. The training objective is to provide participants with basic skills in identifying and managing child maltreatment. A qualitative research design was based on semi-structured interviews with 26 professionals from different disciplines, who had attended the training programme 18 months earlier. Thematic analytic framework was used.

Results: Three major themes emerged, on: a) benefits of translating training into practice; b) constraints of translating training into practice; and c) recommendations for improving training, services and policy in the future. This was identified as having positive impact by increasing knowledge, developing skills, and raising awareness. However, participants noted that the implementation of the training programme was often rendered difficult by
social factors and bureaucratic impedances.

**Conclusion:** The study highlighted that there is a demand for further legislation, as well as a range of organizational actions and processes to protect children from maltreatment. There is further need for on-going and sustainable training; inter-agency co-operation at policy and operational level; and awareness programmes to change cultural attitudes.
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### Abbreviations

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<td>ACRWC</td>
<td>African Charter on the Rights and Welfare of the Child</td>
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<tr>
<td>BECM</td>
<td>Bureau of Experts at the Council of Ministers</td>
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<tr>
<td>CAN</td>
<td>Child Abuse and Neglect</td>
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<tr>
<td>CDC</td>
<td>Centres for Disease Control and Prevention</td>
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<td>CPCs</td>
<td>Child Protection Centres</td>
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<td>CPS</td>
<td>Child Protection Services</td>
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<td>CRC</td>
<td>Convention on the Rights of the Child</td>
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<td>DCPW</td>
<td>Department of Child Protection and Family Support</td>
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<td>GASP</td>
<td>General Administration of Social Protection</td>
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<td>ILO</td>
<td>International Labour Organisation</td>
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<tr>
<td>ISPCAN</td>
<td>International Society for the Prevention of Child Abuse and Neglect</td>
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<td>KAIMRC</td>
<td>King Abdullah International Medical Research Centre</td>
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<tr>
<td>KSA</td>
<td>Kingdom of Saudi Arabia</td>
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<tr>
<td>KPIs</td>
<td>key performance indicators</td>
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<tr>
<td>MOH</td>
<td>Ministry of Health</td>
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<td>MOSA</td>
<td>Ministry of Social Affairs</td>
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<tr>
<td>MTD</td>
<td>Multidisciplinary Team</td>
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<td>NGOs</td>
<td>Non-governmental organisations</td>
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<tr>
<td>NGHA</td>
<td>National Guard Health Affairs</td>
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<tr>
<td>NHC</td>
<td>National Health Council</td>
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<td>NFSP</td>
<td>National Family Safety Programme</td>
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<td>NFSR</td>
<td>National Family Safety Registry</td>
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<tr>
<td>NSPCC</td>
<td>The National Society for the Prevention of Cruelty to Children</td>
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<td>OPSC</td>
<td>Optional Protocol on Sale of Children, Child Prostitution, and Child Pornography</td>
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<td>OPAC</td>
<td>Optional Protocol on the Involvement of Children in Armed Conflict</td>
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<tr>
<td>ORIC</td>
<td>Organisational Readiness for Implementing Change</td>
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<tr>
<td>PEM</td>
<td>Paediatric Emergency Medicine</td>
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<td>PHCCs</td>
<td>Primary health care centres</td>
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<td>SCAN</td>
<td>Suspected Child Abuse and Neglect</td>
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<td>SPC</td>
<td>Social Protection Committees</td>
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<td>Triple P</td>
<td>Positive Parenting Programme</td>
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<td>UPP</td>
<td>Universal Primary Prevention</td>
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<tr>
<td>UN</td>
<td>United Nations</td>
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<td>UNCRC</td>
<td>United Nations Convention on the Rights of the Child</td>
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<tr>
<td>USA</td>
<td>United State of America</td>
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<tr>
<td>UK</td>
<td>United Kingdom</td>
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<td>UOL</td>
<td>University of Leicester</td>
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<td>WHO</td>
<td>World Health Organisation</td>
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Definitions of terms relating to multi-agency working

Multi-agency /cross-agency working: more than one agency working together. Service provided by agencies acting in concert, and drawing on pooled resources or pooled budgets (Atkinson, Jones & Lamont, 2007; Percy-Smith, 2005).

Three different models of joint working were identified by Watson et al. (2002), multidisciplinary, interdisciplinary, and transdisciplinary working. These are all based on several experts working together effectively in a particular service context, and linked with family requirements in a holistic approach; but also have distinct differences:

**Multidisciplinary working** involves single agencies made up of individual professionals (Watson et al. 2002). For instance, a psychologist, a social worker, a psychiatrist, a surgeon, an obstetrician/gynaecologist working within the same health agency. Professionals though work separately to assess the child, and as a consequence they produce separate documents; so they do not share their goals and aims, which makes it difficult to assess the child as a whole. Their care is only focused on the child’s health care needs, without integrating with educational, emotional and social care needs. There is a low equivalent partnership approach with the family and low communication with other agencies; usually family members take on this role. This leads to interprofessional working and collaborative practice as envisaged by the World Health Organisation (WHO, 2010).

**Interdisciplinary working** involves different agencies and their professionals working together, by initially assessing the child and his/her family needs separately, but then meeting to set joint goals.

**Transdisciplinary working**, where different agencies work together by sharing goals, knowledge, tasks and responsibilities. This model is focused on a primary provider, the key worker, who is responsible for the delivery of an integrated programme for the child and family.
CHAPTER 1

CHILD MALTREATMENT: CONTEXT AND EVIDENCE-BASE
1.0 Introduction

This chapter critically situates the current debates and evidence on issues surrounding child abuse and neglect in a variety of contexts. A historical and cultural background is established, with reference to the international perspective and overall prevalence, using literature provided by key organisations such as the United Nations (UN) and the World Health Organisation (WHO). This context is contrasted with the social policy in the Kingdom of Saudi Arabia (KSA) – an environment currently undergoing considerable transitions due to recent state requests for increased policy and evidence-based improvements with respect to child abuse and neglect. Therein lie significant variables that make KSA somewhat distinguishable from other countries when dealing with the maltreatment of children, namely the socio-cultural idiosyncrasies, socio-economic factors, and the interaction of Sharia Law with social policy.

1.1 Legislation and Policy of Child Protection

Over decades, child protection has been a major concern on the political agenda of the international community. Moreover, child protection laws historically have a great impact on changing attitudes and beliefs regarding the role of government in protecting children from being maltreated. In 1919, the first legal framework for child protection was adopted by the International Labour Organisation (ILO), which set the Minimum Age Convention for industrial work. In 1924, the concept of ‘rights’ was used for the first time by the Geneva Declaration on the Child’s Rights (Geneva Declaration of the Rights of the Child, 1924; Olowu, 2008). In 1959, the Declaration of the Rights of the Child included ten non-legally bindings principles set by the General Assembly for the purpose of providing special protections for children (Pinheiro, 2006; Declaration of the Rights of the Child, 1959).
Legal instruments for the protection of children’s rights faced further elaboration and evolution over the years. The most notable and influential global policy documents were the United Nations (UN) Declaration and UN convention on the Rights of the Child (UNCRC) amongst others (Assembly, 1989). In 1989, the General Assembly adopted legally binding standards that were set by the Convention on the Rights of the Child (CRC) (Assembly, 1989; Pinheiro, 2006).

Definitions have similarly evolved during this period. The United Nations Convention on the Rights of the Child defined a child in article 1 as: “every human being below the age of 18 years unless, under the law applicable to the child, the majority is attained earlier" (Unicef, 1989, P.2). The UNCRC defines children and young people who are under 18 years old a comprehensive set of rights in 42 fundamental articles, within the context of international human rights law. Certain articles have been particularly important for child protection policy, legislation and service development. Article 19 calls for child protection from all forms of violence and abuse by proposing legislative, educational, administrative and welfare actions; “Article 19 (Protection from all forms of violence): (a). Children have the right to be protected from being hurt and mistreated, physically or mentally. Governments should ensure that children are properly cared for and protect them from violence, abuse and neglect by their parents, or anyone else who looks after them. In terms of discipline, the Convention does not specify what forms of punishment parents should use. However, any form of discipline involving violence is unacceptable. There are ways to discipline children that are effective in helping children learn about family and social expectations for their behaviour. (b). Ones that are non-violent are appropriate to the child's level of development and take the best interests of the child into consideration. In most countries, laws already define what sorts of punishments are considered excessive or abusive. It is up to each government to review these laws in light of the Convention” (Unicef, 1989, p. 5). Articles 32 to 36 emphasize the legal rights of the child to be protected from exploitation, including economic and sexual exploitation, forbidden use of illicit drugs, kidnapping, sale, and trading; “Article 32 (Child labour): The government should protect children from work that is dangerous or might harm their health or their education. While the Convention protects children from harmful and exploitative work, there is nothing in it
that prohibits parents from expecting their children to help out at home in ways that are safe and appropriate to their age. If children help out in a family farm or business, the tasks they do should be safe and suited to their level of development and comply with national labour laws. Children's work should not jeopardize any of their other rights, including the right to education, or the right to relaxation and play”. “Article 36 (Other forms of exploitation): Children should be protected from any activity that takes advantage of them or could harm their welfare and development” (Unicef, 1989, p.9-10).

Children’s rights have been acknowledged and almost universally adopted, as 192 countries have approved the United Nations (UN) Convention on the Rights of the Child (CRC) and are still bound by their articles. Only two countries, the USA and Somalia, have not adopted the convention (Olowu, 2008; Pinheiro, 2006; Zolotor & Puzia, 2010). Reading and colleagues (2009) stated that “the failure to ratify the UNCRC should not be taken to indicate that the USA disregards children’s rights, as it has been a perverse incentive to policy makers and academics to pay greater attention than in many other high-income countries that take their obligations less seriously” (P.334). However, many countries violate the rights of particular groups for children. For example, in the UK, laws discourage asylum seekers and deny essential benefits and services to those refused asylum may contradict the Convention on children’s basic rights. Similarly, in the USA, many Latino families are marginalised because of inequalities in welfare and healthcare policy. Consequently, although their children living in poverty and are more likely to be recorded by child protection services than white children, their access to support services is limited (Zambrana & Capello, 2003). Therefore, despite the endorsement of children’s rights principles, even in high income countries their situation appears to have worsened in recent years (Children’s Rights Alliance for England, 2008; UK Children’s Commissioners, 2008).

Although it is mandatory that the UNCRC is enforced and necessary for the child-maltreatment policy of any country, with the desirable impact on children’s well-being, it is often challenging to implement the UNCRC, given the political and social norms. Contradictions appear in every country and region because of tensions between the rights of the child and other conflicting values. In Africa, for example, Article 31 on the African
Charter on the Rights and Welfare of the Child (ACRWC) states that the child should take responsibility of contributing to family solidarity, obey and respect parents and elder people at all times, and provide them with support when this is needed (African Union, 1999). Thus sociocultural values, as well as socioeconomic factors such as living in harsh environments with limited resources, adversely impact the implementation of international conventions (Ajayi and Torimiro, 2004). In the same light, whilst many countries are adopting a more child-centred approach, others still believe, to a varied extent, in physical punishment as an acceptable parenting approach to discipline (Runyan, 2008; UNICEF, 2007).

The Committee on the Rights of the Child emphasized the requirement for banning all types of violence against children, including all forms of corporal punishment. In 2006, the Committee highlighted the duty of all countries to move forward in prohibiting all forms of punishment of children (Pinheiro, 2006). Zolotor and Puzia (2010) published a systematic review on bans against corporal punishment. The study focused on the legal context in the 24 countries with legislative prohibitions on corporal punishment, and the relationship between the law and changing attitudes. They found that one country in the Middle East, 19 countries in Europe, three in Central or South America, and one in Oceania have legislative bans on physical punishment. These countries have elected or representative types of government. A range of penalties are defined by law such as imprisonment, fines, probation, community service, or correctional labour. By using historical or geographic comparisons, most studies have shown a dramatic reduction in the proportion of the population favouring corporal punishment following a legislative ban.

In order to implement the UNCRC to improve the children’s health and well-being, Webb and colleagues (2009) proposed that, firstly, there must be raised awareness of the convention among children, young people and their advocates. Secondly, the UNCRC should be followed by all health professionals through training on the relevance of the UNCRC to health and health care. Thirdly, the UNCRC can then form the foundation for service standards and guidelines.
1.1.1 The Kingdom of Saudi Arabia and the United Nations Convention on the Rights of the Child

On 25th February 1996, Saudi Arabia signed and ratified the United Nations Convention on the Rights of the Child (UNCRC) following a decade of well documented high profile cases of child abuse and neglect at major hospitals throughout the kingdom (Abdul-Hamid, 2008; Abdul-Hamid, 2011). However, although hospitals subsequently received an increasing number of child abuse and neglect cases, the size of the problem in Saudi Arabia even in these health care settings is difficult to establish due to the absence of reliable statistics on incidence and prevalence (Almuneef & Al-Eissa, 2011). The Saudi government also expressed an overall reservation with regard to all CRC articles that interfered with the Islamic Sharia law. Optional Protocols to the Convention on the Rights of the Child on the child’s involvement in armed conflict, slavery, prostitution and pornography have not been ratified as yet by the Saudi government (Abdul-Hamid, 2008; Abdul-Hamid, 2011).

Al Buhairan and colleagues conducted a cross-sectional survey throughout Saudi Arabia with school professionals to examine their level of child maltreatment awareness, knowledge of national policies and procedures, efforts in protecting children from different forms of abuse, and the implementation of CRC Article 19. The results illustrated that child maltreatment awareness appeared low across all maltreatment domains, but most participants were willing to attend child protection training. This evidence highlighted how resources and efforts should address the identified gaps in the country (Al Buhairan et al., 2011).

In October 1998 and November 2003, the original and revised reports, respectively, were submitted to the UN Committee on the Rights of the Child by Saudi Arabia. On 18th August 2010, the government consented to the Optional Protocol on Children Sale, Child Prostitution and Child Pornography (OPSC). In the following year (June 2011), Saudi Arabia agreed to another Optional Protocol, the Convention on the Involvement of Children in Armed Conflicts (OPAC) (Abdul-Hamid, 2011).
Many legislative measures were put in place in order to protect children who were being maltreated. In 2006, a National Plan of Action was incorporated in the national periodic report. The Committee on the Rights of the Child welcomed the implementation of this plan for the period between 2005-2015. As part of the implementation of the National Plan of Action, significant changes have been made in the child protection field throughout the country (Abdul-Hamid, 2011).

Al-Shail et al. (2012) stated that, in 1994, the first initiative for preventing child abuse, including detecting and reporting, was established by one of the leading hospitals in Saudi Arabia as a Committee of the Child Advocacy. Surprisingly, this included internal policy and procedures in reporting suspected cases to legal authorities in the city. Subsequently, in 2005, the National Family Safety Programme (NFSP) was established by a Royal Decree for the purpose of building a foundation that endorses a safe community and supports victims of domestic violence, including child maltreatment victims. Promoting awareness among the society about the individual and collective impact of domestic violence, and educating staff on dealing effectively with child abuse and domestic violence cases are the strategic objectives of NFSP. Child Protection teams were thus provided with advanced training by the International Society for the Prevention of Child Abuse and Neglect (ISPCAN) (Abdul-Hamid, 2011). In 2008, the Ministry of Health authorized that healthcare professionals must report any child maltreatment cases; following which there was a dramatic increase of child protection centres from four to 41 throughout the province (Al-Shail et al., 2012).

In 2011, the Shoura Council (legislative parliament) approved a Child Bill draft, which was suggested in 2006 by the Committee on the Rights of the Child. There were 26 articles in the Child Bill, which focused on children’s’ rights, particularly on protecting children from different forms of abuse, including labour and trafficking. However, these articles do not include the minimum age for marriage, which was advised by the Committee to set a universal acceptable age. Within the Ministry of Justice, there is an ongoing debate regarding the minimum age, which is likely to be set at 16 years (Abdul-Hamid, 2011) (figure 1.1).
Figure 1.1
The landmark legislation and changes in Children’s Rights in Saudi Arabia

- **1994**
  - First initiative for preventing child abuse

- **1996**
  - Saudi Arabia ratified on the UNCRC (all articles; exclude the armed conflict, slavery, prostitution and pornography)

- **2005**
  - Establishing the National Family Safety Programme (NFSP)

- **2006**
  - A national plan was welcomed by the Committee on the Rights of the Child for the period between 2005-2015

- **2008**
  - The authorisation of the Ministry of Health that healthcare professionals must report any child maltreatment cases

- **2010**
  - Consented to the Optional Protocol on Children Sale, Child Prostitution and Child Pornography (OPSC)

- **2011**
  - Consented to the Optional Protocol on Children in Armed Conflicts (OPAC)
The legal prohibition of physical punishment is increasing around the world as a result of greater endorsement of human rights principles. Corporal punishment is prohibited in over 100 countries at all levels of general education and in 23 nations in all public sector settings. The purpose of these laws is to promote children’s security, positive child rearing and nurturing, and resilience. These countries criminalised corporal punishment by defining it as another form of criminal assault. These changes were followed by landmark prosecutions and court decisions (Durrant, 2008).

Overall, there is no explicit legislation that bans corporal punishment in different settings in the Kingdom of Saudi Arabia such as the home, school, or penal system (Abdul-Hamid, 2011; The Global Initiative to End All Corporal Punishment of Children, 2012). For instance, the Ministry of Education instructed that at all stages of general education, corporal punishment should not be used in their regular circulation. Penalties against teachers were introduced in schools to deter beating or maltreating, but these regulations remain ambiguous, and are thus not consistently implemented (The Global Initiative to End All Corporal Punishment of Children, 2012). Al muneef and Al-Eissa (2011) stated that there is an absence of criminal laws addressing child abuse and neglect (CAN) in Saudi Arabia. Whilst investigations occur when cases of sexual assaults and serious physical abuse are referred to law enforcement officials, only serious criminal cases are prosecuted in court. Between 2009 and 2011, three death sentences were given for murder in fatal CAN cases.

Al-Eissa and Almuneef (2010) stated that the Saudi Shura Council (legislative parliament) was reviewing drafts for two regulations addressing the issues of CAN, which it considered as a turning point in child protection efforts. The first draft focused on child protection against maltreatment according to the Convention on the Rights of the Child (CRC). The second draft is more general and focuses on comprehensive policies and procedures for managing domestic violence involving CAN cases (Almuneef & Al-Eissa, 2011). In recent years, some national and international newspaper reports indicated that Saudi Arabia is preparing to pass laws against domestic violence. Under the 17-article legislation, those found guilty of committing psychological or physical abuse could face prison sentences of up to one year and fines of up to 50,000 riyals (£8,600) (Ott, 2013; Saul, 2013).
1.1.2 The Kingdom of Saudi Arabia and Child Rights under Sharia Law

It is vital to have an overview of the legal system in Saudi Arabia, which is largely based on the Islamic ‘Sharia law’. Sharia is the Islamic legal framework, which is derived from the holy Quran, the Sunnah, the Ijma and the Qiyahs (Olowu, 2008). Furthermore, Sharia law is the direction of the obligatory punishment or penalty, which is called a ‘hadd offence’. For instance, flogging is one of the mandatory penalties, which are prescribed for a number of offences, or additional punishment by the judge’s decision (Abdul-Hamid, 2011; The Global Initiative to End All Corporal Punishment of Children, 2012).

It is important to note that the Committee of the Rights of the Child has rejected religious justifications for corporal punishment (Durrant, 2008). Moreover, this Committee stated that religious practices should consistently respect human dignity and integrity. For instance, Islam does not authorize maltreatment of children. In contrast, Islam forbids all forms of maltreatment against human beings and animals by means of clear sections in the Quran (Al-Shail et al., 2012). Islam has narrowly restricted even the seemingly permissible corporal punishment in such a way that it effectively looks like a sign of disapproval rather than a means for harming the body. The practice of reporting child abuse cases in Saudi Arabia is similar to what is observed universally. The Kingdom seemingly acknowledges that child maltreatment is an unfortunate reality that it shares with many other nations (Al-Shail et al., 2012).

1.2 Definitions of child maltreatment and arising issues

Child maltreatment is often considered as one of the most invisible forms of violence against children by adults within the family context, because of its occurrence within domestic life privacy. It is, nevertheless, similarly prevalent across the globe. For instance, there is an annual estimation of child maltreatment around the world of 40 million victims under the age of 14 years (Butchart et al., 2006). Recent statistics from studies shows that more than 120,000 children in the United States are victims of physical child abuse leading to a significant mortality (Shein et al., 2012). Although, Svevo-Cianci and colleagues stated that child maltreatment rates in western countries are lower than in some other societies,
especially in developing countries. It is highlighted that around 150 million children, 1 in 15 children who are under 18 years old, are abused and neglected annually. This alarming figure is far greater than the World Health Organization estimation (Svevo-Cianci et al., 2010). The extent of this problem globally indicates that effective response to and prevention of child maltreatment requires a common understanding and consistent definitions (Goldman et al., 2003).

The World Health Organisation (WHO), in their World Report on Violence and Health, defined violence as “the intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community that either results in or has a high likelihood of resulting in injury, death, psychological harm, mal development or deprivation” (Krug et al., 2002, P.4).

To understand the link between violence and child maltreatment, it is worthwhile to know under which category this falls. In the World Report on Violence and Health, child maltreatment is viewed under the broad categorization of violence. The topology of violence is further divided into three categories: self-inflicted, interpersonal and collective violence. Child maltreatment is classified as interpersonal violence. Interpersonal violence is further subdivided into two categories, family and community. Child maltreatment, partner and elder abuse each fall within the family group (Figure 1.1). All categories are subdivided to represent types, settings and nature of violence, i.e. physical, sexual, psychological, deprived or neglectful acts (also Figure 1.2) (Butchart et al., 2006, Krug et al., 2002). Krug and colleagues (2002) stated that it is common problem in all countries that child maltreatment and intimate partner violence often co-occur in the same family.
Howe (2005) stated that definitions of child maltreatment are subject to change and they vary according to cultures, generations and locations. Similarly, Cawson and colleagues stated that it is inherently difficult to define, not least due to the reality that children are exposed to harm in many potentially dangerous situations (Cawson et al. 2000).

In some early studies, researchers resolved the problem of the absence of explicit definitions and the difficulty of operationalizing concepts of maltreatment by using labels assigned to the act by responsible parties such as hospitals, child protection services, and legal authority. At a later phase (in the 1980s), this approach was adopted in the use of empirical data based on child protection services records, as this was thought to provide useful descriptive information with minimal data collection efforts. During the 1990s, efforts were made to develop more precise operational definitions of acts of maltreatment as opposed to relying on professionals’ opinions. Even though this was a step in the right direction, it was argued...
that comparability between studies was compromised due to wide variations in the
definitions adopted and their impact on the estimation of the different types of child abuse
and neglect (CAN) (National Research Council, 1993; Zuravin 1991; Wyatt and Peters,
1986).

In order to explore and investigate the definitions of child maltreatment, two particular issues
should be taken into consideration. Definitions of child maltreatment definition are
influenced by the discipline of the professional defining the phenomenon and by cultural
and political contexts (Hutchison, 1990; Mennen et al., 2010; Shanalingigwa, 2009). The
causes of abuse were included in some definitions, but not in others (Shanalingigwa, 2009).

Many countries, including Saudi Arabia, broadly adopt the World Health Organisation
definition of child maltreatment as “all forms of physical and emotional ill-treatment, sexual
abuse, neglect, and exploitation that results in actual or potential harm to the child’s health,
development or dignity in the context of a relationship of responsibility, trust or power”
(WHO, 1999, p.15). In parallel, most countries also utilise their own definitions. For
instance, in the US, the Child Abuse Prevention and Treatment Act describes child
maltreatment as: “Any recent act or failure to act on the part of a parent or caretaker, which
results in death, serious physical or emotional harm, sexual abuse, or exploitation, or an act
or failure to act which presents an imminent risk of serious harm” (Child Abuse Prevention
and Treatment Act, 2010, p. 6).

In an effort to assist in the collection and usage of the data of the public health-based child
maltreatment, the Centres for Disease Control and Prevention (CDC) developed a definition
of child maltreatment, which is considered another widely used definition. The CDC
partnered with experts from a diversity of settings, such as universities, state health and
welfare departments, and health and social care agencies. As a collaborative effort to develop
the definitions, the definitions were drawn upon the existence and use in other sectors.
Modification were made in order to meet the public health professionals’ needs whose goal
is to protect children from being abuse and neglect (Leeb et al., 2008). They defined child
maltreatment as “any act or series of acts of commission (abuse) or omission (neglect) by a
parent or other caregiver that results in harm, potential for harm, or threat of harm to a child” (Leeb et al., 2008).

In the UK, the Government Guidance Working Together to Safeguard Children defined child abuse and neglect as all forms of child maltreatment could which could potentially cause harm, or may fail to prevent harm to the child directly or indirectly by adults known to the child, strangers, or institutional or community settings (HM Government, 2010). These are indicative examples of common themes as well as differences, which are prominent across most countries too. In Saudi Arabia, child maltreatment is defined as “any form of exploitation, physical, emotional, or sexual harms or threaten act by a person to another person under his authority, family relationship, custody, supervision, caregiver or guardianship; also involving fulfilment of duties or obligations for family members or others responsible for the child under Islamic law” (Bureau of Experts at the Council of Ministers, 2013, p.7 & Ministry of Social Affairs, 2013, p.1).

In a review of adopted definitions from different countries, Gough (1996) identified two main components in the definitions of maltreatment, harm and person who is responsible for causing harm. All definitions referred to the harmful action and the consequences of the abuse, which may be the impact on the child’s physical, emotional or cognitive development, or additional child rights infringements. However, the WHO definition does not include the person who causes the harm to the child, but rather refers to other acts that cause harm to the child.

1.2.1 Types of Child Maltreatment and their Impact

This section will discuss the types of child maltreatment which have been recognized by the above child maltreatment definitions, followed by evidence on their measurement, prevalence and consequences for the victims. The most widely recognized child maltreatment types are four, and are commonly used by services in their operational definitions. These are physical abuse, sexual abuse, emotional or sometimes referred to as
psychological abuse, and neglect. These may occur individually, or in many cases as multiple forms of maltreatment (HM Government, 2010; Trocmé et al., 2008).

The most widely used definitions in the literature are the definitions of the Centres for Disease Control and Prevention (CDC) including the subtypes of child maltreatment (Gilbert et al., 2009a; Leeb et al., 2008). These definitions are associated with the definitions of the World Health Organization (WHO) and acknowledge Article 19 of the United Nations Convention on the Rights of a Child, which refers to child protection from all forms of violence, exploitation, and abuse in regard to care from parents and other caregivers (Runyan et al., 2002; Unicef, 1989).

Since maltreatment perpetrators are often also the source of support for the child, it is challenging to establish prevalence or incidence rates based on information from caregivers, parents or other family members (Butchart et al., 2006). Gilbert and colleagues (2009a), consequently reviewed epidemiological methods from community studies and official statistics, and concluded that reliable measurement of child maltreatment frequency and severity is not direct. Community studies largely focus on victims’ self-reports of sufficient cognitive capacity, or parents’ reports on their child rearing style, including corporal or physical punishment. Victims’ and offenders’ statistics are usually collected by agencies such as child protection services and the police. The sampling, measurement and operational differences between the studies explain the wide variation of their findings. Self-reports by victims tend to show higher rates of maltreatment than statistics by child protection agencies. If interpreted in conjunction with parental reports on their rearing style, the estimates of maltreatment are probably closer to reality than official reports from agencies, which usually reflect the more serious, detected, reported and investigated cases.
Table 1.1
Child maltreatment types definitions

<table>
<thead>
<tr>
<th>Child maltreatment</th>
<th>Definitions by the Centres for Disease Control and Prevention (CDC) (Leeb et al., 2008)</th>
<th>Definitions adopted in Saudi Arabia</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Child maltreatment</strong></td>
<td>“Any act of commission or omission by a parent or other caregiver that results in harm, potential for harm, or threat of harm to a child”.</td>
<td>Law of Child Rights and Protection: “Any form of exploitation; physical, psychological or sexual, or the threat thereof committed by an individual against another exceeding the limits of powers and responsibilities derived from guardianship, Dependency, sponsorship, trusteeship or livelihood relationship. The term “abuse” shall include the omission or negligence of an individual in the performance of his duties or responsibilities in providing basic needs for a family member or an individual for whom he is legally responsible” (Ministry of Social Affairs, 2013, p. 1)</td>
</tr>
<tr>
<td><strong>Physical abuse</strong></td>
<td>“Intentional use of physical force against a child that results in, or has the potential to result in, physical injury” (p. 14). Physical harm includes acts that can range from not leaving physical marks, such as shaking or poisoning; to those which leave marks such as hitting, burning or scalding, drowning. These can cause disability or even death in</td>
<td>Law of Child Rights and Protection: “Vulnerability of the child to physical harm” (Ministry of Social Affairs, 2014, p. 1).</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Law of Protection from Abuse: “Any act or omission or negligence by a person to another person under his authority, family relationship, custody, supervision, caregiver or guardianship which</td>
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</tbody>
</table>
severe cases. Physical abuse can be the result of correcting or controlling the child’s behaviour by the parents or caregivers.

result in assault to this person’s body, thus causing physical harm” (Ministry of Social Affairs, 2013, p. 2).

National Family Safety Program: “Infliction of an injury on a child (by beating, shaking, kicking, beating, burning, biting, suffocating, or poisoning) regardless of the perpetrator’s intention. It also includes Munchausen syndrome by proxy, in which the perpetrator fabricates or falsify signs and symptoms of a disease or actually cause it. It also includes Shaken Baby Syndrome in which the infants’ brains (and other organs) are injured secondary to violent shaking resulting in long term deficits.” (The National Family Safety Program, 2013, p. 10).

Sexual abuse

“Any completed or attempted sexual act, sexual contact, or non-contact sexual interaction with a child by a caregiver” (p.14).

Penetration: between mouth, penis, vulva, or anus of the child and another individual.
Contact: intentional touching directly or through clothing of genitalia, buttocks, or breasts (excluding contact required for normal care).
Non-contact: exposure to sexual activity, filming, or prostitution.


Law of Protection from Abuse: “Exposure to any sexual act, utterance, or exploitation illegally from a person who uses his authority, family relationship, custody, supervision or guardianship” (Ministry of Social Affairs, 2013, p. 2).

National Family Safety Program: “Exposing a child to any adult sexual activity or behaviour, including oral sexual contact, touching, caressing, or penetration of the child by genitals or any body part or instrument, as well as verbal sexual harassment. It also includes exploitation of the child in prostitution, pornography, and exploitation through communication tools for sexual

<table>
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</tr>
<tr>
<td>Contact:</td>
<td>intentional touching directly or through clothing of genitalia, buttocks, or breasts (excluding contact required for normal care).</td>
</tr>
<tr>
<td>Non-contact:</td>
<td>exposure to sexual activity, filming, or prostitution.</td>
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</tr>
<tr>
<td>Psychological (or emotional) abuse</td>
<td>“Intentional behaviour that conveys to a child that he/she is worthless, flawed, unloved, unwanted, endangered, or valued only in meeting another’s needs” (p.16).</td>
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<tr>
<td>Neglect</td>
<td>“Failure to meet a child’s basic physical, emotional, medical/dental, or educational needs; failure to provide adequate nutrition, hygiene, or shelter; or failure to ensure a child’s safety” (p.17). Includes failure to provide adequate food, clothing, or accommodation; not seeking medical attention when needed; allowing a child to miss large amounts of school; and failure to protect a child from violence in the home or neighbourhood, or from avoidable hazards (pp. 17-18).</td>
</tr>
</tbody>
</table>
1.2.1.1 Physical Abuse

Definitions of child maltreatment types can be influenced by the agency or discipline involved. For instance, the definition of physical abuse by the Ministry of Social Affairs in Saudi Arabia (2013) is general, unclear and could be misleading to professionals because it focuses on the adult’s act to cause physical harm but does not state how it is directly related to the child and how it can be translated to other situations. Physical harm according to this definition might occur in many ways, which is cover a wide variety of people under supervision by an adult, so it could assault a child, a wife, an elder person, maid, or any other person. Here the purpose is the focus on the relationship between the parent or caregiver and the child, and the consequences of their act upon their child. Negligence is mentioned in this definition, but ambiguous in its meaning. The NFSP definition focuses on the physical harm that could happen to the child by a parent or caregiver, including six forms of behaviour. In contrary, physical abuse as defined by the Centres for Disease Control and Prevention (CDC) refers to physical acts from any adult that cause physical injury, whether these are intentional or not.

According to the US Department of Health and Human Services (2015), biological parents represent 88.6% of perpetrators, of whom men and women are fairly equally represented at 49.6% and 48.2, respectively. When figures rely on informants’ report, Fergusson and colleagues (2000) and Finkelhor (2008) stated that parents’ reports for young children and a combination parent and self-reports by adolescents reached similar estimates in the two broad age groups. For instance, a systematic review by Woodman and colleagues (2008) in the UK concluded that of the 1 in 11 children who were physically abused, 1 in 31 of children exposed to severe parental violence, 9% were inspected by child protection services, and only 0.4% eventually received a child protection plan. Gilbert and colleagues (2009a) focused on high-income western countries and eastern European countries and found that reported incidence rates varied from 4% to 16%.
The immediate physical consequences can be minor such as cuts and bruises or severe such as haemorrhage, fractures and sometimes death (Preer, Sorrentino, & Newton, 2012). Although some of these consequences can be temporary, the pain and suffering that the abuse causes to a child cannot be disregarded (Dumaret & Tursz, 2011). Research has shown that long-term physical consequences include Abusive Head Trauma (Shaken Baby Syndrome) (Preer et al., 2012; Shein et al., 2012), impaired brain development (Al Odhayani, Watson, & Watson, 2013) and general poor physical health (Norman et al., 2012).

Children’s quality of life can be affected in several domains. Adverse implications can continue into young adulthood. For instance, people who suffered serious physical abuse as young children, were more likely to have lower skilled jobs controlling for other sociodemographic factors (Dyson, 2008). Boden, Horwood and Fergusson (2007) conducted a longitudinal population-based cohort study in New Zealand, and found that around 6–10% of children who were abused accomplished a university degree compared with 28% of those not abused; as such variances were greatly explained by parental, socioeconomic and individual characteristics, they indicate that a number of factors can be involved to adversely affect the prognosis of psychosocial functioning, but also provide opportunities for early intervention.

1.2.1.2 Sexual Abuse

The Law of Child Rights and Protection by the Ministry of Social Affairs (2014) sexual abuse focuses on the child’s weakness to exposure to any kind of sexual abuse and sexual exploitation. While the Ministry of Social Affairs (2013) definition placed an emphasis on sexual behaviours by an adult in authority, family relationship, or guardianship, it does not specify the different types of sexual acts. Additionally, it does not include strangers in their definition. In contrast, the National Family Safety Programme definition provides more details on the child’s exposure to any adult’s sexual activities and classifies the illegal sexual activities. Similarly, the Centres for Disease Control and Prevention (CDC) definition includes three categories of sexual acts, sexual contact and exploitation. Sexual acts can be completed or non-completed; and involve physical contact, including penetration and oral
Sex. Sexual contact includes non-penetrative acts such as masturbation, kissing, rubbing and touching. Exploitation includes non-contact activities such as involving children in sexual activities by looking at sexual images, adults watching child sexual activities, and encouraging children to behave in sexually inappropriate ways (HM Government, 2010; Leeb, 2008).

Measurement of sexual abuse often relies on retrospective self-reports by adolescents or adults. Population-based studies in high-income western countries, countries such as Australia, New Zealand, Canada and the US, showed that between 5-10% of girls and 1-5% of boys had been exposed to penetrative sexual abuse during childhood, although figures on any form of sexual abuse are much higher (Mullen & Fergusson, 1999; Nelson et al., 2002). A UK study by Radford et Al. (2013) reported high rates of sexual assaults experiences, which involved all forms of sexual abuse, ranging from touching to rape, among 7.2% of females aged 11–17 years, and 18.6% of females aged 18–24 years assaulted during their childhood by an adult or peer that included physical contact. Andrews and colleagues (2004) conducted a meta-analysis of worldwide studies. They established the prevalence during childhood of various types of abuse as follows: 3.1% male, 6.8% female of non-contact sexual abuse, 3.7% boys, 13.2% girls experienced contact sexual abuse, 1.9% boys, 5.3% girls assaulted of penetrative sexual abuse, and 8.7% boys, 25.3% girls exposed to any sexual abuse. Despite the quality assessment of the included studies and the rating criteria of the meta-analysis, even these rates maybe underestimate for the methodological reasons discussed earlier. According to the US Department of Health and Human Services (2015), 9.0% of children under 18 years old were sexually abused.

In relation to the impact of sexual abuse, a systematic review was conducted by Maniglio (2009) to investigate the literature between 1966 and 2008, on short and long-term outcomes. The results showed that childhood sexual abuse survivors are significantly at risk for a wide range of problems; for instance, medical problems, which appeared as chronic non-cyclical pelvic pain, but not with menstrual pain (dysmenorrhoea); and sexual transmission of genital herpes. Non-epileptic seizures were significantly higher among children with a history of sexual abuse. Results also indicated that there was a strong association between child sexual
abuse and adult mental health disorders such as borderline personality disorder and depression, anxiety, eating and post-traumatic stress disorders. As well as problems like child victims are more likely to have early and often abusive sexual experiences, as well further sexual victimization and domestic abuse in adulthood. Although longitudinal studies have several advantages, they are resource-intensive, for which reason similar findings have been corroborated in retrospective studies by adults with these types of mental health disorders, and who had higher reported rates of sex abuse as children (Brewerton, 2007).

1.2.1.3 Emotional Abuse

The Law of Child Rights and Protection by the Ministry of Social Affairs (MOSA, 2014) definition of emotional abuse focuses on the failure of taking responsibility to take care of someone, which could thus lead to psychological and health harm. While in the Law of Protection from Abuse the definition highlighted the repetition of ‘bad acts’ from a person in authority for the purpose of making another person to feel down about themselves. However, the term ‘bad’ in this definition is vague and requires more specificity. For example, this could be translated in a family situation that the caregiver behaves in an immoral way towards the child. The consequences of such on-going immoral behaviour maybe causing harm to the child’s dignity and lower his/her moral. In contrast, the National Family Safety Programme definition is more comprehensive than those put forward by MOSA and BECM, which involve the psychological act of an adult against the child, which can lead to mental health problems. Trocmé and colleagues (2011) stated that emotional abuse is hard to detect as a distinct form of abuse, or to prove in court proceedings, although this is often accompanied by other forms of maltreatment (Henderson & Scannapieco, 2006).

The Centres for Disease Control and Prevention (CDC) highlights the consistency of the child’s emotional maltreatment in their definition. Emotional abuse of children may involve different acts, such as making them feeling unloved or inadequate, not giving them chances to communicate freely and to express their feelings and views, intentionally silencing them or ‘making fun’ of their communication, not giving them opportunities to explore or learn by being overprotected, or preventing them from participating in normal social interaction.
In more severe circumstances, facing bullying may cause children to feel constantly anxious or in danger, before internalizing their distress such as through deliberate self-harm (HM Government, 2010).

Few studies have assessed the prevalence or incidence of psychological abuse. For example, self-reported community studies in the UK and the US indicated that around 9% and 4% of women and men, respectively, reported experiences of severe psychological abuse during their childhood (Edwards et al., 2003; May-Chahal & Cawson, 2005). Similar figures have been recorded by Finkelhor and colleagues (2005) for psychological abuse in both boys and girls (10.3%). Higher rates of annual incidence between 12% to 33% were estimated for moderate to severe psychological abuse in eastern European countries, including Macedonia, Latvia, Lithuania and Moldova (Sebre et al., 2004).

Johnson and colleagues (2001) conducted a prospective study that showed an increased risk of developing personality disorders in adult life for maltreated children, especially those who had experienced verbal abuse; and which was independent of physical or sexual abuse, or neglect. These findings emphasise the need for further research into the effects of psychological abuse. The short-term psychological consequences of child abuse and maltreatment include fear, isolation and inability of the child to develop trust for other people. However, these short-term consequences can persist and develop into long-term psychological consequences, including depression, low self-esteem and relations difficulties (Dumaret & Tursz, 2011).

1.2.1.4 Neglect

Although poverty is not a cause of neglect, it is associated with multiple risk factors, particularly impaired parenting capacity and punitive attitudes (Munro, 2010). Neglect is defined as a failure by a caregiver to meet the child’s basic needs. These may include appropriate nutrition and hygiene; safe accommodation; and clean clothing of an appropriate size that is suitable for the weather. Failing to meet emotional or psychological needs. Medical/dental needs may involve not accessing any medical care or treatment. Not
enrolling a child in school and missing school without valid excuses are both examples of neglecting a child’s educational needs. Neglect, therefore, tends to result in impairment of the child’s health and development (HM Government, 2010; Leeb et al., 2008). Similarly, the National Family Safety Programme (2013) uses the definition of neglect, which focuses on the parents’ or caregivers’ failure to provide for the child’s needs.

Straus and Kantor (2005) stated that measurement of neglect in the community is challenging, because of several aspects of omission or absent of care provision that could expose the child to the risk of harm. Neglect is the most common maltreatment type in the USA. 79.5% of children who were maltreated suffered from neglect. Additionally, 76.0% of the perpetrators who medically neglected their victims were women (US Department of Health and Human Services, 2015). UK and US studies determined that between 1.4 and 15.4 percent of children lacked constant care or sufficient supervision, either, which could place a child at risk (Hussey et al., 2006; May-Chahal & Cawson, 2005; Theodore et al., 2007). Despite high prevalence of neglect according to child protection agencies records, there is limited research of it based on self- and parent-reports (Department for Children, Schools and Families, 2010; US Department of Health and Human Services, 2015). Stoltenborgh and colleagues (2013) conducted a meta-analysis and estimated a prevalence of 163/1,000 for physical neglect and 184/1,000 for emotional neglect, without any gender differences. Parents who suffered neglect as children are more likely to inflict abuse on their own children, which forms the evidence-base for the intergenerational transmission of abuse (Sneddon, Iwaniec & Stewart, 2010).

1.2.1.5 Other Type of Abuse

Gilbert and colleagues (2009a) proposed that witnessing intimate-partner violence should also be considered a form of child maltreatment. Intimate-partner violence was defined by the Centres for Disease Control and Prevention report (Leeb et al., 2008) as “any incident of threatening behaviour, violence, or abuse (psychological, physical, sexual, financial, or emotional) between adults who are, or have been, intimate partners or family members, irrespective of gender or sexuality”. Although men are the most frequent perpetrators in
heterosexual couples, there is an increasing recognition of violence perpetrated by women (Gilbert et al., 2009a).

Many studies have investigated the impact of intimate-partner violence on the child. O'Campo, Caughy and Nettles (2010) found that children who witnessed such violence showed adverse outcomes such as mental health and behaviour problems. These could continue in later life, particularly depression and deliberate self-harm (McHolm, MacMillan & Jamieson, 2003; Russell et al., 2010). Other adverse outcomes include alcohol or drug misuse (Bair-Merritt, Blackstone and Feudtner, 2006; Dube et al., 2002) and low educational attainment (Kitzmann et al., 2003). It is important to highlight though that exposure to intimate-partner violence is strongly associated with other types of maltreatment, which thus play a major prognostic role in these continuities.

The National Society for the Prevention of Cruelty to Children (NSPCC, 2010) supplements the above definitions with bullying being included as a form of child maltreatment. Bullying is defined as repetitive and intentionally hurtful behaviour over a period of time, where it is challenging for those who suffer from bullying to protect themselves. The main types of bullying are physical, which includes hitting, kicking and other physical acts; verbal, which may involve racism, threats or name calling; and emotional, which may preclude an individual from social activities or involvement with his or her peer group.

Wolke and colleagues (2013) investigated a large cohort of 9-16 year-old children and their parents asking whether the child had been bullied during the previous three months and then later followed up in their young adulthood as part of the Child and Adolescent Psychiatric Assessment. The results showed that victims who faced bullying in childhood were at a higher risk of poorer outcomes in adulthood relating to health social relationships. Again, other inter-related child and family risk factors were involved in these mechanisms.
1.2.1.6 Overview of Adverse Impact of Child Abuse and Neglect

Overall, researchers have established the association between child abuse during infancy and later difficulties in young life and even adulthood (Zero to Three, 2011; Norman et al., 2012). These difficulties include attachment difficulties (such as disorganised style – Al Shali et al., 2012), ill mental health, predominantly of emotional nature (Felitti & Anda, 2010), cognitive impairment (Gould et al., 2012) and social difficulties (Al Odhayani et al., 2013). Many of these consequences can be long-term (Messman-Moore, Walsh, & Di Lillo, 2010). In turn, young people’s psychosocial difficulties can lead to a range of other adverse outcomes such as juvenile delinquency and adult criminality (Gold et al., 2011), abusive behaviour (Al Odhayani et al., 2013), and alcohol and substance abuse (Felitti & Anda, 2010). Although child abuse usually occurs at the family level, it has far reaching socioeconomic implications for the society. For instance, a study by Fang, Brown, Florence and Mercy (2012) found that the annual cost of child abuse and its related consequences (in terms of service, care, legal and judicial costs) in the US was $124 billion, which is costlier than the two of the leading causes of death, type 2 diabetes and stroke.

