Original article

Child maltreatment prevention readiness in Bahrain

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ABSTRACT

Background and Objectives: Child maltreatment (CM) is a major public health problem worldwide. Despite the well-documented cases of all forms of CM and the improvement of the national response to CM in Bahrain, efforts on the prevention of CM are still limited. The objective of this study was to assess the readiness to implement a national evidence-based CM prevention (CMP) program in Bahrain.

Methods: The cross-sectional study was conducted with 45 key informants who had influence and decision-making power over CMP.

Results: The overall score indicated low to moderate readiness. The key informants scored the highest on legislation, mandates, and policies (7.9), which was followed by the knowledge of CM prevention (7.2), institutional resources and links (5.2), and informal social resources (noninstitutional) (5.2). However, the lowest scores were the human and technical resources (1.2), attitudes toward CM prevention (3.3), will to address the problem, and material resources (3.8), current programs implementation and evaluation, and scientific data on CM prevention (4.5).

Conclusion: This research has identified strengths and gaps in the country that needs to be addressed to develop programs that are responsive to the needs of the community. The development of a comprehensive well-resourced CMP program requires the collaborative efforts of legislators, political leaders, and professionals.

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1. Introduction

Child maltreatment (CM) is a major public health issue worldwide that exists in all corners of this planet [1]. In addition, extensive research on the consequences of CM including bruises, burns, fractures, muscle injuries, head injuries, and pulmonary and abdominal trauma cannot be ignored. In the Kingdom of Bahrain, pediatricians recognized CM prior to 1990, but it was not reported. Between 1991 and 2001, the first 150 cases of CM were reported with child sexual abuse (CSA) representing 65% of the cases. High divorce rates (24% of the families) and a preponderance of children coming from a low socioeconomic background (64% of the cases) were the identified risk factors for CM [2]. CM research publications for the following decade (2000–2009) revealed an increase in the number of physical abuse and CSA cases. The number of reported physical abuse cases increased annually from 11 in 2000 to 54 in 2009. Regarding CSA, the number of cases increased steadily from 31 in 2000 to 77 in 2009 [3].

Despite the well-documented cases of all forms of CM and the improvement of the national response to CM, limited efforts have been made for its prevention. The educational efforts continued by the Child Protection Center have remained far below the
community’s requirement. The focus of professional efforts has been on the response to the increasing number of CM cases with very little time or energy available for prevention efforts. Non-governmental organizations (NGOs) have played a major role in public education and in increasing awareness. However, without official government support for human resource development and appointments, the outlook for progress is limited. To prevent CM, the National Childhood Committee under the Ministry of Social Development drafted a National Plan of Action, which follows the public health approach to three levels of prevention: primary prevention that targets the general population, secondary prevention that targets children and families at high risk of CM, and tertiary prevention that focuses on responding to CM [4].

Through the well-planned adverse childhood experiences studies, we now know that the long-term consequences of CM are not less serious than the short-term consequences [5]. Social repercussion may manifest as an increased likelihood of poor academic achievement, failed marriages, unemployment, and incarceration. In addition to the cost of human suffering that cannot be quantified, there are staggering costs of providing health care, social support, and mental rehabilitation to victims, let alone the costs of law enforcement, and legal system involvement. Furthermore, there is human suffering resulting from society’s failure to protect its future and most precious asset—its children. A society with broken children is a doomed culture. All of these factors call for immediate action. Prevention is less expensive than treatment or remediation at all levels and promotes healthier and happier individuals and communities.

In the Gulf Cooperation Council (GCC) countries, local investigators, stakeholders, and field leaders indicated that there is inadequate research on CM prevention in these countries. The National Family Safety Program in the Kingdom of Saudi Arabia collaborated with investigators from other neighboring countries to examine their level of readiness, share technical support, and implement large-scale evidence-based CM prevention programs. Such assessments strengthen the collaboration between policymakers, individuals, and organizations in terms of CM. The aim of this study was to evaluate the readiness of the Kingdom of Bahrain to implement a national evidence-based CM prevention program.

