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Children's Rights Journal of Rawalpindi Medical University (crJrmu)

ABOUT crJrmu

The "Children's Rights Journal of Rawalpindi Medical University" is a free, open-access, peer-reviewed journal that is uniquely focused on the rights of children through a holistic prism. The Journal is focused on interdisciplinary research that is linked to practical, evidence-based policy solutions for issues around child rights. This journal provides a platform to reflect on various dimensions of child rights, both at the national and international levels. It provides insight into the greater understanding of the rights of the children and their impact on childhood development, families, and societies. It encourages to study of broader aspects of child rights provision and how individual, familial, cultural, and societal factors interplay to create an effect on childhood development. The journal reflects the perspectives of a broad range of disciplines and contributes to a greater understanding of children's rights and their impact on the concept and development of childhood. The journal caters up to date information on all the disciplines relevant to the rights of the children including health, law, psychology, psychiatry, international relations, child development, social work, economics, education, and social anthropology so that it can be useful for diverse professionals, including policymakers, medical practitioners, child rights advocates, social workers, legal practitioners, and educationists. This journal welcomes local as well as broader perspectives on child rights including original research articles, review articles, and statistical reports relevant to child rights.

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Second Issue of the Journal of Children's Rights-Rawalpindi Medical University

Rai Muhammad Asghar[1], Tufail Muhammad[2]

[1] Executive Editor, Children Rights Journal of Rawalpindi Medical University, Rawalpindi.

[2] Member Editorial Board, Children Rights Journal of Rawalpindi Medical University, Rawalpindi.

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It is with great pleasure that we are presenting the second issue of the Child Rights Journal-Rawalpindi Medical University. The main objective behind the journal is to broaden and deepen the knowledge base around children's rights and their violations in homes, schools, workplaces, Institutions, and other such settings.

The UN General Assembly adopted the Convention on the Rights of the Child (CRC) in November 1989 and since then has been almost universally ratified. The goal of the CRC is to ensure the establishment of rights and provision for children in the socio-cultural, health, political and economic spheres. All state parties to the CRC, including Pakistan, have pledged to bring all their laws and policies in conformity with the CRC. They are further obliged to strive for the enforcement of these rights across the board without any discrimination or biases. Promoting children's rights and protecting children against abuse, neglect, and exploitation is a collective responsibility of the state and the society at large. Children's rights can be realized through protective laws, public awareness of children's rights, and creating an enabling environment, where all children have the opportunities to reach their full potential.

In this issue of the Child Rights Journal, Nabila Chaudhry has undertaken a critical review of "Pakistan's Policy for Persons with Disabilities and National Plan of Action". Children with disabilities are uniquely at greater risk for abuse, discrimination, and exploitation due to the fact that they are disabled and that they are children. According to the Convention on the Rights of persons with disabilities, the State Parties shall ensure that children with disabilities have the right to express their views freely on all matters affecting them, their views being given due weight in accordance with their age and maturity, on an equal basis with other children, and to be provided with disability and age-appropriate assistance. Although Pakistan has a National Plan of Action for Children and a Plan for Disabled Persons, the fact is that these plans are inadequately funded and thus poorly implemented. The problem has been further compounded after the 18th constitutional amendment and devolution of power to the provinces. It is high time that both the National Plan of Action for Children and the National Plan for Persons with Disabilities be revisited and updated in line with the new realities, including the provision of adequate resources for implementation.

Letter to the Editor

Mobilizing students: A novel solution to tackle child abuse in Pakistan

Maria Khan[1], Kishwar Enam[2]

[1] Aga Khan University, Karachi, Pakistan.

Author's Contribution

[1,2] Conception of study
[1,2] Experimentation/Study conduction
[1,2] Analysis/Interpretation/Discussion
[1,2] Manuscript Writing
[1,2] Critical Review
[1,2] Facilitation and Material analysis

Corresponding Author

Dr. Kishwar Enam,
Aga Khan University,
Karachi, Pakistan
Email: kishwar.enam@aku.edu

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Child abuse is rampant in Pakistan.[1] Brushed under the carpet, it may not always present to the legal system.[2] But it is more likely to present to the healthcare system. Here, the lack of awareness, stigma, fear of accountability, and practically no reporting forensic system[4] and the fact that healthcare workers are not mandated to report such incidents in place makes healthcare workers misdiagnose or ignore signs of child abuse. Such knowledge must be incorporated at an early level in healthcare education to break this cycle, however, dissipating any such knowledge is merely a mechanical exercise. A novel solution to this gap has emerged from a tertiary care hospital: Child Protection Services (CPS).[3]

CPS is an organization aimed at tackling child abuse, consisting of healthcare workers and medical students advocating for child rights. This organization has a subgroup which is essentially a student society powered by nursing and medical students, who participate not only as general members but are organized into society wings such as the research and community wing. They have leadership roles at each level of the hierarchy, from the head of the society to the wing leadership. Interested undergraduate students can apply to the society, are shortlisted via their CVs and interviews, and assigned to the wing of their choice. Their work and contribution earn them promotion to leadership positions.

CPS serves to raise awareness amongst students about the importance of child abuse as a social and healthcare issue by its simple presence. It helps harness students' interests in this subject and gives them a chance to interact with like-minded individuals to advocate this cause. The function of the society is even greater; the society generates meaningful research about child abuse, connects students with faculty mentors who are experts in this area, and raises awareness in the community. This includes campaigns in schools, increasing the knowledge of key stakeholders, such as school teachers, and so on.

Child abuse must be reintroduced into the medical curriculum, not only as the forensic and paediatric clinical caveat, but as a social issue, it is and stands to be until groups such as the healthcare workforce are mobilized to advocate for laws, policies, and robust frameworks for reporting child abuse. An example can be via a workshop[4] so that the whole picture of child abuse is seen instead of being scattered across disciplines. We must be ready to manage and treat patients who have suffered child abuse, with or without a reporting system- the two stand independently. We must, therefore, ensure that not only are diagnosis and management adequately taught but that the importance of the issue and the moral responsibility of students as individuals in society and as healthcare workers is reflected via our curriculum and via co-curricular, such as that of CPS.

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Letter to the Editor

Advertising to Children- Ethical Aspects

Aisha Mehnaz[1]

[1] Chairperson KONPAL, Child Abuse Prevention Society & Focal Person, PPA, CRG, Sindh.

Author's Contribution

[1] *Conception of study*
[1] *Experimentation/Study conduction*
[1] *Analysis/Interpretation/Discussion*
[1] *Manuscript Writing*

Corresponding Author

Dr. Aisha Mehnaz,
Chairperson KONPAL,
Child Abuse Prevention Society &
Focal Person, PPA, CRG, Sindh
Email: draisha_mehnaz@yahoo.com

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A number of advertisements being aired these days either involve children or are shown to children which is unrealistic and often unethical. Advertising agencies allure children to demand from their parents, items they neither understand nor needed to buy in the first place. Unable to differentiate between reality and fantasy, children start believing in what is shown to them.

On average young children and youth watch more than 30,000 to 40,000 adv. per year on television, in addition, they are further exposed to advertisements through print media like magazines, dailies, pamphlets, etc. Attractive advertisements on billboards and posters on public vehicles are in addition. Internet and social media sites are enticing more children with their slick promotional strategies.

This mammoth exposure is significantly contributing to poor health and nutritional issues in children like obesity and emotional problems. In most countries selling to children and youth is a business strategy. Since it is easier to lure children toward branded items, advertisers find innovative and creative ideas that instantly appeal to young minds. Research has shown that young children are cognitively and psychologically immature and cannot differentiate right from wrong; hence they are defenseless and thus are an easy target. In a number of countries like Sweden and Norway advertising to children, less than 12 years of age are forbidden by law. In some countries, Children Television Act (1990) allows only 10.5min/hour on weekends and 12 mins./hour on weekdays. No such TV act exists in Pakistan. In the USA in 1998, the children online privacy protection act (Publ no.105-277) states that commercial webs cannot collect information from children <13 years and are directed to provide notice on the sites to parents about the collection, use, and disclosure of children personal information and must obtain parental consent prior to advertisement,

Of the number of advertisements, children are exposed to more than 50% are about highly processed food, sugary cereals, fast food, and high caloric snacks and beverages. A good example is an advertisement that promotes a type of spaghetti. All nutritionist agrees that it has no nutritive value but the attractive advertisement is so alluring that children compel their parents into buying the product often throwing tantrums if their desire is not full filled. In most circumstances, parents succumb to their persistent demands.

These instant foods are highly processed because they are made to last a longer shelf life. Their nutritive content is low but fat, calories and sodium are high. Most items are coated with artificial colors, flavors, and preservatives.