1.2.2 History and Prevalence of Child Abuse and Neglect in the Kingdom of Saudi Arabia

The history of child abuse and neglect in KSA can be grouped under three periods, defined by significant changes in legislation and resulting shifts in services and practices. Information for each period is provided below and includes the number of maltreated cases, who identified maltreated cases, and the legal and child protection services (Table 1.2).
Table 1.2  
**History of CAN in KSA, with the characteristic of each period**

<table>
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<td><strong>Number of CAN cases</strong></td>
<td>11 case study reports identified 40 CAN cases (Al-Ayed, 1998; Al-Eissa, 1991; Y. A. Al-Eissa, 1998; Al-Jumaah, Al-Dowaish, Tufenkeji, &amp; Frayha, 1993; Al-Mugeiren &amp; Ganelin, 1990; Al-Odaidan, Amu, Fahmy, Al-Khalifa, &amp; Ghazal, 2000; Elkerdany, Al-Eid, Buhaliqa, &amp; Al-Momani, 1999; Karthikeyan, Mohanty, &amp; Fouzi, 2000; Kattan, Sakati, Abduljabbar, Al-Eisa, &amp; Nou-Nou, 1995; Kattan, 1994; Roy, Al Saleem, Al Ibrahim, &amp; Al Hamzi, 1999).</td>
<td>188 cases of CAN were reported (Al Eissa &amp; Almuneef, 2010).</td>
<td>616 CAN cases were referred between 2010-2012 (Al-Shail, Hassan, Aldowaish, &amp; Kattan, 2012).</td>
</tr>
<tr>
<td><strong>Number of SCAN teams</strong></td>
<td>No multidisciplinary team, but CAN cases were identified by health care professionals.</td>
<td>Establishment of multidisciplinary teams in major hospitals resulted in 38 hospitals with CPCs.</td>
<td>Increase in the number of multidisciplinary teams throughout the province of KSA, with 41 CPCs.</td>
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<tr>
<td><strong>Legislative and organizational milestones</strong></td>
<td>In 1996, KSA signed and ratified the UN Convention. No child protection legislation or child protection services.</td>
<td>National media highlighted the lack of legislation and the need for child protection services, thus raising awareness. Establishment of governmental and non-governmental agencies. In 2005, establishment of NFSP (quasi-governmental agency). In 2007, the Child Protection Centres (CPCs) project was introduced, Advanced training by ISPCAN.</td>
<td>In 2008, physical punishment was banned in schools. In 2009, a web-based data registry system was developed as a centralized database for child abuse cases.</td>
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*PS. KSA: CAN: Child abuse and neglect; Kingdom of Saudi Arabia; CPCs: Child Protection Centres*

During the **first period between 1990 to 2000**, health care professionals began to recognize child maltreatment as an unusual problem in Saudi Arabia. Eleven case studies were published in medical journals, and forty maltreated children were reported. Of those, five children had been killed, 24 cases were reported because of physical abuse, six cases because

These children were aged 0-10 years and presented with different forms of maltreatment such as physical abuse (burns, shaken baby syndrome, bruises, fractures, head injuries and bite marks) or sexual abuse (e.g. anal tear). During this period, there was lack of legal frameworks, but some children were referred for social services and psychiatric care. Al-Shlash et al. (1996) conducted a survey of children admitted to burns unit in Tabuk. Approximately 70% were children under 12 years, and the most common injuries were scalds then flame burns. However, it was reported that only two of 435 had injuries attributed to child maltreatment.

The **second period was between 2000 and 2008** and was characterized by the creation of government agencies and NGOs with the goal of preventing child maltreatment. At the time, the national media recognized child maltreatment as a public issue and focused on the absence of prevention, intervention and legal action. Two years (2005 and 2006) were instrumental, as additional state and non-governmental agencies were dedicated to the prevention and treatment of child maltreatment. In 2005, the National Family Safety Programme (NFSP) was established by Royal Decree of the King, and is still considered one of the most notable child protection programmes. Between 2007 and 2008, the NFSP submitted a national project to establish a child protection centre in one of the major hospitals. This project received the full support and approval of the National Health Council (NHC), the highest health service authority in the KSA.

During this second period, an important study reviewed the reported cases of child abuse and neglect (CAN) between 2000 and 2008. A total of 188 children were referred after being investigated by the Suspected Child Abuse and Neglect (SCAN) team in just one
region, King Abdulaziz Medical City (Al Eissa & Almuneef, 2010). This period was also characterized by the increasing number of Child Protection Centres (CPCs) around the province of KSA from 4 to 41 (Al-Shail et al., 2012).

During the **third period since 2009**, the government began to address the lack of official data by establishing a centralized database for child maltreatment cases through the National Family Safety Registry (NFSR). The NFSR uses a web-based data registry system from all over the Kingdom of Saudi Arabia for the purpose of collecting data and providing analysis on child maltreatment cases. This data has facilitated the identification of risk factors, policies and guidelines. Between October 2010 and February 2012, 616 child abuse cases were registered in Child Protection Centres (CPCs) throughout the province of KSA. Almost 90% of these cases were children of Saudi nationals, and boys and girls were almost equally represented (51.1% and 48.9% respectively). These figures are representative of CPCs in the public health care system but not of non-Saudi children who are treated in the private health care system (Al-Shail et al., 2012). The Ministry of Interior highlighted that, on a daily basis, around 20% of children suffer from abuse and neglect, and nearly 50% of children are at risk of violence in general (Abdul-Hamid, 2011).

**Risk and protective factors of child maltreatment**

Child maltreatment cannot be explained by any single factor, but rather through the interaction of multiple risk factors (MacDonald, 2001), which usually operate at several levels, i.e. individual, interpersonal and societal. Several frameworks have been put forward (e.g. Belsky, 1980 and 1993; Bronfenbrenner, 1979; Garbarino, 1985; Garbarino & Collins, 1999). Several factors increase the risk of maltreatment while others protect or decrease such risk. Some factors have continuous impact, while others can be time-limited or situation-specific.
Many researchers studying the complex interaction of risk and protection adopted the Social Ecological Model (Bronfenbrenner, 1979). This has also influenced the development of a comprehensive public health approach (Figure 1.3) (Al-Shail et al., 2012; Butchart et al., 2006). Therefore, risk and protective factors and the existing evidence will be discussed within these four levels and the context of the socioecological framework.

**Figure 1.3**
Ecological model of risk factors for child maltreatment

1.3.1 Individual Level
This level includes biological and inherent components such as age, gender, temperament, and the child’s developmental capacity along several domains – although it is acknowledged that these can also be the effect of maltreatment.
The age of the child

In the US, Douglas and Mohn (2014) reviewed existing data and found that younger children were at higher risk of death than older ones as a result of maltreatment. The age group between 0 to 3 years represent around 80% of fatal cases (Damashek, Nelson & Bonner, 2013), with almost half of them being under one year (Damashek, Nelson & Bonner, 2013; Douglas & Mohn, 2014; Makhlouf & Rambaud, 2014). Ishida and colleagues (2013) conducted a study in Puerto Rico, and found children between one and six years had the highest victimization rates. Recently, in USA, children who were younger than 3 years old represented of 70% of child fatalities, however, this rate decreases with age (U.S. Department of Health and Human Services, 2015).

In the UK, Spencer and colleagues (2006) stated that prematurely born infants (under 34 weeks) had increased rates of child abuse and neglect compared to full-term infants. Other studies have replicated the finding that prematurely born infants and those with low birth weight are at an increased risk of child maltreatment (Li, Godinet et al., 2011; Sidebotham & Heron, 2006; Pino, 2010; Wu et al., 2004). It is important to stress that our interpretation of these findings on the effect of age, should take into consideration the difference between chronological (from birth) and developmental (real capacity or functioning) age of a child.

The gender of the child

Many studies have showed that there is a correlation between the gender of the child and other risk factors that increase the risk of the child maltreatment. For instance, studies from high-income countries have repeatedly shown that girls have a greater risk of being sexually abused than boys, whilst there is no significant difference in relation to the other types of maltreatment (Andrews et al., 2004; US Department of Health and Human Services, 2015; Department for Children, Schools and Families, 2008). In contrast, girls are at greater risk of infanticide, sexual abuse and neglect in low-income countries, whilst boys appear to be at increased risk of harsh corporal punishment (Pinheiro, 2006). Disabled males are at higher risk of maltreatment than females, including maltreatment in the form of sexual abuse (Hershkowitz, Lama & Horowitz, 2007; Sobsey, Randall & Parrila et al., 1997). In USA, in
2013, their child maltreatment report showed that 58% of the reported fatalities from CAN were boys and 41.7% were girls, while unknown gender represent 0.3% (U.S. Department of Health and Human Services, 2015). These different patterns reflect gender-related differences across families, communities and societies.

**Children with disabilities**

Govindshenoy and Spencer (2007) conducted a systematic review on abuse of disabled children, and concluded that children with disabilities are at higher risk of maltreatment even though the cause is unclear. The increased risk could be related to unresolved ambivalence and eventual rejection from the parents, in addition to fear and stigmatization. Vice versa, a US study showed that children without disabilities are less in danger of being abused, in contrast with disabled children who showed an increase from 9% to 31% in the prevalence of maltreatment respectively (Sullivan & Knutson, 2000). Many studies have replicated this overall pattern that children with disabilities are more at risk of abuse and neglect (Algood et al., 2011; Bonner; Brown et al., 1998; Douglas & Mohn, 2014; Gore & Janssen, 2007; Hollomotz, 2009; Mandell et al., 2005; Skarbek, Hahn, & Parrish, 2009; Sullivan & Knutson, 2000; Sullivan, 2009).

A child with a developmental disorder is twice as likely to experience physical and sexual abuse compared with a child without such a delay and associated impairments (Grossman & Lundy, 2008; Mandell et al., 2005; Manders, 2009; Mepham, 2010). Children with more severe disabilities are three times more likely to suffer from sexual assault than children in the general population (Skarbek et al., 2009). Factors that can also explain this association include the child’s increased vulnerability, inability to protect themselves, and cognitive constraints in comprehending and processing risks.

**Ethnicity**

In the US, there is disagreement about the degree between the ethnic differences and indication of maltreatment, and in mortalities from injury because of maltreatment (Ards et al., 2001; Falcone et al., 2007; Finkelhor et al., 2007). However, the differences of ethnicity
in the risk of maltreatment are explained by sociodemographic characteristics, and children, who are mixed or multiracial, showed higher risk of maltreatment (Hussey et al., 2006).

1.3.2 Interpersonal Level

This level concerns (usually close) social relationships with the primary caregiver, other family members and peers. It includes attitudes, knowledge, adults’ own history and psychological well-being, family status, marital and other family conflict, domestic violence, and unemployment.

Several parental factors increase the risk of child maltreatment such as lack of or impaired parenting skills, young age, mental problems without support or treatment, learning disability, drug and alcohol abuse, and criminality (DCPW, 2009; Dyson, 2008; Sidebotham & Heron, 2006; Yampolskaya, Greenbaum, & Berson, 2009). These have been replicated across different countries (Bartlett, Raskin, Kotake, Nearing, & Easterbrooks, 2014; Brown, Cohen, Johnson, & Salzinger, 1998; Kotch et al., 1995; Kotch et al., 1997; Sidebotham & Heron, 2006). Poverty and associated factors such as low educational achievement, subsequent unemployment, overcrowding, and living deprived neighbourhoods moderate these parental factors (Berger, 2005; Hussey et al., 2006; May-Chahal & Cawson, 2005; Sidebotham et al., 2002).

Obviously this association is bidirectional, as parental and family risk factors, also increase the likelihood of life events and further deprivation, hence the vicious cycle of child maltreatment (Li, Godinet, & Arnsberger, 2011; Roberts et al., 1998; Stith et al., 2009).

Preventive interventions have been developed to target certain high-risk groups such as single and/or young parents, conversely large-size families, and particularly victims and perpetrators of domestic violence (Berger, 2004; Brown, Cohen, Johnson, & Salzinger, 1998; Sidebotham, Heron, & ALSPAC Study Team, 2006). There has also been greater sensitivity and awareness of child maltreatment risks in mental health, drug and alcohol,
learning disability, and forensic services (Douglas & Mohn, 2014; Percy, Thornton, & McCrystal, 2008; Yampolskaya et al., 2009). Social care agencies similarly often extend – as much as resources allow – their remit to family support for such high risk families (Brown et al., 1998; Finkelhor, Ormrod, Turner, & Holt, 2009).

Particular mention should be given to the well-established link between domestic violence and all types of child maltreatment (Gage & Silvestre, 2010; Sidebotham & Heron, 2006), especially physical abuse (Hines et al., 2004). Children of parents or caregivers who regularly used verbal aggression towards them, for example, showed an increase in social and behavioural problems such as their own demonstration of physical violence (Al Faryan, 2003; Nix et al., 2005). Several studies found that mothers who had experienced or were experiencing abuse from their spouse were at greater risk of using violence against their children (Apple & Holden, 1998; DiLauro, 2004; Guterman & Lee, 2005; Kanoy, Ulku-Steiner, Cox, & Burchinal, 2003; Tajma, 2000; Taylor et al., 2009).

Overall, most studies have examined the role of interpersonal risk factors for child maltreatment, with a relatively recent increase in research activity on the protective factors involved. Some of these factors have been the reverse of risk factors, but not necessarily so. Parents with a high level of education, stability, and social support have been shown less likely to exhibit abusive acts (Kotch et al., 1999; Li, Godinet, & Arnsberger, 2011). Some protective factors have been associated with a reduction in the risk of child maltreatment such as resilience of parent, social connections, parenting skills and knowledge and child development (Shaw, & Kilburn, 2009; Li, Godinet, & Arnsberger, 2011).

1.3.3 Community Level

The community incorporates different settings that can contribute to abusing children such as schools, neighbourhoods, and workplaces. Gilbert and colleagues (2009a) stated that the community environment appears to have a small to moderate impact in addition to family and child characteristics. A UK cohort study by Jaffee et al. (2007) identified the risk factors
of living under high neighbourhood ‘stress’, which was demonstrated by criminality, low social cohesion, and informal social control. Similarly, a systematic review by Sellstrom and Bremberg (2006) stated that there is an association between neighbourhood socioeconomic status and social climate that contributed by 10% to the risk of child maltreatment. Different studies have shown that poverty increase the odds of maltreatment at both the individual and community level (Coulton, Korbin, & Su, 1999; Drake & Pandey, 1996; Kotch et al., 1995; Lee & Goerge, 1999; Sledjeski, Dierker, Bird, & Canino, 2009; Trani & Cannings, 2013; Zelenko, Lock, Kraemer, & Steiner, 2000).

1.3.4 Societal Level

The last level includes macro-level factors that have significant influences on child maltreatment such as cultural customs, beliefs, social norms and policies, as well as religious and economic factors. Such influences can create conflicts and inequities between individuals and groups (Al-Shail et al., 2012; Butchart et al., 2006). There are a growing number of countries that prohibit corporal punishment in all settings. The Global Initiative to End All Corporal Punishment of Children (2016) reported that 49 countries have laws that protect children from corporal punishment in all settings including homes. However, belief in corporal punishment is quite high among Arab communities. For example, according to UNICEF figures from countries in the Middle East and North Africa collected between 2005 and 2013, 80% to 90% of children ages 2 to 14 years old experienced physical punishment in home. Further, the percentage of the mothers and caregivers who believe in corporal punishment as a necessity in discipling the behaviour of the child ranges from 20% to 40% (UNICEF, 2014a). Likewise, in Iran and Iraq, between 2005 and 2012, UNICEF reported that 79% of children between 2 and 14 years old experienced corporal punishment in home (Central Statistics Organisation & Kurdistan Regional Statistics Office, 2012; UNICEF, 2014b). In contrast, in other societies, such as some countries in Europe, parents or caregivers are against the use of corporal punishment. For example, in 2007, a study that was conducted in five European countries including Austria, France, Germany, Sweden, and Spain reported that the range of parents who agreed that “non-violent child-rearing is the ideal” rise between 85% to 93% (Bussmann, Erthal, & Schroth, 2011).
In 1965 in Sweden, more than half of the population believed in the importance of corporal punishment in child rearing. By 1994, this percentage had declined to 11% of the population. Also, between 1996 and 2006, there was a dramatic decrease in the number of adults who believed that hitting children was acceptable, from 75% to 33% (Durrant, 2008).

In 2003, a survey of administrators and teachers in Saudi Arabian schools showed that over half of the respondents were in favour of re-introducing physical punishment, while 38.5% were against it (The Global Initiative, 2008). A cross-sectional study in Yemen by Alyahri and Goodman (2008) examined the incidence and types of physical punishment used in Yemen, as well the relationship between harsh corporal punishment, socio-familial background, and children’s education attainment and mental health. Findings illustrated that rural caregivers used harsh corporal punishment more than urban parents or caregivers. The use of harsh physical punishment was significantly associated with poor outcomes of school performance and conduct disorder. Also, there was a correlation between the use of physical punishment and factors such as large family size, low maternal skills, and having a male child.

It has been highlighted by Durrant (2008), that the Committee of the Rights of the Child has rejected religious justifications for corporal punishment. Moreover, this Committee has stated that religious practices should consistently respect human dignity and integrity. One study highlighted that there is a dramatic decrease in child maltreatment when there is a legislative ban on physical punishment (Zolotor & Puzia, 2010). However, this study was indecisive whether this indication to direct reduction, unless accompanied by other measures to change attitudes, and improve services and practice.

In summary, this framework has improved our understanding of the complex factors and mechanisms involved in the onset and maintenance of child maltreatment and, to a lesser extent on factors that protect children. It has thus informed policies and interventions aimed at minimizing such risk factors, e.g. by providing families with support; and to creating
preventative programmes such as parenting education that would enhance the parenting skills and nurturing.

1.3.5 Risk and Protective Factors in Saudi Arabia

Certain cultural factors are common among Arab families and may play a mediating or moderating role. Attitudes towards physical punishment of children have already been discussed. Al- Mahroos (2007) also highlighted a range of families’ social circumstances such as early marriage, polygamy, or large age gap between mothers and their own fathers.

Despite the overall economic position of Saudi Arabia, there is also considerable poverty in certain population groups, and Arab families in other Middle East countries face substantial deprivation. In Israel, Khoury-Kassabri and Straus (2010) conducted a comparative study between Arab and Jewish mothers that found there were associations between cultural and socioeconomic status and child abuse. The two important factors that were highlighted were ethnicity and the educational level of the mother. They found that Arab mothers used more inconsistent parenting styles in response to their child’s misbehaviour. This could be associated to social stressors, awareness and parenting skills.

With regards to the characteristics of parents at risk of child maltreatment, low socioeconomic and education status, particularly unemployment, was identified in a number of studies (Al Saud, 2005; Al Tayar, 2010; Al-Zahrani, 2004). This socioeconomic trend was, however, not consistent, as abuse can also occur in better-educated and more affluent families (Elarousy & Al-Jadaani, 2013). Marital conflict is another strong predictor (Al Saud, 2005; Al Tayar, 2010; Al-Zahrani, 2004). Parents who abuse illegal substances are also more likely to maltreat their children (Al Tayar, 2010), as well as parents who suffered from chronic diseases, with both groups possibly associated with impaired parenting capacity (Elarousy & Al- Jadaani, 2013).

Al-Mahroos and Al-Amer (2011) found that the incidence of child sexual abuse increases in densely populated areas, which are associated with poverty and other socioeconomic factors.
It usually occurred in relatives’ or neighbours’ homes, followed by primary school, preschool and kindergarten, shops, and public or abandoned areas (Al-Mahroos et al., 2005; Al-Mahroos & Al-Amer, 2011). Most perpetrators are male and are either family members or individuals well known to the family such as relatives, friends and domestic workers (Al-Mahroos et al., 2005; Al-Mahroos & Al-Amer, 2011).

Children could also be used by their mothers for the purpose of ‘punishing’ their partners or husbands. For example, second wives may feel jealous towards the other wife and re-assert their position within the family by punishing their own child. Whatever the cause for the family conflict, this could have a negative impact on the children in different ways including physical abuse. Al-Abri (2010) offered possible reasons why parents abuse their children in Saudi society. He emphasised two main misunderstandings in Saudi mentality in relation to child abuse. Firstly, fathers in Saudi Arabia think that they have the right to do anything they want because they believe they know what is best for their children. Secondly, there is a misconception that children must be treated harshly rather than humanely, for disciplinary purposes.

In the last fifty years or so, the Saudi Arabia society has gone through significant changes, including changes to the family structure. This is constantly shifting from extended to nuclear family because of modernization and increasing employment opportunities. As a consequence, people tend to prefer living in a nuclear family. However, some people are still living with their extended family members, which may consist of grandparents, aunts, uncles, cousins, nephews and nieces. Family structure affects child rearing, as children previously looked after by their grandparents are now predominantly cared for by housemaids. With the absence of both working parents, housemaids are thus playing a substantial role in bringing up children. Housemaids have left their own children behind to work in a culturally different country, usually as unskilled workers.

So far, there is limited research evidence to support the hypothesis that housemaids are responsible for increase in child abuse incidents (Al-Shail et al., 2012). The hypothesis or narrative does exist, though, in the public domain through the media and anecdotal sources.
Al-Kinani (2005) reported in an Asharq Al-Awsat newspaper article titled “Eye on Saudi Maids Reveals Child Abuse” that two families had installed hidden cameras when they suspected that the maids were abusing their children. Afterwards, they discovered that the maid had been beating and hitting them. However, Muhammad Salheen, counter-argued that such stress and potential violence could be avoided if families improve housemaids’ working conditions. Changes in work legislation would also support improved working conditions.

1.4 Child protection systems

Countries who have approved the United Nation Convention on the Rights of the Child (UNCRC), are required to establish integrated child protection systems to ensure that children and families receive co-ordinated responses (Svevo-Cianci, Hart, & Rubinson, 2010). Such integrated systems usually consist of three components: (1) mandates, including laws, regulations, and policies; (2) interventions and supporting mechanisms such as education, service programmes, and data management; and (3) measurement of child outcomes, including performance measures of the child’s health, development, and well-being (Pietrantonio et al., 2013; Svevo-Cianci et al., 2010).

Wekerle (2013) placed mandatory reporting in the heart of a child protection systems, with adequate resource to ensure its delivery. Early detection of abuse will start a potentially lengthy process, hence ensure that children receive appropriate support that will prevent further harm and set them on the road to recovery, without initiating help-seeking themselves. These multiple goals can only be achieved through co-ordination between agencies from the legal, health and welfare sectors (Krug et al., 2002). In contrast, poor identification and reporting will place children at high risk for further victimization, which can result in morbidity and even fatalities in the more serious circumstances (Sege et al., 2011).

Children who are at risk of further harm are usually placed in out of home care, including foster or residential placements, (DHS, 2007). Children living in such homes usually have
histories of multiple risk factors such as suffering from domestic violence, poverty, parental substance abuse, and physical and sexual abuse (Osborn, Delfabbro, and Barber, 2008). Several studies have shown that they are consequently at risk of suffering from short- and long-term mental health, educational and relationship difficulties, which are related both to their early experiences and to the secondary effects of being in care such as experiencing several moves and caregivers (Al Faryan, 2003; Gavita et al., 2012; Miron et al., 2013; Norman & Christiansen, 2013; Russell & Summers, 2013). Moreover, a UK study which compared children who stayed in care and children who reunified with their families, reported that maltreated children who stayed in care showed positive outcomes such as the improvement in their well-being and their safety than the children who were reunified with their families and were re-abused by their caregivers (Biehal, Sinclair & Wade, 2015).

A systematic review on studies from the US, UK and Australia highlighted that child maltreatment may be reported up to 2% in foster care in any one year. This prominence supports the importance of preparing, supporting, evaluating, and supervising the professionals who are delivering this service (Biehal, 2014). Thus, there is need for providing ongoing support, training and access to services for foster and residential carers; and for designated interventions and services for children in their care, which would be integrated to their overall social care plan (Gavita et al., 2012; Walakira et al., 2014). There has been a growth of such interventions and services, which have been greatly influenced by attachment theory, in recent years, albeit not always with sufficient evidence, (Bowlby, 2005; Howe, 1999, 2005 & 2012).

Existing legislation mandates all professionals in contact with children and their families report concerns to governmental authorities. However, there are many challenges and barriers faced by these professionals in implementing legislative guidelines. For example, Pietrantonio and colleagues (2013) identified concerns on the negative impact that reporting may have on their future working relationship with the family or even on the child’s welfare. In USA, the majority of the paediatricians in a national survey were clear on the advantages and procedures of reporting cases to the CPS, but their key reservation cited was
compromising their future relationship with the family (Flaherty et al., 2006; Asnes & Leventhal, 2010).

There are other factors that may also impact professionals’ decision-making by making them reluctant to inform or report child abuse cases to child protection services such as having previous negative experiences with CPS, particularly non-response or when they considered that the response caused more harm (Flaherty, Schwartz, Jones, & Sege, 2012; Jones et al., 2008). Some professionals may thus try to address problems with the family (Flaherty et al., 2000; Jones et al., 2008). Additionally, Flaherty and colleagues (2012) stated that almost 50% of professionals face verbal or even physical threats from the caregivers, which can be intimidating and act as deterrent. Consequently, it is important to provide professionals with ongoing supervision, training and support. For instance, countries like Canada, Australia and the US provide legal protection to professionals who report cases of child abuse and neglect in good faith (Alvarez et al., 2004; Matthews & Kenny, 2008).

Several frameworks and packages have been developed to provide a systematic tool for professionals to work through the steps of reporting and managing child maltreatment cases. One such widely used framework is SPIKES, an acronym for the following approaches: setting, perception, invitation, knowledge, emotion, strategy, and summary, which was proposed by Baile and colleagues (2000). This involves different strategies in relation to the setting, perceptions, invitation, knowledge, dealing with difficult emotions, and overall goals and care plan. These strategies have been found to be easily understood and implemented in difficult situations such as in breaking bad news (Baile et al., 2000). For example, creating a private and safe setting with the caregivers can prevent misinterpretations and threats and thus support the professional involved. This setting will enable them to concentrate on investigating the caregiver’s perceptions of the concerns. This is a difficult part of the process, which requires experience and expertise in interviewing skills. Invitation is the next difficult step of ideally seeking permission to disclose information about the child’s health and welfare, in order to create an honest and therapeutic ethos, even if this information can be shared without permission. This, of course, may not be possible in the more severe cases. Knowledge leads to appropriate medical evidence or related information that supports
reporting to CPS; also by using simple language that can be understood by the caregiver and all agencies. Dealing with difficult emotions expressed by the caregiver but also experienced by professionals is essential throughout the conversation and overall process and requires acquisition of competencies, on-going training and support (Pietrantonio et al., 2013). All training will be discussed in detail in chapter 2.

1.5 Effective interventions for Child Abuse and Neglect

As already demonstrated, the substantial body of research evidence show that child abuse and neglect is associated with serious physical, psychological, behavioural, and societal consequences. Its recognition, management and prevention are, therefore, important objectives of public health and welfare systems. As many preventive programmes have been developed, from different theoretical frameworks, and with variable extent and quality of evaluation, their emerging themes and key findings will be discussed at three levels of prevention, i.e. primary, secondary and tertiary.

1.5.1 Primary Prevention

The prevention of child maltreatment requires an investment for the future by influencing the current family conditions and parents’ attitudes and rearing style (Stagner & Lansing, 2009). This can be achieved by implementing primary (or universal) prevention programmes minimize risk and maximize protective factors, in order to prevent abuse before it occurs. Unfortunately, as most available child protection services have limited resources, they tend to target those on secondary and tertiary interventions (Waldfogel, 2009). Nevertheless, several primary interventions and approaches have been evaluated and found to show promising results. These often target risk factors such as unawareness of positive parenting techniques, inadequate social support, the stigma of asking for help, parental impulsivity, and inappropriate expectations for a child’s developmental stage (Poole, Seal, & Taylor, 2014).
One such approach that has been widely evaluated is the Universal Primary Prevention (UPP). One of the UPP initiatives is the Triple P - Positive Parenting Programme, which originated in Australia and had been implemented in many countries (Barth, 2009). The Triple P programme is underpinned by social learning theory, and proposes that parental abusiveness can be reduced if their understanding is improved (Sanders, Kirby, Tellegen, & Day, 2014). The programme thus provides parents with simple and practical strategies for the management of child behaviours, and facilitates a strong and healthy parent-child relationship. The Triple P programme involves five levels of interventions with increasing strengths that parents can use to manage the behaviour of their children, from birth to the age of 12 years (Aghebati et al., 2014) (Figure 1.4). The first level provides access to information in order to increase awareness and to encourage participation in the programme. The second level consists of the provision of anticipatory and developmentally appropriate guidance to the parents of children who exhibit mild behaviour difficulties. The third level provides the parents with an active skills training of four sessions for the management of mild to moderate behavioural difficulties. The fourth level targets more severe behavioural presentations, while the fifth level includes enhanced and intensive family interventions (Aghebati et al., 2014).

**Figure 1.4**
Levels of Triple P-Positive Parenting Programme (Institute of Medicine, 2014)
This primary prevention approach has accumulated more than 30 years of evidence on its effectiveness and has built on parents’ contributions (Sanders et al., 2014). Most of the evaluation studies have aimed at reducing parental stress and children’s challenging behaviours, rather than reduce maltreatment incidents per se. The main such randomized controlled study by Prinz et al. (2009) implemented the Triple P programme in 18 South Carolina counties, which were randomly assigned to the Triple P intervention group or the services-as-usual control group. The study found that there were 688 fewer cases of child maltreatment in the experimental than in the control group, among 100,000 children aged below 8 years. The counties in the intervention group were found to have 18% reduction in child maltreatment, in contrast with 20% increase in the control counties. The study also found that the intervention counties had a 12% decrease in out-of-home placements compared to the 44% increase in the control group.

Other primary prevention programmes were demographic-based by targeting large high-risk sub-populations such as or low-income families and first-time parents, and have been shown to be more effective than standard provision by generic services (Stagner & Lansing, 2009). A widely established and evaluated primary prevention programme has been based home-visiting, which is usually referred to as Head Start or adapted models, that can reach high-risk families with infants and young children (Howard & Brooks-Gunn, 2009). Home-visiting services aim at improving parenting practices by providing information, facilitating referrals, providing emotional support and other resources. A systematic review of the large number of evaluation of home-visiting interventions by Segal, Sara Opie and Dalziel (2012) established that, overall this is an effective primary intervention for preventing child abuse, but the success of the programme depends on the use of a mechanisms of change, the theory that underpins the home-visiting programme, and its compatibility with the target population.

Similarly, MacMillan et al. (2009) concluded that home-visiting programmes such as Early Start and the Nurse-Family Partnership are effective in preventing child maltreatment and reducing the impact of its consequences. Indeed, a pilot study by Jack et al. (2015) found that it was feasible to enrol parents into the Nurse-Family Partnership programme and that
the programme was appropriate to implement in Canada with nurses delivering the intervention. Although this programme involves extensive home-visiting, Jack et al. (2015) established that the frequency of visits was acceptable to families and healthcare providers as it facilitated engagement and trust.

Other studies have shown that home-visiting services aimed at supporting abused women, are also effective in reducing partner violence (Prosman, Lo Fo Wong, van der Wouden, & Lagro-Janssen, 2015). By extension, reduction in intimate partner violence also prevents child abuse because of the strong association between the two (MacMillan & Wathen, 2014; Moylan et al., 2010).

Primary prevention programmes increasingly use new technologies such as social media to create public awareness regarding the importance of preventing the harsh child rearing practice and its associated consequences. Social media platforms such as Facebook and Twitter have shown promising trends in reaching out to the general public, and thus complement in a resource-effective was the existing face-to-face interventions (Jones et al., 2013). The technology of social media also provides an opportunity for child abuse educators and interventionists to engage a large number of parents to the general principles and more specialized programmes (Baggett et al., 2010). A study by Edwards-Gaura, Whitaker and Self-Brown (2014) demonstrated that social media, Facebook in particular, is increasingly being used to educate the public about the risk factors of child abuse and maltreatment. The study also found that most parents found this approach user-friendly and non-threatening and had a Facebook account.

### 1.5.2 Secondary Prevention

Secondary child abuse prevention strategies are designed to prevent child maltreatment in child and parent populations who are considered to be at increased risk (Waldfogel, 2009). Examples of these approaches include home-visiting; support services for young, single and isolated parents; and respite services such as crisis care. As already discussed, home visiting is also a primary prevention approach, and has been widely implemented and reaches high-
risk families with infants and young children, i.e. it can be adapted for both levels (Howard & Brooks-Gunn, 2009). Indeed, a systematic review of other reviews by Mikton and Butchart (2009) established that home visiting of high-risk patients is also an effective approach. However, the study also reported methodological shortcomings of the selected studies. For instance, three of the included studies did not provide details of randomization despite using a classic experimental design and no study provided the methods used for allocation concealment. Howard and Brooks-Gunn (2009) identified that home visiting is, however, effective if service providers strictly follow the guidelines, i.e. adhere to its fidelity.

A support service for young parents is another important secondary intervention. Young parenting has been associated with poverty, maternal and infant death, inadequate family support, increased risk for domestic violence and other negative family factors, including child abuse and neglect (Lee, 2009; Wathen & MacMillan, 2013). Therefore, young parents, especially teenagers, are at increased risk of child abuse. The provision of support services to young parents can help mitigate these factors, thus reduce child abuse. The provision of support services to young parents has been found to improve knowledge regarding the process of parenting, improve the parent-child relationship, reduce family violence, and increases economic independence (Dornig et al., 2009). A study by Desiderio et al. (2010) found that supportive services for teen parents promote self-sufficiency, as the parents can learn to directly access the required services and resources without the intervention of the case managers. As is no specific evidence on services that support isolated young parents, this area should be a future research priority.

Respite services such as crisis care are required when the family caregiver experiences domestic violence, illness or death in the family, and other emergencies (Lifespan Respite Programmes, 2013). Therefore, respite services provide a temporary relief to the family caregivers. Temporary relief prevents a crisis and other negative physical or emotional effects for the caregiver, so as to ensure the well-being of the entire family. The provision of respite services has been shown by a systematic review (Strunk, 2010) to facilitate therapeutic opportunities, independence and quality time for all family members. The same study found that respite care is an effective and appropriate intervention that can reduce
stress and increase adaptive coping strategies for parents of children with disabilities, who are at particular risk of maltreatment (Murphy, 2011). However, some studies (Jardim & Pakenham, 2009; McLennan, Doig, Rasmussen, Hutcheon, & Urichuk, 2012) have reported that respite programs may also increase parental stress when not provided in a timely manner and is therefore not associated with the prevention of child abuse. The provision of respite services for the young parents may also help to reduce maternal and infant death, inadequate family support, increased risk for domestic violence and other negative family factors thereby including child abuse and neglect (Lee 2009; Wathen & MacMillan 2013).

School-based programmes have also been developed to help identify children at increased risk of maltreatment through awareness and prevention skills. Teachers are in a strong position to prevent, identify and offer assistance, due to their frequent interactions with children (Zwi et al., 2015). School-based prevention programmes such as child and teacher education have been shown to be effective (Topping & Barron, 2009). A Cochrane review established their effectiveness in reducing the aggression, which can add to the cumulative risk of negative parental responses (Petersen et al., 2014). The positive impacts of the programme were found to be maintained in all studies that included at least a 12-month follow-up.

1.5.3 Tertiary Prevention

These programmes aim at preventing the recurrence of child maltreatment in families where incidents have already taken place (Dubowitz, Feigelman, Lane, & Kim, 2009; Jonson-Reid, Kohl, & Drake, 2012). Therefore, tertiary preventive approaches focus on reducing the negative consequences of the abuse, as well as its continuation. Short- and long-term consequences are well documented and include physical, emotional, and behavioural problems, including risk-taking acts (Dumaret & Tursz, 2011). Physical consequences include head injuries (Preer, Sorrentino, & Newton, 2012; Shein et al., 2012), impaired brain development (Al Odhayani, Watson, & Watson, 2013), and poor physical health across several domains (Norman et al., 2012).
Tertiary preventive approaches include intensive family preservation services, parent mentor programmes, parent support groups, and mental health services for the children and family. Intensive family preservation services are community-based but family-focused interventions aimed at maintaining children’s safety at home in order to avoid family separation (Martens, Family, & Network, 2009). Evaluation of this intervention has been inconclusive in its findings (O’Reilly, Wilkes, Luck, & Jackson, 2010). For example, Campbell et al. (2010) did not find that intensive family preservation services were associated with a reduction in repeat children maltreatment incidents. Further development and adaptation of contemporary family-centred approaches maybe required, with combined evaluation, before we understand which aspects of such approaches can be effectively used in future.

Parent mentor programs offer peer training on the consequences of child abuse and how to prevent such incidents. This has been associated with reduction in negative parenting attitudes and rearing, including for parents with multiple problems such as drug abuse. Parent support groups are anonymous groups where parents can learn from mutual experiences how to strengthen their relationship with their children. This forum has also been associated with reduction in child maltreatment practice (Polinsky, Pion-Berlin, Williams, Long, & Wolf, 2010). Finally, provision of mental health services for parents with mental illness can contribute by treating a substantial mediating factor (Nelson, Selph, Bougatsos & Blazina, 2013) Access to mental health assessment and intervention for children who have suffered abuse and who present with mental health problems can improve their psychosocial functioning, and contribute to their resilience-building and self-protection.

Table 1.3 below provides a summary of the primary, secondary and tertiary preventive approaches, and evidence on their effectiveness in preventing child maltreatment:
<table>
<thead>
<tr>
<th>Preventive Approach</th>
<th>Examples</th>
<th>Effectiveness</th>
</tr>
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<tbody>
<tr>
<td><strong>Primary</strong>&lt;br&gt;Universal approaches to preventing child maltreatment before it occurs, by targeting the general population</td>
<td>• Triple P-Positive Parenting Programme&lt;br&gt;• Social Media such as Facebook&lt;br&gt;• Demographic-based targeted such as Early Start and Nurse-Family Partnership home visiting programmes</td>
<td>• Triple P programme is effective in preventing child abuse and instead improve parenting&lt;br&gt;Demographic-based targeted prevention strategies (Early Start and Nurse-Family Partnership) are effective in preventing child maltreatment</td>
</tr>
<tr>
<td><strong>Secondary</strong>&lt;br&gt;Designed to prevent child maltreatment in specific sections of the child and parent population who are considered to be at increased risk</td>
<td>• Home visiting for high-risk parents and children&lt;br&gt;• Support services for young and isolated parents&lt;br&gt;• Respite services such as crisis care&lt;br&gt;• School-based programmes</td>
<td>• Respite and support services for young parents are effective in reducing the risk associated with child maltreatment&lt;br&gt;• Home visiting requires strict adherence to fidelity guidelines&lt;br&gt;• Further research is required on the effectiveness of isolated single parent support services&lt;br&gt;• School-based programmes have been found to be effective in reducing child aggression and in enhancing awareness and risk prevention skills</td>
</tr>
<tr>
<td><strong>Tertiary</strong>&lt;br&gt;Approaches aiming at preventing the recurrence and minimizing the consequences in families where the incident has already taken place</td>
<td>• Intensive family preservation&lt;br&gt;• Parent mentor programmes&lt;br&gt;• Parent support groups&lt;br&gt;• Mental health services</td>
<td>• Parent mentor programmes, parent support groups, and mental health services for children and adult’s family are effective in contributing to prevention and improving outcomes&lt;br&gt;• Intensive family preservation services are not associated with a reduction in repeat of child maltreatment, and further research is required</td>
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CHAPTER 2

INTERDISCIPLINARY CHILD PROTECTION TRAINING
Introduction

The purpose of this literature review is to critically evaluate the theoretical and empirical basis of interdisciplinary child protection training programmes. This literature review has been structured to progress from general to specific, and from theoretical to empirical issues. Overall, interdisciplinary child protection training programmes can be understood in terms of (a) generic, (b) public health, and (c) child-service-centric organisational structures:

Figure 2.1

Positioning of interdisciplinary child protection training programmes

As such, determining how interdisciplinary child protection training programmes should function requires examining (a) general organisational dynamics related to training, (b) specific organisational dynamics related to public health, and (c) even more specific dynamics related to child-centric public health services. Interdisciplinary child protection training programmes can thus be understood in a more systematic and useful manner through this framework.
This literature review first includes an evaluation of theories that explain the underpinning of a training programme – specifically one of interdisciplinary child protection content. Which kinds of organisational changes are necessary to give rise to a relatively new form of programme? Moreover, which are the mechanisms and measurements of impact? These kinds of questions need to be resolved through the application of theory. Second, the literature review contains an evaluation of both theories and empirical findings that illuminate how and why interdisciplinary child protection training programmes can make an impact on services, practices and ultimately children. Whilst theory is required to select and justify both the metrics and mechanisms of impact, empirical analysis - both quantitative and qualitative - is required to address the questions: (a) which characteristics of interdisciplinary child protection training programmes are impactful, (b) why these are impactful, and (c) precisely how much of an impact they have. Third, building on the foregoing discussion of theory and empirical findings, the literature review is concluded with a critical discussion of general and specific training precepts that can be applied to interdisciplinary child protection training programmes. This discussion follows naturally from the theoretical and empirical directions taken earlier in the literature review.

2.1 Theory

Interdisciplinary child protection programmes require the active co-ordination and commitment of existing organisations. These can combine personnel from healthcare, social services, advocacy, research, policy and law enforcement (Agirtan et al., 2009; Bagatti, Englert, & Cline, 2016). Interdisciplinary child protection programmes are seldom, if ever, self-enclosed, self-directed or self-funded; far more frequently, they are provided by umbrella organisations that combine resources and personnel from several sources (Zanoni, Warburton, Bussey, & McMaugh, 2013). With this point in mind, organisational theory is directly relevant to interdisciplinary child protection programmes in terms of (a) explaining how such programmes come together, (b) examining their goals, and (c) identifying the underlying organisational characteristics of successful organisations.
2.1.1 Theories of Organisational Change

Interdisciplinary child protection programmes are relatively new. Child protection services were first established in the United States and the United Kingdom in the late 19th century, but did not start to become interdisciplinary until several decades later (Jalongo, 2006; Machtinger, 1999; Thomas, 2012). The formation of interdisciplinary child protection programmes thus represents organisational change (White, & Morris, 2014; Zanoni et al., 2013); in other words, the formation of interdisciplinary child protection programmes requires organisations, administrators, and administrative processes to embrace some form of change (Weiner, 2009).

In the modern understanding of public management (Cheibub, Gandhi, & Vreeland, 2010; Soud Mohammad, 2013; Turner, Reeder, & Wallace, 2013), the organisations and agencies that contribute resources to interdisciplinary child protection programmes do so in a goal-directed manner. Simply put, both public and private organisations change because they believe that doing so is likely to bring them closer to a specific goal, which can be financial such as that of increased efficiency (Tiemann & Schreyögg, 2012), but which can also be a social goal such as the kind of social responsibility reflected by the caretaking of children (Mezzadri, 2014).

Organisational readiness for change is, according to Weiner’s (2009) theory, the sequential endpoint of a number of antecedents. In Weiner’s model, the originating point in the chain of organisational readiness for change is a set of contextual factors that include, but are not limited to, the following:

- Organisational culture
- Policies and procedures
- Past experience
- Organisational resources
- Organisational structure
These contextual factors inform what Weiner described as ‘change valence’ (that is, the attractiveness of the desired change) and informational assessment, which includes the categories of task demands, resource perceptions, and situational factors. Change valence and informational assessment combine to create organisational readiness for change, which Weiner measured in terms of two distinct constructs, change commitment and change efficacy. Organisational readiness for change next dictates the change-related effort, which is subdivided into initiation, persistence, and co-operative behaviour. Finally, the quality of change-related effort determines implementation effectiveness for the chosen change.

Weiner’s (2009) theory can be applied to developments in interdisciplinary child protection team formation and concepts. For example, Weiner’s category of past experience can be applied in the context of two key cases in the United Kingdom, those of Baby P (Peter Connelly) and Victoria Climbié. Baby P died at the age of one year when, in 2007, he succumbed to an accumulation of injuries caused by his mother, his mother’s boyfriend, and his mother’s boyfriend’s brother (Elliott, 2009). The case was similar to that of Victoria Climbié, who was tortured and murdered in 2000, when she was eight years (Elliott, 2009). The Victoria Climbié case in particular is an example of what Weiner referred to as ‘past experience’. Victoria Climbié’s death illustrated the various gaps in the United Kingdom’s approach to child protection that led to numerous changes, including the Children Act of 2004, that had the collective result of incorporating more individual and organisational perspectives into initiatives related to child protection (Cooper, 2005). Thus, while interdisciplinary child protection teams existed before this time, the Victoria Climbié case was responsible for an increase in their scope and remit. The Baby P case was not associated with legislation, but the inquiry in the wake of that scandal revealed how breakdowns across an interdisciplinary child protection team could lead to a catastrophic outcome such as the murder of a child who ought to have been removed from an untenable domestic situation. Victoria Climbié’s case, perhaps the more important of the two in terms of impact, demonstrated how past experience can alter a bureaucracy’s vision of itself, resulting in changes to organisational culture, policies, resources, and structure.
Weiner’s (2009) theory of organisational change is distinguished by its sequential nature, as well as by its modularity. This is sequential, because of the assumption that organisational readiness (a) itself arises out of attitudes, contexts, and behaviours that are rooted in the past; and (b) serves as the precursor to an actual change-related effort. It is also modular, because it assumes that there are discrete constructs in the chain of change, such as the perceived attractiveness of a change (its valence), which can be considered as distinct from actual organisational readiness for change. These aspects of the theory can be understood in light of the Baby P and Victoria Climbié cases - particularly the latter, in which organisational readiness to change was clearly a function of changes in attitudes and experiences.

These theoretical points are all important in terms of predicting how and why interdisciplinary child protection programmes are formed. The formation of interdisciplinary child protection programmes, therefore, has to be understood in the context of the culture, policies and procedures, past experience, resources, and structures of the respective organisations from which these are formed. Going back far enough in the history of child protection (Machtinger, 1999; Thomas, 2012), interdisciplinary child protection teams emerged from a change in social consensus on the value of children, which eventually permeated into bureaucracy, and drove organisational readiness to address child protection through interdisciplinary policies.

Weiner’s (2009) theory, while developed specifically for organisational settings, is similar to theories developed for the analysis of individual approaches to change. This is perhaps more similar to the theory of planned behaviour (Ajzen, 2005). In fact, the use of the term valence derives from mid-20th century theories of individual behaviour changes, such as the expectancy theory. This states that the strength of the tendency for an individual to perform a particular act is a function of (a) the strength with which s/he expects certain outcomes to be obtained from the act, and (b) the attractiveness of the expected outcomes. This theory is frequently summarized by the phrase “force equals expectancy times valence” \( F = E \times V \) (Hackman & Porter, 1968, p. 418).
In Weiner’s model, valence is one of the two precursors of organisational readiness for change. The other precursor is informational assessment, which is similar to the construct of expectancy (the degree to which individuals expect certain actions to result in desired outcomes). Expectancy theory suggests that the formation of interdisciplinary child protection programmes rests on (a) how much society in general (or key decision-makers in particular) value the goal of child protection; and (b) the extent to which public and / or private agencies believe that coming together to form an interdisciplinary child protection programme is likely to result in the desired goal of child protection. Cases such as those of Baby P and Victoria Climbié indicate how much social angst emerges from cases of failed child protection, highlighting the value that the UK society places on children’s safety.

What Weiner (2009) referred to as contextual factors (organisational culture, policies and procedures, past experience, resources, and structures) also appear in theories of individual planned behaviour (Foxall, 1997, 2007; Gwaltney, Shiffman, Balabanis, & Paty, 2005; MacIntyre, Dornyei, Clement, & Noels, 1998). Individual judgments about the attractiveness of outcomes, and individual assessments about the alignment between expected effort and desired reward, are conditioned by individuals’ social and behavioural contexts, histories and backgrounds (Ajzen, 2005; Foxall, 2010, 2011; Nasri & Charfeddine, 2012; Oliveira-Castro, Foxall, Yan, & Wells, 2011). Weiner merely applied the same structure to organisations rather than to individuals, noting that organisations, no less than people, want certain outcomes. Because organisations are goal-directed, they can be understood in terms of the same vocabulary of desired outcomes, expectancy, motivation, and other change-readiness categories that exist when describing individual behaviours. If so, interdisciplinary child protection programmes can be approached as rational, goal-directed agents rather than as mysterious entities whose behaviours and characteristics are inscrutable.