2. Methods

2.1. Participants

The research team met and discussed potential key informants as participants, which involved identifying individuals who have influence on CM prevention. This included people from international organizations represented by the United Nations Development Program (UNDP) office, government decision-makers, and employees from the Ministries of Health and Social Affairs, and leaders within civil society, educational institutions, and the community.

Out of 56 key informants who were approached, 45 consented to be interviewed as part of the study (80% response rate). As shown in Fig. 1, 69% of participants were women and 31% were men. As for the type of organizations where participants were employed, over half (60%) were from government organizations, 13% were from NGOs, 13% were from international organizations, 7% were from universities, and 7% were from private and other sectors. To ensure a representative sample, participants were selected based on a preset sample selection matrix; however, because of the small geographical area and population of Bahrain, the scope of work of the participants’ organizations of almost all of the sample (98%) was at the national level.

2.2. Procedures

The research team included two pediatricians, a social worker, and an occupational therapist from Arabian Gulf University and the Ministry of Health, Bahrain. Research team members have a strong background in working with maltreated children and their families. The team attended a workshop about the research project and the investigation instrument, which was conducted by the principal investigator.

Convenience sampling was used to recruit potential participants who were contacted by telephone to invite them to participate in the study, and agree on an appointment day for the interview by one of the four researchers. All interviews began by sharing an invitation letter describing the goals and confidentiality of the study. This was followed by obtaining informed consent from each participant before starting the interview. Time spent with each participant was about 30–60 min and there was no incentive for participation. There were no obstacles encountered during the data collection phase.

The Institutional Review Board of the Arabian Gulf University approved the study. Study participants were fully informed about the study and their right to withdraw their participation at any time during the study. To ensure participant confidentiality, a number of steps were undertaken.

2.3. Research instrument

The instrument used was the Child Maltreatment Prevention Readiness (CMPR) questionnaire, which is based on the Readiness Assessment for the Prevention of Child Maltreatment. World Health Organization developed the instrument, field tested, and implemented it in several countries. The CMPR questionnaire consists of 10 dimensions: (1) attitudes toward CM prevention; (2) knowledge of CM prevention; (3) scientific data on CM prevention; (4) current program implementation and evaluation; (5) legislation, mandates, and policies on CM prevention; (6) the will to address CM problems; (7) institutional links and resources; (8) material resources; (9) human and technical resources; and (10) informal social resources (noninstitutional). The scoring system for the CMPR questionnaire and the resulting scores are based on 10 dimensions [6–8].

2.4. Data analysis

Frequency distributions were performed with demographics and responses to various interview questions. Initially, scores were
calculated for each participant. After calculating, mean scores for all respondents on each dimension and mean total scores were calculated. In each dimension, the score was categorized into two groups: a mean score of five or above indicated high readiness, and below five indicated low readiness [7,9].

3. Results

3.1. Mean scores on the different dimensions

The distribution of mean scores of 10 dimensions are presented in Table 1 and Fig. 2. The overall score for 10 dimensions was 46.6. Of the 10 dimensions, key informants scored the highest on legislation, mandates, and policies on CM prevention (7.9) followed by knowledge of CM prevention (7.2), institutional links and resources (5.2), and informal social resources (non-institutional) (5.2). The lowest scores were found in human and technical resources (1.2), attitudes toward CM prevention (3.3), the will to address CM problems (3.8), material resources (3.8), current program implementation and evaluation (4.5), and scientific data on CM prevention (4.5).

3.2. Comparison of Bahrain findings with other GCC countries

The overall mean score in Bahrain was almost the same as the mean score for the GCC countries (Bahrain = 46.6 vs. GCC = 47.8). Additionally, Bahrain scores were generally the same as the GCC countries for the majority of dimensions, including current program implementation and evaluation (4.5 vs. 4.4), attitudes toward CM prevention (3.3 vs. 3.2), material resources (3.8 vs. 4.1), institutional links and resources (5.2 vs. 5.0), and legislation, mandates, and policies on CM prevention (7.9 vs. 8.1). However, Bahrain scores were higher on dimensions of knowledge of CM prevention (7.2 vs. 6.8) and scientific data on CM prevention (4.5 vs. 3.5), while scores were lower on dimensions of the will to address CM problems (3.8 vs. 4.5), human and technical resources (1.2 vs. 1.8), and institutional links and resources (5.2 vs. 5.9) (Table 2).