The salt used is mostly monosodium glutamate (MSG) which is a chemical preservative derived from the petroleum industry and is added for its taste-enhancing properties. Regular intake of these food items can cause health issues including dependency.

The justification most parents give for buying and giving non-nutritive food is that children refuse to eat home-cooked food and remain hungry until their demands are met, so they have no option but to give in to their demands. This paves for more such demands from the children. Often this leads to Mal(bad) nutrition which can lead to weight loss or obesity. The essential micronutrients like vitamins and minerals

necessary for optimal growth of the body are largely missing in a tinned or packaged food item.

Children especially in our country are suffering from various kinds of malnutrition and related micronutrient deficiencies, insufficient knowledge of parents regarding balanced food and unhealthy food advertisement are playing a major part. Often ready to prepare tinned food was shown to be superior to home-cooked food. The manufacturing companies are spending more than twice on marketing as compared to what they should spend on research about their product and their impact on children.

Advertisers need to be careful not to send wrong messages targeting children to indulge in unhealthy eating habits

Another devastating effect of advertising is emotional trauma to children, promoting a certain hair oil or shampoo, or skin product claiming that it will increase their popularity among their peers often leads to a lack of confidence and self-esteem among children who unfortunately do not possess a silky hair or flawless skin. Children in their innocence and ignorance make fun of their peers prompted by the false claim made by the product owners. Thus advertising to children at an impressionistic age has a downside which is considered unethical by most child rights activists.

Well-advertised products attract everyone even adults. Often the product advertised is so appealing that one ends up buying the product, most of the time it may not be a necessity. Children especially do not have the capacity to process the information in their minds and weigh the necessity of obtaining the product.

Advertisements are often so fascinating sometimes that children and youth form an opinion based on what is being portrayed. Soft drinks, for instance, are shown to be the reason behind the growing strength, vitality, and happiness. They start to believe that those who drink a particular soft drink or vitality drink are going to gain more strength, will perform better in exams and sports, and will make them more popular among friends. Little do they know that on the contrary over-indulgence in such energy-dense drinks can lead to obesity and other health issues.

Another detrimental effect of advertisement is the risk of infection. Our advertisers promote children playing with dirt as a sign of healthy recreation and later promote their products to easily wash off the dirt. Little that they realize that children could get sick while playing with dirt and are exposed to infections including worm infestations. Such advertisements do not issue a warning that washing hands thoroughly after playing and or wearing protective gloves is essential before indulging in such activities.

Another category of advertisement particularly appealing to adolescents are where their famous hero is shown to be playing stunts like jumping around on bicycles or taking a dive from a cliff, a number of accidents and even deaths have occurred in adolescents while trying these stunts. There is often no warning at the end of the adv. (like in smoking advertisements.) as a result kids are restless to show off the aerobatics to their friends. Adolescents' health is also directly affected by advertisements. Which promotes smoking and drugs, especially so in our country where almost any drug is available over the counter.

The responsibility primarily lies with the government and the regulatory authorities to scrutinize the product advertised for children or products with an impact on children's physical and or emotional health but parental guidance is equally important. In order for children to understand and differentiate between reality and fiction, the guidance of the parents is of utmost importance. Parents need to talk to their children and made them see through the content of the advertisement. With good reasoning, they can make children understand the gimmick of the advertising industry. Parents need to explain to the children to differentiate between healthy and unhealthy food and teach them basic values in life. Making fun or ridiculing other children for not wearing the proper attire or a physical shortcoming like a dark complexion or fizzy hair can damage their relationship and others' self-esteem which is far more harmful than using the particular product. This way the child will learn to be more empathetic, considerate, and responsible.

Parents are definitely accountable for what their children need, but more important is teaching their kids true values in life.

The advertisement companies need to be more responsible especially when advertisements are targeting children.

It is imperative that advertisements that are unethical be removed and banned completely. Only the products that impose no harm should be allowed to be advertised. A committee comprising of Pediatricians, Nutritionists, and Child Psychologists besides technical persons should be constituted to screen the advertisement before any product with untoward effects on children is aired on electronic media or printed in print media.

The constant rise in the number of fast-food restaurant chains, junk eating, and decrease in healthy cooking at

home has a drastic effect on our lifestyle. Obesity, heart diseases, diabetes, and renal problems are on the rise More and more children are becoming obese. Obesity is closely linked with PCOS in young girls which may lead to infertility with its ensuing emotional and marital issues. Obesity in children often leads to obesity in adults with its ensuing health problems like coronary heart diseases, diabetes, and hypertension which are expensive to treat and lead to an increase in the medical budget

If the current trend of unhealthy eating among kids and a sedentary lifestyle is not checked Childhood obesity and the Prevalence of type 1 and 2 diabetes will rise which will leads to major health problems later as they grow, already adult onset Diabetes has involved a considerable population of Pakistan, obese children will add to already dangerous prevalence of DM.

A number of countries like Hungary have imposed a fat tax on food high in sugar and fat. It will be highly beneficial to a country like Pakistan if we impose taxes on food products that are known to be dangerous to health.

Original Article

Training Newly Qualified Social Workers: Evaluation of an evidence-based training and coaching programme

Stephen Pizzey[1], Rosemarie Roberts[2], Jenny Gray OBE[3], Arnon Bentovim[4]

[1,3,4] Director, Child and Family Training, UK. [2] Consultant C & FT, Child and Family Training, UK.

Author's Contribution

[1,2] Conception of study
[3] Experimentation/Study conduction
[3,5] Analysis/Interpretation/Discussion
[1,2] Manuscript Writing
[1,3,5] Critical Review
[2] Facilitation and Material analysis

Corresponding Author

Dr. Stephen Pizzey,
Director,
Child and Family Training,
United Kingdom
Email: stephenjtpizzey@gmail.com

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Abstract

Introduction: Child and Family Training (CFT) was commissioned by a large local authority (LA) in England to provide a comprehensive training and coaching programme designed to improve newly qualified social workers' knowledge, skills, and confidence in child and family assessments, parenting assessments, analysis and decision making in child protection and intervention approaches.

The CFT training and coaching programme formed part of the LA's Assisted and Supported Year in Employment (ASYE) programme. The content of the programme was based on the application of the Framework for Assessment of Children in Need and the Families[1] (the Assessment Framework) in practice. It comprised modules on the identification of abuse and neglect, assessment tools and approaches, analysis, and planning and delivering interventions using the Hope for Children and Families Intervention Resources supported by practice and coaching sessions.

Objective: An evaluation of the CFT pilot training and coaching programme was commissioned at the outset and was designed to understand whether ASYEs' skills, knowledge, and confidence improve following training and whether the training is integrated effectively into their practice.

Participants: Two groups of newly qualified social workers completed a CFT evidence-based training and coaching programme over twelve months between May 2015 and September 2016.

Method: The following measures were used to evaluate the training and coaching programme: the Self-Efficacy Scale for Social Workers (Pedrazza et al. 2013); the Quality of Assessments Questionnaire (Cox and Bingley Miller 2015; Roberts et al. 2016); and, a Confidence Scale (Roberts 2015).

Results: This evaluation found that practitioners improved their skills, knowledge, and confidence. There were statistically significant changes in practitioners' ability to carry out good quality assessments. Improvements were made in practitioners' ability to recognise their own limits, establish good relationships with children and families, and in finding support from other professionals when needed. There were significant improvements in practitioners' confidence in their ability to make effective high-quality assessments, their decision-making skills regarding safeguarding, and their ability to plan and carry out effective interventions with children and families.

Conclusion: These findings are similar to evaluations of CFT training programmes in other organisations and countries. The programme offers training to practitioners to enable them to use the evidence-based tools and approaches to respond to the needs of children and families from a range of cultures delivered in a variety of settings.

Keywords: Evaluations, CFT training programmes.

Introduction

The Framework for Assessment of Children in Need and the Families

In England and Wales, the Assessment Framework[1] was introduced as part of the process of enlarging the field of vision of professionals concerned with children in need of services, as well as in need of protection. This eco-systemic framework provides a conceptual map to help professionals consider the child's functioning and needs, the capacity of parents to provide for those needs, the way their needs were being met (or not), and the role of family and environmental factors on the child or the parenting capacity of their caregivers. The approach was intended to extend professional practice from a narrow focus on 'risk assessment' and protection to a broader holistic consideration of the child and their family and the context in which they lived, to raise the standard of professional understanding of needs and to focus interventions more effectively.

The Assessment Framework is underpinned by a series of principles that emphasise the centrality of the child, that an understanding of child development is critical to working with children and their families, the importance of collaboration with children and their families, placing an emphasis on identifying strengths as well as difficulties and the influence of environmental factors on parent's capacities to respond to their child's needs.