Schroder, & Belland, 2014; Pettijohn, Schaefer, & Burnett, 2014; Richardson et al., 2013; Schomerus et al., 2011; Scott & Dearing, 2012; Taylor & Reyes, 2012; Usher & Pajares, 2009). There are, therefore, good theoretical reasons to adopt Weiner’s theory of organisational readiness for change as a basis for understanding (a) how and why interdisciplinary child protection programmes are formed out of existing organisations and their resources; and (b) why interdisciplinary child protection programmes engage or do not engage in certain actions.

However, it is also important to note that Weiner’s (2009) theory is not the only approach in exploring the phenomenon of organisational change (Shea et al., 2014). The management literature contains several other theories of change. One such theory is the theory of transformational leadership. As its name implies, transformational leadership is a process that changes and transforms people. It is concerned with emotions, values, ethics, standards, and long-term goals. It includes assessing followers’ motives, satisfying their needs, and treating them holistically as human beings. Transformational leadership involves an exceptional form of influence that moves followers to accomplish more than what is (Northouse, 2010, p. 171).

Transformational leadership is an alternative account of organisational readiness for change, as it places more emphasis than Weiner does on the role of the leader in driving change. Weiner’s theory of organisational readiness for change appears to place an emphasis on the entire organisation - its structure, past, personnel, etc. - as both the motivator and the agent of change. Transformational leadership theorists have argued that individual leaders can preside over successful change, even if the organisation is not organically ready for change (Arnold, Barling, & Kelloway, 2001; Barling, Weber, & Kelloway, 1996; Bass & Avolio, 1990; Effelsberg, Solga, & Gurt, 2014; Kouzes & Posner, 2006; Pearce & Sims Jr, 2002; Piccolo & Colquitt, 2006; Ross et al., 2014; Spreitzer, Perttula, & Xin, 2005). In terms of interdisciplinary child protection programmes, transformational leadership is a factor that allows leaders who are strong, effective and passionate advocates for interdisciplinary child protection to push through changes, and to create administrative structures that might not have existed but for these leaders’ efforts. In the case of the UK, the death of Victoria
Climbié illustrates the role of transformational leadership. Victoria Climbié’s death provided a platform for transformational policy leadership that resulted in new legislation (Elliott, 2009). Consequently, policy changes impelled by this kind of leadership were responsible for the change in organisational behaviour across the entire infrastructure of child protection in the UK.

Weiner’s (2009) theory of organisational readiness for change was the foundation of Shea et al.’s (2014) development and psychometric assessment of an instrument known as the Organisational Readiness for Implementing Change (ORIC). ORIC contains nine items that measure organisational readiness along two axes, change commitment and change efficacy, as in Weiner’s original model. An overview of ORIC is provided in Table 2.1 below.

<table>
<thead>
<tr>
<th>Table 2.1</th>
<th>Organisational Readiness for Implementing Change (ORIC) items</th>
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<tr>
<td><strong>Change Commitment Items</strong></td>
<td><strong>Change Efficacy Items</strong></td>
</tr>
<tr>
<td>We are committed to implementing this change</td>
<td>We can manage the politics of implementing this change</td>
</tr>
<tr>
<td>We are determined to implement this change</td>
<td>We can support people as they adjust to this change</td>
</tr>
<tr>
<td>We are motivated to implement this change</td>
<td>We can co-ordinate tasks, so that implementation goes smoothly</td>
</tr>
<tr>
<td>We want to implement this change</td>
<td>We can keep track of progress in implementing this change</td>
</tr>
<tr>
<td>We want to implement this change</td>
<td>We can handle the challenges that might arise in implementing this change</td>
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Thus, using ORIC and a 7-point Likert scale, organisational readiness can be measured as an interval variable ranging from 9 to 63, with 9 being the minimum possible level of organisational readiness and 63 being the maximum possible level of organisational readiness. These change commitment and efficacy items can be used to understand how, why and to what extent (a) existing organisations commit to pooling resources in a manner that supports the emergence of an interdisciplinary child protection training programme; and (b) interdisciplinary child protection training programmes, once formed, measure, manage, define, and improve the actions needed for success.
2.1.2 Theories of scope and measurement

In public policy, the creation of a new organisation requires the specification of goals and benchmarks against which the organisation can be measured (Blank & Shaw, 2015; Halloran et al., 2014; Larkin, Felitti, & Anda, 2014; Rabin, 2012; Zitha, 2013). The foregoing discussion on organisational change suggested a theoretical framework that allows the emergence of child protection in general, and interdisciplinary child protection in particular, to be considered in light of organisational desires, limitations, and structures. This theoretical framework is important because of its ability to explain how and why child protection has become a major issue in public policy; simply put, child protection services exist because they reflect a social consensus according to which children are considered autonomous, valuable, and yet vulnerable members of society (Duncan et al., 2012; Jack & Jordan, 1999; Landsverk et al., 1996; Tambra & Tyrone, 2014). The previously discussed theories and measurement process offered the opportunity of capturing the readiness of countries’ existing public and private organisations to engage in the changes necessary to (a) create an interdisciplinary child protection programme for the first time; or (b) to improve the functioning of an existing interdisciplinary child protection programme.

While this theoretical contribution is particularly important in explaining the formation of interdisciplinary child protection programmes, it does not address exactly how the success of such programmes can or should be measured. Without specifying some theoretical standards for success, it is impossible to evaluate the performance level of interdisciplinary child protection programmes, or to make changes for improvement. Accordingly, this section of the literature review has been devoted to addressing issues of scope and measurement pertaining to the performance of interdisciplinary child protection programmes.

In the US, the Children’s Bureau - an interdisciplinary child protection organisation that combines elements of policy, research, public health, social care, law enforcement, and therapeutic interventions - is rated on a number of outcomes, including those related to a
number of adoptive placements, adoption training and technical assistance, child abuse, child welfare statistics, foster care outcomes, and guardianship outcomes (Thomas, 2012). One measurement of the Children’s Bureau targets lies in the percentage of children who need foster matching and who are actually placed into foster care. Ideally, the Children’s Bureau would place 100% of available children into foster settings. However, any regulated operational standard that requires such high levels of placement would not be realistic, because of shortage of foster carers, or caregiver- and child-related factors (e.g. rearing attitudes or challenging behaviours) that lead to placement breakdowns.

Unfortunately, the Children’s Bureau does not appear to have addressed the qualitative aspects of services in its key performance indicators (KPIs). Although it does keep track of statistics such as how many children placed into foster care are abused, this data does not count towards the Children’s Bureau’s self-assessment. Rather, the Children’s Bureau is ranked on metrics that have to do with the dissemination of services; for example, the percentage of foster-placed children; or the percentage of children requiring welfare that is signed up for welfare payments or food remittance. This latter measurement makes more sense as a KPI, because there is no scenario in which ensuring a child’s eligibility for food or monetary welfare could be a wrong action (Machtinger, 1999; Thomas, 2012). However, the Children’s Bureau could easily make the wrong decision about what kind of family to place an orphaned child with (for example, by not doing proper diligence on the family). By the same token, there is an open question as to how much responsibility the Children’s Bureau or similar agencies should have to bear for certain outcomes involving children (Fazel et al., 2012). If, for example, a family ends up abusing a child despite the fact that they were properly vetted by the Children’s Bureau, it is not clear whether the Children’s Bureau ought to shoulder the blame.

In both the US and the UK, funding is tied, at least in part, to the documentation of activities. In the US, Child Protective Services (CPS) must show that they have been active, in order to obtain funding (Inkelas & Halfon, 1997). State-level CPS departments thus demonstrate their activity by submitting reports on how many investigations they have conducted, how much funding they have spent on services (such as reimbursing foster parents, paying CPS
employee salaries, etc.), and how many children have been assigned to foster care as a result of CPS interventions. Hence, there is constant pressure on CPS to show activity - albeit not necessarily results - pertaining to the agency’s mission.

One of the negative effects of including quantitative metrics such as percentage of children placed or provided with a service, is that these indicators can create further pressure for the Children’s Bureau and other organizations to think in terms of quantity-oriented processing rather than quality-related provision (Machtinger, 1999; Thomas, 2012). Nevertheless, it is hard to determine how else related activities could be measured. A consideration of the literature on interdisciplinary child protection programmes indicates that researchers (Agirtan et al., 2009; Featherstone et al., 2014; Zanoni et al., 2013) have had difficulty in defining precisely how their success should be measured. The review of empirical studies that follows in the next section of this chapter contains an evaluation of some suggestions for performance measurement.

2.2 Empirical studies

2.2.1 Qualitative Studies

Relatively few empirical studies have examined aspects of interdisciplinary child protection teams. While the literature on child protection is extensive, interdisciplinary child protection is a distinct topic area, and one that has received far less attention from scholars (Bell, 2001; Platt & Turney, 2014). Nonetheless, there are some important studies on interdisciplinary child protection teams. The qualitative studies discussed in this section provide a basis from which to better understand their effectiveness and impact.

Bell’s (2011) study of interdisciplinary child protection teams in New Jersey, US, provided insight into relevance to theories discussed earlier. Bell, for example, found that some individuals in such teams contributed more work than others. This empirical finding is in line with Weiner’s (2009) theory, in which organisational change can be understood in pragmatic and goal-driven terms. Bell’s findings suggest that different functional areas
within interdisciplinary child protection have different levels of motivation in terms of contributing to team success. Weiner’s theory of organisational readiness for change suggests that variant levels of participation in interdisciplinary child protection can be understood as a function of individual and organisational stakes in outcomes. An uncritical way to interpret Bell’s findings would be to suggest that some team members do not have as much at stake in the protection of children. However, theories of bureaucracy and public policy (Niskanen, 1968; Rabin, 2012; Weerakkody, Janssen, & Hjort-Madsen, 2007) suggest that there can be internecine conflict between representatives of different organisations, even when these broadly agree on objectives. Some scholars have used the term ‘stratarchy’ to identify an organisation that has many veto levels and a relative flat distribution of power (Luther, 2008). Bell’s case study suggested that, in some States, interdisciplinary child protection teams might be stratarchical, with representatives from different groups (such as social work, medicine, policy, etc.) each approaching the problem of child protection from their own professional or institutional perspectives, and in that way retarding the process of consensus needed for an interdisciplinary child protection team to evolve.

Platt and Turney (2014) pointed out that, in the context of social work in the UK, interdisciplinary decision-making is supposed to be simplified by the adoption of standardised approaches such as so-called threshold decisions for elevating child protection cases. Platt and Turney suggested that, on paper, a strength of this approach is the fact that so many personnel in the UK are capable of making child protection decisions. However, the same authors also suggested that there can often be a trade-off between efficiency and equity in this regard. The adoption of standardised threshold decisions makes the overall system more efficient, in terms of extending the power of interdisciplinary child protection teams to make decisions, but sacrifices the ability of certain team members to make judgment calls that fall outside formally specified parameters. In this sense, Platt and Turney’s (2014) findings recall those of Bell’s (2001), as both of these studies called attention to ways in which interdisciplinary child protection can fail to have their intended impact. In Bell’s study, interdisciplinary child protection was observed to be dominated by some institutional interests over others. While Platt and Turney praised the ability of UK interdisciplinary child protection teams in terms of (a) inclusion of different stakeholders, and (b) ability to act,
they suggested that these could be made stronger by empowering individuals to make different kinds of threshold decisions within their teams.

An important ongoing question (Hebert, Bor, Swenson, & Boyle, 2014) for both policy-makers and practitioners is how to structure interdisciplinary child protection teams that, within the institutional limitations noted by Platt and Turney (2014), can function well. Hebert et al. conducted such a study by interviewing the members of an interdisciplinary team within Australia’s Multisystemic Therapy Child Abuse and Neglect Programme. They found that staff who felt positively about their communication within the team were more likely to be frequent and meaningful contributors. There is a substantial body of literature on the construct of communication satisfaction (Downs & Hazen, 1977) that is relevant to Hebert et al.’s (2014) findings. One seminal theory was proposed by Downs and Hazen; its components are presented in Table 2.2 below.

<table>
<thead>
<tr>
<th>Dimension</th>
<th>Description</th>
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<tbody>
<tr>
<td>Communication climate</td>
<td>The extent to which communication is successful in prompting workers to achieve organisational goals and to identify with the organisation</td>
</tr>
<tr>
<td>Supervisory communication</td>
<td>The extent to which individuals perceive their superiors to be (1) open to ideas, (2) willing to listen, and (3) willing to offer guidance</td>
</tr>
<tr>
<td>Organisational integration</td>
<td>The extent to which individuals are kept abreast of relevant events in the organisation</td>
</tr>
<tr>
<td>Media quality</td>
<td>The extent to which communication is purposeful, concise, and properly-organised</td>
</tr>
<tr>
<td>Co-worker communication</td>
<td>The extent to which communication with peers is helpful and transparent</td>
</tr>
<tr>
<td>Corporate information</td>
<td>The extent to which the employee is kept abreast of relevant events at the corporate level</td>
</tr>
<tr>
<td>Personal feedback</td>
<td>The extent to which the employee is given relevant feedback about his or her performance, actions, and role in the organisation</td>
</tr>
<tr>
<td>Subordinate feedback</td>
<td>The extent to which subordinates (1) respond productively to communication from managers, and (2) initiate helpful communication with managers</td>
</tr>
</tbody>
</table>

Source: Adapted from Downs and Hazen (1977)
Communication satisfaction can be an alternative explanation to organisational in-fighting, as a possible reason for Bell’s (2001) observation of uneven contributions within an interdisciplinary child protection team. If interdisciplinary teams are not structured properly, then it is possible that they will be less effective, as individuals who are not satisfied, for example, with functional communication, will be less forthcoming. Indeed, the empirical literature on team dynamics suggests that both the quantity and quality of member contributions to the team is governed by satisfaction, not only with communication, but also with autonomy and other factors (Ale Ebrahim, Ahmed, & Taha, 2009; Cao, Xu, Liang, & Chaudhry, 2012; Kriger & Zhovtobryukh, 2013; Mitchell & Zigurs, 2009; Shachaf, 2008; Thomas & Bostrom, 2008; Tsay & Brady, 2012; Wadsworth & Blanchard, 2015).

2.2.2 Quantitative Studies

While there have been several studies on issues pertaining generally to child protection, there are relatively few empirical and quantitative studies specifically on the impact of interdisciplinary child protection programmes. One such study was carried out by Agirtan et al. (2009) in Turkey. This encompassed the formation of interdisciplinary child protection teams between 2002 and 2006. Agirtan et al.’s work was important for two reasons. First, it focused specifically on interdisciplinary child protection teams. Second, the study sought to examine possible performance measures

Agirtan et al. (2009) indicated that the formation of interdisciplinary child protection teams in Turkey began to take place in 2002, with the collaboration and encouragement of the University of Iowa Child Protection Programme. The authors indicated that, at the outset of the formation of the teams, the University of Iowa and Turkish public health officials collaborated on defining outcomes of success. These can be assessed in light of the foregoing theoretical discussion of success measurement in child protection. The outcomes were as follows:

- Number of training activities
- Number of individuals attending training activities
- Number of multidisciplinary teams
• Number of activities carried out by multidisciplinary teams
• Geographic dissemination of multidisciplinary teams.

Based on these stated measurements, Agirtan et al. concluded that the Turkish experiment was a success. The programme was associated with an increase in the number of existing interdisciplinary child protection teams from 4 to 14 within the period of the study. A total of 18 training activities were held, which were attended by 3,570 professionals. The number of abuse cases reviewed by interdisciplinary child protection teams increased fivefold. These also increased lectures to medical professionals by 83.8% and to non-medical professionals by 69.2%.

While these metrics are useful, and provide a basis according to which the success and impact of interdisciplinary child protection teams can be measured, it should be noted that the chosen metrics were not tied back to the central mission of improving children’s outcomes. However, as Agirtan et al. (2009) pointed out, establishing causal relationships between the activities of interdisciplinary child protection teams and children’s outcomes is extraordinarily difficult, because (a) there are many confounding variables, and (b) the contributions of interdisciplinary child protection teams cannot be directly measured. A simpler solution to measuring impact could be to adopt the kinds of metrics Agirtan et al. utilized in their study.

In other contexts, the tasks of interdisciplinary child protection teams are distributed across different functional roles (Al-Dabaan, Asimakopoulou, & Newton, 2015). Al-Dabaan et al.’s study pointed to the feasibility of creating the functional equivalent of interdisciplinary child protection teams by creating higher awareness of issues related to child protection among medical professionals. This was of particular interest because of its geographic focus; it was conducted in Saudi Arabia, which is also the focus of the current study.

Specifically, Al-Dabaan et al. (2015) conducted a pre- and post-training evaluation of knowledge and practice, by using a survey designed for dental practitioners in Saudi Arabia to assess a web-based child protection training programme. Self-reported attitudes and
reported suspected cases were assessed after one month from completion. Results showed a significant increase in knowledge immediately after the training, which was highly perceived overall; after one-month, 21% of dental practitioners had or intended to adopt a child protection policy, and 29% could identify the staff member who was leading on child protection. Participants showed an increasing awareness on the signs of child maltreatment (CAN) in their daily practice, and 27.4% had made a report of a suspected case of CAN. These findings indicate the feasibility of educational techniques to involve healthcare personnel in making functional contributions, even if such activities do not take place under the rubric of a formal interdisciplinary team as discussed by Agirtan et al. (2009).

2.3 Child Protection and Prevention: Some Illustrations

There are three types of prevention that apply to child sexual abuse: (1) primary prevention (in which child sexual abuse is prevented before it happens); (2) secondary prevention (in which specific circumstantial risks for child sexual abuse are reduced); and (3) tertiary prevention (in which further offense and victimisation are precluded, typically by punishment of the identified abuser). Smallbone et al. (2008) suggested that the media, public, and politicians tend to focus more on issues of tertiary prevention. The reason that more attention is usually more focused on tertiary rather than primary and secondary prevention is that the latter requires wider systemic approaches and potentially changes based on acknowledging the faults of existing systems and institutions; and these are far more difficult to implement than targeting offenders. As such, the concept of the interdisciplinary team should not be viewed only at the level of frontline personnel; instead it should be extended to also include parents and other community members.

This point can be illustrated through a specific case that was discussed in the context of the Wood Inquiry conducted in Canada (Matthews, 2014). The Inquiry was told of a 17-year-old boy who showed pornographic DVDs to young children, and who subsequently made them enact scenarios from these DVDs. The Inquiry was further told that the local community was aware of this boy and his activities, but did nothing. As far as can be determined, there were two reasons for the community’s inaction. First, there was an element
of shame, as the community did not want to acknowledge the predator in its midst. Second, and more disturbingly, parents simply did not report the incident or keep their children away from the offender; for them, it was not merely a shame, but also inertia and disinterest in the welfare of their children that was to blame.

With this illustrative story in mind, it is easier to understand why, as Smallbone et al. (2008) claimed, more attention is paid to tertiary prevention. In tertiary prevention, there is a single and clear-cut perpetrator. In contrast, in primary and secondary prevention, larger social units such as families, neighbourhoods and cities, are also to consider and target, at least for a degree of passivity and neglect that form part of the breeding ground for child sexual abuse. Understandably, the public is less eager to criticise itself rather than identifiable abusers, which is probably why, among other reasons, more attention is paid to tertiary prevention. Child sexual abuse, like all crimes, takes place against an environmental backcloth; while primary responsibility certainly lies with the abuser, the community and general environment provide the context in which child sexual abuse arises. If potential child sexual abusers feel that their environment is inimical to abuse, then it is possible that their instincts may not express themselves. For example, if the 17-year-old boy referenced in the Wood Inquiry had been aware that he would not get away with showing the DVDs to children, he might never have become an abuser.

In terms of efficiency, it is preferable to prevent crime than to punish after it has already occurred (Donner et al., 2014; Galicki, Havens, & Pelker, 2014; Haber, 2015; Knepper, 2014; Pyrooz, 2014). For child sexual abuse to be prevented, it is thus necessary to address primary, secondary and tertiary prevention within a comprehensive model. However, this requires communities and societies at large to be willing to engage in self-critique. What is pernicious about the nearly single-minded media, political, and public focus on tertiary prevention is that this can divert much-needed resources away from primary and secondary prevention (McMinn & Dunn, 2011).

Another salient point in response to Smallbone et al.’s (2008) claim is that it is not fully clear how, in an open society, primary prevention can take place in a manner that preserves the
rights and privileges of democratic life. Erring on the side of over-surveillance versus under-surveillance is one of the unresolved tensions in the Wood Special Inquiry on Child Protection Services. An aggressive approach to primary intervention requires, as the Wood Inquiry makes clear, more assertive governmental decisions and value judgments about particular families and communities. These decisions and judgments can themselves run afoul of the law. For example, although Section 38(1) of the Child Welfare Act in Canada creates a statutory duty to disclose information pertinent to child abuse, including circumstances in which a child may be in danger (and thus relevant to the context of primary prevention), professionals can fail to act upon this guidance.

An appropriate example was provided in the Canada by Young v. Bella, in which the accused was a social worker in training, who allegedly wrote a case study of sexual abuse as a so-called cry for help (Redmond & Bright, 2007). Her supervisors, peers and colleagues reported her to the police and ruined her reputation on no factual basis; as a result, her University was required to pay her substantial damages. The case of Young v. Bella illustrates some of the dangers of overzealousness in primary prevention. Simply put, it is more difficult and often unjust to leap to conclusions about child abuse in a primary context. Therefore, part of the reason that the public, politicians, and the media do not focus closely on primary and secondary prevention is that, often there is no substantial indication that child abuse is or has taken place in a particular environment. Without a more tangible basis, it is thus possible for primary prevention to devolve into life- and career-destroying accusations and suspiciousness. It is not necessarily easy to draw the line between the kind of early reporting that is mandated by the Child Welfare Act, and that properly serves the function of primary prevention, and the kind of early reporting that, as in the case of Young v. Bella or the so-called satanic day care cases reported in the US (Hier, 2008) are on the verge of paranoia. This is relevant to the training and practice of members of interdisciplinary teams, who can be risk-aversive because of the fear of personal liability. This fear can constrain their actions in some respects, and can also lead to taking no action in the absence of specific bureaucratic justification.
It is also possible to counter-argue that placing the emphasis on primary and secondary prevention removes the focus from tertiary prevention, where it rightly belongs. This argument is based on the premise that child abuse is predominantly, if not exclusively, the responsibility of the abuser, and that placing the focus elsewhere is either morally or legally pointless. The argument can be buttressed by examining *Brown v. University of Alberta Hospital* (Mathews, Payne, Bonnet, & Chadwick, 2009). In this case, a man named Steve Brown took his three-month-old daughter Nadine to the emergency department with a head injury consistent with abuse, but also with accidental injury. The attending doctors noted the possibility of child abuse but did not report to social services. A year later, Steve Brown inflicted a catastrophic brain injury on Nadine. At that point, Nadine’s mother sued the hospital. One of the dangers of focusing too intently on primary and secondary prevention is that moral and legal responsibility can be transferred from the actual perpetrators to bystanders, who are required to take on a perhaps unrealistic and unfair quantum of responsibility. The absurdity of this approach is on view in *Brown*, in which the mother of the abused child blamed neither her husband for the abuse, nor herself for being a party to it, but rather blamed the hospital for not forcibly preventing her husband from injuring her daughter. There is only so much that unrelated individuals and broader communities (including members of interdisciplinary child protection teams) can do to bear their share of responsibility for primary and secondary prevention; the true responsibility lies with the near parties to child abuse, which is perhaps why a focus on tertiary prevention is justified, albeit this is not mutually exclusive with other approaches (Smallwood et al., 2008).

### 2.4 Training

Insight gained from the above review of empirical studies can help to inform the consideration of the role of child protection training. The section on training also contains an overview of relevant training theories. Wherever possible, theoretical positions and empirical findings were related to the function of interdisciplinary child protection teams, as discussed in earlier sections.
2.4.1 Three Levels of Training

Child protection training at different levels usually addresses deficiencies in knowledge, skills and attitudes. Other performance gaps may, however, require a different solution (Blanchard & Thacker, 2007). Reay (1994) suggested that asking the right questions is the first step in identifying training needs, followed by analysis and interpretation of the respondents’ views. A training needs analysis will support the organisation in effectively adapting to environmental changes and growing demands. This can be implemented at three levels: organisational, departmental and individual.

At an organisational level, training should be positioned within a collective mission and objectives. Although analytic methods have evolved, an early framework by McGhee and Thayer (1961) remains instrumental. The authors suggested four steps, namely defining the organisational goals, analysing human resources, measuring efficiency, and measuring the environment. Organisational training needs analysis can be activated by a series of actions. For instance, performance problems could urge the need for changes in the management structure or instilling new work patterns. Managers at different levels are included in this process, as well as different departments within the organisation, the workforce, and external stakeholders such as commissioners or investors. The results of the analysis are then contrasted with the objectives of the organisation, in order to identify target areas for training or other solutions (Blanchard & Thacker, 2007). For instance, Raman, Holdgate and Torrens (2012) compared knowledge of child protection, as well as confidence and skills, among clinicians in general practice and hospital settings in Australia. The results showed significant variation across all variables between the primary care and hospital groups, with confidence and competencies being significantly lower among GPs. The implication was to extend child protection training from hospital to community settings.

Training at a departmental level can be concentrated on a unit of similar functional needs such as a community paediatrics or social work team. As well as taking into account specific individual requirements, the interactive, collaborative and team–related needs should be identified. For example, addressing the roles and interactions between child protection team
or committee members could be as important as enhancing their knowledge base. An Australian study by Crisp and Lister (2006) investigated nurses’ perceptions of their knowledge, skills and training needs in relation to recognition of child abuse, their roles and responsibilities. Despite most participating nurses being actively and routinely involved in child protection work, a substantial proportion considered they were most in need of ongoing training and practice. This was even more striking in a study by Ward et al. (2004) that assessed the experience, knowledge and training of Canadian paediatric residents. Almost all participants (92%) stated that they required further training in child protection.

Individual training is required when there are problems in a practitioner’s performance. This can be achieved throughout their professional development and through different opportunities, which means that not all individual demands can be met by training alone. In order to identify those training needs, there must be a good understanding of the individual’s role and job requirements, before determining how the employee could meet those, and which changes in their occupational functioning would help decrease their performance gap. Possible methods of conducting an individual training needs analysis include performance appraisal, different types of interviews, questionnaires, tests, behavioural analysis, checklists, critical incidents, recording, surveys, and observations (Blanchard & Thacker, 2007). For example, Menoch, Zimmerman, Garcia-Filion, and Bulloch (2011) conducted a US survey on child abuse education that targeted paediatric residents, general paediatricians (GPs) and paediatric emergency medicine (PEM) physicians. The findings indicated that over 50% among all three medical groups lacked essential knowledge on child abuse.

2.4.2 Training Insights Relevant to Child Protection

Bannon and Carter (2003) proposed that (a) child protection training should be mandatory, and not dissimilar e.g. to advanced life support; (b) child protection training should be accessible to all practitioners within health care and welfare who are in contact with children and their families; and (c) the content and scope of child protection training should be adapted to the trainees’ remit, with ideally different levels of training being available. These principles are increasingly being endorsed by healthcare organisations that offer: (a) A basic
level on key policy, protocols, and available services and resources; (b) a standard level on key knowledge and competencies; (c) an advanced level that provides more detailed information such as on legal aspects and court proceedings; and (d) designated doctor and nurse training, which may lead to a postgraduate qualification (Diploma or MSc) (Starling, Sirotnak, & Jenny, 2000).

Child protection is increasingly being integrated with other types of training (such as in resuscitation skills) and combined in introductory or basic training courses for new employees, or as booster training at regular intervals. This is also being extended to safeguarding that includes topics such as domestic violence awareness, and childcare practices among different cultural groups (for example, female genital mutilation) (Wilkinson & Cranston, 2015). Bannon and Carter (2003) listed, in their review, the clinical competencies required for professionals to participate effectively in child protection work such as history recording, clinical examination, documentation, ability of communication with peers, confronting abusing carers with confidence and courage, and decision-making. Additionally, they should be equipped to cope with difficult emotions when dealing with child maltreatment cases. Efficient education and training should not be confined to increasing knowledge and skills, but should also aim to enhance appropriate attitudes regarding the role of practitioners, and these should be relevant to all professional groups as well as to society as a whole.

Practitioners are the most valuable resource in terms of diagnosis, management and treatment of child maltreatment; yet, many physicians remain unaware of the pertinence of child abuse, and either do not seek training or have limited access to it. Consequently, untrained specialists can either under- or miss-diagnose such cases (Starling, Heisler, Paulson & Youmans, 2009). This can even apply to experienced clinicians, who may fail to recognize or deal with a maltreated child. Prompt action, referral to appropriate agencies, accurate documentation, medical findings and other supporting information on concerns are essential responsibilities of all practitioners in contact with children. Not only are these professionals expected to carry out these responsibilities, but they must also be prepared to testify in court and to defend their views in accordance with current legislation. In a UK
review on recognition and response to child maltreatment, Gilbert et al. (2009b) found that the deficiency of awareness and knowledge on the signs of child abuse and neglect and of reporting procedures to child protection agencies; as well as the perception that reporting might lead to more harm, are common reasons for not reporting.

The processes for investigation and prosecution of child sexual assault allegations are partially in accordance with current understanding on the nature and underlying dynamics of child sexual abuse, especially in terms of approaches to evidence. To begin with, empirical research has established that victims of child sexual abuse do not tend to disclose their victimisation in childhood. Fleming’s (1997) analysis of 710 Australian women who had been victims of child sexual abuse found that that only 10% had disclosed such assaults that were subsequently reported to the authorities. These findings were reinforced by the empirical work of Easteal (1992); and of London, Bruck, Ceci, and Shuman (2005). According to (Lamb & Edgar-Smith, 1994) the mean delay between the onset of child sexual abuse and disclosure was between three and 18 years. There are several implications arising from these findings. First, unlike other crimes, child sexual abuse is highly under-reported to authorities, or even to a victim’s family member or friends, meaning that authorities are simply not alerted to the crime and cannot collect physical evidence (Gomes-Schwartz, Horowitz, & Cardarelli, 1990). Second, given the delay between onset and reporting in those cases, too much time has elapsed for physical evidence to be gathered, therefore lead to prosecution (Gomes-Schwartz, Horowitz, & Cardarelli, 1990). Given these characteristics of child sexual abuse, both investigation and prosecution must often rely primarily on the testimony of the victim, which many do not want to give or are incapable of giving, because of capacity and / or trauma. Consequently, the members of an interdisciplinary team musty receive expert training in identifying the signs and symptoms of child abuse in order to minimise the pitfalls in the process, from early recognition to taking appropriate action.

2.4.3 Evaluation of training

Various studies have highlighted that evaluation was relatively neglected in the early development of training programmes (Werner & De Simone, 2009; Junaidah, 2006).
Junaidah (2006) indicated that reasons for not undertaking training evaluation include naivety or ignorance on its importance, and cost implications for both the evaluator and the participants.

These criticisms have led to a substantial increase in training evaluation in recent years, although their quality and designs vary considerably, with a large number of organisations involved in such evaluation. Their focus initially was on the reactions of the trainees rather than on the learning process, and its later impact on job performance or other indicators (Goldstein & Ford, 2002). This is largely still the case, as many evaluating practices are implemented in non-systematic ways, and evaluation is not a priority for commissioning organisations, who often opt for short-term and simple means (Junaidah, 2006; Russ-Eft & Preskill, 2001). These flaws and gaps have, nevertheless, also led to the realisation that non-evidenced training is not in the interests of organisations, their employees or their professional bodies that commit considerable time and funding to new and continuing training. Common errors that could be avoided include the lack of systematic assessment, evaluation by the trainer provider, improper data collection and interpretation (Robillos et al., 2014). Because of this realisation, there has been more investment in resources and quality in carefully designed and independent evaluation in recent years, and this is often a pre-requisite for commissioning to training providers (McConnell, Breitkreuz, & Savage, 2012; Sanders & Kirby, 2014).

Among the different classification systems of evaluation, one commonly adopted by researchers includes four types, i.e. formative, summative, confirmative and meta-evaluation (Dessinger & Moseley, 2004). These four types are only relevant for relatively long-term training programmes rather than for ‘one-off events’, as they consider the pre-, during- and post-training phases, including their implementation in practice. Consequently, their application is particularly relevant to evaluation of child protection training. Different types of evaluation are often used, because they provide insight into distinct aspects of the training to suit the needs of the organisation (Su et al., 2010). Even more so, they are relevant to inter-agency training, as the required professional collaboration of the evaluation procedure mirrors the nature of the training programme (Stufflebeam & Shinkfield, 2007). Therefore,
although it is acknowledged that other evaluation models are no less important, this particular system will be discussed in more detail.

2.4.3.1 Types of evaluation

Dessinger and Moseley (2004) considered formative evaluation as the oldest type. Formative evaluation concerns data collection while conducting the training programme, which covers the identification of the drawbacks and unexpected outcomes that could be useful in making appropriate adjustments (Goldstein & Ford, 2002, p. 166). Junaidah (2006, p. 186) defined formative evaluation as "examining how the training was designed, developed and carried out", thus paying more attention to the process of evaluating. This will ensure the quality of a programme and what actions can be taken to improve it. Evaluation methods include the use of questionnaires and tests administered to participants, independent observations, and decision-maker feedback.

Summative evaluation investigates the effectiveness of the training programme, i.e. whether this has attained its objectives (Patton, 1994). It is considered as an extension of formative evaluation. In addition, throughout the summative evaluation, other components of the training programme can be evaluated such as the trainees, the content of the training, the coaches or trainers, the provided facilities, and even the provider (Dessinger & Moseley, 2004).

Thus, there must be consideration of various aspects of training delivery such as flexibility in the content and style tailored to the participants’ professional needs (Hornik et al., 2007; Schraeder, 2009), whilst matching their job requirements (Armstrong, 2003; Arthur et al., 2003; Buckley & Caple, 2004; Cole, 2002; Goldstein & Ford, 2002). As trainees tend to learn differently (Chambers, 2005), a number of factors should be taken into account such as their education and skills level and their experience (Chen et al., 2004; Lingham et al., 2006; Kauffeld & Willenbrock, 2010). Trainers’ selection criteria should include high knowledge about the subject, enthusiasm, communication and motivational skills, learner-orientation and empathy with the target group (Kirkpatrick & Kirkpatrick, 2006). Trainers’
own training should highlight the importance of listening and questioning, interactive skills, experience in the content, problem-solving, and transferring knowledge in different settings (Gauld & Miller, 2004; Massey, 2003).

"The designer/developer or evaluator may select from or blend some strategies for conducting summative evaluation: cost-benefit analysis, attitude ratings, testing, surveys, observation, interviews, focus groups, or statistical analysis" (Dessinger & Moseley, 2004, pp. 6-7). Summative and confirmative evaluations are thus often sequential stages in the evaluation process.

2.4.3.2 Importance and purpose of evaluation

The evaluation of training programmes is an integral step that contributes to sustaining and improving training quality and impact through different methodological approaches (Goldstein & Ford, 2002). In other words, as Stufflebeam and Shinkfield, (2007) stated, evaluation can play a major role in finding out what is “going right and wrong”. Bimpitsos and Petridou (2012) emphasised that training evaluation is necessary, and should thus be considered as a fundamental part of training. Additionally, Werner and De Simone (2009) indicated that evaluation can build credibility, by demonstrating that training objectives are fulfilled.

Many researchers have focused further on the specific purpose of the training evaluation, and how this could significantly influence the development and improvement training programmes. For instance, three main purposes are highlighted. Firstly, in justifying its occurrence and budget by investigating how it contributes to the objectives of the organisation. Secondly, it can help the organisation in deciding whether it is worth to continue the training programme and, if so, what is required for its sustainability. Thirdly, it can help in attaining information on how to improve training quality in the future (Kirkpatrick, 2006). Bramley (1991) defined evaluation as part of the training cycle, and placed significant importance in providing feedback on (a) the methods effectiveness; (b)
the objectives achievement that is set by both trainers and trainees; and (c) whether the identified needs at both levels (organisational and individual) have been met.

Conversely, it is important to understand the reasons for ignoring evaluation findings. For instance, Kirkpatrick (2006) stated that post-training response sheets are often used by most companies, without including other more in-depth evaluation methods, or implementing the evaluation findings. The explanations cited are: it may not consider as important; lack of knowledge about what or how to conduct it; no force to perform it more; people are secure in their job and see no further requirement; and being busy with other essential or desirable duties. In addition, Werner and De Simone (2009) stated that evaluation is a complex and time-consuming process that requires resources and capability which may influence the performance of employees such as cost, equipment, or policies. Finally, there is often unspoken fear of the consequences on human resources, staff performance and other organisational factors should the evaluation findings prove to be negative.

2.5 Concluding summary

The literature reviewed in this chapter highlights the increasing influence of child protection training, particularly of interdisciplinary constitution, in improving practice and service delivery across the world. The key findings also indicate that the evaluation of training programmes is vital in ensuring that such programmes deliver their intended services, but that such evaluation is rendered complex by the various levels at which training programmes function. In the Kingdom of Saudi Arabia, the research site and geographic focus for this study, interdisciplinary child protection teams and the associated training are relatively new. It is thus all the more important to be able to define and justify how interdisciplinary training is delivered and perceived by participating practitioners. Crucially, there is also a need to establish its impact on practice. The rationale for this study was to address these research priorities.
CHAPTER 3

METHODS
3.0 Introduction

The argument demonstrated thus far has illustrated that the Saudi Arabian cultural context has a limited evidence-base, both on child abuse in general and specifically on professionals’ training. It has, therefore, been necessary to translate empirical findings from other cultural contexts, which are useful but not necessarily generalizable, to Middle East countries. The aim of this chapter is to provide the methodological context to the study and to illuminate methodological decisions. An explicit rationale, along with information regarding the theoretical framework and research procedure, is provided, along with a description and justification of the setting and participants, ethical principles, data collection and analytic plan.

3.1 Research aim and objectives

The overall aim was to inform and improve child protection multidisciplinary training, namely the National Family Safety Training Programme (NFSP) for child maltreatment, in Saudi Arabia.

The specific objectives of the research were to establish:

a) Professionals’ experience of the delivery of the training programme.
b) Their experience of its implementation.
c) Their recommendations for improving the training.

In order to meet the aim and objectives of the research a number of research questions were addressed. The research questions for this study were:

1. What are professionals’ perceptions, including the benefits and limitations of the child protection-training programme, in aiding their practice with child abuse and neglect cases?
2. What are the factors that they perceive to influence the implementation of child protection training?
3. How can policy, services and training be improved to meet children’s needs?
3.2 Qualitative design and theoretical framework

In this research, a qualitative approach was used in order to investigate the perceived impact of the training on practice. In order to explore, discover and reveal the experiences and perceptions of individuals, a qualitative research design is the preferred method of addressing the research questions (Corbin & Strauss, 2008). The researcher can thus achieve complex but rich and in depth data collection towards the previously stated objectives (Barker et al., 2002). Such an approach may also result in interesting findings that were not anticipated at the outset.

Qualitative research enables the generation of knowledge through a philosophical interpretation or critique of words (Fossey et al., 2002), in contrast with quantitative research, where logic and numbers produce knowledge (Holloway & Wheeler, 2010). Thus, a qualitative approach is underpinned by a different epistemological framework from quantitative work, which would provide the basis to achieve a better insight into the perceptions and experiences of professionals who are dealing with child maltreated cases, by explaining and interpreting the data. Also, the researcher can establish an intuitive and empathetic engagement with their participants (Robson, 2011), which is a particular advantage when exploring sensitive topics such as ‘child abuse’ (Bryman, 2008).

Qualitative research cannot be conceptualized without philosophical or epistemological positions, as it may include a wide range of methodological perspectives (Robson, 2011). Additionally, it was stated by O'Reilly and Kiyimba (2015) that the consistency between the philosophical position and methods should be clear in order to promote congruence in the design. Moreover, there must be a consideration to match between the most appropriate choice of methods and the aims of the research. These aims are influenced by the perspective of the researcher and his/her interests, which are encouraged and determined by their worldview. This should be acknowledged, and the matching between the worldview and methods used should be transparent (O'Reilly & Kiyimba, 2015). This research adopted a qualitative approach whose aim was not to test hypotheses, but rather to identify emerging themes, due to the exploratory nature of the study, and the relatively new area for study. It is thus
important to comprehend the reasoning behind the design and analysis. It is also essential for researchers to understand the philosophical assumptions that it brings to the research, what type of strategy should be linked to these assumptions, and how the research methods can be applied in practice (Creswell, 2009).

The choice of theoretical framework will guide the reader on how the research knowledge was structured and derived (Anfara & Mertz, 2006; Bryman, 2012; Meyrick, 2006). The theoretical framework that underpinned this study was derived from a social constructionist perspective. Social constructionism has been defined as “the view that all knowledge, and therefore all meaningful reality as such, is contingent upon human practices, being constructed in and out of interaction between human beings and their world, and developed and transmitted within an essentially social context” (Crotty, 2003, p. 42). The human being, according to social constructionists, is tied to cultural, historical, political, economic and linguistic influences (Holstein & Gubrium, 2013). It embraces the viewpoint that individuals make sense of their own world through a combination of sociological and psychological practices that are both unconscious and conscious (Burr, 2003). The interaction between people allows them to learn and form their experience and knowledge, as expressed through language and practices (Cunliffe, 2008; Hruby, 2001). Social constructionism in its inception was argued by Berger and Luckmann (1967) that this generally ignored phenomenon enables us to construct our reality and make sense of our world.

The focus is, therefore, to explore the reality views that individuals hold for themselves as a social world outcome in their daily lives. It is acknowledged that certain realities do occur as a result of perspective, and are created by humans based on their own beliefs, personalities and experiences (Guba & Lincoln, 1994). This study will explain how realities are constructed, and how they shape their experience and views. The participants of the study will individually have their own beliefs and opinions about how they use the training components on their practice, but there may be shared some common themes or social constructs that lead them to form these opinions. There is no objective phenomenon to be described, but rather the emphasis will be on how the individuals’ experiences of child protection training have shaped their perceptions of reality. The ‘knowledge’ that was sought
through this research was, therefore, a description of how the participants have constructed these realities.

Epistemology examines the relationship between the knowledge and the researcher during discovery (Guba & Lincon, 1994); or what is (or should be) acceptable knowledge in a discipline (Bryman, 2012). The position of epistemology is concerned more with the researcher’s beliefs about the nature and forms of knowledge, and how it can be developed (Cohen et al., 2007; Snape & Spencer 2003). Epistemology both informs and is informed by the methodology, which is a necessary component of the theoretical framework of any qualitative study; whilst the methodology indicates how we discover knowledge in a systematic way, is thus more specific in its practice base than epistemology. The choice of the appropriate methodology in this study was driven by its overall theoretical framework and the social constructionist position of the interviewer.

3.3 Setting

3.3.1 Overview of health care services in Saudi Arabia

The structure and organisation of child care within the health system

It is worth considering the health care system in the Kingdom of Saudi Arabia, one of the largest countries in the Middle East, with 2,250,000 square kilometres of land. The economy of Saudi Arabia is highly reliant on oil demand and pricing. The population expanded dramatically from 7.3 to 24.6 million between 1975 and 2005 (Walston et al., 2008). In 2013, the Ministry of Health reported a population of 29.9 million (Ministry of Health, 2013). Healthcare services are influenced by two demographic factors: a large percentage of foreign workers, about 6.1 million people; and the number of young people, with 40% of the population being less than 15 years old (Walston et al., 2008).

Saudi citizens and immigrants who work in the public sector are provided with free healthcare. For people who work in the private sector, their employer must provide some
level of healthcare cover, as required by the government (Walston et al., 2008). The largest healthcare provider is the Ministry of Health (MoH), which covers over 60.2% of in-patient facilities and is free of charge. Other sectors are also important: over 9.2% of in-patient care is provided by institutes run by the Government, and 30.6% by private health organizations (Figures 3.2 and 3.3) (Ministry of Health, 2013). The public sector, government institutes and the private sector provide health services at all levels, including primary or community; secondary or general hospital; and tertiary, specialist or teaching hospital levels (Baranowski, 2009; Qureshi et al., 2009; Almalki et al., 2011).

Primary health care centres (PHCCs) are distributed throughout the Kingdom and are accessible to all citizens (Qureshi et al., 2009). Each health centre provides preventive and therapeutic interventions, and refers cases that need more advanced care to public hospitals (secondary level of care). Secondary care such as medical, dental, surgical, paediatric and other specialist services are not covered by the PHCs, and are instead provided by hospitals which include comprehensive maternal and child health care. Moreover, some medical colleges provide clinical training for both undergraduates and postgraduates, for example in antenatal care, as 90% of women give birth in hospital. Furthermore, the MoH system is enhanced by joint care pathways and sharing information. Patients who need more complex levels of care are transferred to central, specialized hospitals for rare or chronic illness (Almalki, FitzGerald & Clark, 2011; Al Mazrou & Salem, 2004; Al-Mazrou, Al-Shehri & Rao, 1990; Baranowski, 2009; Saudi Health Council, 2015a & 2015b) (Figure 3.1.).

Health centres focus on the seven main components of the PHC approach: First, health education and awareness about health and social problems prevailing in the community; and methods of preventing and controlling them. Health education is based on three main objectives: a) acquisition of health information; b) changes of unhealthy behaviours; and c) replacement by adaptive health lifestyles.

Second, provision of adequate basic sanitation in the environment, in co-ordination with other relevant executive bodies such as municipalities, which aim at disease-prevention caused by drinking contaminated water or low level of personal hygiene. Agency duties
include monitoring of food hygiene in public places, supervision and inspection of drinking water sources, and follow-up of food poisoning incidents.

Third, education of citizens in following proper hygiene practices in food preparation, and adaptation to different group needs, especially children and pregnant women. Also, early detection of cases of malnutrition resulting either from insufficient nutrients, or lack of diet balance that, for example, can result in diseases such as anaemia and night blindness.

Fourth, provision of comprehensive maternal and child health care, particularly for high risk groups such as children below the age of five years, pregnant women, or women of childbearing age (i.e. aged between 15-45 years), who constitute a large proportion (up to 70%) of the population in any area. The aim of maternal and child care is to: a) reduce pre- and postnatal morbidity and mortality; b) improve health in relation to reproduction; c) improve children's physical and psychological development. To this effect, in 1985 a health information system was established, and introduced family health records and health cards. Ten years later, in 1995, primary health team members began to systematically follow-up pregnant women, provide pre-natal advice, and administer immunization against diseases like rubella and tetanus. As a result of these measures, the proportion of births under medical supervision has since increased to 95%.