3.3. Participants’ responses to the CMPR questionnaire

Over half of the participants (53%) reported that CM prevention had medium to high priority in comparison with other health and social issues. Furthermore, 58% revealed that measures taken so far to prevent CM were inadequate. Regarding the consequences of CM to victims, two-thirds (67%) were able to report more than five consequences. As for risk factors for CM, 78% were aware of 1–4 risk factors. Few participants (13%) revealed that data on the magnitude and distribution of CM existed and in good quality. Little over a quarter (26%) were able to mention four or more CM programs, when the participants were asked to provide names of programs they were aware of that were currently being implemented or had been in the past. Three-quarters (75.6%) of the participants revealed that there were government organizations or NGOs mandated with CM prevention. Few (20%) reported that there were committed political leaders who expressed their commitment in CM prevention and were taking effective measures to address this issue. Nearly half (49%) listed five or more institutions currently involved in CM prevention. More than a quarter (29%) reported that the Ministry of Social Development had an allocated budget to prevent CM. When participants were asked about dedicated budgets in other government organizations (e.g., other ministries, departments, etc.) besides the Ministry of Social Development, over three-quarters (80%) reported that they did not believe there were such organizations or were unaware of their existence. The vast majority (91.1%) revealed that professionals specialized in the field of CM prevention were not sufficient. When participants were asked about citizens’ participation to respond to various health and social issues, 64% revealed that it was medium to high.

4. Discussion

CM has a short- and long-term catastrophic impact on individuals and societies [1]. The average lifetime cost per child of maltreatment is staggering [10]. Therefore, it is imperative to address the prevention of CM as a public health and human rights issue, as well as a cost-effective endeavor.

This research has disclosed interesting data that can assist in planning and implementing evidence-based national CM prevention programs in Bahrain. Significant strengths were identified with

![Fig. 2. Mean Participants score on the 10 Dimensions.](image-url)
regard to the knowledge of CM prevention and the legislation, mandates, and policies on CM prevention. These two dimensions, knowledge and legislation, form the foundation for addressing any pervasive health or social dilemmas such as CM. Other countries have identified a similar trend [7]. These positive findings are the result of a long national drive to improve child laws that started in the early 1990s after ratification of the United Nations Convention on the Rights of the Child (UNCRC) and culminated in the enactment of Bahrain’s Child Law (2012) that devoted Chapter 7 to child protection from maltreatment. It is of note, however, that none of the 18 articles related to CM has been devoted to the prevention of maltreatment. Thus, there is a need for advocating and working with national legislators to add articles addressing CM prevention. Of note, less than a quarter (24.4%) of the key informants were not aware of the existence of the mandatory reporting law (Article 46 of the Child Law) and the mandated reporting agencies (Article 47). This emphasizes the need for increasing awareness about the law among professionals specifically and the general public as well. The high score in the knowledge of CM is most likely due to an increased awareness about CM, as a result of numerous formal and informal educational activities. Attitudes toward CM prevention had a low score, and nearly half (47%) of the participants believed that CM prevention has a low priority in comparison to other health and social issues. This finding highlights the need to focus particularly on CM prevention and evidence-based programs in formal and informal educational programs.

The will to address the problem of CM prevention also received a low score. For more than three quarters (80%) of the participants, either it was not clear to them or they did not think there are or know if there are political leaders in Bahrain who express their commitment to CM prevention. Regarding current program implementation and evaluation, the participants listed the names of a few CM programs that they were aware of that are being implemented in Bahrain or have been in the past. A closer look at these programs reveals that most are focused on public awareness, social skills development, child self-protection skills, parenting skills, and educational materials. There were no home visitation programs. Most are done sporadically and as ad hoc activities and not as part of a well-organized and well-resourced national program. In addition, these programs have not been evaluated for their effectiveness. The National Childhood Strategy to prevent CM included prevention programs based on three dimensions of public health approach to prevention [4]. However, the implementation and evaluation of these programs are lagging behind. It is necessary to implement evidence-based national prevention programs in which the assessment of the effectiveness of programs is an integral part.