A series of tools and approaches were identified and developed to support the implementation of the Assessment Framework for use by a range of practitioners from different professional and voluntary backgrounds and with differing levels of experience and expertise.

Identification of abuse and neglect, assessment, and analysis

The assessment tools included the Family Pack of Questionnaires and Scales[4] which included tools to gather information about emotional and behavioural difficulties in both children and adults, parenting problems, recent life events, mental health difficulties, alcohol problems, and the quality of family life; the HOME Inventory UK Approach[5] which was originally developed as a research tool in the USA[6] and assesses the quality of parenting and the home environment provided for a child using a semi-structured interview schedule[7]; and which enables practitioners to assess family functioning and family relationships, including parenting, and the impact of family history.

The *Safeguarding Children Assessment and Analysis Framework* (SAAF)[8] was developed to assist practitioners to make an analysis of the information gathered using the assessment tools. The SAAF makes a systemic analysis of the strengths (protective and resilience factors) and difficulties (risk and harm factors) identified from the assessment, provides a prediction of the likely outlook for the child if nothing changes, assesses the prospects for successful intervention, and provides the evidence for the plan of intervention.

In 2013 the Department for Education (DfE) funded CFT to promote the use of DfE and other published resources on neglect including Childhood Neglect: Improving Outcomes for Children 2011.[9] comprised a series of 16 neglect courses. These courses covered: an introduction to childhood neglect; a focus on children and young people; a focus on parents; and, managing neglect.

Approaches to intervention

Finkelhor described "polyvictimization"[10] i.e., young people who described being exposed to multiple forms of maltreatment over their childhood. Responses to earlier child maltreatment (e.g. including anger and aggression) put them at risk of further victimization. Their families are more likely to be characterised by interpersonal violence, disruption, and adversity. The reality of child maltreatment is that complex overlapping forms of maltreatment are the rule, rather than the exception.[11] Herrenkohl and Herrenkohl, in their review of the frequency of multiple maltreatment across populations of identified abused children, described a range of polyvictimization between 33–94% depending on the child's social context.[12]

There are several evidence-based interventions that have been found to be effective for a single type of maltreatment. In the UK, the provide links to previous NICE guidelines dealing with associated aspects of child maltreatment.[13] The guidance on intervention invites practitioners and commissioners to consider utilising about 15 evidence-based manualised approaches for specific forms of child maltreatment from different theoretical approaches (psycho-dynamic, systemic, and cognitive-behavioural). These are to be delivered in the home or office, for a range of parenting relationships (birth, foster, or adoption) and developmental stages of children. The importance of being trained in the relevant approaches is stressed.

In general, these are well-evidenced approaches, which will be helpful to services for children aged 0-5 years, children looked after by the state, and sexually abused children and adolescents. It is recognised that

the most effective interventions working with maltreated children draw on different theoretical models and concepts. However, in practice, the implementation of such a complex set of evidence-based approaches presents a considerable challenge to planners and commissioners of services because both practitioners and their managers need training and supervision in the different approaches mentioned above and elsewhere. Moreover, multi-type maltreatment is the norm rather than single-type maltreatment. Addressing the needs of individuals who have experienced multi-type maltreatment and multiple adverse childhood experiences presents a challenge to those developing effective interventions as these experiences have a cumulative harmful impact on the developing child's mental health and wellbeing.

Marchette and Weisz[15] draw attention to the paradox that there are many focal treatment manuals in the child mental health field, which have contributed to practice but that are not used widely in everyday practice, due to a focus on single disorders rather than the reality of comorbid, co-occurring problems. Few practitioners or service providers have the time or resources to learn a different approach for each disorder or problem type. In addition, there is little in the NICE guideline on how to 'navigate' among the different approaches – psychodynamic, cognitive-behavioural, and systemic – to meet the complex needs of the child and family. This deficit raises the risk of confusion and muddle if practitioners attempt to apply a focal treatment for one type of maltreatment to another type of maltreatment that requires a different treatment approach. Attempting to use the single maltreatment type of approach described in the NICE guideline on Child abuse and neglect will pose many problems for practitioners dealing with multi-type maltreatment cases.[13]

Bentovim and Elliott[14], and Marchette and Weisz[15] have discussed this problem, described a possible solution, and made suggestions for intervention. Marchette and Weisz[15] suggest the need for:

… the development of treatment approaches (multi-focal, rather than single-focused) that can address multiple disorders and problem areas, capitalizing on the benefits of manualised treatments and their supporting evidence while affording greater flexibility to meet the complex needs of youths and their families (p. 271).

These solutions include using evidence-based Common elements approaches, which address multiple forms of psychopathology, by bringing together therapeutic procedures commonly used for each.[16] The components are identified to target disorders and problems and organised into menus of treatment procedures, which can be selected to fit the needs of the individual.

The Hope for Children and Families Intervention Resources

The Modular Approach for Children with Anxiety, Depression, Trauma, and Conduct problems[17] is a multi-disorder intervention system that incorporates treatment procedures (elements) and treatment logic (coordination) based on four successful evidence-based interventions for childhood anxiety, depression, trauma, and conduct problems, with modifications allowing the system to operate as a single protocol. The MATCH-ADTC has strong empirical support in multiple community-based randomised controlled trials.[18] This approach provided the foundation for a modular approach to work with polyvictimization and multiple adverse childhood experiences through the addition of interventions with the parenting and family factors that trigger and maintain child maltreatment and adversity.

The Hope for Children and Families Intervention Resources[19] provide an intervention approach which matches the identified needs of children, parents and family and can be adjusted to changing responses. Using the methodology developing the MATCH-ADTC, common treatment elements were distilled from across the field of interventions for individual forms of child maltreatment. Twenty-two RCTs were identified for the treatment of different forms of maltreatment.[20] The Hope for Children and Families Intervention Resources incorporated common elements-therapeutic procedures distilled from the approaches recommended by National Institute for Health and Care Excellence (NICE) guideline on Child abuse and neglect (2017) and other evidence-based approaches which have been shown to be effective.[14] These elements are targeted at parents, children, young people, and families. They aim to engage and motivate; provide psycho-education about the harmful impact of maltreatment; understand the historical and current stressful origins of abusive responses; interrupt and modify harmful abusive and neglectful processes, and their impact through establishing a trauma narrative, and promote positive parenting and the resilience of children and young people (Ibid. 2014).

The common elements have been integrated into modules, and a set of intervention guides structured around the Assessment Framework. The domains and dimensions of The Framework for the Assessment of Children in Need and their Families[1] provide the basis for organising the information into the Hope for Children and Families Intervention Resources.

There are nine intervention guides. Each guide focuses on a relevant theme. It includes briefing modules, a

step-by-step guide to delivering an evidence-based intervention, scripts, guidance notes, activities, handouts for parents, and worksheets. Practitioners can choose approaches that fit with the specific needs of the children and families with whom they are working.

The first Engagement and goal setting[21], provides a set of steps, associated scripts, and worksheets to engage children and parents, and help the practitioner to set collaborative goals in light of the analysis, establish a plan of intervention, promote a sense of hopefulness, establish how progress is to be monitored and measured, and describe the consequences of success or failure.

Four intervention guides consider work with parents in addressing different areas of parenting; Promoting positive parenting[22]; Promoting children and young people's health, development, and wellbeing[22]; Promoting attachment, attuned responsiveness, and positive emotional relationships[23]; Modifying abusive and neglectful parenting.[22]. Modules in these guides specifically focus on providing an understanding of the historical and familial stresses associated with abusive and neglectful parenting; the impact of abuse and neglect on children's health and development; and, interrupting and modifying abusive and neglectful processes, modifying negative perceptions of children, and improving the standard of care in a neglectful household.

Two intervention guides consider working with children and young people; Working with children and young people: Addressing emotional and traumatic responses[24]; and Working with children and young people: Addressing disruptive behavior.[25] These are the core guides working with children and young people who have been exposed to abusive and neglectful parenting. The traumatic responses associated with abuse, neglect, and through complex neuro-biological processes have an extensive impact on children's development, physical and mental health. An overlapping set of emotional and traumatic responses result. These need to be responded to through the use of a range of modules that help practitioners work with parents and caregivers to develop children and young people's generic skills to manage their emotions, find safety, and develop problem-solving abilities. Specific anxiety, mood, traumatic responses, and disruptive behaviour need to be addressed once basic coping skills have been mastered.

One intervention guide considers work with families: Working with the family as a group, and in various combinations is an essential skill for practitioners. The Working with families[26] guide helps practitioners to engage with parents and children together to facilitate parent-child communication, and to work to interrupt and find alternatives to conflict within the family, and between the parents, and community.