Fifth, immunization to children against infectious diseases at healthy child clinics, which also monitor growth and development from birth to school age (e.g. height, weight and head circumference). The programme initially targeted six diseases, i.e. tuberculosis, diphtheria, tetanus, polio, whooping cough, and measles. These were later complemented hepatitis, rubella, and mumps vaccinations. Consequently, infection rates have noticeably dropped in recent years.

Six, prevention and control of locally endemic diseases such as malaria, measles, schistosomiasis and hepatitis. Other diseases require changes in lifestyle such as diabetes, tooth decay and hypertension.

**Figure 3.1**

*Health Care System in the Kingdom of Saudi Arabia and hospitals within each sector*

<table>
<thead>
<tr>
<th>Health care system in KSA under the leadership of The Ministry of Health (MoH)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Government sector (free)</strong></td>
</tr>
<tr>
<td>MoH (public) All levels of health care</td>
</tr>
<tr>
<td>Primary Care: 2,259 centres</td>
</tr>
<tr>
<td>Secondary Care: 268 hospitals</td>
</tr>
<tr>
<td>Tertiary Care: 56 hospitals</td>
</tr>
<tr>
<td>Other Governmental agencies All levels of health care</td>
</tr>
<tr>
<td>39 hospitals</td>
</tr>
<tr>
<td><strong>Private sector (fees charged)</strong></td>
</tr>
<tr>
<td>All levels of health care</td>
</tr>
<tr>
<td>139 hospitals</td>
</tr>
<tr>
<td>Referral hospitals</td>
</tr>
<tr>
<td>Teaching hospitals</td>
</tr>
<tr>
<td>School health units</td>
</tr>
<tr>
<td>ARAMCO health services</td>
</tr>
<tr>
<td>Armed forces medical services</td>
</tr>
<tr>
<td>Security forces medical services</td>
</tr>
<tr>
<td>National Guard health services</td>
</tr>
<tr>
<td>Health services in the Royal Commission for Jubail and Yanbu</td>
</tr>
<tr>
<td>Red Cresent</td>
</tr>
</tbody>
</table>
Figure 3.2
Numbers of healthcare professionals working in different health sectors in KSA in 2013

- Public sector:
  - Doctors: 37,895
  - Nurses: 50,743
  - Health Allied Professionals: 13,577

- Other Governmental Agencies:
  - Doctors: 29,969
  - Nurses: 22,641
  - Health Allied Professionals: 29,003

- Private sector:
  - Doctors: 40,737
  - Nurses: 18,397
  - Health Allied Professionals: 22,641

Figure 3.3
Percentage of hospitals that provided health care services in KSA in 2013

- MOH: 60%
- Other government agencies: 9%
- Private: 31%
3.3.2 Child protection authority roles

Al Faryan (2014) provided an overview of the five Ministries in the Kingdom of Saudi Arabia that have significant roles in child protection, including responsibilities for prevention and interventions. These are briefly described in the next section.

Ministry of Social Affairs
The Ministry of Social Affairs (MoSA) is responsible for legislation on Protection from Abuse, and for recording child maltreatment and domestic violence figures annually. Secondly, the Ministry has a vital role in safeguarding by raising awareness through campaigns and other means. The MoSA develops plans and organises training courses for social protection staff, in collaboration with other authorities (see below). Thirdly, it has responsibility for the detection and management of child and female abuse cases. This includes social and psychological rehabilitation, re-unification with the family or care placement, and supervision in the community.

Ministry of Health
The Ministry of Health (MoH) also contributes to awareness and training programmes. It is responsible for the health care input to victims of neglect and abuse. This includes medical and physiological assessment, preparation of reports for the General Administration of Social Protection (GASP), health treatment and rehabilitation. All health institutions must report child maltreatment cases to their regional Social Protection Committee within 48 hours, after concluding all necessary investigations.

Ministry of Education
The Ministry of Education (MoE) makes two key contributions. First, through its public awareness role in promoting adaptive relationships that are free from violence, and in meeting children’s rights throughout their developments stages. This involves conferences and seminars, in co-ordination with the Public Administration of Social Protection (PASP) and other sectors. The second specific role relates to recognising maltreatment cases according to the standards of the School Direction and Guidance Committee; and co-ordinating strategies with the Social Protection Committee (SPC) and the Unit of Guidance.
Services in the Ministry of Education. The MoE encourages University staff and students to conduct research and to host training courses in the field of social protection and domestic violence, in order to increase the level of skills and knowledge of the workforce under the General Administration of Social Protection (GASP).

**Ministry of the Interior**

The Ministry of the Interior (MoI) also contributes to community awareness, including media campaigns, interventions, and supervision. The police provides assistance, intervenes in abuse cases which are within the public security domain, by examining the authenticity of the received information, and interventions within criminal procedures. The police coordinates with regional Social Protection Committees (SPCs) in order to collect information, accompany child protection teams on home visits to provide protection, and make referrals to other authorities. Additionally, the police provide support and protection to victims from further abuse.

The Ministry of Interior actively enrols their staff in national and international courses or conferences associated to child and family violence, pilots new investigation strategies mainly in domestic violence, and carries out legislative studies concerning domestic violence. Further, the MoI participates with the MOSA and other authorities in public awareness activities such as delivering seminars and training courses for the members of the police in different regions.

**Ministry of Justice**

Domestic violence is also the main remit of the Ministry of Justice. The Ministry thus conducts seminars and training, including update workshops for judges.

**3.3.2.1 Child protection services**

Child protection services are overseen by two agencies that play a major role in the Kingdom of Saudi Arabia by co-ordinating all other key stakeholders. The first one represents a social perspective, with 17 Social Protection Committees (SPC) under the General Administration
of Social Protection (GASP) at the Ministry of Social Affairs. The second one reflects a health approach, with the National Family Safety Programme (NFSP) being administratively linked to the National Guard Health Affairs under the Ministry of Health, which will be discussed in detail in the next section.

### 3.3.2.2 The National Family Safety Programme

In 2005, the National Family Safety Programme (NFSP) was established by Royal Decree of the King, in order to enhance detection and management of child protection across the country. Between 2007 and 2008, the NFSP established a child protection centre at one of the major hospitals. This project received the full support and approval of the National Health Council (NHC), the highest health service authority in the Kingdom of Saudi Arabia (Al Eissa & Almuneef, 2010). Since then, 41 child protection centres have been set up and distributed in all regions of the Kingdom of Saudi Arabia (as shown in Map 3.1). They all consist of multidisciplinary teams. The centres and their respective teams were accredited by the Board of Health Services in the following areas: Riyadh Province, Eastern Province, Makkah Province, Asir, Tabuk Region, Northern Border Area, Madinah, Al-Jouf Area, Patio Area, Najran, Hail, Jizan, and Qassim Region, as also highlighted below (Map 3.1).

The NFSP has two departments implementing child protection services directly by Social Work Outreach to the community, which intervenes clinically in King Abdul-Aziz Medical City, and provides services by telephone through the Child Help Line. This Line was established by the National Family Safety Programme in 2010. The Child Help Line provides consultation, safeguarding assessment, and guidance to children and young people under 18 years of age who seek psychological, social, health and legal help. This service is not exclusive to this age group, but also to parents and professionals in relation to similar child protection matters. Currently, the service is staffed 12 hours a day, five days a week, and is planned to expand to 24 hours daily over seven days in the future. However, the Child Help Line faces obstacles in recruiting qualified staff and who can pass the health check required by the National Guard Health Affairs.
Through the department of training and development, the National Family Safety Programme aims to increase professionals’ knowledge and skills, to identify and manage child abuse and domestic violence. This training programme was activated in 2007. The first training session was conducted in the central region. In 2014, 26 training courses were developed by the NFSP and several partners. These included the Arab Professional Society for the Prevention of Violence Against Children, International Society for Prevention of Child Abuse and Neglect, World Health Organization, Ministry of Health, Ministry of Social Affairs, Ministry of Education, Ministry of the Interior, Health Affairs at the Ministry of the National Guard, and Naif Arab University for Security Sciences. These courses involved approximately 2,000 trainees from all disciplines and different regions of the Kingdom of Saudi Arabia (KSA).

3.3.2.3 The child protection multidisciplinary training programme

The child protection multidisciplinary training, which is the main focus of this research, is part of a series of courses that are offered annually by the NFSP in collaboration with other
agencies. The first two courses were delivered in Riyadh, in the central region of Saudi Arabia. These were followed by courses in Jeddah, Dhahran, Qassim, Najran, Abha, Tabuk (2013), Gizan (2014), and Riyadh (2015) (Table 3.1). The original multidisciplinary training programme on the prevention of child abuse and neglect was developed by the International Society for the Prevention of Child Abuse and Neglect (ISPCAN). The NFSP translated and customized it according to the culture, religion, and systems of the Kingdom of Saudi Arabia. The NFSP has an ongoing partnership with ISPCAN.

Table 3.1
Multidisciplinary child protection training since 2008 in different regions of KSA

<table>
<thead>
<tr>
<th>The Training</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>2008</td>
<td>Riyadh</td>
</tr>
<tr>
<td>2008</td>
<td>Jeddah</td>
</tr>
<tr>
<td>2008</td>
<td>Dhahran</td>
</tr>
<tr>
<td>2009</td>
<td>Qassim</td>
</tr>
<tr>
<td>2010</td>
<td>Jeddah</td>
</tr>
<tr>
<td>2011</td>
<td>Najran</td>
</tr>
<tr>
<td>2012</td>
<td>Abha</td>
</tr>
<tr>
<td>2013</td>
<td>Tabuk</td>
</tr>
<tr>
<td>2014</td>
<td>Gizan</td>
</tr>
<tr>
<td>2015</td>
<td>Riyadh</td>
</tr>
</tbody>
</table>

The programme consists of four teaching modules combined with workshops, and a pre- and post-training survey. The first module relates to child maltreatment, with a workshop on the detection of different types of child abuse and neglect. Assessment and interventions form the focus of the second module. The third module considers the basic guidelines in working with child abuse and neglect cases. Its workshop promotes child protection multidisciplinary team working and formulation of reports. The final module addresses the establishment of prevention strategies across different levels of the healthcare and welfare systems (Table 3.2) (see Appendix 1).

The National Family Safety programme includes an evaluation component based on the distribution of questionnaires to the participants. This evaluation includes two surveys (pre- and post-training), which measure the level of knowledge on child maltreatment immediately before and after the training (see Appendix 2, pre/post-training survey in Arabic.
and translated to English). Between 2011 and 2013, the participants’ knowledge ratings appeared to increase after the training. It showed that, following the 2011 training in the Najran region, the percentage of the participants’ knowledge that was deemed as essential increased from around 50% before the training to nearly 70%. Similarly, the training which was conducted in the Abha region in 2012 was associated with respective changes from 54.6% to 75%; whilst the training in Tabuk in 2013 was associated with even more marked changes from around 37% to nearly 60%, as illustrated by Figure 3.2. The limited depth and validation of these encouraging findings highlighted the need for this qualitative research.

Figure 3.4
Frequencies of participants’ essential knowledge ratings in pre- and post-training survey over three years

<table>
<thead>
<tr>
<th>Region</th>
<th>Pre-survey</th>
<th>Post-survey</th>
</tr>
</thead>
<tbody>
<tr>
<td>Najran 2011</td>
<td>53.4</td>
<td>71.2</td>
</tr>
<tr>
<td>Abha 2012</td>
<td>54.6</td>
<td>75.1</td>
</tr>
<tr>
<td>Tabuk 2013</td>
<td>37.4</td>
<td>62.7</td>
</tr>
</tbody>
</table>
Table 3. 2
Structure and content of the multidisciplinary training programme

<table>
<thead>
<tr>
<th>Module (one day per module)</th>
<th>Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>Module 1</td>
<td>Overview of history of child maltreatment</td>
</tr>
<tr>
<td>What is child maltreatment?</td>
<td>Definitions of child maltreatment</td>
</tr>
<tr>
<td></td>
<td>Social risk factors</td>
</tr>
<tr>
<td></td>
<td>Indicators and effects of child maltreatment</td>
</tr>
<tr>
<td></td>
<td>Children’s rights and child protection policy</td>
</tr>
<tr>
<td></td>
<td>Workshop on detection of child abuse and neglect</td>
</tr>
<tr>
<td>Module 2</td>
<td>Assessment and medical interventions</td>
</tr>
<tr>
<td>Assessment and interventions</td>
<td>Assessment and social interventions</td>
</tr>
<tr>
<td></td>
<td>Assessment and psychological interventions</td>
</tr>
<tr>
<td></td>
<td>Child abuse and neglect interview techniques</td>
</tr>
<tr>
<td></td>
<td>Role of health services in child protection</td>
</tr>
<tr>
<td></td>
<td>Workshop on assessing child abuse and neglect cases</td>
</tr>
<tr>
<td>Module 3</td>
<td>Assessment and safety interventions</td>
</tr>
<tr>
<td>Guidelines and procedures</td>
<td>Caring for child maltreatment victims</td>
</tr>
<tr>
<td></td>
<td>Workshop on analysis of violence roots</td>
</tr>
<tr>
<td></td>
<td>Child protection Multidisciplinary team working rules</td>
</tr>
<tr>
<td></td>
<td>Workshop on child protection multidisciplinary team working</td>
</tr>
<tr>
<td>Module 4</td>
<td>Social and educational rehabilitation of child abuse cases</td>
</tr>
<tr>
<td>Prevention of violence</td>
<td>Prevention strategies</td>
</tr>
<tr>
<td>against children</td>
<td>Workshop on establishing prevention strategies</td>
</tr>
</tbody>
</table>

Each workshop is briefly described below:

a. Detection of child abuse and neglect

Seven case vignettes are discussed that focus on different types of abuse, i.e. the shaken baby syndrome (physical abuse), sexual abuse, neglect, emotional abuse, suspected physical and sexual abuse, and other types of physical abuse. The key questions addressed by small group discussion, are: What kind of abuse does the child suffer from? What are the physical indicators of this abuse, if any? What are the psychological and behavioural indicators of this abuse, if any? What are the risk factors in these cases?

b. Assessment of child abuse and neglect cases

One case is discussed from different perspectives. The case is then divided in four stages, with specifications for each stage:
In the first stage, this is discussed under supervision in relation to how the child showed fears of going home, with four arising questions for discussion: What are the possible reasons for the child’s behaviour? Why do you think so? Would you like to collect more information? What? How and who can you get this information from?

In the second stage, the child had an accident in school and was subsequently taken to hospital. At the hospital, physicians suspected abuse and followed-up with a scan, which showed old fractures and burns on the child’s body. The questions here are: How could we explain these injuries? Based on what evidence? What made the child act this way? Do you wish to obtain additional information? What? How and from whom can you get this information?

The third stage involves talking about the child’s parents, who were responsible for the child not attending school. The mother’s reasoning was that they had relatives staying over. The questions are: What do you think of the mother’s justification for her child’s absences? What are other potential reasons for these absences? Why did the child’s mother justify his absences in this way? What is your next step?

In the fourth stage, the child was admitted to hospital. He had a severe head injury, multiple rib fractures, and multiple bruises on different parts of the body. The questions are: Do you wish to intervene in this case? What do you expect? Revisiting your previous answers; were the decisions made appropriate? How can you learn from this case? How are you feeling now?

c. Child protection multidisciplinary team-working

This workshop considers a family scenario of a father aged 42 years and a mother aged 25 years with two children, a son of seven years and a daughter of five months. The mother and children suffered domestic violence. They lived in a small house in a deprived area. In this case, there are several risk factors for domestic violence. The questions are: What are the risk factors in this family that contribute to the children’s exposure to violence? What are the risk factors relating to each individual, concerning relations with others, the relationship
between the father or mother and the children, socioeconomic status and the community? The child protection multidisciplinary team then formulates a report describing the whole scenario of the family, with the appropriate assessments and different interventions domains.

d. How to design prevention programmes

In this workshop, the emphasis is on creating preventive strategies. Different scenarios are distributed to the multidisciplinary team, in order to recognise the type of abuse by answering specific following questions: draw a circle around the specified type of violence that relates to your group (physical, sexual, emotional, neglect); draw a circle around the specified level of protection for your group (primary, secondary or tertiary); then design a prevention programme that would address this type of abuse. Where will the implementation of this programme happen, and which are its proposed stages? What are the resources that are needed to implement this programme? How will they be made available? What are the obstacles to the implementation of this programme?

3.4 Sample

The sampling frame depends on the aims of the research (Cohen et al., 2007). In order to achieve these aims by conducting as many interviews as necessary (Kvale, 2007), a purposive sample technique was chosen, in selecting participants who share certain characteristics and are able to give their perspective on the research questions (Cohen et al., 2007; Smith & Osborn, 2008). In this research, multidisciplinary professionals who had attended the training programme 18 months earlier (i.e. in 2013), and which had been held in Tabuk City, would have had adequate time to implement the training in their practice. As described below, 26 professionals from different disciplines agreed to participate out of 85 eligible subjects. These consisted of 20 males and six females, who worked across 15 settings. The majority were health care professionals working in 11 hospitals under the regulation of the Ministry of Health; one rehabilitation centre and one shelter under the Ministry of Social Affairs; the Guidance and Counselling Department under the Ministry of Education; and the Bureau of Investigation and Public Prosecution (see Appendix 3).
Several difficulties faced the researcher in the recruitment process. First, when the researcher initially sent information by letter and a consent form by e-mail to the participants, 14 e-mails bounced back, as their addresses had since changed. Subsequently, text messages were sent on their mobile phone and their WhatsApp (mobile app on their smartphone), followed by phone calls (Figure 3.5).

![Figure 3.5](image)

Qualitative studies tend to recruit a smaller number of participants compared to those of quantitative methods, as the former approach enables the researcher to obtain individual, in depth and detailed data. Participants thus have more freedom to choose their own words and to express themselves (Barker et al., 2002, Wilkinson et al., 2004). The sample size of this type of research is compatible with such requirements (Braun & Clarke, 2013). The quality indicator for qualitative research sampling is sampling adequacy, achieved through saturation of the data. Thematic saturation is achieved by continuing the data collection until no new data appears interesting, including ideas, patterns or emerging themes (O’Reilly &
Parker, 2013; Guest et al., 2006; Francis et al., 2010). Consequently, sample recruitment was not concluded until thematic saturation was reached. Francis and colleagues (2010) stated that the data saturation occurs at approximately ten interviews with a single group, and recommended to complete three further interviews for checking, which means that no new themes develop throughout data collection in relation to the research question. However, as the sample of this research was multidisciplinary, i.e. participants from different professional backgrounds, saturation was not reached until 23 subjects were interviewed, following which the researcher completed the three further recommended interviews for checking. Accordingly, the sample of 26 professionals was considered sufficient.

3.5 Ethical issues

3.5.1 Potential ethical issues

Ethical principles that have been identified as fundamental in any research with human subjects include the researcher’s responsibility to respect individual's’ autonomy, beneficence, non-maleficence, and justice (Gravetter & Forzano, 2012; Report, 1979). Ethical considerations for in depth interviews are similar to those of other methods of social research, including maintaining confidentiality and privacy, anonymity by protecting participants from being harmed, providing adequate information in the information letter, seeking informed consent, and protecting from deception or exploitation (Allmark et al., 2009). However, a number of ethical issues can occur in relation to qualitative research on sensitive topics, for instance, participants who have been exposed to any violence in their childhood maybe more likely to report distress when they recollect past trauma. On the other hand, such participants are also more likely to report the benefit of expressing their feelings through their participation (Decker et al., 2011). Sensitive topics in research are defined as those that may pose risk to the participant and/or the researcher (Renzetti & Lee, 1993). Particularly in qualitative health and social care research, participants can be confronted by anxiety and distress, mistreatment, misrepresentation, and the possibility of identification at the dissemination phase (Richards & Schwartz, 2002).
As a consequence, any study that involves human subjects should apply these principles through informed consent. As the researcher recruited professionals who had attended the child protection training programme, most of whom were in contact with abused children and their families; these fell under the ‘sensitive’ category. Participants were, therefore, in a second-order sensitivity/threat, i.e., they faced it daily but were not directly exposed to it themselves. The researcher considered the ethical tensions due to the potentially sensitive nature of the interview topics, which could be dealt with through a rigorous anticipation of potential ethical issues. Otherwise, the general validity and reliability of the findings could be compromised.

In this research, there was a probability for participants to recall upsetting incidents by discussing difficult cases during the interview, due to the nature of the asked questions. Such incidents could be perceived as attributions of having made a wrong decision, thus potentially feeling as though being blamed. They might also feel apprehensive about discussing barriers in their practice that could be related to colleagues, managers or particularly the authorities. Therefore, the researcher ensured that the professionals were fully informed of the content of the interviews, their right to withdraw at any time, and the option of stopping the interview and taking a break if required. These small risks were likely to be outweighed by the benefits of participating in the study, in the knowledge that someone was taking an interest in their experience, and that they had the opportunity to improve services for maltreated children and their families in the future.

In term of researcher safety, Parker and O’Reilly (2013) suggested that it is crucial to provide the researcher with formal supervision in order to effectively managed their qualitative research. Also it was highlighted the importance of the risk assessment protocols and management in the research environment. Thus in this research the researcher attended training modules on preparation for conducting research and on ethical issues that can be faced through the data collection process. Piloting the interview enhanced the researcher’s confidence in conducting such a sensitive topic, and her skills in managing risks that might arise during the research (see Appendix 4 also section 3.6.1.2).
3.5.2 Ethical procedure

Throughout this study there was co-operation between the National Family Safety Programme (NFSP), a national government entity subject to the regulations of King Abdullah International Medical Research Centre (KAIMRC), King Saud Bin Abdulaziz University for Health Sciences, King Abdulaziz Medical City, the Ministry of National Guard - Health Affairs, and the researcher in agreeing to the terms and conditions below, and in providing the required security conditions:

1. The researcher had the right to obtain any official programme documents with the agreement of the programme administrators.
2. All information provided by the programme was confidential and subject to the conditions of maintaining professional integrity. The researcher was responsible for keeping and disposing of this information.
3. The programme had the right to approve or decline the implementation of the research in case of breach of conditions or misuse of information.

The first step was for the two main parties (NFSP and researcher) to sign the agreement and to secure research ethics approval. This process took around a year before obtaining ethical approval from both the University of Leicester (UOL) and then the NGHA research ethics committees (Figure 3.4) (also see Appendix 3, Ethical approval from both UOL and NGHA).

The modifications initially recommended by the University ethics committee included two broad areas, i.e. on the writing style in general, and on seeking elaboration and clarification of certain ethical issues. The revised application received one final request for modification, i.e. to clarify that;

“if the interviewee discloses that they had an adverse experience, or they have mistreated a child, even if they are considered as a professional who deals with maltreated cases, I will ensure that they receive guidance on getting support, or if they need any further action”
Eventually, the ethics committee approved the research, and the ethical approval was submitted to the National Guard of Health Affairs. This initial phase took four months. After a further six months, the Institutional Review Board of the NGHA asked the researcher to add the translation of the consent form and interview questions. The study was eventually approved on 30th January 2014. The Research Ethics Committee reference number for this project was Ref./SP13/011 (Figure 3.6) (see Appendix 5).

**Figure 3.6**
Process of obtaining ethical approval from both the University of Leicester and the National Guard of Health Affairs Research Ethical Committees

3.5.1.1 Informed consent

Consent forms were included with the information sheets that were distributed through the National Family Safety Programme to obtain participants’ permission. These were in the same style for all participants, even though they came from different sectors, as they attended the same training programme. Consent forms provided an opportunity for them to withdraw
their data from the study and to relay that they understood what the research involved. English was not the participants’ first language; therefore, the consent form was translated in Arabic, using simple and clear wording. The interview was conducted in English if the interviewee was bilingual and fluent in both languages; if not, the researcher conducted the interview in Arabic, the first language in KSA (see Appendix 6: invitation letter and consent form). The researcher transcribed the interviews in Arabic, and then translated to English for the analysis.

3.5.1.2 Right to withdraw
The right to withdraw was made clear to the participants, both through their information sheets and verbally during the first phase of this research. The researcher also gave the participants the opportunity to withdraw if they wished before their appointment. When consent was sought at the end of that appointment, the participant was again given the opportunity to withdraw from the study.

3.5.1.3 Anonymity and confidentiality
Participants’ personal data was treated as confidential and was presented anonymously at each stage. Once the transcripts of the recordings were complete, they were anonymised, with identifying features removed and names being replaced with code numbers for all subjects. Recordings were kept in a locked filing cabinet, and their digital versions were stored on a password-protected hard drive. All other computerized information was also password-protected. Details of specific recordings and cases were not discussed with anyone outside of the research team, beyond the student and her two supervisors. Confidentiality was maintained throughout the duration of the research. However, within confidentiality constrains, it was advised by Elliott and colleagues that researchers should describe the participants’ characteristics and provide any details which could have an impact on the research outcomes, to imply possible relevance of the results (Elliott et al., 1999). For instance, in this research the details of the hospital names were removed and were replaced with the geographical location, thus make it difficult for anyone to trace any identifiable information about the participant. Nevertheless, anonymity was challenging and could not
be guaranteed 100%. This was explained to participants as part of the consent process, and was documented in the ethical approval. As the researcher made it clear that all names would be removed to ensure the anonymity of the data, even including their shared stories.

3.5.1.4 Protection from harm

Due to the nature of the data being collected, it was important that the researcher was sensitive to the participants’ needs. For example, some participants might share some stories of suspected cases and how they would apply the training contents on their practice. In those circumstances, participants might feel being placed under pressure of sharing sensitive information. The researcher clarified that they could proceed at their own pace, take a break or stop if they did not feel comfortable, whilst trying to maintain the focus of the research.

3.6 Data collection: semi-structured interviewing

In this qualitative study, the interview technique was chosen to collect in depth data after 18 months of attending the multidisciplinary child protection-training programme. This period of time was chosen in order to provide adequate time for the training to be embedded in the participants’ practice; i.e. to implement what they learnt from the training programme, and in particular improving the recognition, management and documentation of child abuse cases.

An interview is a “conversation between the researcher and the interviewee that is constructed with a purpose which is determined by the interviewer” (Kvale & Flick, 2007, p.7). This is usually planned in advance, which differs from daily spontaneous communications (Oates, 2006), while involving careful questioning and listening for professional interaction (Kvale, 2007). This data collection technique is especially useful when the researcher is looking for detailed information by asking in-depth or complex questions; exploring feelings and experiences that cannot be easily captured or described; and investigating sensitive topics or confidential information that the interviewee might feel more comfortable to express verbally rather than write on paper (Oates, 2005).
Kvale (1996) reported that the classification of interviews may vary according to their purpose of openness; to what extent these are exploratory or hypothesis-testing; and whether they are interpretative, descriptive, cognitive- or emotion-based. Oates (2005) classified interviews in three categories according to their degree of structuring, i.e. structured, semi-structured or unstructured. Close-ended answers are characteristic of structured interviews, where the investigator provides the participants with specific questions of context that is unchangeable (Bryman & Bell, 2007). These types of interview questions are much akin to questionnaire items, in promoting standardization of both asked questions and recorded answers. A semi-structured interview contains a list of broad question topics that should be covered, is therefore more flexible. For instance, the researcher could go through the questions in a different order or by asking more questions, thus encouraging the interviewee to be more expressive and to provide more details.

In the semi-structured interview, the researcher “has a list of questions on fairly specific topics to be covered, often referred to as an interview guide, but the interviewee has a great deal of leeway in how to reply” (Bryman & Bell, 2007, p. 474). Overall, all questions are covered, but there is flexibility in their order. The interviewees can express themselves even more freely in an unstructured interview. S/he may prepare a single question, and from the interviewee’s conversation, data would emerge without any additional asked points (Bryman & Bell, 2007) (see the interview guide in Appendix 7).

The semi-structured interview method was chosen amongst other types of interviews, as it was suitable for the aims of this study, which was to shed light on potentially unexpected results. Unlike unstructured interviews, however, the scope of issues to be covered in a semi-structured interview is already known, thus the researcher had specific topics to cover, in this case relating to the training programme. Hence, the semi-structured interview was more fitting for this research purpose.
3.6.1 Stages of conducting interviews

Seven stages were suggested by Kvale (2007) in the use of qualitative interviews: thematizing, designing, interviewing, transcribing, analysing, verifying and reporting. The first four stages of this framework constituted the data collection, while the remaining three stages were part of the data analysis. This framework guided the researcher in a continuum sequence, and each step will be described in further detail in the remainder of the chapter.

3.6.1.1 Thematizing

In this stage, the researcher should explain what they are going to adopt as the data collection approach, and to illustrate its rationale. In this research, the qualitative semi-structured interview was chosen as the data collection method, in order to enable the participants to elaborate on different aspects of their training involvement and its subsequent perceived impact (Wilkinson, et al., 2004). The researcher may, therefore, end up with interesting, albeit unexpected, findings (Barker et al., 2002). This would help the researcher to understand and make sense of the participant’s experiences and beliefs by considering a phenomenon from their point of view.

3.6.1.2 Designing

Researchers in the qualitative health and social care fields face a number of challenges, including establishing rapport, self-disclosure, listening to new narratives, and dealing with difficult emotions of their own or in relation to the participants (Dickson-Swift et al., 2007). In certain types of research, interviewers may also have to consider potential physical or emotional risk during the process. All these issues were considered in designing the interview guide that will be discussed in detail in the following section also it was discussion in section 3.5.1.

The semi-structured interview topic guides were thus designed, and the interview schedule was prepared. The semi-structured interview took several steps to be formulated. In the first
step, the topics of the interview were derived from the National Society for the Prevention of Cruelty to Children (NSPCC) evaluation of the effectiveness of a child protection trainers course, which is part of the systematic training cycle model adapted from Bramley (1991) (Figure 3.7). The interview questions were subsequently piloted with colleagues in English, and then discussed with the postgraduate child mental health research group at the Greenwood Institute of Child Health, University of Leicester. Notes were recorded of all these inputs in revising and finalizing the interview guide. The minor amendments that were required for the interview guide included deleting any repetitive questions that could be answered elsewhere, and adding some opening questions to make the interviewee more comfortable.

Sampson (2004) recommended that the semi-structured interview must be piloted before its application. The interview guide was piloted in Arabic with experts in the field of child protection, who had previously trained in the same programme. There were seven piloted interviews, three females and four males, who have a different background, psychiatrist, emergency specialist, nurse, social worker, a general practitioner in the hospitals’ management, and two consultant paediatricians. They are working in two regions in Saudi Arabia, Najran and Mekkah regions. Although these participants were trained in the last two to three years ago, they still remembered the contents of the training programme by expressing their benefits from attending the training, their obstacles that they face in implementing these contents, and their recommendations to maximise their benefits in the future. Piloting guaranteed that interviewing skills were practised and alternative ways were used to engage participants could be experimented with. Consequently, the researcher established which parts of the interview were easily understood and which needed refining, by making questions clearer and jargon-free. For instance, when the participant does not understand the question, the researcher asked ‘probing’ questions to illustrate points or to promote more explanation by asking how, why and could you elaborate more on this point. The researcher learnt how to avoid leading questions, and make sure that all the points are covered even if the questions does not follow the same order. The importance of capturing the participants’ perceptions of the training programme and the application of acquired competencies was highlighted at the outset, as well as the potential benefits of improving it
in the future, in order to ultimately provide children and families with better quality services (see the interview guide in Appendix 7).

3.6.1.3 Interviewing

This stage mainly focuses on the actual implementation of the interview. The semi-structured interviews were conducted during a one-month period, i.e. September 2014, and over the telephone, for several reasons. Participants were distributed across large geographical areas; therefore, it was more cost-effective to conduct the interviews over the phone rather than face-to-face (Wilson, 2014). Participants in this research were working in hospitals and other organizations across several regions of the Kingdom of Saudi Arabia - as presented in Table 3.3. As the training was targeting the Tabuk region, most participants came from that area, but there were also participants from other regions such as Makkah and Asir. It was thus difficult for the researcher to travel because of time and resource constraints; instead it was convenient for both herself and the interviewee to conduct the
interviews by phone. Additionally, a study conducted by Sturges and Hanrahan (2004) on a comparison between face-to-face and telephone interviewing in qualitative research, found no significant differences in terms of efficiency and accuracy of information collected. However, there are some disadvantages posed by phone interviews. For example, the researcher might not be aware of the interviewee’s setting while asking questions that might impact on their responses; or could miss non-verbal clues such as the interviewee becoming fatigued by repetitive questions (Wilson, 2014). The researcher took this into account throughout this stage. For example, when the interview questions were piloted, the researcher asked the interviewees if this was an appropriate time to start, otherwise she would call back for a better time and place, without any distractions. This will be discussed further in the next section.

The setting of the interview is very important too (Bryman & Bell, 2007). Consequently, the researcher sought to select the most appropriate place. This should be characterized of being quiet and private, thus offering ample time to the interviewee. As the interviews were conducted over the phone with professionals being based in their work settings, the researcher ensured that they were comfortable, and that there were no distractions or noise. This was particularly important, because participants were located in busy clinical settings or offices.

The interview process was completed in three phases. The first phase began by welcoming the participants. The researcher introduced herself, briefly described the purpose of the study; highlighted the importance of the interviewee’s point of view; and reassured them on issues like consent and confidentiality. Some initial questions were asked to break the ice between the researcher and the interviewee such as asking them to introduce themselves, describe features of their role, their recollection of the contents and delivery of the child protection training, and to what extend this was related to their role. The aim of these open questions was to make the participant feel comfortable before exploring more sensitive topics (Memon & Bull, 2000).
In the second phase, the researcher explored their perceived impact of the child protection multidisciplinary training programme, its positive or negative aspects, and participants’ experiences in implementing the training into their practice. These prompts aimed at unravelling the reasons behind positive and negative appraisals.

During the third and final phase, questions were related to participants’ opinions on improving the training, and related policy or practice in the future. At the end, they were provided with a summary of their views to determine if these had been understood correctly. Interviewees were also asked if they wanted to add any other points. Some prompts were used, if appropriate, to encourage sharing more information, for instance, “could you explain to me more or how?”

Permission for the recording was granted by each participant prior to the beginning of the interview (see Appendix 6). The interviews were recorded using a digital MP3 player with several features. This allowed the researcher to transfer the files easily on the computer and to ensure that these were safely stored. The transferred files supported the researcher in slowing down or speeding up on the computer when required. However, a recorded interview may also be considered as de-contextualized in the absence of visual aspects (Kvale, 1996). It can be argued that non-verbal signs would add richer information (Cohen et al., 2007); however, video recording is costly and may cause the participant to feel uncomfortable. It may also result in the collection of broad information that is time-consuming and cumbersome to transcribe. Thus, the use of a voice recorder was the chosen method.
Table 3.3

<table>
<thead>
<tr>
<th>Interviewee</th>
<th>Gender</th>
<th>Location</th>
<th>Type of professional</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interview 1</td>
<td>Female</td>
<td>Tabuk region</td>
<td>Psychologist</td>
</tr>
<tr>
<td>Interview 2</td>
<td>Female</td>
<td>Tabuk region</td>
<td>Social Worker</td>
</tr>
<tr>
<td>Interview 3</td>
<td>Female</td>
<td>Tabuk region</td>
<td>Psychiatrist</td>
</tr>
<tr>
<td>Interview 4</td>
<td>Male</td>
<td>Tabuk region</td>
<td>Psychologist</td>
</tr>
<tr>
<td>Interview 5</td>
<td>Male</td>
<td>Tabuk region</td>
<td>Social Worker</td>
</tr>
<tr>
<td>Interview 6</td>
<td>Male</td>
<td>Tabuk region</td>
<td>Surgeon</td>
</tr>
<tr>
<td>Interview 7</td>
<td>Male</td>
<td>Tabuk region</td>
<td>Psychologist</td>
</tr>
<tr>
<td>Interview 8</td>
<td>Male</td>
<td>Tabuk region</td>
<td>Administrator (Medical Records)</td>
</tr>
<tr>
<td>Interview 9</td>
<td>Male</td>
<td>Tabuk region</td>
<td>Head of Nursing Department</td>
</tr>
<tr>
<td>Interview 10</td>
<td>Male</td>
<td>Tabuk region</td>
<td>Hospital Director</td>
</tr>
<tr>
<td>Interview 11</td>
<td>Female</td>
<td>Tabuk region</td>
<td>Co-ordinator of Child Protection Committee</td>
</tr>
<tr>
<td>Interview 12</td>
<td>Male</td>
<td>Asir region</td>
<td>Psychiatrist</td>
</tr>
<tr>
<td>Interview 13</td>
<td>Male</td>
<td>Tabuk region</td>
<td>Supervisor, Ministry of Education</td>
</tr>
<tr>
<td>Interview 14</td>
<td>Male</td>
<td>Tabuk region</td>
<td>Social Worker</td>
</tr>
<tr>
<td>Interview 15</td>
<td>Male</td>
<td>Tabuk region</td>
<td>Social Worker</td>
</tr>
<tr>
<td>Interview 16</td>
<td>Female</td>
<td>Tabuk region</td>
<td>Nurse</td>
</tr>
<tr>
<td>Interview 17</td>
<td>Female</td>
<td>Makkah region</td>
<td>Shelter Director</td>
</tr>
<tr>
<td>Interview 18</td>
<td>Male</td>
<td>Tabuk region</td>
<td>Public Health Educator</td>
</tr>
<tr>
<td>Interview 19</td>
<td>Male</td>
<td>Tabuk region</td>
<td>Psychologist</td>
</tr>
<tr>
<td>Interview 20</td>
<td>Male</td>
<td>Tabuk region</td>
<td>Obstetrician and Gynecologist</td>
</tr>
<tr>
<td>Interview 21</td>
<td>Male</td>
<td>Tabuk region</td>
<td>Surgeon</td>
</tr>
<tr>
<td>Interview 22</td>
<td>Male</td>
<td>Tabuk region</td>
<td>Nurse</td>
</tr>
<tr>
<td>Interview 23</td>
<td>Male</td>
<td>Tabuk region</td>
<td>Obstetrician and Gynecologist</td>
</tr>
<tr>
<td>Interview 24</td>
<td>Male</td>
<td>Tabuk region</td>
<td>Psychiatrist</td>
</tr>
<tr>
<td>Interview 25</td>
<td>Male</td>
<td>Tabuk region</td>
<td>Head of Audit Office and Implementation, Prison Service</td>
</tr>
<tr>
<td>Interview 26</td>
<td>Male</td>
<td>Tabuk region</td>
<td>Nurse</td>
</tr>
</tbody>
</table>

3.6.1.4 Transcribing

Transcribing is the stage of preparing data for the analysis, by converting it from audio to text format. There is a consequent risk of losing some contextual richness and vibrancy of the data through rigid or abstract transcribing (Cohen et al., 2007). To prevent this, the process of transcribing should also interpret the data, and contain sequences of judgments and decisions (Kvale, 1996). There are different types of transcribing by relying on the transcription usage. For instance, statements can be transcribed exactly, including, “hmm, err, ….” and pauses; or be compressed and summarized. In this research, detailed transcription helped to gain insight into participants’ views and experiences.
Two fundamental issues are highlighted by O’Reilly and Kiyimba (2015) in dealing with translated materials. When data is collected through an interpreter, its focus is in English via the interpreter, while the participant speaks another language. The data is then translated to English for an international audience. In this study, both the researcher’s and the participants’ mother tongue were Arabic. It has been argued that researchers prefer to analyse their data in their first language, and then translate it into a different language for dissemination (Nikander, 2008). In this study, the researcher decided to collect the data in Arabic, but opted to experience translating from Arabic to English, and vice versa. So, for this research the researcher veered towards collecting data in Arabic and then translating it to English for the analytic stage. Both files were checked with peers and professionals to ensure that they matched the same meaning in both languages. The analysis could then be easily shared with the supervisors and disseminated more widely for all English speaking audiences.

3.7 Data Analysis

The emphasis of this stage was to generate themes from the transcribed data. Qualitative analytical approaches are diverse and are based on different frameworks, but they also share some overlapping characteristics. Thus, a qualitative design was adopted by applying a thematic approach, which has a more recent history in contrast to other more traditional qualitative frameworks. Currently, thematic analysis has been acknowledged as a distinct qualitative method, influenced among others by work carried out by Braun and Clarke (2006). They highlighted the unique strengths of utilising such a thematic approach in a research, because it is epistemologically flexible (O’Reilly et al., 2013).

Thematic analysis is frequently utilised and referred to as fundamentally a tool rather than a method in qualitative research (Boyatzis, 1998). Furthermore, it captures the meaning communicated by the participants (Braun & Clarke, 2006). When thematic analysis is used as a methodological tool, it encompasses searching for recurrent patterns. One of the main
advantages of thematic analysis is its epistemological flexibility, as it it is not tied to any certain theoretical or epistemological position. As it can be applied to a variety of theoretical frameworks, it is well-suited for most types of qualitative study, as there is congruence between the analytic approach and the researcher’s world view. For example, thematic analysis is known to accommodate well with a social constructionist project (Braun & Clarke, 2006; Colahan, Tunariu & Dell, 2012). The subjectivity of narratives and accounts of this study were considered in designing the research, whilst also acknowledging the researcher’s role in generating knowledge from the findings. Consequently, this approach enables the researcher’s accountability in their relationship with the participant, which is important for the data creation process and for the final interpretative claims.

Thematic analysis helps in generating patterns of meaning from the data by identifying the salient issues at stake for the participants, which can be interpreted through the lens of the researcher’s theoretical positioning (Braun & Clarke, 2006). Themes are the outcome of intellectual processing by the researcher (Ely et al., 1997). Thematic analysis is different from other analytic methods, which focus on describing patterns in the data, because of their theoretical anchoring.

It is vital to provide clear guidelines around the procedure and the exact epistemological stand. In this study, thematic analysis was selected for the purpose of identifying, analysing, interpreting and reporting patterns within the data (Boyatzis, 1998; Braun & Clarke, 2006). It follows an inductive comprehensive thematic analysis where the themes are close to the data itself (Patton, 1990). Here, the investigation occurs at a latent or interpretative level, which is opposed to the simple semantic or clear level, where only the simple descriptions of the data are delivered.

The present study focuses on mapping the subjective views of the trainees, especially on how they have implemented the child protection training programme in dealing with child abuse cases and their families in their practice. The process of thematic analysis requests a series of themes to emerge, and focus on those that appear relevant to the research questions.
Braun and Clarke (2006) suggested six phases for the analysis (Figure 3.8) in order to establish the emerging themes, and these were followed throughout this study. In the first phase, the researcher familiarized herself with the data by transcribing the interviews in Arabic, and then translated it to English. This included proofreading to ensure that the translation reflected the same meaning by reading and re-reading the data, and formulating some initial ideas.

In the second and third phase, the completed files were downloaded to the NVivo 10 software, which can organise and store a large amount of data. Bryman (2008) acknowledged that NVivo can improve the process by categorising and coding such large qualitative datasets which works as organisational tool but does not do the analysis. Coding was initiated with forming ‘nodes’, as defined by NVivo, starting with the interesting

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**Figure 3.8**
**Phases of thematic analysis adapted from Braun and Clarke (2006)**

<table>
<thead>
<tr>
<th>Phase</th>
<th>Description of the process</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Familiarizing yourself with your data</td>
<td>Transcribing data (if necessary), reading and re-reading the data, noting down initial ideas.</td>
</tr>
<tr>
<td>2. Generating initial codes</td>
<td>Coding interesting features of the data in a systematic fashion across the entire data set, collecting data relevant to each code.</td>
</tr>
<tr>
<td>3. Searching for themes</td>
<td>Collecting codes into potential themes, gathering all data relevant to each potential themes.</td>
</tr>
<tr>
<td>4. Reviewing themes</td>
<td>Checking if themes work in relation to the coded extra (Level 1) and the entire data set (Level 2), generating a thematic map of the analysis.</td>
</tr>
<tr>
<td>5. Defining and naming themes</td>
<td>Ongoing analysis to refine the specifics of each theme, and the overall story the analysis tells, generating clear definitions and names for each theme.</td>
</tr>
<tr>
<td>6. Producing the report</td>
<td>The final opportunity for analysis. Selecting of vivid, compelling extract examples, the final analysis of selected extras, relating back of the analysis to the research question and literature, producing a scholarly report of the analysis.</td>
</tr>
</tbody>
</table>
features of the data, before placing all relevant data under each node. In the fourth phase, nodes were grouped together into categories, and then the researcher began to identify themes and patterns by turning categories into potential themes. The broad generated themes that addressed the research questions included the benefits and limitations of translating training into practice; and recommendations for improving this translation in the future. These three themes and their sub-themes will be presented and discussed in detail in chapters 4, 5, and 6 respectively.

3.8 Verifying

Verifying is the sixth stage, which determines the generalisability, reliability and validity of the findings. These components will be discussed in the next section, particularly in relation to this study.

3.8.1 Strategies for trustworthiness

The purpose of qualitative research is thus to generate justification of the method of data collection, which can be independent, so that another researcher could examine the same data in the same way and come to similar results or assumptions (Lincoln & Guba, 1985; Lietz et al., 2006). Researchers have used different terms to stress the importance of rigor in qualitative research such as establishing ‘truth value’, ‘neutrality’, ‘applicability’ and ‘consistency’ (Guba & Lincoln, 1981; Sandelowski, 1986). Several schemes have been recognized in the literature in order to determine trustworthiness in qualitative research, which has similar principles to those of quantitative methods (Le Compte & Goetz, 1982; Rubin & Rubin, 2011). These schemes share the same aspects that comprise of credibility, dependability, conformability and transferability; and which parallel internal and external validity, reliability and objectivity in quantitative research, respectively (Lincoln & Guba, 1985). In order to be rigorous and transparent in this research project, these aspects were taken into consideration such as being clear in recording, classifying and discussing the methods of analysis.
3.8.2 Dependability

Elo and colleagues (2014) stated that dependability indicates to the data’s constancy over time and under different circumstances or situation. Additionally, it was stated by Guba and Lincoln (1994) that dependability means to how extent the findings of the research can be replicated by those who’s carrying a similar study. However, in qualitative research the researcher must provide a precise detail of the processes within the study (Caelli, Ray & Mill, 2003; Fossey et al., 2002). Thus, in-depth coverage will enable the reader to evaluate the extent to which appropriate research practices have been followed, and to develop a comprehensive understanding of the used methods and their effectiveness (Shenton, 2004). Here in this research, in term of dependability, describing the research process in great detail will enable the investigator or other researchers to follow the same or similar process when conducting comparable studies (Lincoln & Guba, 1985). This principle was adhered to by the researcher throughout this study. The choice of qualitative methods was justified, including the use of semi-structured interviews and thematic analysis. For instance, this study adapted Kvales’ framework, in formulating the research questions, design, sampling frame, process of data collection, and analysis (Fossey et al., 2002; Shenton, 2004).