The majority of participants (71%) believed that scientific data exist in Bahrain, but its quality is low or fair, or they were unaware about the quality. Furthermore, only 13% of participants believed that scientific data on CM exist and its quality is good. Keeping in mind that key informants might overestimate existing data, most believed that we need to improve the quality of scientific data on CM. Most of the national research on CM is based on a retrospective examination of hospital-based data of CM cases [2,3,11–13]. National surveys are required to identify the prevalence of CM and to assess its risk factors and consequences. These information would be essential to develop an effective national CM prevention program.

National institutional resources and informal social resources received the same score indicating borderline high readiness. These findings reflect the input of various ministries and the active role of NGOs who have always been involved in advocating children’s rights and CM prevention. The relatively high prevention readiness of informal social resources would also be helpful in the guidance of funding for NGO programs. Regarding material resources, few participants reported that the Ministry of Social Development had an allocated budget for CM prevention. Furthermore, the majority of participants did not believe or were unaware of any other ministries or government entities that had an allocated budget for CM prevention. This is valuable information for legislators, government bodies, and NGOs to highlight the need for child-responsive budgeting [14], which is an indication of any country’s genuine commitment to children’s needs. Human and technical resources achieved the lowest score, which is an alert to legislators, decision-makers, and educational institutions in the country to focus on human resource development, because without these professionals, all strategic plans and programs will remain as mere ink on paper.

5. Conclusion

In conclusion, Bahrain’s readiness in the implementation of CM prevention programs at the national level is low to moderate. This research has identified strengths and gaps in the prevention of CM that need to be addressed to develop programs that are responsive to the needs of the community. Professionals working in the field of CM need to work with legislators, political leaders, and key people to be able to develop a comprehensive and well-resourced CM prevention program.

Authors contribution

Fadheela T. Al-Mahroos - contributed to interpretation of results and drafting the article. Aysha A. Alnoaimi - prepared the data for analysis and wrote sections of the methods. Eshraig A. AlAmer - contributed to the discussion section, oversaw the production of the data, and helped to conceptualize the article.
Haitham A. Jahrami - contributed to the discussion section and revise the manuscript.

Hassan N. Saleheen - carried out the analysis of the data, and brought the sections on the results.

Maha Almuneef - prepared aspects of the discussion and the literature review.

Majid A. Al-Eissa is the principal investigator of the study, acquired the funding, and participated in the design, and analytic plan.

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**Ethical statement**

The study was approved by the Institutional Review Board (IRB) of King Abdullah International Medical Research Center (KAIMRC) (RC15/067). Participants eligible to participate were fully informed about the study, their right to refuse or withdraw at any time during the study, and all procedures put in place to ensure the privacy of the interviews. They were asked individually to review an informed consent statement before agreeing to participate in the study. Prior to providing their consent, they were described about the nature of the study and given more information on the types of questions that they would be asked. Subsequently, the participants either signed or initialed the informed consent form.

All data comprised participants’ answers to a survey. Data were collected only for the purposes of this study, and were not used for other purposes. A number of steps were taken to protect participants’ confidentiality [1]: All project staff received ongoing supervision in areas related to ethical conduct, confidentiality protection, and other issues in human subject protection [2]; the questionnaire did not contain participants’ names, and instead were labeled with reconstructable personal alphanumeric identifiers [3]; all data were stored in a locked cabinet or designated computer with an access-limited hard drive at the National Family Safety Program (NFSP); and [4] a hard copy of the information was stored in a locked cabinet that did not contain any other data.

Government and nongovernment organizations (NGOs) dealing with child maltreatment prevention (CMP) are expected to directly benefit from this study; by contrast, there were no direct benefits to participants. The study is expected to indirectly benefit health educators, social workers, research groups, and individual researchers. Participants did not experience any psychological distress or harm as a result of answering the questions.

**Declaration of competing interest**

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

**Visual abstract**

Supplementary data to this article can be found online at https://doi.org/10.1016/j.ijpam.2020.03.010.

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