One intervention guide Working with child sexual abuse[27] considers working with children and young people who have been abused sexually and with their parents/caregivers, and with those who are responsible for or who display harmful sexual behaviour. Working with child sexual abuse is challenging for practitioners. Given the emerging burden of child sexual abuse and sexual exploitation it is essential that practitioners develop skills to support children and young people who have been exposed to sexual abuse and demonstrate sexually harmful behaviour, often in association with other forms of maltreatment and adversity, and to support their parents.

Piloting the Hope for Children and Families Intervention Resources

A multi-agency pilot of the *Hope for Children and Families Intervention Resources* in the UK demonstrated the value of the guides and the utility of the common practice elements and modular approach across different types of service provision for children and families.[28] This integrated approach is particularly valuable when working with complex, multi-type abuse, where co-morbidity in children and high-risk factors in families are the norm, not the exception.[14]

In common with other implementation projects, during the piloting of the Hope for Children and Families Intervention Resources, the importance of commitment from and sign-off by senior management was noted. This included them communicating effectively with staff throughout the implementation project, setting and monitoring regularly clear implementation targets, and identifying a range of practitioners with different needs and different parts to play in the implementation process. A project implementation group was essential to successful implementation as was having internal champion(s). Within this group, a project co-ordinator had responsibility for monitoring and updating the project plan.

Core training on each intervention guide was followed up by reflective supervision with a senior professional who had also completed the training, and regular coaching groups. These activities were essential to integrate the knowledge and skills gained during

training into the practitioner's work so that the new approach became 'practice as usual'.

The key messages from practitioners participating in the pilot project were that: the staff found using the materials enjoyable; the materials provided an efficient way of working and saved practitioner time; the voice of the child and family was evident within their work; elements of need and risk were identified, and use of the materials enabled practitioners to intervene purposefully and demonstrate outcomes as opposed to undertaking numerous home visits with no clear therapeutic purpose.

International Application

The assessment, analysis, and intervention resources have been translated into several languages including Arabic, Finnish, Portuguese, Romanian, Russian, Spanish, Turkish, and Welsh. Where necessary they have been customised for each country's legislation and linguistic and cultural context. Training programmes using some or all the tools and approaches have taken place in Egypt, Finland, Ireland, Mexico, Moldova, Oman, Turkey, Russia, and the UK. These programmes have demonstrated successfully that the resources are able to be used in different countries and transcend differences in language, culture, religion, and legislation.

Some of the approaches and associated training materials have been translated into every language of the European Union as part of the Multi-disciplinary Assessment and Participation of Children in Child Protection Proceedings[29] a European Union-funded project, developing a modularised train-the-trainer programme for qualifying practitioners in child protection.

Training Programme Content

In an English local authority, several of these tools and approaches were used in the training and coaching programme. The twelve-month ASYE pilot training programme delivered by CFT was run in two cohorts from April 2015 to September 2016. It involved: training sessions for ASYEs (15 days); practice requirements between training sessions; monitoring participants' progress; briefing sessions for supervisors (four half days); and coaching sessions for ASYEs (13 days).

The training programme comprised: Assessing parenting and the family life of children, including children with disabilities using the HOME Inventory UK Approach[5] and the Family Pack of Questionnaires and Scales[4] (3 days); the recognition of signs and symptoms of neglect in children and young people and concerns about parenting difficulties that may contribute to child neglect (Department for Education 2011, 2012; Thomas 2013) (2 days)[30] (2 days); Assessing families in complex cases using[7] (3 days); The Hope for Children and Families Intervention Resources[31] (5 days) comprising five one-day workshops on engagement with children and families (initial stages); working with parents and carers, including promoting positive parenting; working with disruptive behaviour: problems of children and young people; working with parents and carers, including promoting attachment and responsiveness; and targeting abusive and neglectful parenting.

Four half-day briefing sessions were arranged for managers and supervisors on assessing parenting and the family life of children; intervention resources; child protection decision-making using the SAAF; and, assessing families in complex cases.

Profile of the course programme participants

At the outset of the programme the course participants and their supervisors and managers completed information and consent forms consenting to data gathered for the purposes of course programme evaluation being anonymised and combined for analysis.

The newly qualified social workers participating in the Assisted and Supported Year in Employment programme (ASYEs) were asked to complete a registration form to provide information about themselves, their qualifications, education, and working experience prior to the first training sessions. Information was received from 36 practitioners. The majority had a job title of social worker (33, 92%) and 3 (8%) of youth support officer (YSO). All the latter were from Group One. Thirty-one (86%) are female and 31 (86%) describe themselves as white.

Although the mean age for the combined groups is 34 years, the range is 21–52 years (SD 9.83). This is reflected in the wide variety of experiences with some entering social work soon after university and others having a career change later in life. Ten (28%) people have professional qualifications in another field, such as teaching (5), police (1), childcare (2), and youth and community work (2), and another 20 (55%) had some relevant experience working with children and young people, families, or both in different settings prior to social work qualification training.

Half of the practitioners have a BA (18, 50%) in social work, 8 (22%) have a BSc and 10 (28%) have a master's level degree in social work. A high proportion (12,

33%) had been awarded either a first-class degree, or a merit or above for their master's degrees.

Table 1 below shows the differences and similarities between the two ASYE groups. All of the second group qualified as social workers in 2015. The first group was more mixed with over half qualifying in 2014 and the rest qualifying in 2013 or 2012 and therefore had potentially been working for longer post qualification before entering the ASYE programme.

The time practitioners had been working in their current post ranged from seven days to eight months. There was a difference between the two ASYE groups, as group one had generally been in post longer – about six weeks on average before starting the training, compared to group two who had mostly been in post for only two weeks.

Group one also had more relevant pre-training experience. Group two had more practitioners aged under 30 years and a higher percentage of practitioners with a master's level social work degree qualification.

ASYEs were asked about what they hoped to gain from the training. Practitioners commented that they hoped to gain specific tools for working with children and families and increase confidence, knowledge, and skills. Somewhat surprisingly, only one person hoped for improved analytical skills, one for better intervention skills, and two for improved assessment skills.

Table 1: Demographics by ASYE Group

Characteristic	*ASYE Group 1 n=20*	*ASYE group 2 n=16*
1. Job title		
SW	17 (85%)	16 (100%)
YSO	3 (15%)	
2. Age		
Mean	35 years	33 years
Range (SD)	22–52 (9.27)	21–51 (10.91)
Under 30	7 (35%)	9 (56.25%)
31–49	11 (55%)	6 (37.5%)
50+	2 (10%)	1 (6.25%)
3. Gender		
Female	15 (75%)	16 (100%)
Male	5 (25%)	
4. Ethnicity		
White	17 (85%)	14 (87.5%)
Black/BlackBritish	1 (5%)	1 (6.25%)
Asian/AsianBritish	2 (10%)	-
Mixed Heritage	-	1 (6.25%)
5. SW Qualification		
BA/BSc	16 (80%)	10 (62.5%)
MA/MSc	4 (20%)	6 (37.5%)
6. Year of qualification		
2012	3 (15%)	-
2013	6 (30%)	-
2014	11 (55%)	-
2015	-	16 (100%)
7. Time in post (days)		
Mean	54	13
Range	21–252	7–21
8. Other professional qualifications	5 (25%)	5 (31.25%)
9. Pre-Training Course Experience		
Children/Young People	11 (55%)	
Families	2 (10%)	
Both	6 (30%)	
None	1 (5%)	

The evaluation measures

The following evaluation measures were administered to the ASYEs prior to the training and repeated at the end of the training period.

Self-Efficacy Scale for Social Workers (SESSW)

The SESSW was designed and validated in Europe with Italian social workers.[2] The scale measures three dimensions: emotional regulation (confidence in one's ability to manage negative emotions that arise when dealing with complex cases/situations); procedural self-efficacy (ability to deal with different aspects of social work practice, such as establishing effective relationships with clients, writing and updating case reports and not giving up in the face of failure); and support request (confidence in the ability to look for and find support in others).

ASYE practitioners were asked to tick a box to indicate their level of agreement with 12 statements about work situations, leading to a score for each of between 1 ('strongly disagree') and 7 ('strongly agree').

Example questions include: *I always manage to keep my anxiety within certain levels when dealing with serious situation; I am always able to manage the powerlessness I sometimes feel when dealing with difficult situations; I always manage to find enough time to write and update case reports and When faced with failure, I am always able to redefine objectives and start again from the beginning.*

Self-efficacy is an important concept in social work as it reflects people's judgements about their capacity to exercise influence in specific situations and to achieve successful outcomes. Self-efficacy is related to resilience, perseverance, and motivation. For example,

people with high self-efficacy sustain motivation and improve skills development, increase efforts in the face of failure, more easily recover after failures, and are more likely to view difficult tasks as something to be mastered rather than avoided. Studies have revealed that self-efficacy is a significant predictor of performance at different levels of task complexity and is positively related to job satisfaction and low burnout.