3.8.3 Conformability

The purpose of conformability is to ensure that the findings represent the information that the participants provided, and that they are not susceptible to biases such as the researcher’s subjectivity. However, the researcher’s influence could occur unintentionally during the data collection (Malterud, 2001; Reynolds et al., 2011; Robson, 2011). In order to enhance the reliability of the data, the researcher should remain as much as possible self-aware; and maintain honesty and sincerity with one's self, their supervisors, colleagues and readers of the thesis (Tracy, 2010). This can be safeguarded by putting aside any personal interpretations, beliefs, subjective values and assumptions (Pope & Mays, 2006). Polit and Beck (2012) and Sandelowski (1995) argued the necessity of using the quotations in order to indicate the trustworthiness of the findings. Thus, there must be a reflection of the voice of the participants in the findings and conditions of the inquiry (Lincoln & Guba,
1985; Polit & Beck, 2012). In order to maximise the conformability of this research, reflective notes were written and kept at all stages of the research process, beside regular meetings with PhD supervisors to ensure that the data was represented clearly. Moreover, direct quotations from participants were used in reporting the results.

3.8.4 Transferability

Transferability in qualitative research means that the findings could have possible value to others in similar situations, therefore theoretical generalizability should be considered (Bryman, 2012). It is important to provide a careful description of the studied phenomena, and adequate contextual information that can support the reader in making a coherent judgment about the suitability or applicability of the findings to other settings (Sandelowski, 1993). Producing a thick description has been proposed as the best technique in establishing a degree of transferability (Geertz, 1994; Guba & Lincoln, 1994). The findings were thus expressed in different ways, including in-depth description; extensive contextual information to achieve their transferability; and supporting the reader in making a suitable judgment whether assessing the research quality and figuring out if the findings could be transferable to other people in comparable situations. For example, this study could be applicable and helpful to the same child protection training across Saudi Arabia. Although this study represents one region (Tabuk), the findings could be applicable to child protection training in other Saudi Arabia regions, as well as in other middle eastern countries which have similar culture and religion. This would not preclude sharing similar results with other countries too in relation to the implementation of interdisciplinary child protection training.

3.9 Summary

The current study will adopt a theoretical framework of social constructionism and interpretivism, utilising thematic analysis to accommodate an interest in child protection professionals’ talk, understanding, obstacles and experiences with interdisciplinary child protection training, and the recognition of the cultural and institutional discourses in shaping this account. The overall research questions are to explore how child protection professionals
understand the attended interdisciplinary child protection training programme and how they consequently manage child protection cases in their practice.
CHAPTER FOUR

RESULTS (1)

THEMATIC GROUP 1:

BENEFITS OF TRANSLATING TRAINING INTO PRACTICE
4.0 Introduction

To address the research questions, the analysis has been divided into three chapters according to the broad emerging thematic groups. These are: participants’ perceptions of benefits of translating training into practice; their perceptions of constraints of translating training into practice; and recommendations for improving such translation in future.

This first of the three analytic chapters focuses on the participants’ perceptions of the delivery of the training programme, and the benefits of the implementation of the training into their practice. In this chapter, three themes were considered as integral to professionals’ perceptions of translating training into practice, and these are outlined and explored. An overview of these themes and their sub-themes is displayed in Figure 4.1.

The first theme emphasises the delivery of the training, including the importance of the knowledge that the trainees gained, the trainers’ characteristics, and the importance and benefits of practice workshops. The second theme focuses on the impact of the training on professional skills such as becoming more aware and recognising potential cases; being cautious of any suspected cases; and the general impact of the training on their personal life, including positive aspects of raising children. In the third theme, the focus is on initiatives of raising awareness in schools and hospitals. An overview of these themes and their sub-themes is displayed in Figure 4.1.
Benefits of translating training into practice

- Training Delivery
  - Knowledge
  - Trainers' skills
  - Workshops
  - Greater awareness of abuse cases
  - Personal development
- Skills
- Raising Awareness
  - For schools
  - For hospitals
4.1 Training Delivery

In this theme, participants discussed their impressions and opinions regarding the content of the child protection multidisciplinary training programme, including the gained knowledge of child abuse and neglect, trainers’ competencies, and training methods. This theme provides insight as to how the participants evaluated the delivery of the training and the perceived benefits of using the current delivery methods.

4.1.1 Knowledge

Overall, the child protection multidisciplinary training programme was positively received. The majority of the participants described it as useful, providing beneficial knowledge, and widening their horizon about child abuse and the importance of childhood generally. They expressed their appreciation of sharing vital information. However, the perception of which information was important varied according to their role in relation to child maltreatment. This perception was usually translated to which area of the training they found most useful, and which information was new to them.

For instance, an administrator specified their approval of the knowledge they gained in distinguishing between different types of abuse and learning how to deal with each type. This contextualized level of knowledge was valued as being related the administrative duties and processes in order to become more efficient in protecting children.

“We benefited from acquiring knowledge about abuse and the types of abuse, and how to deal with it.” Participant (8), Administrator

Knowledge on the types of abuse, recognition and handling such cases were also recalled as benefits of the training programme by a nursing practitioner. It is interesting to note that both the administrator and the nurse considered the same areas of knowledge as important. This suggests that some core topics such as the types of abuses and learning how systems should
respond to them are applicable to most, if not all, professions that were included in the programme.

“This was my first time attending the training session about children; it was excellent, I learnt how to deal with children, how to recognise the case, and know the types of abuse; so, generally I have benefited from this training session.” Participant (16), Nurse

Another nurse described the training programme as an eye opener, suggesting that they had gained a lot of knowledge and insight that they had been unaware of previously, in particular on the background on child abuse. This indicates that, maybe surprisingly, some healthcare practitioners, like nurses, had limited prior knowledge on child abuse, and that the training programme helped them to address this gap.

“The programme was splendid, and I have benefited greatly, and it has opened my eyes to lots of things.... It gave us great background about abuse against children.” Participant (26), Nurse

A co-ordinator of a Child Protection Committee re-enforced this overarching importance for all participants of the training. The rationale was that the training covered a wide range of issues and information that all professionals involved would largely find applicable in their practice.

“There was a big advantage to obtain a lot of information in the field on violence and abuse.” Participant (11), Coordinator of Child Protection Committee

Some participants were interested in how the theoretical framework and the overall training programme related to their existing practice. They found that this had helped them recognise potential cases earlier, liaise to other professionals within their organization and externally, and relate better to children and parents. For instance, a psychologist admitted to have learned a lot from the training that they had not been familiar with before, despite their professional training in psychology and mental health. The benefit lied in the ability of the programme to instil awareness to some professionals who were generally not used to dealing with these types of child abuse because of their specialized roles.
“...we have benefited a lot from the training course, especially with things that we were not familiar with; especially because I've worked in a mental health hospital. Considering the psychological aspect of the programme is the most important for me. This is because, when working in a mental health hospital, I often do not have the same experiences as the people who discover children who are suspected of suffering from abuse.... All of the training components were good.... very interesting and important topics that were sophisticated and useful for us.”

Participant (1), psychologist

Another benefit mentioned, aside from widening the awareness of professionals, was translating theory into practice. Most of the professionals, especially in the medial field, may have only received some theoretical child protection training during their undergraduate or generic postgraduate studies, without having the opportunity to apply it in their current working context. As a result, they might not know how to use their theoretical knowledge in their clinical practice. This was the sentiment expressed by one surgeon.

“it was very useful in terms of theoretically, and practically, certainly it helped us in practical terms, from practical to clinical directly. I mean, you take theory and try to apply it practically, to help us to know things that we were not aware of.” Participant (21), surgeon

A psychiatrist, despite already knowing most of the topics that were discussed during the training, expressed their positive evaluation of the training programme that had provided them with a clear picture of what to look for in order to decide whether a child is likely to have experienced abuse, by looking at a number of indicators such as physical features that are correlated to child abuse.

“The training course was basically talking about the definition of children with symptoms of abuse (physical or sexual), and others. Of course, there is an increase in the indicators. I can sympathise with the child situation - it means the child exposed to some kind of illness
dictates that I must follow the steps to aid the recovery process. The greatest benefits that I got were regarding the clarity of any physical features and how to recognise them very quickly.” Participant (3), psychiatrist

Another psychologist acknowledged the benefits of all parts of the training, and further emphasized the importance of the holistic approach that covered statistics, case examples and expert advice that encompassed different cases of child abuse that they were likely to face in their profession.

“….. I have benefited from the expertise and the existing statistics, the complaints, the protection, and children's rights. I benefited from all aspects. I liked the information and knowledge about child protection.... We used the training materials, depending on the case situation.”
Participant (7), psychologist

Two social workers identified more specific areas of the training that they found most beneficial for them. These included the visible symptoms of child abuse and the negative impacts of child abuse on the child’s mental health.

“The training outputs were very good. It could be even more excellent by getting benefits from the information that has been presented, dealing with abuse cases and ways to discover the types of assault or abuse; and psychological effects in the future means adding valuable information.”
Participant (14), social worker

“We benefited from learning about symptoms that appear on the child.”
Participant (5), social worker

A director of a child protection programme and an obstetrician-gynaecologist agreed that the signs and symptoms of child abuse were the most useful knowledge that they received. They both recognized the importance of this knowledge in order to correctly identify potential cases of child abuse that they or their team would come across within their service. Both of them mentioned the specific topic of the Shaken Baby Syndrome, which they considered as an important new knowledge.
“From my point of view, I was interested to know how to recognise abuse cases from a medical perspective, and how to detect babies that are being abused, because I was not aware of Shaken Baby Syndrome that may lead to retardation. I have become more aware of child abuse cases.” Participant (17), director

“I have been able to take advantage of the course in terms of Shaken Baby Syndrome, and how to recognise abused cases and non-abused ones, in terms of information; but the cases that come to us are very simple cases, but during the whole year may be from 3 to 4 of abused cases.” Participant (23), Obstetrician and Gynaecologist

Generally, the majority expressed a positive impression of the training components in various ways. However, participants with different roles showed diverse emphasis on the training content of the same training programme. This means that the training design was flexible in the content, thus meeting its goals by increasing the level of the trainees’ knowledge (Hornik et al., 2007; Schraeder, 2009). Moreover, the training programme showed that it was suitable for multidisciplinary team members of different backgrounds, and for those who were new to training that was encouraged by the Ministry of Health. The selection of trainees should be achieved on the basis of a shortage of skills and knowledge identified through training needs analysis, and should be suitable in matching their job context (Armstrong, 2003; Arthur et al., 2003; Buckley & Caple, 2004; Cole, 2002; Goldstein & Ford, 2002).

4.1.2 Trainers’ skills

Some professionals highlighted the importance of highly skilled trainers in delivering the training. As highlighted by Kirkpatrick and Kirkpatrick (2006), the trainers’ quality is a strong predictor of achieving the defined learning objectives. Their selection and training are thus essential components of the whole process. Selection can be based on
recommendations, expertise, past experience and track record, and relevance to the topic, although none of these factors per se necessarily guarantee high quality training. For example, a trainer with good theoretical knowledge may not be able to transfer it to practice; vice versa one with extensive practice experience may not provide the framework and evidence behind certain skills.

Several participants were pleased with the expertise, wide experience and specialization of the trainers and pointed out that these trainers were key sources of their perceived benefits from the programme.

“We benefited from attending specialists.” Participant (5), Social Worker

“I have benefited from the expertise.” Participant (7), Psychologist

“I have benefited from experienced people on really important topics.”
Participant (2), Social Worker

Other participants acknowledged the training and coaching efficacy of the trainers by indicating their impressions on how effectively their teaching and facilitating abilities had come across.

“It was excellent, and we have benefited a lot from them; and there were very good workshops, and I remembered the trainers were very good coaches.” Participant (23), Obstetrician and Gynaecologist

“Lecturers who present was one of the things that I was most impressed by with regards to the training.” Participant (17), Shelter Director

One participant gave a very positive evaluation of the trainers in the programme, stating that they were effective in presenting the contents and information of the training.

“The doctors’ presentations were excellent.” Participant (1), Psychologist
This training was delivered by a range of expert trainers from different backgrounds in relation to the field of child protection such as a consultant paediatrician, a director of a Child Protection Department, an emergency medicine consultant, a professor in behavioural therapy, and several others. Trainers should continuously strive to develop their knowledge about the subject, communication and motivational skills while maintaining their enthusiasm, learner-orientation and empathy with the target group (Kirkpatrick & Kirkpatrick, 2006). Additionally, even experienced trainers should retain their ability to listen and question, interact with students, problem-solve, and evidence their delivery skills (Gauld & Miller, 2004). The quality of the training also largely depends on the ability of the trainers to transfer knowledge in different contexts (Massey, 2003).

4.1.3 Workshops

As was mentioned in the Methods chapter, the programme consisted of four teaching modules that were combined with workshops. The programme included different training methods and techniques such as presentations with different visual aids and group discussion. Workshops were also based on different training methods. For instance, in the first module the focus was on the detection of different types of child abuse and neglect, which included seven case vignettes. The second module that included one case scenario focused on assessment and interventions perspectives. The third module promoted child protection through multidisciplinary team working and formulation of reports that were supported by the discussion of a family case scenario. The final module addressed the establishment of prevention strategies across different levels of the healthcare and welfare systems (Table 3.2). The purpose of having workshops in the training is to ensure that participants can learn together and subsequently applies lessons in their practice.

Some participants were particularly positive about the case scenarios presented in the workshops and expressed satisfaction with the information received.
“I haven’t seen any of the cases that have been studied in the course here in the hospital. It gave us great background about abuse against children.” Participant (26), Nurse

“They gave us training samples and some vignettes. The whole idea of the cases of abuse against children was to focus on violence against them. The sessions were excellent such that I wish to attend any similar courses in the future.” Participant (8), Administrator

Some participants expressed how much they appreciated the interactive nature of the workshops, in contrast with previous didactic teaching.

“we have benefited from the workshops when we discussed the cases and review our views about the problem. The training was interesting and impressive.” Participant (17), Shelter Director

“It was excellent, and we have benefited a lot from them, and there were very good workshops.” Participant (23), Obstetrician and Gynaecologist

As already discussed, different methods were used in delivering the child protection training programme. In selecting such methods, programme developers should consider the education of the trainees, experience, skills level and qualifications (Kauffeld & Willenbrock, 2010; Lingham et al., 2006). Additionally, the methods should be sufficiently flexible, as each person tends to learn differently and have favoured styles of learning (Chambers, 2005). The combination of workshops and presentations often facilitates the delivery of complementary teaching methods (Chen et al., 2006).

4.2 Skills acquisition

This sub-theme considers how trainees achieved, understood and retained the learning from the training programme, as evidenced by their perceived improvement or development of particular skills that they need in order to effectively protect children from abuse. The change
in skill level is shown by their knowledge of outcomes, ideas, information, and approaches from the training programme.

4.2.1 Greater awareness of abuse cases

Some professionals stated that the training programme had a substantial impact on their performance and skills. They justified this significant change in their skills by becoming more alert, thus finding it easier to recognise suspected maltreated cases. Some participants reported that they had developed a more thorough and keen ‘eye’ when evaluating a potential case of child abuse, stating their enhanced skills of paying attention to detail and considering the consequences of their actions for all parties involved. The latter indicated a more measured and cautious, albeit informed, approach to difficult circumstances.

“I have become more accurate, so I do account for the possibility of harm that could be worse than before - if you do not watch out for the small details, it may worsen things more so than ever before...We are keen on doing this already. For example, if we do not care about the psychological aspects during early childhood, it would be difficult to deal with it in the future.” Participant (1), Psychologist

Some participants felt that expert advice and tools introduced during the training such as questionnaires helped them become more confident in their evaluation of abuse cases. Furthermore, others expressed their appreciation of skills that allowed them to act quickly, so as not to waste time in accurately identifying abuse case. This finding is important if taken in conjunction with the previous statement of considering potential harm through wrong identification and intervention, thus demonstrating a balanced and more methodical style that is also decisive when needed.

“In dealing with the cases, we have become dynamic, and we are now busier because of things like the presence of questionnaires and interaction with the specialists...The training course has opened our eyes to taking care of children with a level of care that they have not
received before. In terms of applying this in reality, we are living in this small community; we had only dealt with two abuse cases since we took the training course until now.” Participant (16), Nurse

“I have become more aware of detecting abuse cases, especially for children who cannot speak.” Participant (17), Shelter Director

“The clarity of any physical features and how to recognise them very quickly.” Participant (3), Psychiatrist

### 4.2.2 Personal development

Some participants who were not working directly with abused children and their families believed that the training programme had made an impact on their personal life. After attending the training, they began to note ways of dealing with children outside their work environment. This could indicate that participants don’t simply “switching-off” their knowledge and skill when outside or work, as well becoming more child-centred and nurturing.

“I couldn’t apply the training programme, because it doesn’t relate to my work, but I used it outside the work environment; I do talk about it outside work.” Participant (18), Public Health Educator

“I do not deal directly with the children, but the learning achievement from attending this child protection training is personal advantage in raising my children, my family, my relatives, and my colleagues. I felt a difference.” Participant (9), Head of Nursing Department

In accordance to Guba and Lincoln (1994), depending on each one’s realities, nature of work and prior knowledge and abilities, the participants vary a little in their responses on which
areas of the training they think are most important to them. For instance, if a participant thinks an area of a training is more applicable to their job, they are more likely to report these areas as most beneficial, and if an area of the training is something that they already know about, then they are less likely to see its benefit. However, most of them expressed an increased level of knowledge and skills that can result in different attitudes in some aspects of their roles (Bramley, 1991).

4.3 Raising awareness

In this sub-theme, the changing behaviours of the participants during the actual on-the-job and off-the-job application of learned ideas, information and approaches is discussed. Many participants showed that the child protection training programme had made an impact on them by aiding them to implementing what they learnt through raising awareness to external agencies such as schools and hospitals.

4.3.1 Schools

Some participants and their hospital colleagues conducted lectures in schools in their localities on different aspects of child protection such as guidance on self-protection to pupils. However, these lectures were usually not initiated by them but rather were requested by the schools. It appeared that there was some co-operation between the Ministry of Education (schools) and the Ministry of Health, as a consequence of which, medical doctors who had received training subsequently visited schools to further educate teachers and pupils about child protection. It is plausible that the inter-agency nature of the training equipped them better to understand better the needs of schools, teachers and young people.

School awareness seminars were aimed at providing sufficient knowledge to pupils for them to assess their own situations and sense of safety or risk. In the latter case, pupils were provided with both practical information and empowering strategies of possible steps of
Disclosure and help-seeking. A strong message was the assurance that that they were not alone.

“I once went out to an intermediate school with a clinical psychologist to present a lecture about protecting children from violence.... I did a lecture...It was under the school’s request. We discuss the importance of child helpline, the meaning of child helpline, how it can be used, when, and whom we can talk to if we need help. Also, we discuss what is the Family Safety Programme, and the types of violence, and to whom we could talk to if there is any problem in the family. Providing the pupils in the school with the guidance of using the helpline and to whom they can speak to if they need any help.” Participant (1), Psychologist

“We have tried to let all schools who co-operate with the Ministry of Health to conduct awareness lectures, and I am going on a regular basis; each period meets teachers and students.” Participant (3), Psychiatrist

A participant highlighted the importance of the copy of training materials that had been distributed during the training programme, which was thought to be helpful in increasing teacher awareness.

“The Ministry of Education started to raise awareness among teachers that there are symptoms that appear on the student. If teachers were to find these symptoms on the student - whether it be sexual or physical neglect, or maltreatment from the family - they advised them on how they should act.” Participant (13), Director in the Ministry of Education
One participant expressed their concern that these lectures may not be enough to raise awareness in other agencies and settings because of resource and possible attitudinal constraints.

“Some of our doctors go to school to conduct some lectures that are about violence against children, but not in sufficient quantity to cover the area, and our society is increasing each period.” Participant (9), Head of Nursing Department

Overall, participants demonstrated that there was co-operation between the Ministries of Health and Education. However, these initiatives appeared to be limited, with a need to enhance their impact in raising awareness of child protection among the society in general.

4.3.2 Hospitals

Some participants described how the training programme had made an impact on their practice, as they tried to implement different components in their work environment. Such examples were establishing a child protection committee jointly with colleagues who had attended the same child protection training programme, educating specialists, raising awareness across the hospital, and using the child protection assessment forms\(^1\) in the emergency department.

“It begins in the hospital through the psychiatrist and the director of the emergency department, in addition to communications with Obstetrics and Gynaecology, and myself. The four of us established the protection committee after we finished the training session. We had a meeting and

\(^1\) Forms of protection from violence and abuse are distributed from the Ministry. The Ministry recommends that these forms are used in conjunction with the guidance booklet and are filled in by physicians. These forms come under the hospice of the Violence and Abuse Protection Committee.
they gave us the reports of abuse cases that were distributed to us during the training session.” Participant (8), Administrator

“We worked to educate specialists and raise the awareness of this topic in the hospital, and we put the forms of abuse cases in the emergency department. We explained which are cases of abuse, and where is every case included under which list of abuse for emergency physicians. In case of having an abuse case, the Protection Committee must be notified, and then be transferred to the Protection Committee in Tabuk.”
Participant (8), Administrator

“We have ongoing programmes regulating the type of the lectures needed, and determining the staff needs. Some of the lectures were: caring for violence and abuse of children, and a lecture on domestic violence, because we have a special committee concerned for domestic violence.” Participant (9), Head of Nursing Department

These responses suggest that the professionals, especially those in medical practice, had benefited by enhancing their knowledge and skills with regards to child protection, and the training had led them to take action and transfer the knowledge to their colleagues who had been unable to attend. Professionals largely appreciated the importance of the child protection training programme and demonstrated their appreciation by using the training materials inside and outside their practice. Also, findings indicate that raising awareness in the society was considered one of the most important strategies in improving recognition of and response of child maltreatment.

Participants’ responses varied depending on their profession, organization, work setting, prior knowledge, personal circumstances, and individual learning preferences. As stated by Guba and Lincoln (1994), people’s perceptions are often guided by their different realities. However, the training had generally been received positively, as all participants identified at least a few aspects which they felt had been beneficial for them and for the children. The impacts of the training were not limited to the trainees’ improved perspective, knowledge and skills, but also trickled down to different levels of society, where increased awareness
and changes in attitudes were also needed. This appeared to have been partly achieved by reaching school pupils and other hospital employees. As Gilbert and colleagues (2009a) posited that the community has an influence in either combating or fostering child abuse, actively involving a range of community stakeholders was defined as an essential next step.
CHAPTER FIVE

RESULTS (2)

THEMATIC GROUP (2): CONSTRAINS OF TRANSLATING TRAINING INTO PRACTICE
5.0 Introduction

In this theme, the focus is on the perceived factors that impede the implementation of child protection training. As these factors are considered as barriers to practice, but are also closely related to vulnerability for child maltreatment, the ecological framework was used, therefore it is structured and will be presented in this way. The broad theme is divided into four sub themes. Firstly, societal level such as customs and traditions, policy and legal issues; secondly, community level, including staff issues; thirdly, interpersonal level, including family issues; and fourthly, individual level like the age of the child and disability. Some of these findings were pertinent in the context of the research questions, aims and objectives. For example, the participants’ perceptions of their experience of the child protection training programme and the impact of the training programme had important implications on professionals’ practice with child abuse cases. However, the implementation of the training is influenced by many challenges such as those presented in this chapter, thus, making the findings important for future recommendations for policy and service development. These challenges of implementing the child protection training programme are explored in detail in this chapter. The four key themes that emerged in relation to participants’ perceptions of translating training into practice are presented below and summarised in Figure 5.1.
Figure 5.1
Sub-themes in constraints of translating training into practice

Constraints of translating training into practice

- Societal level
  - Customs and traditions
  - Policy issues
  - Legal issues

- Community level
  - Staff issues

- Interpersonal level
  - Family issues

- Individual level
  - Child disability
  - Child age
5.1 Societal level

This sub-theme will focus on the broad societal factors, which create a climate that encourages the use of violence such as customs and traditions, policies, as well as legal issues. These will be discussed in detail in the next sections.

5.1.1 Customs and traditions

Professionals faced several challenges in applying what they had learnt during the training. Many participants emphasised the customs and traditions that are embedded in most of the Saudi society when asked on what was the biggest challenge. They highlighted the importance of the relationship between the physician and the family, and placed this in the context of what they described as a conservative society that largely does not like to disclose or tell the truth, in order to save face or protect a family’s dignity. According to the participants, the implementation of the training to the general public would be difficult, because of lack of readiness and the presence of stigma.

“...there is a simple difference or difficulty in the application, it is not difficult, but there are a few hiccups (obstacles),...sometimes other circumstances prevent us from applying what we have learned because of customs and traditions imposing themselves on us ....nobody likes someone looking for his/her secrets, rejection on the part of the patient’s family to interact with us and give us correct information, fear or distrust of a specialist person, synergy whereby some families do not give us enough information to support the case in the hospital, but with time and sessions we might be able to apply the material training.....we have a society that is not narrow-minded, but is possible to say it is a conservative society, subject to the standards of traditions and customs, difficult to accept everything, but, thank Allah, it makes it possible to accept the culture when they seek help from others.” Participant (14), Social Worker
“Information is very important but very difficult to apply, because of the bad culture in the community. Or, our community is not ready.”
Participant (4), Psychologist

“We are in a country that is governed by culture and traditions. Cases are coming to us and saying, ‘I fell down in the kitchen’, or ‘I fell in the bathroom’, and they are not telling the truth.” Participant (22), Nurse

Participants showed that there are many factors that must be taken into account, e.g. different cultures and customs that are prominent across the Saudi society. These had a significant impact on professionals’ decision-making (Flaherty et al., 2012; Jones et al., 2008). One of the most important factors in this process is forming a relationship with the family, as this can facilitate addressing the problem (Flaherty et al., 2000; Jones et al., 2008). Additionally, others stated that professionals could face verbal or even physical threats from the caregivers, which could be threatening and act as deterrent (Flaherty et al., 2012).

Some of these factors may not be different to those in other populations, whilst others may be more specific to Saudi society such as polygamy as practice of Islam, the presence of housemaids, and reluctance of small communities to share information on child maltreatment. For example, violence against women maybe a result of polygamy, as practiced in Islam, where men are allowed to marry up to four women at the same time. As a consequence, these men could have a lot of children that they cannot take care of.

“Economic matters and polygamy are the reasons for the emergence of abuse cases…. There is still ignorance against women. According to what I see, poverty may be the cause. I now find more women suffering
from violence than children.” Participant (13), Director in the Ministry of Education

Perhaps the nature of the Saudi environment and the shift from the extended to the nuclear family status, with the imposing presence of the housemaid. Maids are considered as an essential part of almost every household in Saudi Arabia and a part of the Saudi culture. At the same time, they can inadvertently play a potential role in enhancing the risk of child maltreatment.

“The cases may have involved physical abuse, or fainting, but these cases are extremely rare. During this year, we had only faced one case. This case involved an individual suffering from depression. We found an intense fear in this case with regards to the maid... There was a quick response to the situation. In the case of this maid, there was no charge, just deportation to her country.” Participant (5), Social Worker

“The exception is abuse cases involving a maid, where information will be given clearly by families. While in other cases, they are trying to hide things as much as possible from different angles.” Participant (6), Surgeon

From the participants’ accounts, it seems that families are not reluctant to accuse a housemaid of any misbehaviour, as they are considered an outsider. However, the natural inclination of the population is to hide the violent behaviour of family members, especially parents or other relatives. In contrast, housemaids are considered one of the risk factors that may increase child maltreatment. In Saudi society, there is a misconception of the role of the housemaids, who are not qualified nannies or babysitters, as a lot of people think; rather they are only expected to help out in household chores such as cleaning. Additionally, housemaids tend to act out when they are treated unfairly and overwhelmed, e.g. from
unlimited working hours, low pay or no job specification (Al-Shail et al., 2012; Al-Kinani, 2005).

In addition to the personal shame that families usually feel upon disclosing possible domestic violence or child maltreatment, the society is also broadly expected to ‘keep quiet’. This is often related to the fear of breaching their privacy, societal expectations to mind one’s own business, and legislation that prevents the specialists from meddling in household affairs.

“We live in a society that prevents you from entering it, and incursion into or getting deep inside it. Especially from a domestic violence perspective, it is hard to get any information, so you need certain habits... There are also laws that prevent you from interfering in people's lives.” Participant (24), Psychiatrist

“Nobody wants others to know anything about them, or any information about them. They keep everything private, but we are trying to clarify that this is confidential, so nobody can know anything that passes between physicians and parents.” Participant (16), Nurse

Furthermore, participants reported that the pressure from society to not report maltreatment; and strong ties within small communities such as villages or suburban areas, where residents tend to support each other in concealing the truth in case of child abuse, also impede the implementation of child protection in the Saudi society.

“The difficulty in the proper application of training relates to the pressures of this society and its lack of acceptance with this subject.” Participant (6), Surgeon

“It has a small community where there is a fear of reporting abuse cases. It is a sensitive subject...everybody knows each other and tries to hide the truth by supporting each other.” Participant (6), Surgeon
In addition to the culture and tradition of keeping household matters private, most of the participants highlighted how they struggled in obtaining any information about child abuse cases from families. Most family members would refuse to give any details about their children, or they would provide false information in an attempt to conceal the truth from the practitioners, for fear of being reported to the authorities. Although this pattern is not different to any other population (McMinn & Dunn, 2011; Smallnone et al., 2008), some of the mediating sociocultural factors may be more specific to the Saudi society.

“There are no parents that clearly admit that they abuse their kids.”
Participant (1), Psychologist

“When questioning the history of a case, parents usually give untrue information. This is the greatest difficulty that we normally face.”
Participant (6), Surgeon

“We suffer from parents who keep thing hidden, and refuse to give us accurate information about the case; everybody knows each other in the region, it is one community in the city. Nobody wants others to know anything about them, or any information about them…” Participant (16), Nurse

“A lot of children come to us and signs of abuse appear on them, but families refuse to give us any information, do not accept the idea, and is not very helpful to give us any information concerning the abused child, despite the fact of repeating the arrival of the child with the family to the hospital. These are the most prolific obstacles that we face with parents…Last time I had a case of a child, and the child’s eye had come out. No one from his family wanted to tell me the truth - they said he fell down on a bottle. But it was obvious it was domestic violence, and their talk was not very logical.” Participant (21), Surgeon

Naturally, parents would try to avoid being questioned about their parenting skills, potential negligence or even physical harm infliction to their own children, for fear of being judged
negatively by their practitioner or, even worse, of being reported to the authorities. Thus, the responsibility lies with the practitioner to extract the truth from the parents by utilizing the skills they learned from training, without appearing accusatory in the absence of sufficient evidence.

5.1.2 Policy issues

5.1.2.1 Lack of awareness programmes

Several participants highlighted the lack of child protection education programmes in schools and other settings such as shelters. Participant (4) recalled the case of a teacher who had emotionally abused a child and made a link with wider school and teacher needs for awareness, early recognition and preventive strategies.

“I received one psychological outline of a 13-year-old girl - her teacher was making fun of her in school. Her whole life was destroyed because of her primary school. This girl was talking normally in her first primary year of school, but now she is not talking any more - violence and abuse are not the family’s responsibility anymore.” Participant (4), Psychologist

Participant (5) mentioned that he had direct contact with teachers, but they did not have any experience or opportunity to attend child protection courses. He highlighted that most child abuse courses are likely to be held in hospitals rather than in schools.

“I never heard before of any sessions held in schools, particularly for teachers for this purpose. I have never heard or come across any suspected case where a child is exposed to any harm in schools, where the child’s wellness is in danger.” Participant (5), Social Worker

A participant (13) who worked at the Ministry of Education, consequently highlighted the need for awareness programmes for schools, from a wider policy perspective.

“Awareness is lacking. The awareness education programmes are supposed to spread in schools - including the teachers in the primary
grades that should be a targeted group to assist in the discovery of abuse cases. There should be awareness education programmes for them, either through CDs, flyers, or brochures. These are very important. The awareness for teachers should help them to know what symptoms are, and how to deal with and direct potential cases.” Participant (13), Director in the Ministry of Education

However, the same participant also acknowledged that they faced a number of difficulties in terms of providing teachers with adequate training such as lack of time and release from everyday teaching duties, inconsistent instructions from the Ministry of Education, and lack of budget.

“We sometimes find it difficult in how we train teachers in the primary grades. It becomes problematic when the teacher remains here for four days in the role of a teacher and a student at the same time...Every year we have new teachers who come to us and they require doses of training...Until now, difficulties still exist in that there are some instructions that we must follow from the Ministry of Education dictating that we do not publish any brochures. The Ministry banned any leaflets or brochures that were directed to the teachers...There must be a special budget for conducting teacher-training sessions in the evening, and for raising awareness in the general community.” Participant (13), Director in the Ministry of Education

Other potential organisers and providers of training felt constrained by not being able to go ahead without permission from the Ministry. In addition, there was often confusion and overlap of responsibilities between three Ministries, i.e. Health, Education and Social Affairs (Welfare).

“If we want to present any courses or sessions, we must have consent from the Ministry of Social Affairs.” Participant (2), Social Worker
5.1.2.2 Mechanisms and procedures

Overall, participants complained that there were no clear mechanisms and procedures that they could follow in dealing with child abuse cases. The most commonly used route was based on mutual relationships between hospitals and police departments, although this did not appear to be based on clear guidelines.

Hospital settings

There are two routes of processing abuse cases inside hospitals. The first route starts from the hospital setting and is followed by the police. Most cases come to the emergency department to seek help, following which a child is examined and there is a chance of suspecting that their injuries may be explained because of underlying maltreatment. Depending on the nature of the injuries or symptoms, the suspected case should then be referral to other hospital departments for further investigations, and then to the police department.

“We receive cases through the emergency department. Cases are assessed in the emergency department to know what the conditions are. When the problem has occurred with the parents, usually they do not bring the case directly. However, two or three days later, a story is fabricated. Usually, we get the case referred from the police department, and then the specialists evaluate the abuse case and fill in the abuse and violence form. Then, we co-ordinate the case among specialists in the protection committee, and then we raise the case papers with the department of protection, mental health, and each section has their role. The psychologist will talk with the child and write a report on the situation and all the circumstances of the case... My role is to co-ordinate between specialists’ meetings and record the meetings with everything of relevance...In the event of an assault by the parents, the police provide them with an official letter to view the situation in the
hospital, and they take samples from them for the forensic department.”

Participant (11), Co-ordinator of Child Protection Committee

In the second route, a family or caregiver seeks help directly from the police for their child or raises concerns about another child. The police then make a referral to the hospital for relevant investigations and reporting.

“First, the case comes to us through the emergency department. Emergency physicians do medical tests and screening, in case there is an assault, such as the effects of a hit, being bruised or beaten…and the physician examines, analyses and writes a report. Then they refer the case to the police, and the police certify the record, then transfer the case to the Social Services department, and therefore follows-up the case with an interview. There are forms that should be filled with two types of information: accurate information and general information about the abuse case, the type of abuse, e.g. physical or emotional abuse, how many times it is repeated, mention of the reason for the abuse. We usually sit with the patient and take the information from his or her interview. We call the spouse or children and try to solve the problem between them. In the case of the children or the wife refusing to go back home, we transfer them to a safe shelter, especially if the case is from outside the region of Tabuk.” Participant (14), Social Worker

Other participants did not detail the procedures that they followed, suggesting that this was dependent on the case or on the local hospital protocol.

“The mechanism used usually depends on the severity of the case, the situation and their condition. Often, a specialist and a social worker, accompanied by police, have the approval of the emirate of the region (this is related to the Ministry of Interior), to enter their house and take hold of the case. They then take the case to the shelter, and study the case situation to then develop solutions.” Participant (2), Social Worker
“We received abuse cases through the emergency department or reception admission.” Participant (21), Surgeon

“It begins in the hospital through the psychiatrist and the director of the emergency department, in addition to communications with Obstetrics and Gynaecology, and myself... We may face some pressure from specialists not to report the cases to the police. In these cases, we need support or guidance from you or a particular procedure to be followed.”
Participant (8), Administrator

Some participants demonstrated a holistic approach in the procedures they followed, involving the co-operation of various hospital departments and the police. In contrast, others did not provide any details or justification, which might reflect a more ad hoc approach.

Bureau of Investigation and Public Prosecution

The roles of the Bureau of Investigation and of the judiciary usually take effect after the occurrence of the offence. In some suspected cases, however, where there is a risk of further violence, they may intervene early and refer the case to the social affairs department for investigation. They may take procedures regarding the case and refer them to the judiciary, if there are no concessions. One participant described the mechanisms inside the Bureau of Investigation and Public Prosecution. He mentioned that they usually received cases at a difficult point of the overall process.

“I mean; we don’t receive any cases at the preventative stage.”
Participant (25), Head of Audit Office and Implementation, Prison Service

When they sensed from the presented evidence that there was a need for preventive strategies, they tried to intervene by transferring the case to specialists in social affairs or to the child protection committee.

“For example, if the accusations between the couple are just verbal arguments, more than having any physical abuse and reaching the
fractures stage, then it is best to seek reconciliation between the parties prior to entering into the corridors of the judiciary.” Participant (25), Head of Audit Office and Implementation, Prison Service

Shelters

The findings suggested that lack of infrastructures and facilities to deal with abuse cases is one of the problems faced by practitioners that prevent them from protecting children. For instance, a participant reported that in the shelter of Tabuk region they received many cases at their centre, but these cases are different depending on their situation. She mentioned that the shelter is under construction, which makes it difficult to deal with abused cases especially if they need a place to live.

“Currently, we are waiting for our Centre to be finished, because the building is under construction by the Ministry of Social Affairs. Everything is on hold until the building is completed.” Participant (2), Social Worker

A participant mentioned that dealing with cases in practice was not as simple as “just writing on a piece of paper.” The first step is to consider possible solutions from a religious perspective. Other perspectives are considered once the potential solutions already offered are proven ineffective. The process of looking for possible solution continues until the problem is resolved.

“We usually develop three possible solutions; we try one and if it doesn’t work we try the second one, so that the case does not reach the stage of desperation.” Participant (17), Shelter Director

5.1.2.3 Liaising with the police

Some participants stated that they had a good relationship in dealing with the police. There were minimal difficulties reported. Whenever the presence of the police is needed, the
process involves writing an official letter to the police department, and then the police will file a report regarding the abuse case.

“For example, in the case of maids, even if the subject is a little bit outside of the main theme, maids should be received by her sponsor and delivered to the police rather than things getting worse. It is better than having any revenge from the maid on the family or on their child in the home, it is best delivered to the police and therefore she can be deported to her country, or returned back to the recruitment office.” Participant (14), Social Worker

“There is strong co-operation between specialists and the police. It is easy to deal with them. We have freedom in reporting, even in the worst cases, and we find the police are consistently respectful and appreciative. In all cases, they come and write a record without any problems. I do not ever remember having any problems with the police.”
Participant (7), Psychologist

In contrast, some participants were concerned that in many cases, family problems were reported to the police, but they then appeared to take the pledge on the perpetrator. The reasons were often related to the sociocultural context described earlier. This inhibited them from referring some cases subsequently.

“They said these are hit by their husbands or beaten by his/her father, and they are free to raise his child in his own way, or to deal with his wife.” Participant (22), Nurse

Moreover, police were sometimes contacted prematurely or even unnecessarily in the absence of clear procedures within the healthcare system, this in turn increased the chance of the police rejecting cases.

“If police come in, then my role is ended.” Participant (22), Nurse
“Police do not take any action if there is just a report, the police movements may be slow because of the lack of situational background, whether it's from the health sector or other authorities. The police lack the preventative side, nor full themed backgrounds.” Participant (25), Head of Audit Office and Implementation, Prison Service

“We not have a protection committee, protection committees in the whole region of Tabuk forward information to the police, the police are carrying out this role, for the police deal with the subject formally.” Participant (15), Social Worker

5.1.3 Legal issues

Some participants highlighted the needs for protection law for abused people to secure their right and for the perpetrator to be punished. A participant claimed that there is a need for laws to protect children similar to the protection of women wherein the victims are safeguarded from any negative behaviour from family members or guardians.

“There is a law that protects illegal pregnancy, there should be a law that protects abused people, where one is illegally pregnant, get her treatment and her parents cannot infringe upon her. I would like to suggest the same thing should happen with abused cases.” Participant (22), Nurse

Similarly, it was highlighted that often there was no punishment for the perpetrator, especially if they were a family member.

“Usually the mother says ‘I didn’t pay attention’. Sister B (another nurse) is usually responsible for abused cases, but we cannot report in these cases where the negligence comes from the parents’ side. We
usually provide advice for mothers to pay more attention to their children.” Participant (26), Nurse

In 2014, there were new rules and regulations that were placed against domestic violence. Under the 17-article legislation, those found guilty of committing any kind of abuse including psychological or physical abuse could face prison sentences of up to one year and fines of up to 50,000 riyals (£8,600) (Ott, 2013; Saul, 2013). However, most people and practitioners are unaware of the details and implications of the rules, hence, they still could not take full advantage of it.

“People need to be full aware of the case situation in order to use this rule. It is good, but those who want to use it must be understanding of the situation, and for these systems, understand the situation of the community, must be open-minded. Its purpose is the liquidation of differences, has exploited some weak people to gain other purposes. It was developed to protect vulnerable people and reform society.” Participant (25), Head of Audit Office and Implementation, Prison Service

5.2 Community level

5.2.1 Staff issues

In this subtheme, different issues faced by professionals are discussed in detail. These included shifting work schedules, obstacles from the administration, and high magnitudes of responsibilities.

5.2.1.1 Shift working time

Some participants highlighted that, when people seek help or treatment at night time, their concerns or identified cases of abuse are not usually reported, due to the lack of attending
professionals who are also experts in child protection. As a result, incidents that are reported during the night are usually left unrecognized and unresolved, without follow-up arrangements to establish whether these merit further investigation. It is plausible that these include some of the children with the more serious injuries, if these are to be brought to emergency departments ‘out of hours’.

“When they come at night-time, no one will communicate with them...they must raise the awareness of parents, and increase awareness level of the specialists at the hospital in the event of abuse cases. When they receive a case a night time they should told that they should come again in the morning, by not completing medical procedures for the case so they can come back again the next day to continue their medical procedures. What happens usually when the case completes their medical procedures, they don’t come again. In the evening, social service is not available nor the mental health service, only a doctor.”
Participant (11), Co-ordinator of Child Protection Committee

“How some cases come to us in the evening and no one is treating these, and it is not recognised that they abused or something.” Participant (22), Nurse

5.2.1.2 Other work responsibilities

A key challenge for staff was that child protection duties were often added on top of their existing and busy generic (e.g. social work or paediatrics) caseload, which meant that sometimes these were often neglected. A participant shared that, in their experience as a protection committee member, these additional responsibilities were usually considered secondary. As a result, the staff usually prioritized their full-time job responsibilities, thus leaving little to no time for safeguarding.

“There is a protection committee, but members who are in this committee have many other responsibilities. I am a member of the protection committee but I cannot be fully responsible for this area
because of other responsibilities. In every hospital there is a protection committee and full-time people who work in domestic violence only. Simply having people who work full-time and are specialists in this area: the management of patients with domestic violence, does not work well. There should be an independent person with an office and telephone number that is just for him/her, in charge of domestic violence only.” Participant (21), Surgeon

The lack of a designated child protection budget is an aligned explanation for overburdening and underperforming staff. Most institutions would try to compensate for the lack of budget by increasing the workload of their employees; thus, staff were expected to multitask and focus on more than one responsibility at a time. As a result, certain tasks – usually those related to child protection - were neglected.

“I want to tell you that without a budget no one will work. I am from the people who want to work for my job, and take my salary and go. To work in another section is tough and I am in charge of doing many other things. All the staff here are in charge of doing things; when there is no separate section in this subject, it is impossible to activate.” Participant (15), Social Worker

Another participant complained of being responsible for a range of patients’ welfare, on top of their standard employment responsibilities at the hospital.

“There should be a responsible person in the hospital who is in charge only of domestic violence, so there are no other duties of this person; but in my case, I deal with all patients’ problems and all the problems of the hospital.” Participant (24), Psychiatrist

The lack of budget and staff assigned to focus on child protection in each institution suggests that this area is not really a priority for most hospitals and other departments. The fact that full-time regular employees assigned to do other work are assigned this responsibility as an
additional task gives a strong message that children’s safety is not taken seriously enough by authorities.

5.2.1.3 Helpline response

One participant mentioned that, when he tries to contact the helpline (protection number), it may take a while to receive a response. This delays the overall process of investigations, and deprives practitioners and families from advice at the crucial point of reporting and decision-making.

“The most problems that I face is communicating with protection numbers…. I have a case and I want to communicate with someone directly, but the Tabuk area is dealing with cases. It takes a long time to respond.” Participant (19), Psychologist

Having to wait for a response reflected lack of efficiency from the helpline service that discouraged both the public and the staff from using it in the future.

5.2.1.4 Lack of authority

Although participants usually wanted to act by reporting cases of abuse, they were often subject to limitations and prohibitions that would not allow them to gather sufficient information towards the evidence required, if the case were to reach the courts. For example, a participant mentioned that taking photographs of children was forbidden.

“In brief, I cannot do anything without the authority, unfortunately…. The fact I cannot intervene, because I do not have sufficient authority to make the decision, means I cannot take any action. In brief, the training was excellent, but poor in terms of being difficult to apply.” Participant (4), Psychologist

Other than privacy policies, administrators posed certain limitations that restricted practitioners’ authority such as mentioned earlier. Participant (7), Psychologist, highlighted that they heard about other training programmes, but the administration did not allow them
to attend. Thus, although some staff may have wanted to take the initiative to learn more, they were restricted by the rules that governed their institution, or by resource constraints.

5.2.1.5 Barriers to reporting cases

One participant mentioned that there are a lot of hospitals where the cases are not usually reported, due to the lack of support offered. She is from within the committee in the region and she complained about the lack of regular meetings to discuss cases, lack of people who would attend the meetings and lack of co-operation with other institutions.

“Reporting of cases is in the narrowest border...Unfortunately, the meetings are very simple. Very few have been meeting about more than two cases only. In the last meeting, we were discussing the lack of co-operation from other hospitals with us in reporting cases. Also, there has been a debate about who will protect us if we report the cases, and because of this, cases are not reported.” Participant (1), Psychologist

Some staff would be fearful of adverse consequences if they reported sensitive cases, for which reason they needed reassurance that they would be protected. However, so far neither the governments nor the local health authorities had legislated to protect professionals who reported child abuse cases.

Refusal to be acknowledged by the committee

Another barrier to child protection that emerged from the data is the refusal of the committee to acknowledge all complaints and inputs. A participant mentioned that they are trying to help solve the matter and address the cases however, they are not supported by the child protection committee. As the Committee is not active and do not respond to enquiries, he cannot persevere anymore. The committee’s reaction highlights how parents refused to acknowledge the abuse.
“What I usually do is inform the Committee and parents about refusal to acknowledge. In this case, it is out of my hands, even if it is clear that there are some marks in specific places on the child’s body (as we have learnt from the training session). It is obvious that is abuse. Nobody is acknowledging the problem, so I did the same.” Participant (4), Psychologist

5.2.1.6 Shortage of Saudi Health and Social Workers

Some participants highlighted that they suffered from a shortage of Saudi health professionals and social workers. There is no Social Worker that can examine the case, sit with the parents and discuss the situation, which may be very simple. However simple the task is, there still is not a worker that would be available to deal with it.

“If there was an organisation registering the abuse case, then you can log a case. But, unfortunately, there is no encouragement to protect the case. I informed the police, and the police only take the pledge.”
Participant (22), Nurse

“Social staff are not available within the hospital.” Participant (24), Psychiatrist

Another problem faced by the staff is the lack of infrastructures that are specifically built to deal with child abuse cases, where hospital staff can refer complex cases of abuse that the hospital is incapable of dealing with, due to their restrictions and limitations in facilities, knowledge and jurisdiction. Overall, there is a shortage of such centres of expertise.

“Honestly, we face problems when we try to treat the cases connected with shortages or non-availability of resources. Lack of resources such as available healthcare centres. For example, if there is a branch or clinic for the National Family Safety Programme that we could refer
some of our mental health or psychiatric patients that we cannot provide a place for in our hospital. By comparison, children are in even more need for such care.” Participant (7), Psychologist

5.2.1.7 Co-operation with colleagues

The relationship among specialists in any public sector environment is essential in its effectiveness and outputs. This is particularly important for child abuse detection and management, where communication of difficult issues and establishment of evidence are pertinent. Some participants highlighted the importance of having a good relationship with others that would facilitate a supportive environment, wherein dealing with special cases such as child abuse is not entirely the responsibility of just a single person. The co-operation and supportive atmosphere in some hospitals was identified as particularly important, although this was not consistent across all settings.

“Co-operation between specialists is essential for us, because it helps confidence grow in dealing with cases of violence. If there are cases of violence, we try to do above and beyond what our energy levels permit, by working hard to handle and treat the condition…. Some cases come to us without phone numbers to anyone close to them. We then try to find different ways to know the person through the national identity card, or through the police to allow us to provide them with as much support as possible. It is impossible not to co-operate with abuse cases.”
Participant (7), Psychologist

“In term of specialists and the hospital administration, they are very co-operative. In the case of courses, they send people to attend courses and partake in education, and they are interested in this topic and in the existing statistics on this topic.” Participant (16), Nurse
“The hospital needs more publicity, and lots of work in term of co-operation is not 100%, say it is 50%.” Participant (21), Surgeon

In contrast, other participants complained about the lack of co-operation, teamwork and communication among colleagues. This affected staff morale, as they felt that they have to manage high-risk situations. As a result, some practitioners are left to make potentially life-changing decisions on their own, such as the case of Baby P (Peter Connelly) and Victoria Climbie (Elliott, 2009), wherein the lack of co-operation among various disciplines and organizations led to the demise of the children that could have been prevented if the cases have been identified, reported and resolved earlier through efficient inter-agency working. As a result, some practitioners are demoralized and fearful, consequently tempted to resign their position.

“For me, I want to resign from them entirely. There is no co-operation among doctors or the people who are responsible for this hospital.” Participant (12), Psychiatrist

“I am feeling very unsatisfied, and it is unacceptable because of this whole situation - no response and no treatment - I tried to face many cases, and there are more cases that are worse that I didn’t talk about it... I tried, and fought to help kids who are exposed to violence, even if I don’t have the authority.” Participant (4), Psychologist

5.3 Interpersonal level

5.3.1 Family issues

The main focus here is on the characteristics of the perpetrators, and the difficulties faced by professionals in dealing with them, mainly parents, who lack nurturing skills, refuse to acknowledge abuse, are under the influence of illicit substances, suffer from mental illness, or experience serious family conflict.
Perpetrators

Participants mentioned that the perpetrator in most child abuse cases was a close family member such as father, mother, or brother; as well as husband in cases of domestic violence. This is consistent with the international literature (US Department of Health and Human Services, 2015; Fergusson et al., 2000; Finkelhor, 2008). It appears that most perpetrators are within the family of the child, as children are often maltreated by their mothers (Kattan, 1994) and fathers, including stepparents (Al-Eissa, 1991).

“The perpetrators are usually brothers or fathers in the majority of abused female cases, and sometimes the husband is the perpetrator for his wife.” Participant (14), Social Worker

“The police usually receive abuse cases, they said these are hit by their husbands or beaten by his/her father, and they are free to raise his child in his own way, or to deal with his wife.” Participant (22), Nurse

In addition to the other established familial and households’ factors that may have influenced family members to be abusive to the children, a participant identified drug influence or, worse, addiction, as exasperating violence and aggression among family members, with children being the usual victims. Drug addiction is a well-established perpetrators’ characteristic that increases the risk of child maltreatment (DCPW, 2009; Dyson, 2008; Sidebotham & Heron, 2006; Yampolskaya, Greenbaum, & Berson, 2009). This is in contrast with Western studies where alcohol is a frequent precipitating factor (Bair-Merritt, Blackstone and Feudtner, 2006; Dube et al., 2002), but this is not acceptable in the Saudi society for religious reasons.

“With regards to most of abuse cases that we see, the perpetrators, for example fathers or brothers, are usually people who are normal people but may have a drug addiction. We directly inform the police to communicate with perpetrators. There were a few cases involving issues
of honour - most of the perpetrators were addicted to drugs.”
Participant (7), Psychologist

Child abuse by family members was reported to not be limited to inflicting physical harm, but rather extended to psychological harm such as by verbal abuse.

“We had a case of a child engaged in psychological issues, and suddenly appeared to have diabetes and depression. The diagnosis from the psychologist proved that the case was subjected to verbal abuse, so we requested the presence of the mother and the parents, and figured out the source of verbal assault. There was an understanding of the causes from the parents’ side for their child’s situation.” Participant (16), Nurse

Furthermore, although some family members do not mean to hurt their children, especially parents, some of the participants reported negligence that often led to mistakes wherein the children would most likely suffer a tragic or even fatal consequence.

“The majority of cases that come to us have been cases of burns due to the negligence of mothers, for example, she has poured hot water on the child accidentally...we received a strangled child, his mother and father are separated, the child was living with his father and his wife, and nobody was taking care of him. The child died due to negligence that occurred, he was playing with a rope. We are in a small village and there are many trees, a child hanged himself and died.” Participant (26), Nurse

“I remember a case of a diabetic child of 12 years who needed to take his treatment on a regular basis, and his mother was neglecting him, and not providing his necessary treatment. We tried some alternative ways of finding the right person to give him treatment.” Participant (7), Psychologist
Another case of negligence would be the case of absentee parents, as reported by one participant, where the parents would just leave their children unattended because they had just ‘given up’.

“Sometimes, the father brings the child and leaves the child with us, and doesn’t appear again! For example, a father once brought his child to us, and he was unclear with us by saying the mother was not present, and did not exist. There are many circumstances of the case he does not want to disclose. The case involved a girl between the ages of 9 to 10 years old.” Participant (11), Co-ordinator of Child Protection Committee

In a few cases, the perpetrator did not live in the household but worked at the child’s school. A participant, for example, mentioned that the child was emotionally abused by her teacher. Alayed et al. (1998) found most cases of abuse occurred within the family of the child or relatives, with relatively few cases of maltreatment by neighbours or others in contact with the child such as a reported incident of maltreatment by a teacher at school.

“I received one psychological outline of a 13-year-old girl - her teacher was making fun of her in school. Her whole life was destroyed because of her primary school. This girl was talking normally in her first primary year of school, but now she is not talking any more - in this case violence and abuse are not the family’s responsibility anymore... The girl does not speak at all despite her ability of speech, and her father is not convinced of psychotherapy, but he brings her to so he can redeem her social security. I was organising treatment sessions for her, but even her mother is not persuaded of psychotherapy. I was trying to communicate with the mother and father about bringing their daughter to treatment, implying that his social security could be jeopardised.... Using an IQ test, I discovered that her intelligence is actually very high, although her father was convinced that his daughter was mentally retarded. All these issues were because of her teacher in primary school. Her dad just brings her to get her social security.” Participant (4), Psychologist
Lack of parenting skills

Participants highlighted parents’ lack of positive child rearing skills and the lack of supporting parent training programmes. Some fathers believed that they owned their children, consequently they were free to do anything to them and their wives. According to a participant, part of the reason why parents do not admit to maltreating their children is the belief that their acts are not abusive. These parents not only lack parenting skills, they also lack the awareness of what is considered maltreatment or abuse.

“Here, lots of parents exposed their children to different types of violence, up to strangling their kids, perhaps causing disability. If they know what will happen to their children, it will stop them and think a hundred times more before any temptation to do anything that hurts their child. This means a lack of awareness and parenting skills.” Participant (7), Psychologist

A participant highlighted that parents or partners are having this misconception that they own their child or their wife, thus they are free to do what they want. He mentioned that the abusive parents or partners would sometimes justify their abusive behaviour and refusal to report the incidents by demanding that the familial relationships should be kept private, and that the government and the health practitioners should not meddle in familial affairs.

“Some personal things are of greater importance such as the relationship between father and child or husband and wife, when we try to question what ‘makes you do such a thing’. They say ‘it’s not your business, this thing between me and my wife or between me and my child’.” Participant (22), Nurse

Sometimes parents were not aware of the importance of receiving counselling or other psychological interventions to help them and/or their children, because they were not convinced about the causes, impact or potential to change. A participant (4) gave a story about how he suffered from this family in their attempts to help their child receive appropriate treatment.
“Sometimes we reach some cases in indirect ways to provide the case with proper treatment. For example, I had one case where a father brings his daughter to take the advantage of having a financial guarantee from the government, because of his daughter's need for psychotherapy. So I asked him many times to bring his daughter to get the proper treatment in return for what he is looking for: ‘sign the report about his daughter situation to get her financial guarantee from the social security department’. You will never know how he treated her. I think he will treat animals better, gentler and kinder than his daughter…. The girl does not speak at all, despite her ability of speech, and her father is not convinced of psychotherapy, but he brings her to so he can redeem her social security. I was organising treatment sessions for her, but even her mother is not persuaded of psychotherapy. I was trying to communicate with the mother and father about bringing their daughter to treatment, implying that his social security could be jeopardised…. So, I'm trying to help this child, but I have no right to blackmail her father, to treat his daughter, and I had no right to do such a thing. I signed the paper and never saw them again.” Participant (4), Psychologist

The apparent lack of parenting skills, high rates of negligence and lack of awareness of what is considered abusive, and lack of knowledge of the importance of seeking professional help may be due to or be accentuated by the lack of parental engagement. A participant referred to the lack of parental initiative to learn more about being a parent. The following statement also indicates that professional efforts to educate parents may not be needs-led or appropriately targeted.

“Usually nurses are educating parents, but there are those who listen and care about the subject and some others who do not care. Even brochures are placed in the emergency department, and nobody is reading these brochures.” Participant (26), Nurse
Participants stated how many parents lacked parenting skills, how they raised their children in traditional ways even if these led to poor rearing practices, and how they did not acknowledge or comply with the need for psychological treatment. These are all established as risk factors for child maltreatment and hinder interventions (DCPW, 2009; Dyson, 2008; Sidebotham & Heron, 2006; Yampolskaya, Greenbaum, & Berson, 2009). They can be viewed within the interpersonal level of the Social Ecological Model (Bronfenbrenner, 1979), in order to identify strategies for prevention and treatment, as will be discussed in chapter 7.

**Reporting and dealing with abuse cases**

Professionals who dealt with abused children reported being pressurized by the families to maintain confidentiality as an excuse of avoiding responsibility and consequences. They were often expected to keep the information to themselves and not report it to the authorities. Furthermore, the children were under pressure to remain silent and lie to the professionals about what had really happened.

“The biggest problems we face are with parents. In some cases, there are young girls seeking to make a complaint, but parents interfere. The father and brother threaten the girl to prevent her from making a complaint. We try to work hard to help, but there are some cases where we are unable to intervene, because of the threat from parents. The victim cannot complain, because of the pressure from parents - even the police are unable to intervene.” Participant (7), Psychologist

“I face a problem when I tell the parents that I need to record the case - they refuse to co-operate with me. As such, I cannot deal with them.” Participant (3), Psychiatrist

“In most cases, we face pressure from families to not report the case. The majority of cases think that the occurrence of any type of violence is a family or personal matter that should not be interfered with by any security agencies.” Participant (8), Administrator
“I sometimes receive difficult cases, but their families may come and take the case.” Participant (24), Psychiatrist

Delays or deferments by the police following an examination and report on suspected symptoms of abuse were also cited as causes for concern. In some cases, these delays may have resulted in missing important evidence that would substantiate court proceedings.

“In the event of an assault by the parents, the police provide them with an official letter to view the situation in the hospital, and they take samples from them for the forensic department. When we receive these samples after two or three days, some changes would have occurred such as changes to clothes, or the disappearance of physical abuse signs. This is one of the difficulties that we face in investigating and dealing with cases.” Participant (11), Co-ordinator of Child Protection Committee

As depicted in the responses above, some participants felt pressurized by parents or families to not report the abuse case; or to not comply with the procedure and intervention. Participant (11) also demonstrated how a family might intentionally not take their injured child directly to the hospital. This could be because they were scared of being reported and being placed on record, or simply because they thought this was a personal matter. As a consequence, poor reporting and agency responses placed children at greater risk for further victimization (Sege et al., 2011).

Another participant (1) put forward other contributing factors, often beyond the parents’ control, which hindered prompt reporting. Family mental illness was a particularly prominent reason that led to impaired parenting capacity, and this should be taken into consideration in the future care plan by concurrently seeking treatment for the parent.

“Not all the cases need to be documented. In some cases, it is sometimes the lack of parenting in terms of how to deal with their child... is more than just a report. With some families, notes from the outset (such as
cases where a parent is mentally ill) indicate that we need to organise counselling sessions. This goes beyond reporting, in some instances.”

Participant (1), Psychologist

Although, as in the situation highlighted by participant (1), not all cases need to be reported, however, the whole family could need help and support, especially if there is evidence of mental illness. If parents with mental health problems do not receive appropriate support or treatment, the risk for further child maltreatment is high (DCPW, 2009; Dyson, 2008; Sidebotham & Heron, 2006; Yampolskaya, Greenbaum, & Berson, 2009).

During the summer months, children are usually on holiday, which can increase the strain on families already under duress. This may explain the trend of higher reported maltreatment cases during this period.

“Usually in the summer time, we receive more cases than the winter period. We received around one case per month. I remember that I had some abuse cases in the summer period, but hardly any in winter period.” Participant (7), Psychologist

Domestic violence

Many participants highlighted risk factors that increased the possibility of domestic violence generally and the associated child maltreatment.

“The majority of cases have superficial wounds, or light scratches. For example, two married young ladies came to us who suffer from domestic violence.” Participant (22), Nurse

“My relationship is more with pregnant women who suffer domestic violence. In addition to that, I am a member of the protection committee, I am supervising abused cases, but these cases come first to surgeons to assess the case of existence of any external injuries, and the uterus as you know remains protected by God; and that there are three walls,
which remain protected in case of injuries, remaining very few, and being mild and superficial.” Participant (23), Obstetrician and Gynaecologist

“Violence against children in the hospital is rare, but most cases are abused women being maltreated by their husbands. We fill the form, but in the end, there is a waiver from reporting the case to the police about the whole situation. Waive everything and the problem remains as it is with the spouse. Procedures can be registered with bruises, and the paper will be kept on file with us.” Participant (26), Nurse

Participants pointed out the relationship between domestic violence and child maltreatment. It is well established that young women or mothers who experience abuse from their husband are at higher risk of using violence against their children, and often lack the strength to protect them from abuse from family members or strangers (Apple & Holden, 1998; DiLauro, 2004; Guterman & Lee, 2005; Kanoy, Ulku-Steiner, Cox, & Burchinal, 2003; Tajima, 2000; Taylor et al., 2009). Socio-economic adversity compounds this risk (Zambrana & Capello, 2003).

Generally, it is accepted in Saudi customs and culture that a husband is financially and emotionally responsible for his household (Al-Abri, 2010). Moreover, there is pressure on the husband to support his parents, which places further strain on the family finances. As women cannot drive and public transport is poor, he continuously has to drive himself, his wife and children. In many cases, the husband may be forced to purchase a second car and hire a driver, so that he does not have to leave work to take his wife to hospital appointments, shopping or to visit her parents. Such economic pressures on the husband may lead to increased aggression that can sometimes escalate to abuse or violence. However, since women rely on their husbands for security, they tend not to aggravate their temper by reporting any domestic abuse to the authorities. This pattern is not limited to Saudi Arabia, as similar reluctance to report household abuse by women is also observed in other societies (Easteal, 1992; Felming, 1997; London, Bruck, Ceci, & Shuman, 2005).
5.4 Individual level

5.4.1 Age of the child

“The reality is quite different from the session. What people usually do: they don’t confess and say the truth, especially when the case is a child - what makes it worse is when the child cannot express what has happened... Until yesterday, I still remembered the details of the training session, the very valuable information, but it was too difficult to apply. Lots of things grabbed my attention in the sessions, for example, the baby shaken syndrome and the consequences”. Participant (4), Psychologist

5.4.2 Special needs

Children with special needs or disability are at high risk of being maltreated because of several reasons such as their perceived weakness, inability to fully express themselves, dependency on adults, and challenging behaviours (Algood et al., 2011; Bonner, Crow, & Hensley, 1997; Brown et al., 1998; Douglas & Mohn, 2014; Gore & Janssen, 2007; Govindshenoy & Spencer, 2007; Hollomotz, 2009; Mandell et al., 2005; Mansell, Sobsey, Wilgosh & Zawallicl, 1997; Schormans & Brown, 2004; Skarbek, Hahn, & Parrish, 2009; Sobsey & Mansell, 1994; Sullivan & Knutson, 2000; Sullivan, 2009; Wekerle et al., 2001). Maltreatment can thus arise through inappropriate attempts to discipline, increased burden on unsupported families, stigma, or belief that they cannot ‘tell’.

“In the case of special needs, it is more sensitive, and more individuals with special needs are exposed to abuse.” Participant (5), Social Worker

To conclude this theme, several sources of barriers that impeded the effective implementation of child protection guidelines and training were identified by the participants. These included the society as a whole that often influenced the behaviour of the general public in concealing the truth in order to save face and dignity, and keeping
household matters such as domestic violence private. Customs in Saudi Arabia can be interpreted as giving complete rights to parents, especially fathers; thus giving them a justification to even hurt their children.

Policies, and lack thereof, also impeded safeguarding. Some of the complaints included the lack of awareness programmes, or the inability of such programmes, if any, to reach the general population. As a result, parents were still largely unaware of their offenses, hence continued to discipline their children in any way they wished. In addition, the community would continue to remain indifferent of any child abuse cases that they may encounter due to the lack of knowledge, initiative and incentive to report such cases to the authorities. What continues to propagate this pattern is the lack of legislation that would protect reporting of such cases, and that would facilitate rather than restrict professionals gathering evidence.

Furthermore, most institutions that are faced with child abuse lack standardized protocols for staff to follow. Lastly, the implementation of child protection programmes is severely constrained by the lack of resources, in terms of manpower, designated safeguarding time, and ongoing training. As a result, child abuse cases piled up without immediate action, and health or social care professionals were discouraged from passing further reports because of the lack of action from the concerned departments.
CHAPTER SIX

RESULTS (3)

THEMATIC GROUP 3: RECOMMENDATION ON IMPROVING

THE TRANSLATION OF TRAINING INTO PRACTICE
6.0 Introduction

In the previous two chapters, the focus was mainly on the child protection training delivery, the positive or negative aspects of the programme, and participants’ experiences of implementing the training into their practice. Due to the number of factors that appeared to impede the successful implementation of the child protection training programmes in the general population, the participants commented on how wider changes across various units of society could remedy these impediments.

These recommendations on improving policy or practice referred to hospitals, schools and social affairs services, and will be discussed in detail in this chapter. The same principle of the socio ecological framework can be applied with regard to prevention. If there are multiple factors that contributed to the maltreatment of children, there is scope for prevention aimed at different levels. The four key themes that emerged in relation to participants’ recommendations are outlined below. These were: individual, interpersonal, community and societal level. The themes and their sub-themes are summarized in Figure 6.1.
Figure 6.1
Themes and sub-themes on improving the translation of training into practice

- Individual level: Raising children’s awareness
- Interpersonal level: Parents’ education
  - Independent department
  - Follow-up committee
  - Guidance (Direct connection with NFSP)
  - Delineation of roles
  - Special form for children
  - Continuity in training
  - Education training kit
  - Train the trainers
  - Advanced level of training
  - Education for teachers and police
- Community level: Special form for children
  - Continuity in training
  - Education training kit
  - Train the trainers
  - Advanced level of training
  - Education for teachers and police
  - Raising awareness through media
- Societal level: Education for teachers and police
  - Raising awareness through media
6.1 Individual prevention level

6.1.1 Raising children’s awareness about what is acceptable and where to get help

Many participants highlighted the importance of raising awareness through schools, by educating pupils through their curriculum on safety aspects and by creating school committees that focus on such issues. Programmes should be tailored to children’s developmental capacity.

“I suggest that the Ministry of Education could add abuse cases as a story in the curriculum for young children to help them to know how to behave in such situations. In case someone abuses the child, it helps this child to deal with the issue cautiously, in case of teaching them this in the curriculum.” Participant (24), Psychiatrist

“Why we do not make a school committee in each area and distribute questionnaires with the pupils’ counsellor in each school to limit the number of students who have abuse issues, and provide these pupils with the support and help that they need? These committees should belong to the Family Safety Programme, so schools can meet and communicate with students, and deal with cases quickly, especially in cases of students who need help from specialists. This would mean they have the authority to interview parents...” Participant (1), Psychologist

As mentioned by participant (1), education should not be confined to the school setting. This should enlist the help of health care and other organizations to form an integrated network that can both enrich training skills and experience, and establish joint care pathways for more co-ordinated and prompt response.

As mentioned by Gilbert and colleagues (2009a) proposed that the community environment has an effect on child rearing attitudes and practice. Thus, as suggested by the participants, an integrated organization with the objectives of awareness, education and training of
educators, students and other members of a child’s immediate milieu could enhance cohesion and change attitudes towards a single goal of protecting the children (Jaffee et al., 2007). For example, integrated school-based programmes have been reported to be effective in increasing the identification of child abuse cases by equipping teachers with better prevention skills (Zwi et al., 2015).

6.2 Interpersonal level

6.2.1 Educating parents about acceptable parenting practices

Participants highlighted the importance of parents’ education in order to increase their level of awareness, and to counter the negative impacts of the current culture and traditional beliefs that impede the practice of child protection programmes.

“Educate parents; rely on religious programmes, seminars such as conservation topics on sex education... In the case of discovering any abused child, there should be psychological preamble for exposed abused children, a way to educate parents. We have a society that is not narrow-minded, but is possible to say it is a conservative society subject to the standards of traditions and customs, difficult to accept everything; but Alhamdulillah (thank Allah) makes it possible to accept the culture when they seek help from others.” Participant (14), Social Worker

A participant emphasised that parent training sessions should be attended jointly by professionals, preferably within an inter-disciplinary context.

“The training was positive and useful. I hope parents and professionals can attend these sessions. Sharing between parents and professionals should not be limited to the health sector only.... Frankly speaking, the training session was very valuable. The session should be generated for parents.” Participant (5), Social Worker
“Must raise the awareness of parents.” Participant (11), Co-ordinator of Child Protection Committee

According to another participant, hospitals should appoint a Saudi national specialist to be in charge of managing child abuse cases, to ensure that they understand the local culture and traditions; hence have a better chance of engaging and educating families. Someone of another sociocultural background might find it difficult to relate to local culture and language, and thus be less well positioned to communicate education messages to parents.

“I need the support from the administration itself; there should be a first line person who corresponds to the patient and family problems. We meet the patient and see the patient's medical and psychological problem, but patients need a Saudi person only. Here, many people are running away from facing their issues.” Participant (21), Surgeon

Several studies have pointed out risk factors at an interpersonal level that increase the likelihood of child maltreatment such as parenting skills and mental capacity (DCPW, 2009; Dyson, 2008; Sidebotham & Heron, 2006; Yampolskaya, Greenbaum, & Berson, 2009). Thus, the education and training of parents should not only aim at increasing awareness of child abuse issues and at improving parenting skills, but also at countering any negative cultural attitudes like the belief that parents own their children and are allowed indiscriminate discipline (Al-Shail et al., 2012; Butchart et al., 2006; Global Initiative, 2008). Consequently, parents who are made aware of topics such as legislation, child development, resiliency and positive parenting are less likely to engage in abusive behaviour against their children (Shaw, & Kilburn, 2009; Li, Godinet, & Arnsberger, 2011).

6.3 Community level (institutional context)

6.3.1 Delineation of roles

Some suggestions involved carefully defining the roles of agencies, committees and professionals, with regards to what tasks they were supposed to handle and how. One of the
impediments to child protection practice is the lack of an accurate description of a responsible officer’s remit.

“We need something that we base on it, such as a comprehensive plan in dealing with abuse cases, whether with children or adult women or men, acknowledged from the Ministry that it is possible to rely on them, such as illegal births supported by police principality, and the Ministry of Health. We need the same idea for a family safety programme, so we can use it, and it covers the situation from A to Z.” Participant (22), Nurse

“There is a need for having a specific description of each doctor to know his/her responsibilities, and there should be social doctors that are responsible for the subject, because the basic problem is dealing with patients’ families, and these doctors should be the link between us and the patients…. We are able to do all the work from beginning to the end, but there is no co-operation… It is not our responsibility to deal with family problems….? Let’s only point out the availability of people dealing with family problems, because some families are so aggressive, there must be specialists and Saudis in this field. Why Saudis? They will be aware of the culture of the country, so that they can deal with the parents.” Participant (21), Surgeon

“As our society is conservative, if we have a female patient we provide her with a female physician to feel more comfortable than she would be with a male, so we can have more information about the case; like the reason for being abused, how many times she has been abused, and the situation of the abuse case - whether it is psychological conditions, physical conditions, or financial conditions.” Participant (14), Social Worker

As pointed out by Al-Dabaan et al. (2015), forming teams with various specializations could help in sharing lessons and improving competencies. Such inter-professional networking,
communication and information sharing should gradually reduce confusion on agency roles, thus enhancing efficiency in joint-working.

6.3.2 Organisational changes (independent child protection department)

Many participants suggested that, in order to widen and sustain the child protection programme, there should be an overarching department across the existing agencies that would specifically target domestic violence and child abuse. This integrated system should embrace all agencies, departments and government branches; liaise with the media; and engage the public.

“...There should be an integrated system that makes sure of the speed to reach reports and speed verification of these reports, investigate if this is reality or not... ...There is supposed to be a committee that is under the supervision of social affairs. Problems should be solved from social point of view, or in the case of a complaint then the occurrence of the crime committed must be forwarded to the judiciary to investigate in the case situation. It is preferred to have the availability of specialists, Social Workers, Psychologists, so that we can reach to resolve the issue, and investigate what is actually real or just claims... ....We don’t want to open the door to all the issues, like the woman who argued with her husband and then dropped charges. Cases must be limited and move fast, authorities have the power to rapidly move and respond to cases, especially women, and children”. Participant (25), Head of Audit Office and Implementation, Prison Service

“...There must be an independent agency in the Tabuk region to be responsible for this programme, and have the activation mechanism, and follow up until activated properly. There must be an activating mechanism for a programme’s needs to medical cadres’ and social cadres’ co-operation of different parties on the kingdom level of social terms and security terms, which means the need to activate.... It is
supposed to collect all the bodies that could be useful in domestic violence, to interact with ministries: first Ministry of Health, the Ministry of Education and the Ministry of Social Affairs, with security agencies as well as the Ministry of Culture. And information has a very important role, the media is important in the community. For example, if there is a burned child then the security authorities must be involved in the case, or the presence of a father with a personality disorder and is beating children and not taking his child to the hospital, security authorities must intervene in this case, so we can communicate with the father and solve the problem.” Participant (24), Psychiatrist

“There must be an independent department in the hospital, which is responsible for the abuse topic, cares about domestic violence, and should have no other responsibilities, but simply specialises in domestic violence.” Participant (21), Surgeon

A similar recommendation was made by another participant, albeit with such a department being placed within the central government. This independent body would have access to other governmental units in order to facilitate communication.

“Suggestions are with regards to activation in the hospital and having a prominent role. As an example, traffic departments specialise in cars; police specialise in the problems of the people along with social security. It should have an independent department, the centre is linked with government departments who have their effective role.” Participant (15), Social Worker

Two participants mentioned the need for an independent structure or centre that would take care of child abuse victims, as well as provide support to families that are going through the difficulties of domestic violence. These centres would deal exclusively with maltreated children, and would work in co-operation with hospitals and specialists, therefore be accessible and remain available to those who needed help.
“I prefer that there is protection for abused people, and that availability centres are in nearby hospitals or in the region. ... We prefer an existence centre we can follow with them, as dealing with people is a totally different aspect to attending lectures... A specialised centre, which can provide abuse cases with care and that is complete with everything necessary for the case. In the case of a centre’s position, this protects the person, and protects the privacy of the person in terms of dealing with the cases... The reason behind this is that in large areas, no one knows anything about others, but in the small centres everybody knows each other’s business. Where people in small towns are known by their jobs and specialties, it is not the same situation in large cities such as Tabuk, Jeddah or Riyadh, where no one knows others.” Participant (22), Nurse

6.3.3 Need for a follow-up committee/need for ongoing guidance

In order to make the training programme sustainable, many participants recommended that there should be a responsible committee, with monitoring and follow-up as its key tasks.

“There should be visits to the hospital every two or three months on a regular basis... For example, the Committee of NFSP from Riyadh visit King Khaled Hospital to see cases that have been dealt with in connection with violence against children. But without follow-up, or from this far, it is difficult to be sure of the whole situation accurately... This Committee shall ascertain what is happening in hospitals in reality, regarding the training programme, where they have been trained by specialists.” Participant (20), Obstetrician and Gynecologist

“I suppose there should be follow-up sessions to discuss the situation that has been discussed before, and use them as part of the second
follow-up session that has been learned, and the presence of continuity, continuous communication between the different parties... there must be constant communication between them, so that they become a nucleus of the programme in all regions of the Kingdom.” Participant (25), Head of Audit Office and Implementation, Prison Service

“I suggest that there be a follow-up committee of the committee of abuse and domestic violence, and therefore include all cases of childhood up to the age of twenty. This committee must be qualified and specialized in follow-up and having the authority to recruit and discharge unqualified people who are not competent. This will help a lot in improving the service, as will a request for a monthly report of cases that come to us. Also, because a lot of children violate their rights, powers of committees need to be reorganized to accommodate this issue.” Participant (4), Psychologist

A follow-up committee could also oversee a secondary and tertiary prevention programme that would review existing cases of child maltreatment, as well as those children who are prone to be maltreated based on risk factors. A follow-up committee could also address the issue of non-response or failure to report to professionals (Flaherty et al., 2012). This committee could encourage professionals to decide to report cases of child abuse that they encounter by constantly and regularly updating them with new information. This could significantly decrease non-reporting among professionals, which was encountered as problematic, and did not allow the emergence of reliable statistics figures (Jones et al., 2008).

Many participants also highlighted the need for guidance on how to act in particular situations regarding child abuse. This could be in the form of practitioners seeking consultation; booklets with information from specialists but conveyed for lay people; or other materials that would provide instructions or procedures to be followed when reporting a child abuse case. These should be produced under the hospice of the National Safety Programme, thus remain up-to-date and consistent with changing policy and services.
“There could be booklets about the same specialty.” participant (16), Nurse

“We need support or guidance from NFSP or a particular procedure to be followed.” Participant (8), Administrator

“Perhaps there could be a Smartphone Application as a guide for the professionals, so they can return to it and be up to date with information. Using technology in recognising abuse cases would be excellent.”
Participant (17), Shelter Director

A similar guiding system or protocol has been suggested and tested by Baile and colleagues (2000). Their SPIKES framework provides strategies that are specific to the context. These include stepped guidance on dealing with families and e.g. challenging difficult emotions. Another suggestion was to create a reporting and referral form exclusively for children that would make the process more standardized, organized and easier, rather than continuing to use the generic form on protection for violence.

“There is a need for a special form for child abuse cases… We only have a general form for violence and abuse; I wish there could be a special form for children to help us in the development of statistics...There are three types of protection forms for violence and abuse (a, b, c). The last form model was c and was almost four pages.” Participant (16), Nurse

“There is an abused case form, but this form is inadequate from the protection side.” Participant (22), Nurse

6.3.4 Need for booster and continuous training

Many participants highlighted that training in child protection was essential, but also wished that it could be repeated. As there is large demand for further understanding in the field, they
recommended that such useful courses could be extended to other groups such as teachers and school mentors. Booster courses would bring professionals in touch with policy and procedures changes, as well as refresh their skills.

“I wish it could be repeated again… I suggest that the training programme should be activated again.” Participant (10), Hospital Director

“We lack many courses in the hospital, and wished the training sessions could be repeated again or conduct something new, especially in the children’s field. There should be many courses in the same field.” Participant (16), Nurse

“The training session is not repeated again. No follow-up after the training session, no continuity of this type of training session, no update information or any statistics. We need sustainable training courses. These training sessions develop our skills and help us to improve in the right way.” Participant (7), Psychologist

The time interval between training sessions was also deemed important and could be effectively reduced through brief booster courses, as well as targeted communication and information. Participants favoured a strategic and sustainable approach to training being integral to their practice, in contrast with induction or ad hoc courses.

“The training courses have many sessions that are spaced out, I mean long periods between these training sessions. For example, there is one training programme every two years. The training sessions supposed to be conducted every three months, or every six months.” Participant (20), Obstetrician and Gynaecologist

“The training should be held at least once a year, so that they can give their views and know about the new ideas in the field, and become
familiar with updates. There should be continuous communication with them. These courses are necessary. More than a year has passed, and it is possible to forget what has been studied during the session due to the absence of any activation regarding the session. We would like continuous and permanent communication.” Participant (22), Nurse

“We need to be contacted more, e.g. every two or three months from the Family Safety Programme, so there will be mutual activation among specialists, or meetings on a regular basis, and constant follow-up. Complaints about the training sessions saw nothing happen for more than a year until now, where help about the continuity and renewal of information is improved.” Participant (6), Surgeon

A participant wanted to expand the training topics by involving trainers from different backgrounds.

“Only the need to intensify this type of training course and diversification of the lecturers for cultural exchange, exchange experiences and knowledge.” Participant (14), Social Worker

Others suggested that, in addition to increasing the frequency and intensity of the training, the training should be broadened sufficiently to relate to other members of society, not just the professionals concerned.

“The programme was excellent, but it needs to be more active, due to the absence of many training courses.... Compared to other regions, we need many sessions at the regional level (Tabuk) about violence against children.... There is also a need for such courses and seminars, as well as a general societal need for this type of courses. When there is an existence of training sessions with expert teams in the field, we will have a greater positive impact, especially when it is face-to-face, because it is a greater interaction with specialists from the point of view of
demonstrations, thereby yielding richer understanding and responsiveness.” Participant (9), Head of Nursing Department

“The training should be on on-going basis, combined with regular meeting for practitioners who are experienced. The training should be distributed across the Kingdom, and not just concentrated in large cities such as Riyadh and Tabuk.” Participant (2), Social Worker

6.3.4.1 Education training kit

The compilation of a training pack from various sources would avoid duplication or each region developing its own training materials. This should include booklets, brochures and digital copies of the training sessions, to enable trainees to revisit them when required.

“Although there was a training bag distributed in the training, but we need more training overall. We have the experience of the training sessions - we train teachers and mentors in our schools.” Participant (13), Director in the Ministry of Education

“There could be booklets about the same specialty.” Participant (16), Nurse

“There should be awareness education programmes for them, either through CDs, flyers, or brochures. These are very important.” Participant (13), Director in the Ministry of Education

6.3.4.2 Training the trainers

In order to improve and sustain the quality of the training, the NSF developers should adopt a long-term strategy and establish a core pool of trainers. A parallel training programme should aim to improve and maintain the competencies of participants.
“There is a need for a specialist to guide them and to help them to become a better trainer.” Participant (13), Director in the Ministry of Education

Two participants mentioned the need for qualified, specialized and regularly trained personnel to lead in terms of execution of plans, training participants to become better coaches that would lead to increased skills and awareness, not just of the participants but also the staff and students that they would pass their knowledge to in future training.

“The programme should be diligent when implementing certain mechanisms. It should be activated by qualified people. It should also have more regular meetings, and should increase the awareness level for people to not wait for more than two or three in child abuse cases, and we know that this is abnormal of any delay.” Participant (11), Coordinator of Child Protection Committee

“Even if we were supervisors, we still need a specialist to guide us to help us become better trainers. This could be by bringing in experienced instructors to train us as to how we can be a successful coach – a ‘train the trainer’ format ...It was a very successful training session - we aspire to be better individuals. One course is not enough to give good positive results. Why do we not try to get the maximum benefit from training us by creating our own educational training kit that covers all the key areas?” Participant (13), Director in the Ministry of Education

6.3.4.3 Advanced level of training

As practitioners developed their skills and experience, their training needs constantly changed. Training should reflect these different needs by providing courses at respective levels such as induction for new practitioners, basic training, and an advanced level for more senior and skilled practitioners. There should also be training available for policy makers, managers and administrators adapted for their job requirements.
“The session was wonderful, but there is a need for a tremendous amount of courses in this area. It is assumed that the trainee is given intensive courses, not just a few courses – this can facilitate deeper exploration into this area... However, when we are more advanced in this area, this will give us a greater opportunity to benefit further...”
Participant (13), Director in the Ministry of Education

“I am interested more in medical points, discovering the finer things that will possibly help me more and more in the area, or new and innovative ways of expression, such as expression through drawing for the child...I would suggest conducting training programmes for managers or directors that can enhance skills of the staff who work in the same environment. As a director I would like to have leadership courses, and these courses should rely on scientific foundations of true innovations.”
Participant (17), Shelter Director

“Honestly, I didn’t get much benefit.... Because the first thing is that the explanation was not clear. Do you mean general information? Yes, it needs more clarity and more accuracy for doctors, I mean I haven’t benefited from the session.” Participant (20), Obstetrician and Gynecologist

Participant (20) thus complained that the training session was vague and general. His specialism may require future adaptation to these needs, rather than combining with all other health settings. As stated by Reay (1994), it is important to find out the specific training needs of each party in order to design a training programme that would specifically address their needs. Even more so, individual training was suggested by Blanchard and Thacker (2007) as being more effective in order to tailor to their particular needs. This should be balanced against the resource implications of providing too many or disjointed types of training, hence the importance of ongoing feedback and evaluation.

“I have a suggestion, which is to receive a simple e-mail about the conducted training courses with their contents before and after the
training, to show us what was happening throughout the training programme, and a summary about the inputs and the outputs. To make a simple report of what happened in the course, so that we can be in touch, this is the first call after the training session... We could suggest having a WhatsApp group that cares for protection committees... I am holding the training here in Tabuk, and all Tabuk regions are sharing in the training, we can do many things and many works through WhatsApp in regards the training. I am in charge of the training section at this Hospital.” Participant (23), Obstetrician and Gynecologist

Participant (23) is one of the busiest professionals in the sample; he suggested the need to communicate with the members of the training team by utilizing technology such as email or applications that allow for easy interactive communication. This method would also help in synthesizing the training programmes and ensuring that all participants are up to date with the latest information and research regarding child protection.

6.4 Societal level

6.4.1 Extension of training to schools

Many participants mentioned the importance of raising awareness on domestic violence and child abuse for the whole school community through the Ministry of Education, by targeting kindergartens, primary and secondary schools. These programmes should involve different types of activities, with active teacher and pupil participation. Their sustainability would be facilitated by high-level collaboration between the Ministries of Health and Education, which would be mirrored at both the school and hospital level. Attention should be given in educating representatives of all school roles, i.e. teachers, special needs instructors, as well as administrators.
“The awareness education programmes are supposed to spread in schools - including the teachers in the primary grades that should be a targeted group to assist in the discovery of abuse cases.” Participant (13), Director at the Ministry of Education

Participant (5) emphasised the importance of involving special needs instructors, because children with learning difficulties, developmental delays, and physical or sensory impairments might not articulate their distress in verbal ways, thus experience of maltreatment might be more difficult to detect. Also, teachers and other educationalists are likely to suspect abuse or neglect at an earlier stage than health specialists, since they know the students better and they are more aware of the children’s circumstances that may place them at risk. They are also more exposed to behavioural or physical changes in the children, thus, they have more chances of identifying possible maltreatment. The problem lies in the lack of knowledge of educationalists as to what to look for in identifying potential cases of maltreatment, how to deal with it, and how to liaise with external agencies.

“Training sessions should be intensive for educators and designed more for special needs instructors. It shouldn’t be exclusive for healthcare sectors. The health specialists are facing only victims of violence who have usually shown very severe symptoms upon entering the hospital. However, with regards to education, the level of knowledge required is not up to standard in the cases of violence... I have direct contact with teachers, but they do not have any experience of child protection courses.” Participant (5), Social Worker

Teachers should be equipped with essential knowledge of recognising signs of child maltreatment and responding accordingly. The key topics that were recommended included the signs and symptoms of child abuse, sexual assault, violence and physical abuse.

“There are many schools that require us to raise awareness about various topics such as sexual harassment, violence, and physical abuse.”
Participant (1), Psychologist
“The awareness for teachers should help them to know what symptoms are, and how to deal with and direct potential cases.” Participant (13), Director in the Ministry of Education

Educationalists could be accessed through print and digital materials, or by experts regularly visiting their schools. Participant (24) mentioned that the school should be the starting point making children aware of safeguarding issues. However, this requires specialist skills and dedicated time to communicate messages in a consistent way.

“There should be awareness education programmes for them, either through CDs, flyers, or brochures. These are very important.” Participant (13), Director in the Ministry of Education

“There should be a direct connection to school; there should be cooperation between the Social Worker at the hospital and the schools or kindergarten...This direct connection with schools is by creating a responsible party in the hospital, such as a psychiatrist specialising in abuse cases, and linked with kindergarten and schools in the area; and any organizations related to children and able to link cases of domestic violence, which cannot be reached with hospitals.” Participant (24), Psychiatrist

6.4.2 Extension of training to police

Participants stated that the authorities, particularly the police need further education in order to become more efficient in protecting children from abuse. The current role of the police is confined to action when abuse has already occurred and the child has been hurt. Participant (25) suggested that it would be more helpful if police are trained to prevent child abuse by becoming more aware of the underlying risk factors in order to identify families that are more likely to engage in child abuse.

“Police do not take any action if there is just a report. The police movements may be slow because of the lack of situational background,
whether it's from the health sector or other authorities. The police lack the preventative side, nor full themed backgrounds… Police need prevention programmes, and especially the abuse topic needs special awareness and special care and background.” Participant (25), Head of Audit Office and Implementation, Prison Service

Furthermore, this participant suggested that the police need further education in collecting evidence that would aide in substantiating a child abuse case. This would be particularly important in the context of the Saudi culture, i.e. the police would benefit from developing skills that would allow them to gather information from family members and neighbours who are frequently concealing the truth or are just indifferent to child abuse situations within their community.

According to Bannon and Carter (2003), child protection training and education should be mandatory; however, its scope and content should be dependent on the recipient’s needs, and current level of knowledge and awareness. Thus, education programmes outside the core health care and welfare professional groups, should be designed to cater to different roles and needs such as those of students, teachers, families, media and police (Starling, Sirotnak, & Jenny, 2000).

6.4.3 Media

Many participants highlighted the need for raising the awareness of the general public through the media. The main benefits of using this channel would be the extensive reach and potential scale of its impact. Some suggested traditional media platforms such as advertising on television or radio.

“First, unfortunately there are many advertisements on television, but no programmes are talking about domestic violence and its effects on society and its harms. I think that the Ministry of Health is spending a lot of money, and what if, for example, it makes two or three programmes on the most popular channels that are watched by many people? It will have
a great impact on people. Why are there no programmes specialised in domestic violence on the channels that people love, and therefore speak to people and enter deep in the society?” Participant (24), Psychiatrist

“The whole role is for the media, the media should raise awareness and prevention programmes also.... Awareness and warning people will reduce the rate of violence.” Participant (21), Surgeon

“Increase the awareness level, people need to absorb the information, and that is the role of various agencies on television or radio or via the Internet, or for any method of communication. But because of ignorance and lack of awareness, activation does not happen, nor interaction with the whole situation. Raising awareness is the only topic that could help.” Participant (19), Psychologist

As mentioned by participant (24), the use of traditional media is costly, and there are several competing areas for the funding by the Ministry of Health. Any financial implications should be considered in the light of core staff to perform child protection duties across a large number of health centres due to budget constraints. Thus, a recommendation was to propagate information about child protection through the more cost-effective internet and social media, which also access a wider audience.

_Or a programme could be made available on YouTube or on the Internet that can reach people easily, for example, making a simple advert to create awareness about domestic violence: if you have a problem you can call this number, for example (child helpline).” Participant (24), Psychiatrist

“These are new concepts for the community. However, work environments and the Internet have begun to influence people mentalities to increase their awareness.” Participant (13), Director in the Ministry of Education
Awareness of the general public through the use of media can address the macro-level impact on child maltreatment as a function of cultural, religious and other societal factors (Al-Shail et al., 2012; Butchart et al., 2006). As suggested by the participants, addressing societal factors through the media could lead to a significant decrease in the rates of corporal punishment, by shifting the underpinning cultural and religious norms that support this (Zolotor & Puzia, 2010).

To conclude this chapter, under the recommendations for improving the translation of training into practice, three subthemes emerged. The first and second subthemes referred to different levels of ongoing educational programmes to meet the needs of different groups. Beyond health professionals, programmes should target schools, through both training and awareness campaigns for teachers and students; and parents, especially those who exhibit the risk factors in order to change perceived cultural norms on methods of discipline, particularly corporal punishment.

The third subtheme suggested changes in organizational structures that would entail formation of groups or committees to exclusively deal with child abuse and child protection. These could include forming an independent department with a clear mission that would have a designated budget for both service and training responsibilities. A follow-up committee should regularly monitor child abuse cases; provide guidance from the NFSP on procedures and practice; delineation of professional and agency roles; and development of a reporting and referral form specifically for children. Ongoing training was recommended, with refresher courses and complementary training materials in various formats. Investment in training a pool of trainers was considered essential for the sustainability and advancement of the programme.