In order to provide an independent measure of self-efficacy to consider whether supervisors might differ in terms of their assessments of their supervisees, a small sample from the first ASYE group were asked to score their supervisee using the same measure. It was hypothesised that newly qualified social workers may overestimate or underestimate their skills and abilities at this early stage in their careers.

Quality of Assessments Questionnaire (QAQ)

This QAQ is designed to provide information about how ASYEs approach assessments based on thinking about a specific case they have recently assessed (Roberts *et al.* 2016). The QAQ was developed from a semi-structured interview designed (Cox and Bingley Miller 2015) and based on the *Assessment Framework* domains and dimensions and the seven steps: planning assessments, gathering, and organising assessment information, analysing, predicting the outlook for the child, planning interventions, and identifying and measuring outcomes Pizzey *et al.* 2016; Bentovim *et al.* 2018).

The questionnaire and interview ask several questions designed to elicit information about the assessment process and practitioners' thinking. To try to overcome the 'demand effect' that can operate within interviews and questionnaires and avoid leading questions, participants were asked questions such as: *What guided your thinking about how to go about the assessment? Where did you get information from? What did you do with the information once you had gathered it? What guided your thinking about this step? What sense did you make of the information? What thoughts did you have about the child? Did you have any thoughts on how the child might be affected by what was going on? What did you think might happen if nothing changed?*

A small sample of nine ASYEs was also to be interviewed face-to-face to compare the validity of the self-administered questionnaire with the in-depth semi-structured interview (Cox and Bingley Miller 2015). This measure is designed to assist in understanding how far the training has been integrated into practice.

Confidence Scale

ASYEs were asked to complete a confidence scale and final feedback survey after the end of the training programme (Roberts 2015). It contained questions on their self-ratings of confidence in several key areas related to the training: assessments, decision making, and interventions, comparing their confidence a few weeks after finishing their social work training and after completing the training programme.

To aid retrospective thinking, ASYEs were also asked to rate whether their confidence in their ability a few weeks after finishing their social work training was an overestimate, about right or an underestimate.

Evaluation Results

Self-Efficacy Scale for Social Workers (SESSW)

Initial comparisons between ASYE self-evaluations and supervisors' evaluations prior to training showed that practitioners rated themselves higher (better) regarding emotional regulation than their supervisors thought them to be, but this was statistically non-significant.

There was good agreement for the support request category (confidence in the ability to look for and find support in others) but differences regarding procedural self-efficacy (establishing effective relationships with clients, writing and updating case reports, and not giving up in the face of failure), where supervisors gave significantly higher ratings than their supervisees ($p<0.00$), showing that supervisors had more confidence in their supervisees' skills in this area than they did themselves (see Table 2 below).

Table 2: Mean pre-training scores for SESSW for ASYEs and supervisors

Means	*ASYEs n=19 (SD)*	*Supervisors n=16 (SD)*	*Paired T-Tests (2-tailed)*
Total score	5.17 (0.40)	5.42 (0.62)	ns
Emotional regulation	5.03 (0.59)	4.70 (1.06)	ns
Procedural self-efficacy	5.14 (0.51)	5.9 (0.37)	p<0.00
Support request	5.40 (0.90)	5.58 (0.89)	ns

Supervisors' scales were not administered after the end of the training as the ASYEs changed supervisors sometimes twice during the training period and change scores could not be produced.

Pre- and post-training comparisons

Thirty-five ASYEs completed the pre-training questionnaire and 25 completed this after the end of the training. Interestingly, the initial scores were higher than the mean scores quoted by the developers of the measure with more experienced social workers (ER = 4.58, PSE = 4.74, SR = 5.32). Some people scored themselves as 6 or 7 across the board while others were more moderate, suggesting that ASYEs' level of confidence was generally high at the outset, and this was supported by their supervisors as shown above.

Table 3 shows the mean scores pre and post-training. The scores show small increases after training on all the scales but none of these are statistically significant.

Table 3: Mean pre- and post-training scores on the Self-Efficacy Scale for Social Workers (SESSW)

Means	Pre-training n=35 (SD)	Post training n=25 (SD)
Total score	5.13 (0.54)	5.32 (0.48)
Emotional regulation (ER)	4.82 (0.86)	5.07 (0.76)
Procedural self-efficacy (PSE)	5.22 (0.56)	5.36 (0.54)
Support request (SR)	5.40 (0.87)	5.59 (0.69)

Three of the individual questions did show a statistically significant increase after training, but all the others were not statistically significant. These are shown in Table 4.

Table 4: Scores on individual questions in the Self-Efficacy Scale for Social Workers

Question and sub-score	Pre-training n=35 (SD)	Post-training n=25 (SD)	P-Value PairedT-tests
3. When dealing with complex situations, I am always able to recognize the limits of my competencies (Emotional regulation)	5.37 (1.26)	5.84 (0.75)	0.05
8. I am always able to establish a friendly, sympathetic relationship with the user (Procedural self-efficacy)	5.74 (0.82)	6.16 (0.75)	0.02
10. I am always able to look for and find support from people in other professions (Support request)	5.09 (1.01)	5.56 (0.87)	0.03

Quality of Assessments Questionnaire (QAQ)

ASYEs were asked to fill in an electronic version of the QAQ (Roberts et al. 2016) and send it back to the evaluator. In addition to completing the questionnaire, a small sample of nine people was also interviewed using the semi-structured interview schedule (Cox and Bingley Miller 2012) to enable comparisons between the self-administered questionnaire and the more in-depth personal interview.

Comparing the interviews with the questionnaires

The nine ASYEs completing the interview schedules were also asked to complete the QAQ on the same case so that they could be compared. All nine completed both at the pre-training stage and five completed both at the post-training stage; data are missing in four cases.

During a face-to-face interview the participant can be asked, 'Can you say more about that' if their answer lacks detail, but this is not possible when a participant is completing the questionnaire on their own. In view of this, it was anticipated that the face-to-face interviews would elicit more information and therefore offer the possibility of increased scores compared with those completing the self-administered questionnaires. However, analysis suggests that this is not the case. At the pre-training stage, although there were slight differences in mean scores, with the interview generating a mean of 31.22 and the questionnaire of 28.67, this is not statistically significant.

Similarly, the mean scores at the post-training stage show less than two points difference; again this is not statistically significant (see Table 5.).

Table 5: Mean scores on QAQ compared with interviews

		Post-training	
Questionnaire n=9	Interview n=9	Questionnaire n=5	Interview n=9
28.67	31.22	40.80	42.33

Although numbers are small, this suggests that the questionnaire is a valid substitute for the interview schedule for the purposes of assessing changes in the quality of assessments and consequently the data for both have been combined for analysis.

QAQ Follow-up results

Following the training, practitioners were emailed a follow-up QAQ to complete. Many of them had moved onto other teams or services and did not

respond. Only 16 out of a possible 31 people (52%) who remained in the programme completed the follow-up QAQ.

Some ASYEs completed the QAQ but provided very little detail and may have been influenced by time constraints, whereas others gave a fluid and detailed account. Those with high scores described more complex cases; for example, social worker A described a case where she had reassessed an 18-year-old client and had not seen the family. In contrast, social worker B described a complex child protection case with a long history of multiple agency involvement and concerns.

Scores for three of the ASYE practitioners dropped after the training. All of these were due to giving very sparse information on the questionnaire – for example, one-word answers when asked to give a description. All others increased their scores.

Table 6 below shows the total scores and the sub-scores for all practitioners completing the QAQ.

Table 6: Mean pre- and post-training scores on Quality of Assessments

	n=31 (SD)	**Post-training n=16 (SD)**	**P-Value Paired T-tests (2-tailed)**
1. Planning the assessment	4.48 (2.11)	5.38 (2.41)	n.s.
2. Gathering information	5.03 (1.74)	7.31 (1.92)	0.0002
3. Organising assessment information	3.32 (2.21)	4.94 (3.29)	0.05
4. Analysis	5.94 (3.09)	9.25 (4.28)	0.0039
5. Predicting outlook for child	1.16 (0.45)	1.44 (1.15)	n.s.
6. Planning interventions	3.22 (1.18)	4.1 (1.71)	0.04
7. Measuring outcomes	2.29 (1.32)	3.31 (1.96)	0.04
Total score	25.45 (8.88)	35.75 (13.47)	0.0002

The greatest improvements in mean scores were in the areas of gathering information and analysis. This is very encouraging and suggests individuals had assimilated the learning from the specific training in these areas.

One of the weakest areas was organisation of assessment information, partly due to the difficulties of eliciting information about the assessment without using leading questions. However, surprisingly few ASYEs mentioned the Assessment Framework domains and dimensions at all, although some of the descriptions suggested they were being thought about in the background.