Lastly, the societal level focusing on the media, in order to target and gradually shift public attitudes; and the police, on procedures and competencies related to early recognition, response and effective liaison with other agencies.
CHAPTER SEVEN

DISCUSSION
7.0 Introduction

In the previous three chapters, the results were presented under three thematic groups. A substantial data set was gathered during the course of the study. The analysis was guided by the need to answer the three research questions, which were as follows:

• RQ1: What are professionals’ perceptions of the benefits and limitations of the child protection training programme in aiding their practice with child abuse and neglect cases?
• RQ2: What are the factors that professionals perceive to influence the implementation of child protection training?
• RQ3: How can policy, services and training be improved to meet children’s needs?

In this concluding chapter, the key findings will be discussed in the context of these research questions, the literature, and their implications for future research, policy and practice. In particular, the methodological implications will be considered, followed by the researcher’s reflection and a summative conclusion.

7.1 Critical overview of the findings

The aims of this research were to explore professionals’ experience of the delivery of training presented by the National Family Safety Programme in Saudi Arabia, the factors contributing or hindering its implementation, and their recommendations for future improvement. Three research questions were formulated for this purpose. It is, therefore, logical to discuss the main research findings under these three main domains. However, there is some overlap of the findings in relation to the first two research questions, which will be discussed in detail below.

In order to answer these research questions, the following steps were taken. First, all the data was manually transcribed and read twice. This step is sometimes known as horizontalization in the literature on qualitative methodology (Bernard & Bernard, 2012; Davies & Hughes, 2014; Denzin & Lincoln, 2011; Flick, 2009; Holloway & Wheeler, 2013; Merriam, 2012;
Punch, 2013). In Chapter 3, this process was referred to as the first phase of Braun and Clarke’s (2006) structured approach to thematic analysis, known as ‘becoming familiar with the data’. The purpose of horizontalization or data familiarization is to ensure that all data is taken into consideration, thus lowering the possibility of ignoring discrepant cases, or otherwise selecting data to support a particular interpretation that is favoured by the researcher but that cannot be justifiably extracted. The next step in thematic analysis recommended by Braun and Clarke (2006) was to generate initial codes. In Braun and Clarke’s framework, codes are used to build themes, so the process of coding is extremely important. Codes and themes are, in turn, connected to the research questions that have to be answered. Table 7.1 below contains the extracted codes and themes for the study.

**Table 7.1**

**Research Questions, Themes, and Codes of the Study**

<table>
<thead>
<tr>
<th>Research Question</th>
<th>Themes</th>
<th>Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>RQ1: What are professionals’ perceptions, including the benefits and limitations of the child protection-training programme, in aiding their practice with child abuse and neglect cases?</td>
<td>RQ1.1: Training Delivery</td>
<td>(a) Knowledge, (b) Trainers’ Skills, (c) Workshops</td>
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<tr>
<td></td>
<td>RQ1.2: Skills</td>
<td>(a) Greater Awareness of Abuse Cases, (b) Personal Development</td>
</tr>
<tr>
<td></td>
<td>RQ1.3: Rising Awareness</td>
<td>(a) Schools, (b) Hospitals</td>
</tr>
<tr>
<td>RQ2: What are the factors that professionals perceive to influence the implementation of child protection training?</td>
<td>RQ2.1: Societal issues</td>
<td>(a) Customs and traditions, (b) Policy issues, (c) Legal issues</td>
</tr>
<tr>
<td></td>
<td>RQ2.2: Community issues (Staff issues)</td>
<td>(a) Shift working time,</td>
</tr>
</tbody>
</table>
## 7.1.1 What are the professionals’ experiences of the delivery of the training programme?

The professionals, especially those in medical practice, experienced the delivery of the training programme in an appreciative manner. They believed that their knowledge and skills vis-à-vis child protection had been enhanced, and they expressed enthusiasm about sharing what they learned with their colleagues who could not attend training. Professionals also appreciated having access to the training materials, which were mentioned as being an important component of the programme.

Professionals’ experiences of delivery varied somewhat, depending on factors such as work role, setting, prior knowledge, personal circumstances, individual learning preferences, and...
other factors. Although professionals brought different perspectives and realities to the training programme, even those who were critical of certain aspects of the programme found some benefits in it. Professionals reported that the results of the training, which were compressed into easily understood materials and practices, were easy to transfer to actual practice settings such as schools and hospitals. This aspect of the evaluation indicates that the training programme was delivered in a manner that was relevant to the participants’ job roles.

7.1.2 What are the professionals’ experiences of the training implementation?

Professionals noted that implementing the training was impeded by social factors, policies that were not fully developed, a lack of standardized protocols, and other variables. Although they identified several benefits of the actual content of the training programme, they reported that implementation was rendered more difficult because of Saudi society, which, unfortunately, attaches secrecy to domestic violence and related matters. This secrecy often prevents individuals from making the kinds of disclosures that are necessary for child protection policies and practices to take effect. Even though professionals lamented the fact that Saudi society does not emphasize children’s rights, this insight was not directly related to the utility of the programme. Rather, professionals indicated that, however well-intentioned, the programme ran into practice difficulties in the realm of implementation.

Implementing the training programme required a certain level of co-operation, not only from society in general, but also from specific strata of the Saudi public sector. Professionals were quick to note the gaps in Saudi policy (including legislation) in protecting child abuse whistle-blowers and in facilitating evidence-gathering by agencies tasked with protecting children. Professionals noted that the absence of standardized protocols and a general lack of resources made implementing the training programme difficult. Participants reported the backlog of child abuse cases and lamented the way in which the bureaucratic system discouraged healthcare and social care professionals from filing additional reports, given the general lassitude in following up on such reports. Overall, the benefits of the training programme appeared related to improvements in individual characteristics (such as skills,
knowledge, and awareness), while its limitations were to the friction imposed by the cultural climate, the practical difficulties of inter- and intra-agency co-operation, and the insufficiency of policy-based support measures.

The findings related to the second research question can be understood in terms of the organizational change literature and models (Gallagher & Worrell, 2008; Madsen, Miller, & John, 2005; Tallon & Pinsonneault, 2011; Wang, Fang, Qureshi, & Janssen, 2015; Weiner, 2009; Worley & Lawler, 2010) discussed in Chapter 2. The key contribution of this literature is that organizational change is a complex process, even when stakeholders are in broad agreement. When there are tensions or conflict of interest between stakeholders, organizational change can be even more difficult, especially in the absence of a top-down change management force. In the context of the current study, perceptions about the training were conditioned by the fact that the training was neither mandatory nor overseen by a central authority that had the power to compel stakeholders to co-operate on the ground. Participants were, therefore, guided by their own perceived costs and benefits. As the data analysis revealed, they perceived various benefits, and it is possible that the perceived costs - such as the difficulties of co-operation with colleagues and across agencies - were related not so much to the shortcomings of the training itself, as to the absence of a central governing mechanism that could bring all stakeholders together.

Another way of connecting the RQ1 and RQ2 findings to theory is through theories of public administration. In Niskanen’s budget-maximizing model, the central claim is that bureaucratic leaders try to enhance the budgets of their own departments because doing so is a reflection of rational self-interest (Niskanen, 1968). In this model, bureaucracies tend to grow as, over time, administrators are able to find ways to increase their budgets. Niskanen’s model thus suggests a secular growth in the apparatus of public administration. In Dunleavy’s bureau-shaping model, the goal of the rational bureaucrat is not necessarily to expand the budget of a department, but rather to shape work, in order to increase personal utility in other ways; for example, by shaping bureaus to engage in what bureaucrats consider rewarding work (Dunleavy, 1989).
The bureau-shaping model is broader than the budget-maximizing model. In the budget-maximizing model, the only true form of utility sought by the bureaucrat can be reduced to money, whereas, in the bureau-shaping model, the money allocated to a bureau is only one of many possible forms of utility that bureaucrats might enjoy. In both of these models, self-interest drives departmental agendas. Given that many of the RQ2 findings were related to the limitations of co-operation across agencies, it could be the case that departmental self-interests precluded the kind of co-operation necessary for the programme to work as intended.

Theories of culture are also important. Given the lack of co-operation among people as well as among departments identified in RQ2, attention should be given to how organizational culture in Saudi Arabia might have created an environment in which people are not encouraged or taught to co-operate properly. Theories of self-interest (Effelsberg, Solga, & Gurt, 2014) as well as of self-focused business culture (Herndon, Fraedrich, & Yeh, 2001; Hofstede, 1994; McKinnon, Harrison, Chow, & Wu, 2003) could help in explaining this finding. Finally, theories of national culture (Rapaille, 2007) are also important in explaining how and why obtaining co-operation from family stakeholders can be challenging too, given that there are aspects of Saudi culture that make it difficult to interdict, detect, and remediate child abuse.

While there appeared to be many distinct findings in RQ2, these can be synthesized according to Rabin’s (2006) open systems view of organizations, presented in Figure 7.1 below:
Based on this model, it is clear that individual skills and talents, as well as institutional resources, are the inputs; the process of training is a transformation, and practice is an output. The benefits of translating training into practice can thus be considered what Rabin (2006) described as services and outputs. Constraints can be considered waste, in that they prevent the transformation process from being as efficacious as it could otherwise be; and recommendations can be considered feedback to improve future cycles of input → transformation → output.

Admittedly, there are many stakeholders in interdisciplinary child protection training programmes. On the basis of the results, such stakeholders include children, parents, psychologists, physicians, social workers, the police, and many other individuals and agencies throughout Saudi Arabia. However, Rabin’s model suggests a means of looking at
all of these stakeholders as part of a complex system. The desired output of this system is child protection; many resources, tangible and non-tangible, are the inputs for this desired output, and training is the transformation process that is designed to yield the output.

The findings for RQ1 and RQ2 can thus be understood as providing guidance about how and why the transformation process is successful, how and why the transformation process is impeded in the generation of the desired outputs, and how the overall system can be improved. With this holistic view in mind, the general point that can be synthesized from the findings is that socially specific, evidence-driven steps can be taken, and are being taken, to improve the manner in which available resources are being applied to the desired end result of child protection. However, the limits of such steps were also noted and related to the need to improve both (a) the quantity and quality of inputs; and (b) the training processes whereby inputs are transformed into practice.

7.1.3 What are the professionals’ recommendations for improving the training?

Professionals offered several recommendations for improving training. A key recommendation was to calibrate the training to the needs of different groups. Participants identified schools, parents, the media, and the police as key groups that also needed to be included in the training programme. Given that the improvement of child services in Saudi Arabia requires the co-operation and co-ordination of multiple social groups, this recommendation has strategic and overarching implications. Professionals were highly specific in their recommendations about how to create targeted awareness programmes in schools and hospitals; promote behavioural changes among parents; convince the media to alter social mores regarding children’s rights; and lobby the police to recognize, respond, and liaise more effectively in matters related to child safety.

Another recommendation focused on how to change organizational structures. Professionals recommended the formation of an independent, cross-functional, and well-funded department with a clear mission related to child protection. This is particularly valuable
insofar as it illustrates the possibility that a new department, with a new bureaucratic culture, might be more effective than attempting to promote change among existing departments. Finally, professionals recommended ongoing training, refresher courses, complementary training materials, and other forms of lifelong learning. Many participants expressed their interest in having a pool of trainers always available to disseminate knowledge.

These recommendations can also be understood in the context of Rabin’s (2006) theory, in that they fell under one or more of its four categories:

• Inputs: Recommendations about how the training required more resources in terms of time, personnel, and guidance.
• Transformation: Recommendations about how to make the training more relevant to trainees.
• Outputs: Recommendations about how to structure the training, so as to ensure that outcomes are beneficial to children and easy for agencies to implement.
• Feedback: Recommendations about how to take the viewpoints of trainees into closer account when designing future versions of the training.

These recommendations can also be understood in light of organizational change theory (Gallagher & Worrell, 2008; Tallon & Pinsonneault, 2011; Wang et al., 2015; Weiner, 2009; Worley & Lawler, 2010), in that the participants were clearly all vested in promoting specific changes related to the training programme. Their recommendations can be interpreted as individual trainees’ insight into how the training could be made more relevant to partner agencies, professionally useful to attendants, and effective in terms of mitigating and managing child abuse outcomes.

7.2 Methodological implications

This study employed a qualitative approach in order to achieve the set objectives. The qualitative design provided the basis to achieve a better insight into the perceptions and experiences of professionals who were dealing with child maltreatment cases, by explaining
and interpreting the data (Barker et al., 2002; Corbin & Strauss, 2008; Fossey et al., 2002). The theoretical framework can guide the reader on how the research knowledge was structured and derived (Anfara & Mertz, 2006; Bryman, 2012; Meyrick, 2006). This theoretical framework derived from a social constructionist perspective, and highlighted how the interaction between inter-agency professionals enabled them to learn and to form their experience and knowledge (Crotty, 2003; Cunliffe, 2008; Holstein & Gubrium, 2013; Hruby, 2001).

In terms of the methodology, the results are important as an illustration of how much rich data can and should be collected in the context of program evaluation. One reason that the accumulated study data were so rich is that open-ended questions were posed, thus allowing and encouraging participants to speak on topics of particular interest to them. Participants were not pigeonholed into responses, which helped to account for both the high volume and the high quality of the findings.

7.2.1 Challenges and limitations

Throughout the study, a number of challenges emerged. First, the sample was self-selected, thus may not necessarily have been representative of all regions of Saudi Arabia, both in terms of socioeconomic and service characteristics. Therefore, there is a possibility of the collected data being biased, which would translate the perceptions of participating professionals to the implementation of the multidisciplinary child protection training programme across the country. There is also a possibility that through such potential self-selection of the sample, important areas with distinct needs may have been overlooked. However, a great deal of effort was made to ensure that the study covered the relevant areas, factoring the budget, human and time constraints.

Second, the distribution of professionals and the lack of inclusion of agencies from the private sector poses a challenge. The majority of professionals were from the health field. Consequently, there is a lack of perspective from other relevant professionals such as teachers, who spend significant time with vulnerable children. The retrospective recollection
of experiences and perceived impact could have detected polarised positive or negative views. A longitudinal study following-up participants after the training could account for some of the constraints, and establish the predictive value of factors related to the trainees and the training programme.

Some participants may have found it hard to freely express any criticisms of the programme, as they may have experienced second-order sensitivity or perceived threat. The implementation of the training to the general public was difficult, because of lack of readiness and the presence of stigma in the Saudi society. This was reflected in the available information being collected. There was thus limited access to service records for more detailed service activity data related to child protection. The use of sensitive interview topics may have been challenging to some participants. Consequently, they may have felt apprehensive about discussing barriers in their practice that could be related to colleagues, managers or particularly the authorities.

Finally, this study could only establish perceptions of impact without corroborating with objective service data. This is a limitation of most training evaluation studies. For example, future research could explore whether the training is associated with increased recognition of child maltreatment, more efficient inter-agency working, and better outcomes for children’s well-being by including a control group from a region with matched characteristics but without access to child protection training. Such designs can be difficult to achieve due to ethical as well as organizational reservations from policy makers and managers. Some of the methodological dilemmas and challenges, and ways of addressing them in future research, are discussed below.

7.2.2 Study design and sample

The study adopted a qualitative methods design that drew upon a purposive sample of professionals exposed to the training programme (Cohen et al., 2007; Smith & Osborn, 2008). As already stated, the design could have been improved through a mixed methods framework by adding a quantitative component that would have allowed the measurement
of changes in knowledge, attitudes and competencies; and corroboration with objective indexes of service activity. As acknowledged in the previous section, the sample was limited in terms of several factors. Medical professionals were over-sampled in relation to professionals involved in policy formation, social work, and other areas. In terms of geography, the sample drew almost exclusively from Tabuk region. The study did not contain objectively measured service data on implementation, asked participants to engage in retrospective recall (rather than encouraging the recording of thoughts concurrently with the training), and lacked a prospective design that would have gathered follow-up data.

7.2.2.1 Analytical framework

The analytical framework used for this study was the three-point qualitative coding technique of data horizontalization, data thematization, and data synthesis. This approach is the standard approach to coding qualitative data (Creswell, 2009). However, the approach could have been strengthened by using coding so as to determine whether themes and trends varied according to participants’ role; for example, the agencies to which participants belonged. Thematic analysis was the preferred approach for this stage of the theory-driven evaluation (Boyatzis, 1998; Braun & Clarke, 2006; Colahan, Tunariu & Dell, 2012; O’Reilly et al., 2013), although future studies that require larger samples across different regions can use content analysis, and thus determine categories to allow comparison between different sub-groups.

7.2.2.2 Interview schedule

The interviews were conducted by telephone because the interviewees were distributed across different geographical areas (Wilson, 2014). These were scheduled to take place within a period of one month. The researcher called the participants on the phone at different times within that one-month period, as previous engagement through emails had not been highly successful. The use of the telephone, based on suggestions from the course organizers, significantly improved the response rates. This increase could be partly explained by
cultural factors. The researcher’s base in the UK was another reason for which it was not possible to engage the participants over a longer period.

Despite these constraints, participants who agreed to be interviewed were largely engaging in sharing their experiences. A semi-structured interview was the appropriate tool, as a structured equivalent would not have enabled participants to add their own experiences and views, whilst an unstructured interview would not have guided or prompted enough, thus focusing on service-related matters (Barker et al., 2002; Oates, 2005; Wilkinson et al., 2004). It would be interesting for future studies to involve service users, i.e. children and families, on their experiences of the process, despite the sensitive nature of the study.

7.2.3 Research procedure

The researcher initially focused on the setting and context of the research through an overview of child protection policies and protection, as well as of health and social care services in Saudi Arabia. Following this overview, the researcher identified the National Family Safety Programme as the key child protection interdisciplinary training forum and liaised with the organizers. The organizers welcomed an additional and more in depth evaluation, and the research was facilitated by the NFSP Directors and the NFSP Research Managers, who made available the existing records and data. This resulted in the identified sample, which took into consideration methodological and pragmatic factors. Although the participants were familiar with previous training evaluation tools, the independence of the researcher and the opportunity to provide their own experiences through interviews appeared to be received positively. It is unclear though whether some participants may have perceived the researcher as related to the NFSP rather than being neutral in her research stance.

7.2.4 Ethical implications

Such potential anxiety by participants could have ethical applications in similar research (Decker et al., 2011; Renzetti & Lee, 1993; Richards & Schwartz, 2002). To this effect, the independence of the researcher and the safeguards for anonymity and confidentiality were
highlighted in writing and verbally before the interviews (Elliott et al., 1999). Similar issues often apply in the dissemination of the research findings in raising participants’ concerns in a constructive manner whilst protecting their anonymity. One of the ethical requirements of research pertaining to vulnerable populations (such as children and professionals involved in their care) is to disseminate the results of such research in a manner that can stimulate positive social change. The results of this study will be widely distributed to Saudi Arabia policy and decision-makers, with the goal of bringing about positive changes in intra-agency co-operation related to the protection of children.

7.2.5 Future research

Future research needs to be integral to the ongoing and evolving training programmes. Brief evaluation forms pre- and post-training could provide regular feedback to trainers and organizers. Independent evaluation though interviews at regular intervals, similar to those conducted in this study, would capture trainees’ views in-depth and act as a conduit to improve the training. Additional focus on its implementation would require co-operation from a range of services, as it should corroborate training-related data with service activity patterns. Similar research could widen its participation to include children and young people, parents, the police, and also some government officials.

Measures should be taken earlier to curb some challenges such as language barriers, and also to minimize the possibilities of emotional distresses among the participants. Future research questions can be shaped both form the findings and challenges of this study. For example, understanding parents’ and professionals’ fears of sharing concerns on maltreatment due to Saudi customs and traditions would be valuable in designing awareness interventions; as well as minimizing the threats that professionals face when confronting some caregivers.

Generally, research in Saudi Arabia is limited, especially in the field of child abuse. Future research in this area should employ different approaches such as a longitudinal study over a period of time; a randomised controlled trial (RCT) comparing professionals in areas that
receive and do not receive the training by using pre- and post-intervention service outcomes; and mixed methods of integrating quantitative and qualitative data. The latter, for example, could combine insight into the subjective importance of training and statistical measurements of its effectiveness across several service domains. Future qualitative studies can involve multiple agencies with larger and more diverse samples. As already stated, knowledge can be advanced further through quantitative research methods to examine the effectiveness of specific interventions and service models, and to establish a range of predictors of child outcome.

7.3 Service implications

The results have national and local importance for the various agencies in Saudi Arabia that are tasked, in one manner or another, with responsibility for abused children. The results identified points of tension between and within agencies that can be used by senior-level decision makers in Saudi Arabia to spearhead a top-down process of change, involving inter- and intra-agency co-operation. The narrative findings of the study offered useful insight into what key officials tasked with child welfare actually think about collaboration. These insights can be used by senior leaders in the context of organizational change management promotion. There is a consensus in the organizational change management literature (Tallon & Pinsonneault, 2011; Wang et al., 2015; Worley & Lawler, 2010) that spearheading change requires, among other things, insights into what the population targeted for change actually thinks.

The service implications of the study are more complex than the literature on organizational complexity reviewed in Chapter 2 suggests. The study found that the delivery of services requires changes that are focused on intervention, as well as management and remediation, which in turn necessitates a high degree of co-operation between agencies. As previously discussed, the literature on bureaucracy (in particular, the work of Niskanen, 1968) suggests that bureaucratic self-interest is often a major obstacle to inter-agency change. Therefore, if services are to genuinely improve, it might be necessary to create a single agency that
centralizes co-ordination functions (as some of the participants suggested). Alternatively, it might be necessary to use top-down leadership to create new incentives for various agencies to improve the efficiency of their co-operation. Service delivery can also be improved through the kinds of preventative approaches discussed below:

Training of participants from the Saudi society provided helpful knowledge on how to raise children by adopting more nurturing rather than punitive rearing approaches. Some participants who embraced the training programme actually applied the skills learned in their personal development, and many went on to provide teaching about safe ways of bringing up children. The participants recommended more training for other people who did not attend the programme. Education was to be administered to schools where children would best engage and where their parents might feel less fearful and more prone to attend. The police would need more targeted training on recognising and managing child abuse cases appropriately, as well as liaising more effectively with other agencies. Changing media attitudes would be the first step in working closely to broaden messages and communication on child safety to the whole society.

Participants recommended the establishment of bodies whose roles would be to establish and monitor policies with the objectives of both minimizing child maltreatment and improving response to existing cases. In order to widen and sustain the child protection programme, there should be an overarching department across the existing agencies that specifically targets domestic violence and child abuse. This system would embrace all agencies, departments and government branches; liaise with the media; and engage the public through schools and other forums.

The findings pointed out at the need for guidance on how to act in particular situations regarding child abuse. This could be in the form of practitioners seeking consultation; booklets with information from specialists but conveyed for lay people; or other materials that would provide instructions or procedures to be followed when reporting a child abuse case. These could be produced under the hospice of the National Safety Programme, thus remaining up-to-date and consistent with changing policy and services. Sustainability of
training was another key recommendation. Positively evaluated training courses could be extended to other groups such as teachers and school mentors. Booster courses would bring professionals in touch with policy and procedural changes, as well as refresh their skills.

7.4 Policy implications

Internationally, there are a number of policies – often referred to or combined with guidelines - that can be used as best practice guides in the national and local contexts of Saudi Arabia. Ideally though, these should be adapted, based on evidence obtained regarding the local needs. The findings indicate that there is a persistent reluctance by professionals to intervene in the family life of the Saudi society, and this resistance is underpinned by culturally-driven attitudes. Consequently, this constrains the application of knowledge and techniques in preventing child maltreatment. In essence, factors such as strong customs and traditions, family status, lack of awareness, legal issues, and absence of clear guidance were reported as creating barriers to professionals during the implementation of the training programme. The importance of the findings can be understood through Bronfenbrenner’s (1979) ecological model in relation to risk factors for child maltreatment. This model was originally developed to identify and integrate factors that influence a child’s development and growth. These factors are categorised at an individual, interpersonal, community and societal level. Participants’ experiences and views presented in chapter Five related to all four levels of this model. For instance, within the family niche, professionals encountered challenges such as refusal to acknowledge abuse, perpetrators being close family members, and lack of parenting skills.

Although, the rights of children have been well-defined by the UN, their implementation can only be acted upon after addressing the challenges highlighted above. Most importantly, a key national policy implication of this study is that concerted actions have to be taken both ‘top-down’ by the government and ‘bottom-up’ by user groups, the media, and other stakeholders. Given the impunity with which children are often abused in Saudi Arabia, no intervention is likely to be widely successful unless there is a national framework to protect whistle-blowers, break the wall of silence that abusers take advantage of, and otherwise
spread the message of children’s rights. Locally, the main policy implication is that there have to be firm incentives, protocols, and processes in place to ensure that agencies co-operate with each other at both strategic and operational level.

In the next five years, the government should pass legislation mandating such inter-agency co-operation (that is, cooperation between the Ministries involved in child protection), and authority leads should follow-up to ensure that such co-operation is being implemented. Realistically, this change is the only major one that can be successfully carried out during this medium-term period; other, more sweeping changes discussed in this chapter, could take longer to be embedded. Also, there should be legislation that creates whistle-blower protection for reporters in local hospitals, and that specifies a clear protocol for reporting and managing cases of child abuse first detected in healthcare settings.

Another important implication of the findings is that substantial and concentrated effort needs to be put in place to ensure that various Saudi agencies are aligned in a manner that allows them to improve their capacity to serve the needs of abused children. The training was beneficial in that it showcased several benefits of co-operation; however, crucially for senior decision-makers, the study also identified those barriers to co-operation that will have to be mitigated in order to achieve the desired impact on children. Even during the training delivery, in which the stakes are usually substantially lower than they would be in actual programme implementation, participants experienced significant barriers to co-operation. The identification of such barriers by this study can facilitate the task of policy and agency leads towards a truly inter-agency paradigm.

7.5 Reflective section

Throughout this research and educational journey, I learned a great many things in relation to the planning, execution and completion of this project. Perhaps the most important insight I obtained had to do with the difficulty of aligning individuals, organizations, and processes, even when multiple stakeholders have agreed on the importance of a goal - a theme that refers to the debate of realism versus idealism. In Saudi Arabia, there is widespread
agreement that child abuse is an extremely important issue; and as such one that is deserving of prevention, management, and remediation as carried out with the full private and public resources of the state. This agreement represents an ideal; reaching the ideal is a matter of understanding and working within realistic cultural, resource, and process constraints. The desired end of the training processes, which was to contribute to the formation of a genuinely inter-agency approach to child abuse in Saudi Arabia, was agreed upon by all stakeholders, but there were constraints in terms of (a) how much value the training could add to individual stakeholders’ institutional roles and (b) how successful the training could be in terms of aligning people and processes that were ordinarily disconnected or not well-integrated.

For me, the most difficult but also most important question arising from the programme is whether the observed limitations were of the programme itself or whether the observed limitations reflected the innate difficulties in organizational change. In other words, if there had been more time and resources to devote to the training programme, to what extent would some of the perceived limitations of the programme have been overcome? I think that this question is important to answer because, in terms of summative evaluation, the limitations of the macro-system (in this case, the various individuals and agencies that were stakeholders) have to be distinguished from the limitations of the programme itself. I believe that, given several limitations, the benefits of the programme were remarkable, and many of these limitations can actually be overcome with more investment in time, planning and resources.

7.6 Conclusion

The study makes a contribution to evidence on the importance of the interdisciplinary child protection training for the Saudi Arabia society. The knowledge that the participants gained for their personal development and professional practice should be generated in all essential settings such as schools and hospitals. The study has provided the authorities and key organizations in Saudi with evidence on how training, practice and services can safeguard children more efficiently. The participants’ personal experiences on the delivery of the
training motivated the call for more and sustainable training that can be incorporated in children’s services strategic plans and culture.

The customs and traditions of some societies can unintentionally act as barriers to disclosing and sharing information about negative child rearing practices, and these could be addressed and challenged based on the findings of this study. Although the experience of the implementation was often a challenge to professionals, it also provided them with insight into such factors within the Saudi society, which led to their recommendations to the government. A qualitative approach enabled the participants to delve in their experiences and the researcher to gain understanding into their perceived impact of the training on practice. The participants highlighted the need for further legislation, as well as a range of organizational actions and processes to protect children from maltreatment. The challenges faced by professionals in implementing the training could be used to formulate questions for future planning and delivery of training, as well as for ongoing evaluation.

Overall, the training programme was well-received. This was identified as having many benefits related to knowledge, skills and awareness. However, participants also noted that its implementation was rendered difficult by social factors and bureaucratic impedances. Both top-down policy and direction, and practitioners’ networks on the ground will be required for agencies to co-operate meaningfully and effectively. A new, centralized agency could help to overcome the current bureaucratic malaise. At the same time, Saudi society will have to undergo change in order to bring greater attention to children’s rights, and thus facilitate the roles and operations of agencies tasked with child protection.
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### Appendix 1

Structure and content of the multidisciplinary training programme

<table>
<thead>
<tr>
<th>Module (one day per module)</th>
<th>Title</th>
<th>Time</th>
<th>Tutors</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Pre-survey</strong></td>
<td></td>
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<tr>
<td><strong>Module 1</strong></td>
<td><strong>What is child maltreatment?</strong></td>
<td></td>
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<tr>
<td></td>
<td>Overview of history of child maltreatment</td>
<td>7.30 am – 3.00 pm</td>
<td>Dr. Maha Al Muneef</td>
</tr>
<tr>
<td></td>
<td>Definitions of child maltreatment</td>
<td></td>
<td>Dr. Abdu Alwadood Kharbosh</td>
</tr>
<tr>
<td></td>
<td>Social risk factors</td>
<td></td>
<td>Mrs. Fatimah Al Shehry</td>
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<tr>
<td></td>
<td>Indicators and effects of child maltreatment</td>
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<td></td>
<td>Children’s rights and child protection policy</td>
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<tr>
<td></td>
<td><strong>Workshop on detection of child abuse and neglect</strong></td>
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<tr>
<td><strong>Module 2</strong></td>
<td><strong>Assessment and interventions</strong></td>
<td>7.30 am – 3.00 pm</td>
<td>Dr. Maha Al Muneef</td>
</tr>
<tr>
<td></td>
<td>Assessment and medical interventions</td>
<td></td>
<td>Dr. Abdu Alwadood Kharbosh</td>
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<td></td>
<td>Assessment and social interventions</td>
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<td>Mrs. Fatimah Al Shehry</td>
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<tr>
<td></td>
<td>Assessment and psychological interventions</td>
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<td></td>
<td>Child abuse and neglect interview techniques</td>
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<td></td>
<td>Role of health services in child protection</td>
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<td></td>
<td><strong>Workshop on assessing child abuse and neglect cases</strong></td>
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<tr>
<td><strong>Module 3</strong></td>
<td><strong>Guidelines and procedures</strong></td>
<td>7.30 am – 3.00 pm</td>
<td>Dr. Abdu Alwadood Kharbosh</td>
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<tr>
<td></td>
<td>Assessment and safety interventions</td>
<td></td>
<td>Dr. Majid Al Eissa</td>
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<tr>
<td></td>
<td>Caring for child maltreatment victims</td>
<td></td>
<td>Mrs. Fatimah Al Shehry</td>
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<tr>
<td></td>
<td><strong>Workshop on analysis of violence roots</strong></td>
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<td></td>
<td>Child protection</td>
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<td></td>
<td>Multidisciplinary team working rules</td>
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<td></td>
<td><strong>Workshop on child protection multidisciplinary team working</strong></td>
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<tr>
<td><strong>Module 4</strong></td>
<td><strong>Prevention of violence against children</strong></td>
<td>7.30 am – 1.00 pm</td>
<td>Dr. Abdu Alwadood Kharbosh</td>
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<tr>
<td></td>
<td>Social and educational rehabilitation of child abuse cases</td>
<td></td>
<td>Dr. Majid Al Eissa</td>
</tr>
<tr>
<td></td>
<td>Prevention strategies</td>
<td></td>
<td>Mrs. Fatimah Al Shehry</td>
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<tr>
<td></td>
<td><strong>Workshop on establishing prevention strategies</strong></td>
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<tr>
<td><strong>Post-survey</strong></td>
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</tbody>
</table>
Appendix 2
Questionnaire (Arabic virgin)
Initial assessment (Pre-survey)

برنامج الأمن الأسري الوطني

الدورة التدريبية للمهنيين المعاملين مع حالات إساءة معاملة وإهمال الأطفال

(متعددة التخصصات)

اسم المتدرب:

الوظيفة:

هل سبق لك التعامل مع حالات إساءة معاملة وإهمال الأطفال؟ ولعدة كم؟

لا □
نعم □

أقل من 5 سنوات □ 5-10 سنوات □ أكثر من 10 سنوات □

الرجاء الإجابة على الأسئلة التالية بـ √ أو X:

1. انضمت المملكة إلى اتفاقية الأم الفردية لحقوق الطفل في العام 2005م.
2. يهدف التقييم الشفهي بصورة أساسية للتحقق من تعرض الطفل لإساءة معاملة.
3. يزيد من معدل وفيات الأطفال الناجمة عن إساءة بزيادة عمر الطفل.
4. يراعي اتفاقية الأم الفردية لحقوق الطفل مصالح الطفل الفضي العائلة عند الاتصال بأي إجراءات اجتماعية أو قضائية.
5. الاحتمال الأقوى للتفسير وجود الكدمات على خد الطفل بمجرد 7 سنوات هو السقوط أثناء اللعب.
6. الخدوم هو أكثر من يبعي معاملة الأطفال جسدياً.
7. غالباً ما يدعي الأطفال الصغار تعرضهم لإساءة معاملة لا تحدث في الواقع.
8. من الشائع وجود الكدمات الناتجة عن الإصابات العرضية للطفل على الفخذين والعنك.
9. الأطفال ذو الإحتياجات الخاصة هم أقل عرضة لإساءة من الأطفال العاديين.
10. في معظم حالات الإساءة يكون الفضيحة عند طريق الصهرة أو الخطأ.
11. تحدث غالبية الإساءات الجنسية للأطفال من قبل أشخاص عرباء.
12. المعاينة الاجتماعية للأسرة تزيد من احتمال تعرض الطفل لإساءة البدنية.
13. الطفل الذي يحتاج للعطفة والاهتمام بدرجة كبيرة هو أكثر عرضة لخطر الإساءة الجنسية.
14. الأطفال الرضع أكثر تعرضًا للإзер العنيف الذي يتسبب في إصابات دمارية من قبل أباء يعانون من ضغوط نفيسة أو معتمدة.

15. يجب تحفيز الاحترام عن الأموال المتعلقة بالحاجاج مع الطفل من أجل إثارة الطفل وقليل عليه على مثل هذه الأمور.

16. تحدد أنظمة الملكة المسؤولية الجدية للأفراد الذين يّعون التغذية.

17. تنشئ الخصائص النموية للمعدين في كافة أشكال إساءة معاملة وإهانة الطفل بشكل كبير.

18. الاسم هو السبب الرئيسي الذي يؤدي إلى إساءة الجنسية.

19. إعداد المعايير وإجراءات التحقيق بما يتناسب مع الطفل يعوي فقط بشكل محدود في مساعدة الطفل على الإفادة من الإساءة المعادية.

20. الوالدين الذين يعانون معاملة طفلهم يعانون في الغالب من اضطرابات نفسية مرعبة.

21. الإبلاغ الفوري للطفل من البلوغ بسبام إساءة يمكن عادة للطبيب ملاحظتها.

22. الطفل الذي ينشأ في بيئة عنف أسري تزيد لديه مخاطر إساءة معاملته لأطفاله مستقبلًا.

23. لا يوجد في المملكة تطبيق نظام على التأمين التأسيسي عن حالات إساءة معاملة الأطفال في القطاع الصحي.

24. تتوفر حالياً أسلوب علاج عائلي للكافة أنواع الإساءة تحت من معاودة الإساءة.

25. يستطيع الطبيب عادة تحديد عدد مرات الإبلاغ الشرجية المتكررة.

26. من أهداف الخدمات الإجتماعية الرئيسي من عدم تعرض الطفل للعنف مجدداً من الوصي الذي سيتلقى أو إعادته إليه.

27. التحقيق في قضية إساءة معاملة الأطفال هو من مهام الشرطة ولا تتوالى هيئة التحقيق والإدعاء العام أي دور فيها.

28. المراهقون الذكور المتحسرون جنسياً بالأطفال هم أكثر عرضة للاجتهاد الإنسانية حتى بعد الالتحاق بالذكور البالغين.

29. يتوجب إعطاء الحوادث مالحة الحمل عند تعرض طفلة بعمر الخامسة عشرة للاعتداء جنسي من قبل شخص غريب.

30. أثبتت الدراسات بأن تعرض الطفل للإساءة زيد من احتمال الإصابة بالسكري وأمراض القلب في المستقبل.

31. يظهر مع مرور الوقت عدم الرابط والثبات حول إصلاح الطفل عن الإساءة.

32. لا يعد إجزاء عدم إعطاء الطفل تنفيذاته الأساسية عندما تكون الأسرة تعاني من الفقر.

33. الإساءة العاطفية هي أكثر أنواع الإساءة التي يتم التعرف عليها نظراً لسوءة الشخص.

34. عندما يدعي الطفل ذو الأربع سنوات أعضاءه التناسلية فإن ذلك يعد سلوكاً جنسيًا غير طبيعي.

35. إصابة الطفل ذو الخمس سنوات بالسكتة تعني بشكل مؤكد تعرضه للإساءة الجنسية.

36. تندي ويحك الأمهات بأن الطيران الطبيعي للطفل هو من أهم أساس إساءة معاملة الطفل.

37. الأطفال الذين تعرضوا للتعقيبة الجنسية يظهرون نداءً أقل تجاه مسلكهم في المستقبل.

38. تظهر أعراض اضطراب ما بعد الصدمة على شكل ومضات الذكاء وأحلام بحتوى الخائنة.

39. جمع الأدلة الجنائية قبل فقدانها من الصبرية يقدم على العلاج الطبيعي العامل.

40. غالبًا ما تكون الفتاة الصغيرة تكتب عندما تقول بأنه حدث إبلاغ وكان الفحص الطبي سليماً.
Questionnaire (Translation)

National Family Safety Program

Training course for professionals dealing with child abuse and neglect cases
(Interdisciplinary)

Initial assessment (Pre-survey)

Trainee Name: ______________________________________
Position: _________________________________________

Have you dealt with abuse and neglect children cases? And for how long?
□ No □ Yes: □ less than 5 years □ 5-10 years □ more than 10 years

Please answer the following questions with √ or x:

2. Psychological assessment aims mainly to check the exposure of abuse to a child.
3. The rate of deaths of children resulting from abuse increase by the child's age.
4. Take into account the United Nations Convention for the Rights of the Child child's best interests when making any social or judicial proceedings.
5. The strongest possibility to explain the presence of bruises on the cheek of a child aged 7 months is falling while playing.
6. The most physically abused children are maids.
7. Often children pretended that being subjected to maltreated while it did not occur in reality.
8. It is common to have bruises caused by accidental injury to a child on the thighs and abdomen.
9. Special needs children are less likely to be abused than ordinary children.
10. In most child abuse cases have disclosure by accident or mistake.
11. Strangers are the majority who sexually abuse children.
12. Social isolation of the family increases the likelihood of child physical abuse.
13. A child who needs sentiment and attention is significantly more at risk of sexual abuse.
14. Infants are more vulnerable to shaking baby syndrome which causes brain injuries by parents who suffering from psychological stress or living .
15. You should avoid talking about things related to sex with the child to prevent the exciting and opened his eyes to such things.
16. Determine the laws of the Kingdom of criminal responsibility for individuals with puberty.
<p>| | |</p>
<table>
<thead>
<tr>
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<tbody>
<tr>
<td>17.</td>
<td>Psychological characteristics of aggressors resemble in all forms of treatment and child neglect dramatically.</td>
</tr>
<tr>
<td>18.</td>
<td>Schizophrenia is the main reason that leads to sexual abuse.</td>
</tr>
<tr>
<td>19.</td>
<td>The preparation of the courts and investigation procedures commensurate with the child contributes only in a limited way in helping a child to make testified about the abuse.</td>
</tr>
<tr>
<td>20.</td>
<td>Parents who maltreated their child suffering mostly from mental disorder satisfactory.</td>
</tr>
<tr>
<td>21.</td>
<td>Anal penetration of a female child before the age of puberty always cause injuries to the doctor can usually be observed.</td>
</tr>
<tr>
<td>22.</td>
<td>A child who grow up in a domestic violence environment often increase the possibility of maltreated his/her children in the future.</td>
</tr>
<tr>
<td>23.</td>
<td>No organization in the Kingdom provides for mandatory reporting of child abuse for workers in the health sector.</td>
</tr>
<tr>
<td>24.</td>
<td>Currently there are available methods of effective treatment for all types of abuse that stop re-offending abuse.</td>
</tr>
<tr>
<td>25.</td>
<td>Your doctor can usually determine the number of times the repeated anal penetration.</td>
</tr>
<tr>
<td>26.</td>
<td>The goals of social services are to make sure the child are not exposed to violence once again in the center, which will be moved, or bring it back.</td>
</tr>
<tr>
<td>27.</td>
<td>To investigate child abuse cases is one of the tasks of the police do not take the Bureau of Investigation and Prosecution any role in it.</td>
</tr>
<tr>
<td>28.</td>
<td>Adolescents male who are sexually harassment children are more likely to re-abused even after treatment compared to adults male.</td>
</tr>
<tr>
<td>29.</td>
<td>Contraceptive pills must be given for fifteen years old girl when she is sexually assaulted by a stranger.</td>
</tr>
<tr>
<td>30.</td>
<td>Studies have shown that child exposure to abuse increases the risk of diabetes and heart disease in the future.</td>
</tr>
<tr>
<td>31.</td>
<td>Appears with the passage of time and lack of bonding stability disclosure about the child for abuse.</td>
</tr>
<tr>
<td>32.</td>
<td>It is no longer considered that child is neglected when he/she not given their basic vaccinations if the family suffers from poverty.</td>
</tr>
<tr>
<td>33.</td>
<td>Emotional abuse is the most common types of abuse that are recognized due to the ease of diagnosis.</td>
</tr>
<tr>
<td>34.</td>
<td>When a four years old child petting their genitals it is considered as unnatural sexual behavior.</td>
</tr>
<tr>
<td></td>
<td>Injury to a child of five years, gonorrhea means certain of being sexually abused.</td>
</tr>
<tr>
<td>35.</td>
<td>(if five years old child got gonorrhea means certain of being sexually abused).</td>
</tr>
<tr>
<td>36. Lack of awareness of parents on the normal development of a child is one of the most important causes of child abuse.</td>
<td></td>
</tr>
<tr>
<td>37. The children who have been subjected to corporal punishment show less remorse towards their bad behavior in the future.</td>
<td></td>
</tr>
<tr>
<td>38. The symptoms of post-traumatic stress disorder occur in the form of flashes of memory and dreams of the content of the incident.</td>
<td></td>
</tr>
<tr>
<td>40. Often the little girl is laying when she says that there had been penetration when her medical examination was proper.</td>
<td></td>
</tr>
</tbody>
</table>
**Questionnaire (Arabic)**

**The final evaluation (Post-survey)**

برنامج الأمن الأسري الوطني

dوراً تدريبياً للمهنيين المعاملين مع حالات إساءة معاملة وإهمال الأطفال

# التقييم النهائي

اسم المتدرب:

وظيفة:

<table>
<thead>
<tr>
<th>الادارة الإجابة على الأسئلة الثنائية ب/أ/ح:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. غالبًا ما تتواجد أثار جسدية تدل على تعرض الطفل للإساءة الجنسية.</td>
</tr>
<tr>
<td>2. الإهمال هو أكثر أنواع الإساءة انتشارًا حول العالم.</td>
</tr>
<tr>
<td>3. الخادمات من أكثر من يسبب في إصابات الدماغ لدى الأطفال الناتجة عن الهز العنيف.</td>
</tr>
<tr>
<td>4. تفيد الدراسات التي تم إجراؤها إلى الآن أن حالات الإهمال هي أكثر الحالات التي يستجيب فيها الوالدان للعلاج.</td>
</tr>
<tr>
<td>5. تتزايد حالات الإساءة للأطفال المزمنة عند الأطفال الذين تعرضوا لإساءة مقارنة بالأطفال الآخرين.</td>
</tr>
<tr>
<td>6. ينبغي أن يركز التقييم النفسي على الأعراض المصاحبة للإساءة ووضع الخطط لعلاجها مستقبلاً.</td>
</tr>
<tr>
<td>7. تشير إضافة الطفل حول الإساءة التي تعرض لها يوجه على المحقق الشك بمصداقية الإساءة وإفلام طفل التحقيق نظرًاً لضارتها الأصلية.</td>
</tr>
<tr>
<td>8. من الشائع وجود الاعتقادات المسببة على رقبة الطفل.</td>
</tr>
<tr>
<td>9. البالغون الذكور من المسؤولين جنسياً يتجنبون بصورة كبيرة عادة إعادة التأهيل أكثر من المراهقين.</td>
</tr>
<tr>
<td>10. الإباحية ضد الأطفال سلوك نفسي عادة ما ينتهي بتجاوز مرحلة المراهقة.</td>
</tr>
<tr>
<td>11. تنص أليّة التعامل مع حالات إساءة معاملة الأطفال في المملكة على حماية الطفل فور إبلاغها عن حالة إساءة مكيدة فقط.</td>
</tr>
<tr>
<td>12. جميع الأطفال الذين تعرضوا لإساءة الجنسية يصبحون بالإضايحة نفسية شديدة.</td>
</tr>
<tr>
<td>13. يتم علاج اضطراب ما بعد الصدمة بالعلاج العصبي فقط حيث لا يجدي العلاج الدوائي.</td>
</tr>
<tr>
<td>14. الأطفال الذين يتم تدريبهم جسديًا هم أقل قدرة على مواجهة إجراءات المتورطين عند غياب الرقابة.</td>
</tr>
<tr>
<td>15. تكلف الشريعة الإسلامية حق ملكية الولد لطفلة القاصر.</td>
</tr>
<tr>
<td>16. المراجعة الروتوتية لحالات وفيات الأطفال يزيد من احتمالية تشخيص حالات إساءة معاملة الأطفال.</td>
</tr>
</tbody>
</table>

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اضطراب العلاقة الودية مع الطفل هو أهم أسباب إساءة معاملة الطفل.

- عندما يبتلع الطفل الذكر في عمر الخامسة من أمه التي في الرابعة مشاهدة أعضائها التناسلية فإن ذلك يعد مؤشرًا قويًا على تعرضه لتحرش جنسي.

- يمكن مساعدة تحديد ما إذا كانت إساءة الطفل هي السبب في تعرضه للإساءة أم هو ناجم عن إساءة المعاملة.

- توجد مساعيات موحدة وتعريفات محددة للكافة أنواع الإساءة من على العالم.

- عند إعادة التأهيل ينبغي التركيز على تعليم الولدنج مهارات الودية السليمة.

- وجود التأييد حول مبادئ الشرع عن القضايا بدل قضائياً على تعرضها لإساءة جنسية.

- إصابات الرأس الشديد هي سبب الوفاة الرئيسي في حالات إساءة معاملة الأطفال.

- تتعرض القائمة الصغيرة عادة لإساءة الجنسية في محيط المنزل.

- عادة ما يكون الآباء الذين تشموا في أسرة يكتفون الطرف أكثر حذرًا على أطفالهم حتى لا تكون معاناتهم مع أطفالهم.

- وجود لجان للحماية الاجتماعية في كافة مناطق المملكة يوفر خدمة التقييم والتدخل الاجتماعي للأطفال من منظمة إساءة معاملة الأطفال.

- الكتلة المالية لإعداد برامج وقوانين لإيجاد المصدرة من تجربة سوسي合うية وجمعية حول حالات إساءة المعاملة.

- السكن في الأمكنة المزدحمة بالسكان يزيد من احتمالية تعرض الطفل للإساءة.

- سلامة غشاء البكار عند القائمة المراهقة ينفي بشكل فعال تعرضها للإجهاض عندما اعتبر عليها جنسياً.

- مواجهة الطفل ضحية إساءة المعاملة بالجانب في جلسة المحكمة لا يوجد عادة على شهادة الطفل.

- تنتشر الإساءة الجسدية في أوساط الطبقات الفقرة والمستوسة فقط دون الغنية.

- يتوجب على الطبيب قيادة فريق حماية الطفل لأنه هو الأقدر من بين المهنيين المتخصصين الآخرين على جمع البيانات والتقييم.

- يعد الأخصائي النفسي أهم أعضاء فريق حماية الطفل ويمكن أن يحل محل أي من بقية أعضاء الفريق من من تلقي التأهيل المناسب.

- يهدف برنامج الأمن الوطني بتنظيم الخدمات لضمان إساءة معاملة الأطفال فقط وتعتبر الدراسات والبحث والبرامج التوعوية من أولوياته الجالية.

- التزام المملكة بالتبعية حقوق الطفل يفرض عليها تقديم تقارير مراجعة دورياً للأمن المعهده في مجال حقوق الطفل فيها.

- ينبغي فصل الوفود للطفل بكميات السر (ما يفسح له عن الإساءة) في طلبه من أجل طهائه للحصول على أكبر قدر من المعلومات.

- من المفيد أن يقترح المحمل على الطفل بعض الألياب التي يمكن أن تثير الإصابة لمساعدته.

- تكرار المقابلة مع الطفل لعدة مرات ومن قبل عدة أشخاص يسمح في تركيز الإفادة التي يفصح بها الطفل وحده من تجاربه وآفاته.

- مصلحة الطفل العصبي هي المعين الرئيسي الذي يستند عليه فريق حماية الطفل عند إعداد تقاريرهم.

- الخلافات بين أعضاء فريق حماية الطفل هي أمر نادر الحدوث.
Questionnaire (Translation)

National Family Safety Program

Training course for professionals dealing with cases of abuse and neglect of children
(Interdisciplinary)

The final evaluation (Post-survey)

Trainee Name: __________________________________________

Position: ________________________________________________

Please answer the following questions with √ or x:

<table>
<thead>
<tr>
<th></th>
<th>Question</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Often present physical signs indicate that the victim was sexually abused.</td>
</tr>
<tr>
<td>2</td>
<td>Neglect is the most prevalent types of abuse around the world.</td>
</tr>
<tr>
<td>3</td>
<td>Maids are more causes of brain injury in infants caused by violent shaking.</td>
</tr>
<tr>
<td>4</td>
<td>According to the studies that have been made so far to negligence cases are more cases where parents respond to treatment. ??</td>
</tr>
<tr>
<td>5</td>
<td>Increasing incidence of chronic diseases in children who have been subjected to abuse compared to other children.</td>
</tr>
<tr>
<td>6</td>
<td>The psychological assessment should focus on the symptoms associated with abuse and develop treatment plans for future.</td>
</tr>
<tr>
<td>7</td>
<td>Changes in the child testimony about abuse subjected by the investigator requires a doubt the credibility of the report and closure of the investigation due to conflicting statements.</td>
</tr>
<tr>
<td>8</td>
<td>It is common presence of occasional bruises on the neck of the child.</td>
</tr>
<tr>
<td>9</td>
<td>Adult males who sexually abused are usually responding significantly to the rehabilitation of more than teenagers.</td>
</tr>
<tr>
<td>10</td>
<td>Pornography against children cause mental disorder usually ends bypass adolescence.??</td>
</tr>
<tr>
<td>11</td>
<td>The mechanism to deal with cases of child abuse in the Kingdom to protect the witness immediately after being informed about the case only confirmed the abuse.</td>
</tr>
<tr>
<td>12</td>
<td>All children who have been subjected to sexual abuse suffer severe psychological problems.</td>
</tr>
<tr>
<td>13</td>
<td>The treatment of PTSD with behavioral therapy only where drug therapy does not work.</td>
</tr>
<tr>
<td>14</td>
<td>children who are physically disciplined are less able to resist the temptations of the positions in the absence of censorship.</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>15.</td>
<td>Islamic laws are ensuring the right of parent ownership of their child.</td>
</tr>
<tr>
<td>16.</td>
<td>The routine review of child mortality cases increases the likelihood that the diagnosis of child abuse cases.</td>
</tr>
<tr>
<td>17.</td>
<td>Disharmony on the relationship between parents is the most important causes of child abuse.</td>
</tr>
<tr>
<td>18.</td>
<td>When a male child at the age of five asked his sister in the four years old to watch her genitals, this is a strong indicator of exposure to sexual harassment with an adult female.</td>
</tr>
<tr>
<td>19.</td>
<td>It can be easy to determine whether the child's disability is the cause of being abused or is the result of ill-treatment.</td>
</tr>
<tr>
<td>20.</td>
<td>There are uniform names and definitions specific to all kinds of abuse agreed around the world.</td>
</tr>
<tr>
<td>21.</td>
<td>When it comes to rehabilitation, it should be focus on teaching parents parenting skills.</td>
</tr>
<tr>
<td>22.</td>
<td>The presence of warts around the girl anus, categorically it shows that she is exposed to sexual abuse.</td>
</tr>
<tr>
<td>23.</td>
<td>Severe head injuries are the main leading cause of death in child abuse cases.</td>
</tr>
<tr>
<td>24.</td>
<td>Usually little girls is sexually abuse in the house vicinity.</td>
</tr>
<tr>
<td>25.</td>
<td>Parents who are usually grown up in domestic violence are more likely affection to their children so as not to repeat their suffering with their children.</td>
</tr>
<tr>
<td>26.</td>
<td>The presence or availability of social protection services in all regions of the Kingdom offers evaluation and social intervention for children who are victims of abuse.</td>
</tr>
<tr>
<td>27.</td>
<td>Financial costs to set up prevention programs to meet the society needs for the prevention of child abuse significantly exceeds the cost of evaluation and treatment of cases of abuse.</td>
</tr>
<tr>
<td>28.</td>
<td>Living in densely populated areas increases the likelihood that a child abuse.</td>
</tr>
<tr>
<td>29.</td>
<td>The safety of the teenage girl hymen denies categorically exposed to penetration when sexually assaulted.</td>
</tr>
<tr>
<td>30.</td>
<td>Facing abused child the victim offenders in a court hearing usually it does not affect the child's testimony.</td>
</tr>
<tr>
<td>31.</td>
<td>Physical abuses spread among the poor and middle classes only, without the rich.</td>
</tr>
<tr>
<td>32.</td>
<td>Physician must lead a team to protect the child because he is the most capable among the other professionals on the data collection and evaluation.</td>
</tr>
<tr>
<td>33.</td>
<td>Psychologist is most important members of the child protection team and is to replace any of the rest of the team when it received a proper education.</td>
</tr>
<tr>
<td>34.</td>
<td>Cares National Family Safety Programme to provide services to victims of child abuse is not only studies and research and awareness programs of the current priorities.</td>
</tr>
<tr>
<td>35.</td>
<td>Kingdom's commitment to the Convention on the Rights of the Child requires the submission of audit reports periodically to the United Nations in the field of child rights.</td>
</tr>
<tr>
<td>36.</td>
<td>It should be cut promises for the child closely guards the secret (as disclosed by the abuse) immediately upon request in order to reassure him to get as much information.</td>
</tr>
<tr>
<td>37.</td>
<td>It is useful for the investigator to propose some of the mechanisms to the child that can justify the injury to help him.</td>
</tr>
<tr>
<td>38.</td>
<td>Repeating the interview with the child several times and by several people contribute to the concentration of benefit that is disclosed by the child and reduce conflicts of his/her information.</td>
</tr>
<tr>
<td>39.</td>
<td>Child's best interest is the main principle, which is based upon the child protection team when preparing their reports.</td>
</tr>
<tr>
<td>40.</td>
<td>Conflicts between child protection team members are rare.</td>
</tr>
</tbody>
</table>
## Appendix 3

*Characteristics of research participants*

<table>
<thead>
<tr>
<th>Interview</th>
<th>Gender</th>
<th>Location</th>
<th>Type of professional</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interview 1</td>
<td>Female</td>
<td>Tabuk region</td>
<td>Psychologist</td>
</tr>
<tr>
<td>Interview 2</td>
<td>Female</td>
<td>Tabuk region</td>
<td>Social Worker</td>
</tr>
<tr>
<td>Interview 3</td>
<td>Female</td>
<td>Tabuk region</td>
<td>Psychiatrist</td>
</tr>
<tr>
<td>Interview 4</td>
<td>Male</td>
<td>Tabuk region</td>
<td>Psychologist</td>
</tr>
<tr>
<td>Interview 5</td>
<td>Male</td>
<td>Tabuk region</td>
<td>Social Worker</td>
</tr>
<tr>
<td>Interview 6</td>
<td>Male</td>
<td>Tabuk region</td>
<td>Surgeon</td>
</tr>
<tr>
<td>Interview 7</td>
<td>Male</td>
<td>Tabuk region</td>
<td>Psychologist</td>
</tr>
<tr>
<td>Interview 8</td>
<td>Male</td>
<td>Tabuk region</td>
<td>Administrator (Medical Records)</td>
</tr>
<tr>
<td>Interview 9</td>
<td>Male</td>
<td>Tabuk region</td>
<td>Head of Nursing Department</td>
</tr>
<tr>
<td>Interview 10</td>
<td>Male</td>
<td>Tabuk region</td>
<td>Hospital Director</td>
</tr>
<tr>
<td>Interview 11</td>
<td>Female</td>
<td>Tabuk region</td>
<td>Co-ordinator of Child Protection Committee</td>
</tr>
<tr>
<td>Interview 12</td>
<td>Male</td>
<td>Asir region</td>
<td>Psychiatrist</td>
</tr>
<tr>
<td>Interview 13</td>
<td>Male</td>
<td>Tabuk region</td>
<td>Supervisor, Ministry of Education</td>
</tr>
<tr>
<td>Interview 14</td>
<td>Male</td>
<td>Tabuk region</td>
<td>Social Worker</td>
</tr>
<tr>
<td>Interview 15</td>
<td>Male</td>
<td>Tabuk region</td>
<td>Social Worker</td>
</tr>
<tr>
<td>Interview 16</td>
<td>Female</td>
<td>Tabuk region</td>
<td>Nurse</td>
</tr>
<tr>
<td>Interview 17</td>
<td>Female</td>
<td>Makkah region</td>
<td>Shelter Director</td>
</tr>
<tr>
<td>Interview 18</td>
<td>Male</td>
<td>Tabuk region</td>
<td>Public Health Educator</td>
</tr>
<tr>
<td>Interview 19</td>
<td>Male</td>
<td>Tabuk region</td>
<td>Psychologist</td>
</tr>
<tr>
<td>Interview 20</td>
<td>Male</td>
<td>Tabuk region</td>
<td>Obstetrician and Gynecologist</td>
</tr>
<tr>
<td>Interview 21</td>
<td>Male</td>
<td>Tabuk region</td>
<td>Surgeon</td>
</tr>
<tr>
<td>Interview 22</td>
<td>Male</td>
<td>Tabuk region</td>
<td>Nurse</td>
</tr>
<tr>
<td>Interview 23</td>
<td>Male</td>
<td>Tabuk region</td>
<td>Obstetrician and Gynecologist</td>
</tr>
<tr>
<td>Interview 24</td>
<td>Male</td>
<td>Tabuk region</td>
<td>Psychiatrist</td>
</tr>
<tr>
<td>Interview 25</td>
<td>Male</td>
<td>Tabuk region</td>
<td>Head of Audit Office and Implementation, Prison Service</td>
</tr>
<tr>
<td>Interview 26</td>
<td>Male</td>
<td>Tabuk region</td>
<td>Nurse</td>
</tr>
</tbody>
</table>
# Appendix 4

## Training Passport

<table>
<thead>
<tr>
<th>Date</th>
<th>Session</th>
<th>Time</th>
<th>Room</th>
<th>Tutor</th>
</tr>
</thead>
<tbody>
<tr>
<td>16 /1/ 2013</td>
<td>Introduction to course</td>
<td>9.30-12.30</td>
<td>Adrian 243</td>
<td>Susan Wallace, Andrew Turner</td>
</tr>
<tr>
<td></td>
<td>3.1 Epistemology underlying qualitative research methodologies</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>17 /1/ 2013</td>
<td>Research in Action</td>
<td>1.30pm – 4.30pm</td>
<td>243</td>
<td>Joel Minion</td>
</tr>
<tr>
<td></td>
<td>3.2 Research in Action</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>30 /1/ 2013</td>
<td>Ethics in practice</td>
<td>9.30am – 12.30pm</td>
<td>243</td>
<td>Susan Wallace</td>
</tr>
<tr>
<td>31 /1/ 2013</td>
<td>Research in practice – managing research information</td>
<td>1.30pm – 4.30pm</td>
<td>243</td>
<td>Joel Minion</td>
</tr>
<tr>
<td></td>
<td>3.4 Research in practice</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3 /2 /2013</td>
<td>Qualitative research design, methods and analyses</td>
<td>9.30am – 12.30pm</td>
<td>243</td>
<td>Madeleine Murtagh</td>
</tr>
<tr>
<td></td>
<td>3.5 Doing interviews and focus groups</td>
<td>1.30pm – 4.30pm</td>
<td>243</td>
<td>Joel Minion/Madeleine Murtagh</td>
</tr>
<tr>
<td></td>
<td>3.6 Policy analysis in research practice</td>
<td>9.30am – 12.30pm</td>
<td>243</td>
<td>Susan Wallace</td>
</tr>
<tr>
<td>26 /2/ 2013</td>
<td>Qualitative thematic analysis</td>
<td>1.30pm – 4.30pm</td>
<td>243</td>
<td>Madeleine Murtagh</td>
</tr>
<tr>
<td></td>
<td>3.9 Approaches to the analysis of qualitative data sources: Transcription</td>
<td>9.30am – 12.30pm</td>
<td>243</td>
<td>Susan Wallace</td>
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<tr>
<td></td>
<td>3.10 Communicating research outcomes</td>
<td>1.30pm – 4.30pm</td>
<td>243</td>
<td>Madeleine Murtagh</td>
</tr>
<tr>
<td>27 /2/ 2013</td>
<td>Critical analysis of qualitative research</td>
<td>9.30am – 12.30pm</td>
<td>243</td>
<td>Madeleine Murtagh</td>
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<td></td>
<td>3.11 Approaches to the analysis of qualitative data sources: Discourse</td>
<td>1.30pm – 4.30pm</td>
<td>243</td>
<td>Madeleine Murtagh</td>
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<tr>
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<td>3.12 Self Directed Learning Exercise: Using NVIVO qualitative analysis</td>
<td></td>
<td>Adrian LT10</td>
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<td>13 /3/ 2013</td>
<td>Interviewing Skills for Professional Researchers</td>
<td>9.30am – 12.30pm</td>
<td>243</td>
<td>University of Leicester</td>
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<td></td>
<td>3.14 Conducting interviews, focus groups and observation</td>
<td></td>
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<tr>
<td>20/01/2015</td>
<td>Making the familiar strange: Ethnography, images and objects</td>
<td>9.30am – 4.30pm</td>
<td>243</td>
<td>Helen Eborall &amp; Clare Jackson</td>
</tr>
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<td></td>
<td>A Practical Guide to Analysing Data Using NVivo 10</td>
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<td>Pam Carter &amp; Liz Brewster</td>
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<td>21/01/2015</td>
<td>Approaches to the analysis of qualitative data sources: Discourse analysis</td>
<td>9.30am – 4.30pm</td>
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<td>Graham Martin &amp; Anne Montgomery,</td>
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<td></td>
<td>Sarah Chew &amp; Liz Sutton</td>
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<tr>
<td>27/01/2015</td>
<td>A Practical Guide to Analysing Data Using NVivo 10</td>
<td>9.30am – 4.30pm</td>
<td>ATT 103, 1st</td>
<td>Clare Tagg</td>
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<td>3.9 Approaches to the analysis of qualitative data sources: Discourse</td>
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<td>Graham Martin &amp; Liz Brewster</td>
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<td>3.10 Approaches to the analysis of qualitative data sources: Discourse</td>
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<td>Session Title</td>
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<td>Room</td>
<td>Presenter(s)</td>
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<tr>
<td>24/02/2015</td>
<td>3.10 Critical appraisal of qualitative research papers</td>
<td>9.30am – 4.30pm</td>
<td>243 Adrian</td>
<td>Susan Wallace &amp; Pam Carter</td>
</tr>
<tr>
<td>25/02/2015</td>
<td>3.12 Using qualitative analysis software</td>
<td>9.30am – 4.30pm</td>
<td>G62 MSB</td>
<td>Emma Angell</td>
</tr>
</tbody>
</table>
Appendix 5

The University Ethical Approval

To: Panos Vostanis

Subject: Ethical Application Ref: pv11-bc33

(Please quote this ref on all correspondence)

02/08/2013 16:25:35

Psychology

Project Title: Enhancing service Delivery in Saudi Arabia: The Evaluation of a National Family Safety Programme for Interdisciplinary Child Protection Training

Thank you for submitting your application, which has been considered.

This study has been given ethical approval, subject to any conditions quoted in the attached notes.

Any significant departure from the programme of research as outlined in the application for research ethics approval (such as changes in methodological approach, large delays in commencement of research, additional forms of data collection or major expansions in sample size) must be reported to your Departmental Research Ethics Officer.

Approval is given on the understanding that the University Research Ethics Code of Practice and other research ethics guidelines and protocols will be compiled with

1. \[ \text{http://www2.le.ac.uk/institution/committees/research-ethics/code-of-practice} \]
2. \[ \text{http://www.le.ac.uk/safety/} \]

The following is the Ethical approval from the NGHA
MEMORANDUM
Ref. #: IRBC/055/14

Date: (G) 30 JANUARY 2014
(H) 29 Rabi’I 1435

To: MS. EJALAL KAMIL JALAL
PhD Student
University of Leicester, School of Psychology
Greenwood Institute of Child Health
United Kingdom of England

DR. MAJID AL BISSA
Deputy Executive Director
The National Family Safety Program (NFSP)
Ministry of National Guard Health Affairs


This is in reference to your subject proposal, which has been reviewed by the IRB Office on the 22nd of January 2014 through the expedited review process. Upon recommendation of the Research Committee, and following the review of the IRB on the ethical aspects of the proposal, you are granted permission to conduct your study.

Your research proposal is approved for one year commencing from the above memo date with the following conditions:

TERMS OF APPROVAL:
1. Annual Reports: Continued approval of this project is dependent on the submission of Annual Report. Please provide KAIMRC with an Annual Report determined by the date of your letter of approval.

2. Amendments to the approved project: Changes to any aspect of the project require the submission of a Request for Amendment to KAIMRC and must not begin without an approval from KAIMRC. Substantial variations may require a new application.

3. Future correspondence: Please quote the project number and project title above in any further correspondence.

4. Monitoring: Projects may be subject to an audit or any other form of monitoring by KAIMRC at any time.

5. Retention and storage of data: The PI is responsible for the storage and retention of original data pertaining to a project for a minimum period of five years.

Prof. Amin Kashmeery
Chairman, Institutional Review Board (IRB)
National Guard Health Affairs

Dr. Ahmed Alaskar
Executive Director, KAIMRC
National Guard Health Affairs

Dr. Bandar Al Knawy
Chief Executive Officer
National Guard Health Affairs

AK/AS/jue
Appendix 6
Invitation letter and consent form

School of Medicine
Greenwood Institute of Child Health
School of Psychology
University of Leicester
Westcotes Drive
Leicester LE3 0QU

Research title: Professionals’ perceptions of the implementation of the interdisciplinary National Family Safety Training Programme in the Kingdom of Saudi Arabia

Invitation Letter & Information Sheet
Dear Sir or Madam,

We are writing to you to invite you to take part in a research study. Before you can decide whether you wish to take part, you need to understand the purpose of the research and what it would involve for you. Please take your time to read the following information carefully and please contact us if anything is not clear, or if you would like any further information before you make your decision.

Background

The interdisciplinary training course is part of a series of basic training courses that are offered annually by the NFSP in collaboration with others. Generally, it provides participants with basic skills in how to deal with child abuse and neglect cases; and identify the types, signs, causes and consequences of child abuse and neglect. Moreover, it supports participants with needed skills to evaluate, intervene and protect, in addition to treatment and rehabilitation techniques. It also aims to provide participants with knowledge of national and international laws and regulations that govern child protection and child abuse and neglect prevention, and to bring to their attention the latest research and studies on the subject.

It would be valuable to understand how participants apply these training aspects in everyday practice, hence our invitation to participate in this study.

What is the purpose of the study?

The aim of this project is to explore professionals’ perceptions of the implementation of the child protection training programme on their practice.

Why have I been invited to take part?

During this year (2013) we will be recruiting NFSP trainees to ask them to help us with our research. All discussions will be about the training and the impact of the training on their practice. Individual cases and any other information will not be shared or discussed.

Do I have to take part?
No – it is entirely up to you to choose whether you wish to take part in this research study. If you agree to take part, we will ask you to sign a Consent Form to show your agreement. You are free to withdraw from this research at any time, without giving us any reason for your withdrawal. If you decide to withdraw from the research, we will destroy any information that may identify you (i.e. address, telephone number) but we will need to use the anonymised data that we have collected from you up until the point of your withdrawal (because once anonymised, we will not be able to identify what data was provided by whom).

**What will I have to do?**

This research proposes to adopt qualitative approach. A small number of participants will be selected and asked to take part in a recorded interview (audio only). By sharing your views through phone interview about the content of the NFSP interdisciplinary training program, you will help us to understand the effectiveness of the training, e.g. which part of the materials has been used in the practice. This interview will take place at a time and place convenient to you (e.g. your office) and will take no more than an hour. You will be contacted to schedule an interview date and time after I receive your consent form.

Please note that if you agree to help us with our research, we would keep your information on file with the researcher (me) exclusively for interview arrangement contact purposes (your name and any other personal information will not be linked to any information you choose to provide in the interview). Information will be deleted after you complete the interview and will not at any stage be shared with any party.

**What are the possible disadvantages and risks of taking part?**

This study has been designed to ensure that the possible disadvantages and risks to you from taking part in this study are minimal. This study has also been designed to cause minimal inconvenience to you in relation to time and travel.

**What are the possible benefits of taking part?**

The information that you share with us will help us to better understand the impact of the training. As a participant at NFSP training your views will then help shape better quality services and therefore offer better future care for children that get the referral for assessment and/or treatment here.

**Will my taking part in the study be kept confidential?**

Yes, all information that you share with us will be handled in confidence and stored securely. Information that you disclose to us that could be used to identify you (i.e. name, address, telephone number) will be stored separately from your research data and will be destroyed at the end of the research programme. Access to research data will only be available to members of the research team (the National Family Safety Programme (NFSP), a national government entity subjected to the regulations of King Abdul Aziz Medical City National Guard and the University of Leicester).

However, if you decide on your own to tell us information that can reasonably be considered by us as putting your or someone else’s health at risk, we might not be able to guarantee complete anonymity in those particular instances. If that is the case, information
you disclosed along with your name might be passed on to relevant individuals for health protection purposes.

**What will happen to the results of the study?**

The results will be presented and circulated through academic publications (i.e. journal articles) and conferences. As explained above, no personal details that might identify you will be included. Please ask if you wish to receive a copy of the findings of the study.

**Who is organising and funding the research?**

The Ministry of Higher Education of the Kingdom of Saudi Arabia funds this research. The research team consists of Ejalal Jalal (University of Leicester) Professor Panos Vostanis (University of Leicester) and Dr Michelle O'Reilly (University of Leicester).

**Who has reviewed the study?**

To protect your rights and safety this research has been reviewed and approved by an independent Research Ethics Committee at the University of Leicester. The protocol of the study was also reviewed by an academic group and underwent a Post-graduate review towards a PhD project.

**What if there is a problem in the future?**

If you have any concerns about any aspect of this research study, or if you feel that you have experienced any harm from taking part then please contact a member of the research team who will do their best to solve your concerns or deal with your complaint.

If you remain unhappy and feel that you were harmed during the research and that this is due to somebody’s negligence then you may have grounds of a legal action for compensation against the University of Leicester, as they are the responsible of this research, but you may have to pay your legal costs.

**What if I have any more questions now?**

If you would like to request any further information or talk to a member of the research team at the University of Leicester then please contact in the first instance: the principal investigator for this research programme:

Ejalal Jalal  
Phd Researcher  
Greenwood Institute of Child Health  
Westcotes Drive  
Leicester, LE3 0QU  
Tel: +44 758 889 0692  
Email: ej75@le.ac.uk

You can also contact the Co-Investigators for this research programme:

Professor Panos Vostanis,  
Professor of Child and Adolescent Psychiatry, Honorary Child and Adolescent Psychiatrist  
Greenwood Institute of Child Health
What should I do next if I want to take part?

1. Consent: Simply read and sign copy of the enclosed consent form and then return to a member of NFSP team. Keep the second copy of the consent form along with this information sheet for future reference.

2. Interview: After I receive your consent form, I will contact you to schedule an interview date suitable for you. Please note that we will inquire about the availability of a private room to hold the interview in to ensure that confidentiality is maintained, and that the interviews cannot be overheard.

We thank you for taking the time to read this information sheet, and hope that you will be willing to help us with our data collection.

Yours Faithfully,

Ejalal Jalal (Principal Investigator)

Professor Panos Vostanis

Research title: Professionals’ perceptions of the implementation of the interdisciplinary National Family Safety Training Programme in the Kingdom of Saudi Arabia

Consent Form

Please initial the following boxes to confirm that you understand the consent process:

☐ I confirm that I have read and understand the information sheet for the above research study. I have had the opportunity to consider the information, to ask questions and have had these answered.

☐ I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason.
☐ I understand that responsible individuals may look at relevant sections of my anonymised data collected during the study from the NFSP or University of Leicester or from regulatory authorities.

☐ I consent to taking part and the interview being recorded

Please tick or initial the following box to indicate which part of the research programme you consent to:

Finally, please insert your name, signature and the date in the spaces below.

Your Name ................ ............. Date .................................................................

Your Signature...............
## Arabic letter information and consent form

نموذج أقرار بالموافقة المستنيرة على المشاركة بحثية

### معلومات عن الدراسة:

**عنوان الدراسة:** التعرف على وجهات النظر المختلفة حول البرنامج التدريبي للمهنيين متداعي التخصصات المتعاملين مع حالات إحياء الأطفال المنظمة من خلال برنامج الأمن الأسري.

**رقم الدراسة:** SP13/011

**مواعيد الدراسة:** وزارة التعليم العالي بالمملكة العربية السعودية، وبرنامج الأمن الأسري الوطني السعودي وسيتم تنظيم وتحليل المعلومات الدراسة مع فريق البحث من جامعة لستر، المملكة المتحدة البريطانية.

**الباحث الرئيسي:** الدكتورا/ إجلاج كامل جلال

**عنوان الباحث الرئيسي:**

University Of Leicester, Greenwood Institute, Westcotes House, Westcotes Drive, Leicester, LE3 0QU, United Kingdom Of England

**مقدمة:** أنت مدعو للانضمام بشكل اختياري في الدورة التدريبية لل المهنيين متداعي التخصصات المتعاملين مع حالات إحياء والأعمال الأطفال، والتي تشكل جزءاً من سلسلة من الدورات التدريبية الأساسية التي يتم تقديمها سنوياً من قبل برنامج الأمن الأسري الوطني بالتعاون مع آخرين.

تهدف الدورة السابقة ذكرها لإعداد المشاركين المهارات الأساسية للتعامل مع حالات إحياء والأعمال الأطفال، والتعرف على أنواعها وأسبابها ومؤثراتها وعوائقها، وتقديم المهارات اللازمة للتقييم والتداخل والوقاية وطرق العلاج والتأهيل. كما تهدف لتعرف المشاركين بكافة التشريعات الدولية والمحلية والإجراءات المتصلة في هذه الحالات، وطلاعهم على أحدث المستجدات العلمية في هذا المجال.

لذلك وسكون من المفيد جداً معرفة كيفية تطبيق هذه الجوانب للمتدربين من خلال المشاركة. قبل توقيعك على هذا النموذج، فضلاً أقرأ بعناية كل جوانب الدراسة لاتخاذ قرار مبني على المعرفة. خلال فترة الدراسة سيحق لك الاستفسار عن أي تساؤل يتعلق بهذه الدراسة. كجزء من عملية الموافقة المستنيرة للمشاركة بهذه الدراسة، سوف يتم إخبارك عن أي معلومات جديدة يتصل إليها الباحثون وقد تؤثر على قرارك بالاستمرار في تلك الدراسة من عدمه.

**أهداف الدراسة:**

**لاسيماً لجوار:** لإجراء الدراسة هو تقييم برنامج الأمن الأسري الوطني المقدم لفئة المهنيين المتعاملين مع حالات إحياء الأطفال، وذلك بالتحقق من مدى تطبيق جوانب التدريب المختلفة بشأن الحد من الإساءة في معاملة الأطفال وإهاليهم.
3. **مدة المشاركة في هذه الدراسة:** إذا قررت الموافقة على المشاركة في هذه الدراسة، فمدة مشاركتك سوف تكون مقابلة شتوية تستغرق من ستين دقيقة إلى الساعة والنصف، وسوف يكون هذا النقاش حول التدريب وأثر التدريب على الممارسات العملية في العمل (أي نقاش أو حوار مكتوب أو مسجل سيكون محمي وغير قابل للنشر).

4. **عدد المشاركين بهذه الدراسة/مواقع واعتادات الدراسة:** العدد الكلي المتوقع للمشاركين بهذه الدراسة سيكون (60) مشارك، ستجري هذه الدراسة على شكل مقابلة شخصية عن طريق الهاتف سيكون في غرفة خاصة لعقد المقابلة لكي يتمكن من ضمان سرية المقابلة.

5. **خطوات الدراسة:** قبل موافقتك على الانضمام في هذه الدراسة، فضلاً يرجى قراءة المعلومات الموضحة أدناه، بدءًا. يقترح هذه البحث اعتماد طريقة-نوعية-مقابلة شخصية.

**الخطوات المتبعة للمشاركة في الدراسة:**

1. **المؤتمر:** ببساطة عليك قراءة توقيع الموافقة وورقة استمارة الموافقة ومن ثم العودة إلى أحد أعضاء فريق برنامج الأمان الأسري الوطني، والانتظار بنسخة ذيتك من استمارة الموافقة وورقة المعلومات هذه التي ترجع إليها في المستقبل.

2. **المقابلة:** بعد تلقي موافقتك، سوف يتم الاتصال بك للتحدث حول المشاركة في اختيار التاريخ المناسب والمكان المناسب للشخص المشارك من كل تخصص لإجبار مقابلة شخصية (في حدود الساعة والنصف). سوف يتم الاستفسار عن وجود غرفة خاصة لعقد المقابلة لكي يتمكن من ضمان سرية المقابلة. خلال المقابلة الشخصية سيتم تبادل وجهات النظر حول محتوى برنامج التدريب، لتقييم فعالية التدريب، على سبيل المثال أي جزء من التدريب قد تم استخدامه في الممارسات العملية.

ملاحظة: في حالة الموافقة على المشاركة ومساعدتنا على عمل البحث، فإنه سوف يتم الحفاظ على المعلومات الخاصة بك في ملف خاص بك، وتمكننا (لن يتم استخدام المعلومات أو البيانات الخاصة بك لأي غرض سوى المقابلة الشخصية). كما سيتم مسح كافة البيانات الخاصة بك بمجرد الانتهاء من المقابلة الشخصية ولكن يتم استخدامها مع أي جهة أخرى لأي غرض ما.

6. **إذا تتنجى مشاركتك في الدراسة:** في حال ما وافقتك على الانضمام في هذه الدراسة، فإن مشاركتك قد تلغى بتوصية من باحث الدراسة في الحالات التالية:

1. إذا قررت سحب موافقتك من المشاركة في الدراسة.
2. إذا قرر الباحث عليك البقاء في حالة أنك لست الأفضل للانضمام من الدراسة.
3. إذا توقفت الدراسة من قبل السلطات التنظيمية التشريعية أو لجنة الأخلاقية المحلية أو ممول الدراسة.
4. إذا كان التزامك بإجراءات الدراسة أو البحث أقل من متطلبات البروتوكول.
5. إذا تعرّض على فريق البحت الاتصال بك ومتآثرك "تعرّض المتابعة.

في حال إلغاء مشاركتك لن يسمح لك بالمشاركة مرة أخرى.

المخاطر واحتمال الملامحة (المشاركات والإزعاجات): الدراسة صممت بشكل يضمن للمشارك الخصوصية ونسبة حدوث أي ضرر معموم.

إذا كانت لديك أي مخاوف حول أي جانب من جوانب الدراسة البحثية، أو إذا كنت تشعر بأنك قد تتعرض لأي ضرر من هذه المشاركة، الرجاء الاتصال بأحد أفراد فريق البحت والذي سوف يبذل قصارى جهده للتعامل مع الموضوع بالشكل الملام.

التكاليف وتعويض عن المشاركة في الدراسة: لا يوجد تكاليف مالية لقاء المشاركة في هذه الدراسة ولن تتحمل تكاليف أي إجراءات صممت فقط لغرض البحت. يجب عليك إثبات الابتكار الرئيسي فورًا إذا لحق بك أي مضايقة أو إصابة خلال فترة الدراسة.

القواعد:

التفاصيل المستقلة من الدراسة تجوعنا على فهم أفضل للتدريب. كما أن تقديم خدمات ذات جودة عالية تعتمد على مشاركتكم، وبالذات وجهات نظركم نفسياً ضمان جودة الخدمات المقدمة للأطفال الذين تم احتالهم للحصول على تقييم وعلاج فعال لهم في الحاضر والمستقبل.

 المسؤوليات المشاركة: مشاركتك في هذه الدراسة اختيارية تماماً ولك الحق دائماً في الانسحاب من الدراسة أي وقت تشاء بدون ذكر الأسباب، وبغض النظر عن القرار الذي سوف تتخذ به بشأن المشاركة في الدراسة، فإن ذلك لن يؤثر عليك ولا على علاقتك بأعضاء فريق الدراسة.

إذا توافقك على إقرار الموافقة لا يعني التنزل عن حقوقك القانونية، ولا يزال يقلص عليك المسؤوليات التالية:

a. اقرأ المعلومات المقدمة في إقرار الموافقة وحاول فهم محتواها.

b. إطمح كل الأسئلة التي تتطلب الاستفسار عنها، واعرف كافة حقوقك.

c. اتبع بعناية كل التعليمات المتعلقة بالخطوات المتعلقة بالمشاركة في الدراسة.

d. أحرص على الالتزام بخطوات الدراسة، وإذا تعرّض عليك الحضور في الوقت المحدد لأي ظرف طارئ، فضلاً أبلغ منسق الدراسة.

e. طالما أنك مشارك في هذه الدراسة وأنت في فترة المتابعة، لا تستطيع المشاركة في دراسة أخرى دون الرجوع إلى الابتكار الرئيسي.

السرية والتكليفي لجمع واستخدام وتصريح عن المعلومات الشخصية:
المعلومات الخاصة بالمشاركين ستبقى سرية، سيتم جمع المعلومات والبيانات بشكل سري وحلفاق عليها. جميع المعلومات الخاصة بك سوف يتم تخزينها (الاسم، رقم الهاتف، البريد الإلكتروني، العنوان) للتوصل في فترة البحث، وسوف يتم مسحها في نهاية البحث.

إن توظيفك على هذا الإقرار يسمح للموظفين المصرح لهم بالوصول إلى كافة المعلومات المتعلقة بك بما في ذلك البيانات الشخصية والمعلومات التي تم جمعها من قبل في الجريدة أو المنظم وغير من دفاتر الدراسة. الأفراد المسؤولين في مركز الملك عبد الله العالم للأبحاث الطبية، ومؤسسات إدارة التعليم العالي، وجامعة ليستر بالمملكة المتحدة البريطانية ولجنة البحوث بيولوجية وغيرهم من الأفراد ذوي الصلة بالدراسة يمكن لهم الوصول إلى سجلات البيانات، مراجعتها وتحليلها. جميع المعلومات التي تم جمعها من سجلات الأشخاص المشاركة في الدراسة تعود ملكيتها لمركز الملك عبد الله العالم للأبحاث الطبية بالمملكة العربية السعودية وقاعدة ليستر بالمملكة المتحدة البريطانية، ولكن سيتم التعامل مع هذه السجلات والمعلومات بسرية تامة وفقاً للقوانين واللوائح المطبقة، سيتم نشرها عنصراً في حال تم نشر أي من نتائج الدراسة، فإنه لن يتم ذكر معلوماتك الشخصية، ولكنها قد تكون مشفرة إلى رمز معروف للفريق البحث دون ذكر معلوماتك.

وسائل الاتصال: في حال وجود أي استفسار ذو صلة بالبحث أو ترغب في طلب أي معلومات إضافية أو التحدث إلى أحد أعضاء فريق البحث في جامعة ليستر، المملكة المتحدة الراجي الاتصال في المقام الأول بالباحث الرئيسي لهذا البرنامج البحثي:

إجلال كامل جلال، معيد جرين وود لصحة الطفل العام، جامعة ليستر، المملكة المتحدة البريطانية.

البريد الإلكتروني: ejalal.jalal@hotmail.co.uk

أو البريد الأول ejal75@le.ac.uk

كما يمكنك الاتصال بالمحقق الرئيسي لهذا البرنامج البحثي:

المؤسس، الدكتور ماجد الغيسي، سما الحسين، جامعة الملك سعود بن عبد العزيز للعلوم الطبية، المملكة العربية السعودية، البريد الإلكتروني: maleissa@yahoo.com

أو البروفيسور ناجي ناجي، أساتذة طب الأطفال والمرأة، معيد جرين وود لصحة الطفل، جامعة ليستر، المملكة المتحدة البريطانية، البريد الإلكتروني: p11@le.ac.uk

أو الدكتور ميشيل أورايلي، أساتذة محاضر بجامعة ليستر، المملكة المتحدة البريطانية، البريد الإلكتروني: mjo14@le.ac.uk

في حالة تود استفسارات تتعلق بحقوقك كشخص مرشح للبحث، فإنه يمكن الاتصال على لجنة أخلاق البحوث الحيوية على الهاتف 14572 8011111 تحويلة 11

11. الخلاصة

بالتوقيع هذا الإقرار بالموافقة المستنيرة، أعلم أنني لم أتأكل عن أي من حقوقي القانونية وتوقيعي يشير إلى:
أني تلقنت معلومات وافية عن الدراسة، وأني قرأت وفهمت المعلومات المقدمة في إقرار الموافقة المستنيرة.

أتيح لي الفرصة لمناقشة الدراسة وطرح الأسئلة حول مشاركتي بالدراسة، وأنا راض عن الإجابات التي قدمت لي من قبل فريق البحث. وفي حال وجود المزيد من الأسئلة سوف أتصل بالباحث الرئيس.

أفهم أن مشاركتي في هذا البحث اختيارية، ولي الحق التام في الانسحاب من الدراسة (في حال قررت الانسحاب سوف يتم مسح أي معلومات شخصية تخصني).

أفهم أن الباحث الرئيس له الحق في إنهاء مشاركتي في الدراسة إذا كان ذلك مناسباً.

أفهم أن عدم التزامي بإجراءات البحث سوف ينهي مشاركتي في الدراسة.

أفهم أنني بعد توقيع هذا الإقرار بالموافقة سوف أحصل على نسخة موقعة ومؤرخة.

بتوقيع وتاريخ هذا الإقرار بالموافقة المستنيرة أعلن موافقتني على المشاركة في هذه الدراسة البحثية.
Appendix 7

Semi-structured interview guide

What they do and what child protection training related to their work

1- Could you tell me about your role please? How are you involved with child protection services?

2- Was this your first training? Or have you attended the training more than once?

Training course (Contents and delivery)

1- Can you describe the training programme for me please? Its content and how it was delivered? E.g. workshops, presentation?

2- Could you identify some part of the course of the training?

3- What is your general impression of the course?

4- Did you explore training with other disciplines?

5- Whether/ how has the training influenced your practice or other type or work?

6- What was the most important aspect of the course? Which part of it do you remember best, or what do you remember and was particularly relevant to you?

7- Have you been able to make practical use of any of the material? If yes, go to question a – if no, go to 8, and why?

   a. Which parts of the training course have you been able to make use of? List all those mentioned? Why and how?

   b. Can you give me an example of how you used this course material? If possible could you describe the actual circumstances in which you used it? Could you also state what the result was? Tell me about the outcome? And why was that?

   c. Given that you have made use of those parts of the course, were there any other parts of the course that you have not been able to make use of, though perhaps you might have liked to? If so, could you tell me what these were, and why you have not been able to use them?

If no, why you have not used any of the material?
If no, why? Why have you not wanted to make use of any of the course material? There may be different reasons for different parts of the course…..

Could we explore the reasons (mainly if related to their jobs) why you have not been able to make use of the course material, given that you would have liked to? Do you envisage yourself incorporating any of these features of the course into your practice at some stage?

**Working together in an interdisciplinary way**

Describe how the training has influenced your work with colleagues, parents and children?

**What would you recommend in the future?**

1- Returning to those aspects of the course that have you used, how would you want to consolidate those aspects, or advance your learning in those areas?

   a. What plans do you have for future practice? Do you see yourself continuing to make use of this material and, if so, how?

   b. What sort of help or support do you think you will need in order to carry out these plans? Who could be most helpful, and how?

   c. Do you think that further training would be particularly helpful in consolidating or advancing this aspect of your work? If so, what sort of things should it cover?

   d. How about those parts of the course you have not used? Do you imagine yourself incorporating them into you practice at some stage?

   e. If yes, what sort of help or support do you think you will need in order to achieve this? Who could be most helpful, and how?

   f. If no, what do you think should happen next, as far as those topics are concerned? (Now go to question 13).

2- Given that you have not been able to use any of the course material during the last year, would you have liked to? If yes, go to a.

   a. If yes, what sort of help or support do you think you will need in order to do this effectively? Who could be most helpful, and how?

   b. If no what do you think should happen next, as far as those topics are concerned?
3- In conclusion, is there anything else you want to say about this course that you have not had an opportunity to say already?
(The translation of the interview guide)

 أسئلة المقابلة الشخصية

 السلام عليكم ورحمة الله وبركاته

 حضرتك الأخ/الأخت .....

 معاك/ معالي الدكتور/ة اجلاء جلال التعاونية مع برنامج الأمان الأسري المتخصص في مجال برنامج وقائية وحماية الأطفال من العنف

 يمكن كم دقيقه من وقتكم لمساعدتنا في تقليم الخدمات المقدمة للتعامل مع حالات الأطفال المعرضين للعنف لرفع مستوى الخدمات للافضل

 ثانيا إذا كم ممكن تجاويني/ تجاويني علي شؤون اسله اكون شاكره لكم ومقدره لوتمكم والله يكتبكم في ميزان حسناتهكم من كمكلفة لمساعدة الدولة في التقدم والتطور فابن الله

 ثالثا المكالمه سوف تسجل لأغراض التوثيق.

 1. ما هو مسماك الوظيفي؟ فين تشتغل؟ مدينة؟ كيف سمعت عن برنامج الأمان الأسري؟
 2. هل وظيفتك مرتبطه بشكل مباشر أو غير مباشر بالبرامج التدريبية المقدمة من الأمن الأسري؟
 3. كم دورة تدريبية حضرتها مع الأمن الأسري؟ هل حضرت دورات تدريبية أخرى؟ كيف تذكرها؟ هل تتذكر كيف تم البرنامج؟ كيف اتقدم البرنامج مثال، محاضرة أو ورش عمل؟
 4. ممكن توصف لي محتوى البرنامج وايش وسائل التعليم المختلفة التي تم استخدامها من خلال البرنامج؟ ذي ورش عمل، محاضرات؟
 5. هل تتذكر جزء معين في التدريب، هل له علاقة بوضيفتك؟
 6. ما هو الانطباع العام عن الدورة؟
٢. هل يوجد هناك جانب معين ترك أثر عليك؟ وضح لي كيف؟

٣. هل تمكنت من تطبيق أي جانب من جوانب التدريب في الممارسة العملية؟ ممكن توضح لي كيف أو كم حالة

٤. عدت عليك قدرت تعامل معاها؟ ماهي المواد أو الجوانب التي تم الاستفادة منها؟ (من ناحية شخصية مثل معاملتك للأطفال وكأخصائي، ومن ناحية دينية وعادات وتقاليدي من ناحية القوانين الدولية والمحلية المطلقة)

٥. هل تستطيع أن تعطيني مثال عن الظروف التي تم استخدام أحد جوانب التدريب فيها؟ وكيف كانت النتيجة؟

٦. بالعودة إلى الجوانب التي تم استخدامها في الحياة العملية، كيف تود التركيز على هذه الجوانب التي تم الاستفادة منها، وتطور من عملية فهمك لها؟ أ. ماهي الخطط التي تود تطبيقها في المستقبل؟ هل تجد نفسك سوف تستمر في استخدام محتوى التدريب؟ كيف؟

ب. ماهي نوع المساعدة أو المساعدة التي تود الحصول عليها حتى تتمكن من تنفيذ خططك المستقبلية؟ من هم الأكثر فائدة في تطبيقها وكيف؟

ج. هل تعتقد أن المزيد من التعليم والتدريب سيكون من المفيد جدا في الممارسة العملية؟ في حالة نعم ماهي القضايا التي تود أن تتم تغطيتها؟

٧. هل هناك أي جانب من جوانب التدريب لم يتم الاستفادة منها؟ لماذا لم تكن قادر على استخدامها؟

*** التدريب مع الأخصائيين في ورش العمل؟ هل أثر في العمل مع الآخرين؟ ومع الأهالي ومع الأطفال؟