Confidence Scale

There were indications of improvements in practitioner perceptions of their confidence in their ability to make effective high-quality assessments, in their decision-making skills regarding safeguarding, and in their ability to plan and carry out effective interventions with children and families. All three areas were significantly improved following the training. Mean scores improved significantly for each area over the training period as shown in Table 7.

The scale ranged from 0–10 where 0 is 'not at all confident' and 10 is 'totally confident'.

Table 7: Mean Confidence Scale scores pre- and post-training n=26

	Pre-training	**SD**	**Post-training**	**SD**
Confidence in ability to make effective high-quality assessments	4.23	1.95	7.90*	1.26
Confidence in decision-making skills regarding safeguarding	4.31	2.13	7.88*	1.26
Confidence in ability to plan and carry out effective interventions with children and families	4.35	1.79	7.81*	1.27

**p<0.001*

Most training programme participants (18, 69%) thought their own assessment of their ability shortly after qualifying was about right. Five (19%) thought they had overestimated their skills and three (12%) that they had underestimated their skills.

Attendance, Ratings, and Feedback

Participant training course attendance

Participants were asked to sign an attendance sheet and to complete feedback forms rating the quality of the training at the end of each course.

Table 8 below shows the percentage of attendance and percentage of ratings of the course as 'very good' or 'good'. Not all the individual course feedback questionnaires were identical, but all had questions on whether the course fulfilled its aims and the quality of the materials provided. Some questionnaires asked whether the trainers were effective in their delivery and how far the course had contributed to practice.

The courses were offered to all 38 ASYEs. However, two dropped out of the first group halfway through the course and two joined the second group after the ASYE training had commenced. The figures have been adjusted to take these differences into account.

Course attendance for individual courses ranged from a high 89% to a moderately low 53%. Combining the two neglect courses, the overall attendance was 74%. Attendance in the earlier sessions that focussed on assessment, understanding neglect, and decision-making was higher than in the five intervention workshops (82% compared with 69%).

Training attendance reduced considerably towards the latter stages of the programme with the lowest attendance at the final three intervention workshops, perhaps reflecting the demands of increased caseloads and responsibilities being experienced by the practitioners.

Although the numbers attending training decreased over the programme the feedback on the quality of the training remained consistently high. Most individuals rated the training as 'very good' or 'good' for the aims and delivery and usefulness of the printed materials. Those that attended the intervention workshops rated them very highly. It could be argued that only those likely to consider that they would benefit from the sessions made the effort to attend but nevertheless their positive views after the end of the training session suggest that these needs were being well met.

Table 8: Attendance and quality ratings of training courses

Course title	Attendance % (n)	% Ratings of very good or good			
		Fulfilled aims	Effective trainers	Printed materials	Contribution to practice
Assessing parenting and the family life of children	86% (32)	94% n=30	93% n=29	88% n=28	91% n=29
Neglect: Focus on children and young people	87% (33)	94% n=31	94% n=16♦	94% n=31	88% n=29
Neglect: Focus on parents	82% (31)	94% n=29	100% n=17♦	94% n=29	87% n=27
Child protection decision-making using SAAF	84% (32)	100% n=32	100% n=32	100% n=32	91% n=29
Assessing families in complex cases	72% (26)	88% n=7♦	100% n=8♦	100% n=8♦	88% n=7♦
Intervention 1. Engagement and initial stages	89% (33)	91% n=30	94% n=31	91% n=30	88% n=29
Intervention 2. Working with parents and carers: Positive parenting	86% (31)	93% n=13♦	93% n=13♦	100% n=14♦	100% n=14♦
Intervention 3. Working with children and young people	53% (19)	100% n=17♦	100% n=17♦	100% n=17♦	94% n=16♦
Intervention 4. Working with parents and carers: Promoting attachment and responsiveness	60% (22)	100% n=8♦	100% n=8♦	100% n=8♦	-
Intervention 5. Targeting abusive and neglectful parenting	56% (20)	100% n=20	100% n=20	100% n=20	-

♦*missing data*

ASYE's individual attendance rates at the 15 training sessions ranged from 5 to 15 (mean 11.15, SD2.84). Unsurprisingly, participants with high levels of attendance at training sessions also attended more of

the coaching sessions and this was significantly correlated (Pearson's r=.59, p=0.00).

Effect of the ASYE training courses on professional practice

As part of the final feedback, participants were asked how the training had affected their professional practice and to rate this from 0 to 10 where 0 is 'not at all' and 10 is 'a great deal' and to give examples to explain their answers. Of the 26 ASYEs who responded 22 (85%) rated the training as 7 and over.

More than half (14, 54%) of the practitioners mentioned the practical assessment tools as particularly helpful.

ASYE practitioners were also asked, 'How likely are you to recommend the training programme to other newly qualified social workers?' on a scale of 0–10 where 0 is 'not at all' and 10 is 'definitely'. Most responses were very positive. The mean was 8.08 with the largest group commenting that they would recommend the training.

A selection of participants' comments about the training programme are set out in Table 9.

Table 9: Sample comments on the training courses

Training courses	ASYE comments
Overall comments	*The breadth of experience I have gained in the last 12 months has been second to none. Coupled with the extensive training and support I feel much more confident in my ability to provide effective assessments and interventions.*
	Brilliant resources and encouraging and supportive staff and management
	Everybody should complete it. Wish it was accredited by university
	I highly recommend the training for all newly qualified social workers. It has made a huge difference in my practice which will inspire me throughout my future practice as a social worker.
Identification of abuse and neglect, assessment, and analysis	*Useful tools, SDQ, scripts, HOME, enhanced understanding of neglect, brain development*
	I learnt a lot about neglect, especially relating it to the assessment framework triangle
	The mental health discussion was the most interesting
	HOME Inventory, a new exciting, detailed, evidence-based resource
	HOME really useful
	Questionnaires and Scales, they were quick and easy to use
	SAAF assessment used prior to case conference to help track what's changed
	Allowed me to work in structured way, mapping info, using scales and questionnaires (evidence-based decisions)
	Insight in [child protection] processes and skills and tools to undertake assessments and use appropriate tools
	I plan to be better at putting observations and what a family say before making a hypothesis
	Helped focus on process rather than jumping to analysis too early
	It will make me think clearly about the child's needs and not lose sight of the child
	Good to relate the training material to my own practice
	Lots of fabulous resources we are able to use in practice
	I hope to use some of the references to give weight to my reports and assessment recommendations.
The *Hope for Children and Families Intervention Resources*	*Helped me understand where to intervene*
	The tools in the 'Modifying abusive and neglectful parenting' book are extremely useful and solution focused and I believe it will be extremely useful in supporting parental self-awareness and better outcomes'
	Fantastic to have photocopiable worksheets
	The training allowed us to consider parental stress and interventions to support sustainable change.

Coaching

The purpose of coaching was to support the consolidation of learning from the overall programme and provide an opportunity for ASYEs to practise some of the techniques, tools, and measures being taught and to present cases from their own practice on which to try these out. The sessions provided an opportunity for participants to reflect on their experience of putting their learning into practice; further, develop and embed their knowledge and skills; and increase their confidence.

Participant attendance at coaching sessions

Overall attendance at the 13 coaching sessions provided was low at 38 percent with some people attending regularly and others not at all. ASYEs' individual attendance rates ranged widely from 0 to 10 (mean 5, SD2.80). The figure below shows the number of sessions attended by individual practitioners. The comments received about coaching suggested that some would have wished to attend more but were constrained by workloads.

Effect of the ASYE coaching sessions on professional practice

As part of the final feedback, participants were asked how the coaching had affected their professional practice and to rate this from 0 to 10 where 0 is 'not at all' and 10 is 'a great deal', and to give examples to explain their answers. Of the 26 ASYEs who responded 18 (69%) rated the coaching as 7 and over.

Benefits of coaching

Feedback on the benefits of the coaching during their ASYE course was received from 24 practitioners of whom 19 (79%) were very positive and 5 (21%) negative. Table 10 gives samples of comments divided into the main themes.

Table 10: Sample comments on coaching grouped into the main themes

Theme	ASYE comments
Knowledge	*The coaching was useful because it consolidated my knowledge of the training sessions and gave me the opportunity to ask questions and practise what I had learnt within a smaller learning environment. I was allowed to tailor questions to my own cases, and these were answered in depth*
	The coaching we received from the Children and Families training course was excellent and helped me to understand the learning better
	Vast information cumbersome
	Critical reflection, training learning and future development
Confidence	*Helped confidence and decision making*
	I have more tools to equip myself, more confidence in evidence-based practice
Reflection	*Coaching was a good space to reflect and explore alternatives*
	A good space for reflection, good source of support
	Helped wellbeing and reflecting about cases
Case discussion	*Given the chance to talk in detail about various issues surrounding families and talk through any difficulties we are facing*
	Linked classroom work to practice, space to discuss cases
	It has been really useful as coach has tailored it to our cases and what support or guidance, we need at that moment which has been really helpful
Time constraints	*It was a drain on my time*
	Some materials repeated therefore time consuming
	I did not attend many of [the] coaching sessions as I did not view them as efficient use of my time
	I've not fully understood the aim of coaching, seemed like repetition
Practice	*Unfortunately, I was only able to attend a few sessions, however, all those sessions provided me with support, informative and ways to improve my practice*
	Very useful where we analysed my completed assessments on what I have done best and what I have missed…I have gained very useful skills.
	I gained a lot from the coaching sessions. It offered me an opportunity to discuss the trainings and how they can be applied to my cases. It was an opportunity for me to tap into the wealth of experiences of the coach. It offered me an opportunity to develop my analytical skills
	Enabled practice implementing what we'd learned
	I've used the scales and questionnaires a lot of the time

Briefing/training sessions for supervisors and managers

Four half-day briefing sessions were arranged for managers and supervisors on: assessing parenting and the family life of children; child protection decision-making using the SAAF; assessing families in complex cases; and, the intervention resources.

Data are available for four of the eight briefing sessions, two of which were on child protection decision-making using the SAAF, and between three and eight people completed feedback

forms. Overall attendance was noted to be around 50 percent or less. All the managers or supervisors completing the evaluation forms rated the aims, resources and materials, and knowledge improvement as very good or good.

Managers and supervisors' comments included:

- Would have preferred a longer session on assessing families
- Great to be provided with tools
- Good training material

Following discussions between the LA and CFT arrangements were made for supervisors to attend the training courses and coaching sessions to familiarise themselves with the content and aid supervision of their ASYEs. There was a limited take up of this offer.

Discussion

The purpose of this evaluation was to help understand the benefits of the pilot ASYE training and whether this impacted on practice. Specifically, it was important to know if the training was beneficial; whether practitioners' skills, knowledge, and confidence improved following training; whether the training was integrated into practice; and what aspects were most/least helpful in the process.

Was the training beneficial and were practitioners' skills, knowledge, and confidence improved?

Evidence from the questionnaires and direct feedback from the practitioners involved demonstrates that ASYEs have benefited from the programme and improved their skills, knowledge, and confidence.

Initial scores on the Self-Efficacy Scale were generally high, giving limited scope for improvement over time. However, these were not significantly different from the ratings given by their supervisors, except for procedural self-efficacy which supervisors rated even higher, suggesting that ASYEs were reasonably realistic in their estimations of their abilities pre-training. There were few statistically significant changes on this measure pre- and post-training although mean total scores and sub-scores did increase slightly. There was an indication that improvements were made in practitioners' ability to recognise their own limits, establish good relationships with service users, and in finding support from other professionals when needed. It should be noted that this questionnaire is context specific so it would be interesting to know how this might change over time when practitioners are in new posts with different work pressures and greater experience, and perhaps with higher expectations from supervisors and managers.

There were also indications of improvements in practitioner perceptions of confidence. The confidence questionnaire focused on three specific areas directly related to the training curriculum, namely confidence in their ability to make effective high-quality assessments, confidence in their decision-making skills in regard to safeguarding, and confidence in their ability to plan and carry out effective interventions with children and families. All three areas were significantly improved following the training, and results from this related well to the Quality of Assessments measure.

Was the training integrated into practice?

Despite difficulties in obtaining post-training data from busy social workers, the Quality of Assessments measure showed very significant improvements had taken place over the training period. The results showed statistically significant changes in practitioners' ability to carry out good quality assessments. Improvements were seen in gathering and organising assessment information, analysis, planning interventions, and measuring outcomes. Small, non-significant improvements were made for assessment planning and predicting the outlook for the child. The greatest improvements were seen in the crucial areas of gathering information and analysis, although systematically organising information appeared to be one of the weaker areas and only just reached statistical significance. Nevertheless, these are very encouraging results and indicate that the practitioners both benefited from the assessment training and successfully integrated it into their practice.

There is, however, no detailed case-based material available for analysis. This has meant that there is limited evidence of the direct use of the specific skills and resources with children and families to demonstrate whether these were usefully integrated into practice.

What aspects were most/least helpful in the process?

The training overall appears to have increased practitioner knowledge, skills and confidence and has been well received by the ASYEs for the most part. ASYEs were very complimentary about the individual training courses and rated them very highly. The course materials and practical guidance on assessments and interventions were reported as particularly helpful. The overall attendance at training courses was moderately good at 74%. The earlier

courses were better attended than the later ones, possibly due to increased workloads.

The attendance at coaching was only 38 percent overall and seemed to suffer as time went on and workloads increased. However, those who attended rated the coaching as extremely helpful, even if they had only managed to attend a few sessions. It enabled some of them to catch up on training sessions missed as well as to put into practice what had been taught. ASYEs particularly appreciated the individualised approach of the coaches in adapting the sessions to their specific needs and sharing their own expertise on complex cases.

Recommendations for future training programmes

Attendance at coaching was much lower than for the training courses. Attempts should be made to increase the involvement of supervisors and managers in monitoring, supporting, and encouraging attendance at both coaching and training sessions to help improve attendance and participants' use of the tools and approaches during the period of the training programme.

As the use and impact of the training on practitioners' work with children and families could not be evaluated, organisations may wish to consider how to capture this in the future and/or what mechanisms currently exist for evidencing training outcomes. Some possibilities may include trainees evidencing learning through case descriptions; reports to child protection conferences or family or criminal courts; or case presentations at in-house supervision groups or workplace seminars.

This evaluation was a pre- and post-design with questionnaires being completed soon after training. As there is often a 'sleeper effect' following training further improvements can sometimes be seen later, as participants integrate new learning into practice. Readministering the Quality of Assessments questionnaires at a suitable time interval, for example, one year post the end of the ASYE training, would offer an opportunity to evaluate whether participants continued to use the new approaches and crucially what impact this had on the lives of children and their families.

Conclusion

This evaluation found that practitioners benefited from the programme and improved their skills, knowledge, and confidence. Improvements were made in practitioners' ability to recognise their own limits, establish good relationships with service users, and in finding support from other professionals when needed. Practitioners' confidence in their ability to make effective high-quality assessments, their decision-making skills regarding safeguarding, and their ability to plan and carry out effective interventions with children and families all showed significant improvement after the training programme. There were statistically significant changes in practitioners' ability to carry out good quality assessments. The training increased practitioner knowledge, skills, and confidence.

These findings are similar to evaluations of CFT training programmes in other organisations and countries. The programme offers training to practitioners to enable them to use the evidence-based tools and approaches to respond to the needs of children and families from a range of cultures delivered in a variety of settings.

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Original Article

Six months Cruel Numbers 2021: A Distressing Scenario of Pakistan

Rizwana Shahid[1], Rai Muhammad Asghar[2], Tanzeela Rani[3]

[1] Assistant Professor Community Medicine, Rawalpindi Medical University, Rawalpindi.
[2] Controller of Examinations & Director Medical Education, Rawalpindi Medical University, Rawalpindi.
[3] Senior Registrar Paediatrics, Benazir Bhutto Hospital, Rawalpindi.

Author's Contribution

[1] *Conception of study*
[1] *Experimentation/Study conduction*
[2] *Analysis/Interpretation/Discussion*
[3] *Manuscript Writing*
[2] *Critical Review*
[3] *Facilitation and Material analysis*

Corresponding Author

Dr. Syeda Sobya Owais,
Consultant Pediatrician ER,
Shifa International Hospital,
Islamabad, Pakistan
Email: sobya.owais@gmail.com

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Abstract

Objective: To determine the frequency of different child abuse acts reported in Pakistan during January–June 2021.

Materials & Methods: A cross-sectional survey was carried out by retrieving the child abuse data 2021 from Sahil NGO. The data was gathered about all the cases of child abuse reported during January-June 2021 pertinent to their provincial and regional placement, age, and gender distribution. The relationship of the child abuser with the victimized child was also investigated. The data was analyzed using Microsoft Excel 2010. Percentages and frequencies of all variables were computed.

Results: Of the total 1896 child abuse cases reported during Jan-Jun 2021 in Pakistan, sexual abuse was maximally (57.2%) registered followed by the cases of abduction (27.6%), missing children (12.5%), and child marriages (2.7%). About 53% of the victimized children were 6-15 years old girls. The majority (60%) of them belonged to Punjab and 58% were residents of the rural community. Approximately 62.2% of the afflicted children were abused by their acquaintances while 25.6%, 2.9%, 2.3%, and 1.9% of the children were mistreated by strangers, relatives, neighbors, and family members respectively.

Conclusion: Child abuse is an exceedingly growing social issue in the Punjab province.

Keywords: Sexual abuse, child marriage, abduction, missing children.

Introduction

Child abuse is a broad terminology that encompasses a variety of crimes associated with hampering of physical growth, mental development, survival, or dignity of an afflicted child.[1] According to World Health Organization, about 1 billion 2-17 years old children across the globe are subjected to physical, sexual, or emotional harm either by their caregivers or strangers.[2] Of the 162 targets of Sustainable Development Goals (SDGs) to be achieved by 2030, one of the target is to eradicate all sorts of child abuse including trafficking and violence.[3]

Although Article 25 of Pakistan strictly condemns the subjection of a child to any kind of cruelty, inhuman act, or punishment; but this legislation lacks adequate protection of a child against ill-treatment that should be the prerogative of the concerned authorities to restrict such adversities.[4] Although the national child abuse law is passed by the Parliament of Pakistan in 2020 to imprison the life of the victim[5]; however current data for 2021 reveals an increase in child abuse offenses to two cases per day relative to last year's statistics.[6]

Missing children is also one of the commonly encountered social issues worldwide that need the attention of our stakeholders to mitigate its frequency.[7] In addition to kidnapping and abduction of children in our community, some are reported as runaway cases as well.[8] By signing the Convention on the Rights of Children (CRC), the state of Pakistan is now destined to develop a comprehensive child protection system through the implementation of multi-dimensional strategies.[9] Due to the connectivity of child abuse with the health and behavior of the afflicted child[10], this matter needs consideration of all parents and society as a whole for the protection of our children from all misfortunes.

The current study is therefore planned to highlight the various facets of child abuse prevailing in our community by analyzing the data gathered by SAHIL NGO.[11] Reflecting the true picture of this issue impeding child protection is imperative to comprehend the gravity of its existence and hence for the motivation of all human beings deemed necessary for its eradication.

Subjects and Methods

A cross-sectional survey was conducted by getting the data pertinent to child abuse from Sahil NGO. This NGO has missionized to protect the children against all kinds of violence, particularly child abuse.[11] The data was collected from this organization about all the cases of child abuse reported during Jan-Jun 2021 with respect to their provincial and regional placement, age distribution as well as gender categorization. The association of the child abuser with the afflicted child was also scrutinized. The data was analyzed using Microsoft Excel 2010. Percentages and frequencies of all variables were calculated.

Results

About 1896 cases of child abuse were reported from all the provinces of Pakistan from January-June 2021.

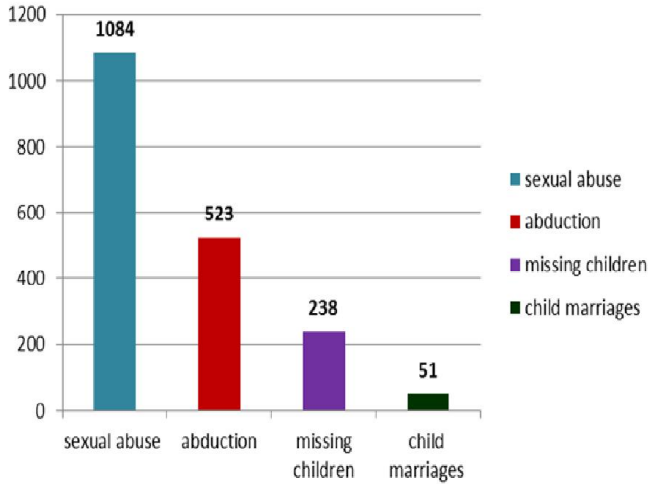

Figure 1: Frequency of Pakistani children subjected to various worrisome situations

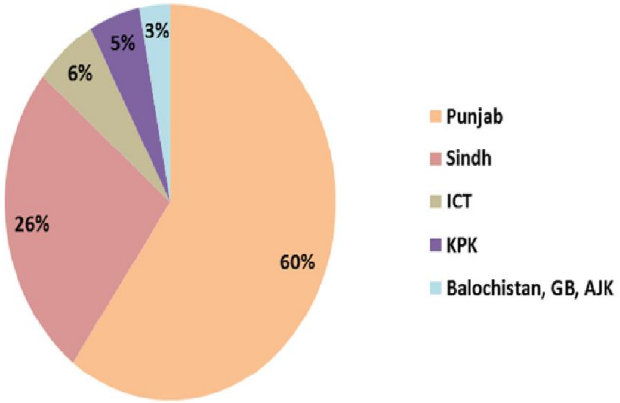

Figure 2: Province–wise distribution of Child abuse cases in 2021

Around 33.8% and 21.6% of the children subjected to such misfortunes were 11-15 years and 6-10 years old respectively. The staff of Sahil NGO was able to investigate the relationship of abusers with about 1676 children who were abused one way or the other and approximately 62.35% of the abusers were close contacts as revealed below in Figure 3.

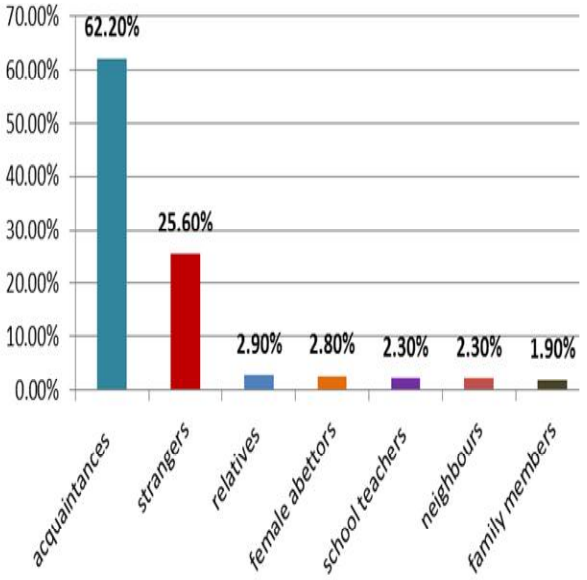

Figure 3: Relationship of the child abusers

Discussion

Of the 1896 children reported with child abuse from January–July 2021 in all provinces of Pakistan, sexual abuse was identified as the greatest afflicted crime (57.2%) followed by abduction (27.6%), missing children (12.5%), and child marriages (2.7%). Approximately 53% of female children 6-15 years old specifically 11-15 years of age were more subjected to child abuse with 60% of the cases detected in Punjab province. About 24 lac child abuse cases with the victimization of approximately 80% girls under 14 years of age were testified in India from 2017-202012. According to National Crime Record Bureau, more than 100 children on daily basis are confronted with any kind of abuse.[13] On the other hand, around 618,399 children residing in the United States were subjected to abusive acts during 2020 and this figure was relatively determined to be the lowest than that of 2012 when 656,372 children were victimized.[14] In-depth review of United States statistics 2020 revealed that Asians residing there were least victimized at the rate of 1.6 per 1000 children.[15] In addition to law enforcement, National Center for missing and exploited children is also established in the United States for child safety and delinquency prevention16. The decline in cases during 2020 in the west might be attributed to this enactment. Physical and mental impairment among our children is partially attributed to this social stigma as well that is being carried out even in homes, schools, and other academies. Law enforcement and stringent implementation against such criminalities are imperative in Asian regions of the globe as well for their elimination from society.

Although child marriage in the present study is detected as the minimally prevailing crime (Figure 1), still this issue needs contemplation of the legislators to root out this evil from our civilization. Child marriage is perceived to be alarmingly high across the globe that needs due consideration by policymakers for its diminution. Apart from the deterioration of development goals of child-like health and education, other human rights are also adversely violated.[17] Financial instability and illiteracy were determined to be the main attributes of child marriages in African and South Asian countries.[18] Although the law is formulated in Pakistan for the prohibition of child marriage; still, grave consequences resulting from child marriage are being faced primarily in deprived regions of the country.[19] One of the targets related to Sustainable Development Goals (SGDs) to be achieved by 2030 is to abolish all illegal practices detrimental to a child including early and forced marriage.[20] Rigorous monitoring of such social issues is the need of the hour in order to refrain our children from the devastating consequences.

Conclusion & Recommendations

Child abuse is alarming rising in Pakistan predominantly in the Punjab province. Strict observance of the law against child abuse by the concerned officials is the need of time to suppress this brutal act in our society.

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Original Article

Understanding Implementation of Pragmatism and John Dewey's Educational Philosophy for enabling participation rights in a Special School

Mehek Naeem[3], Naeem Zafar[2], Waleed Farooq[3]

[1] Director Programs Office, PAHCHAAN (Protection and Help of Children Against Abuse and Neglect), Lahore.
[2] Head of Department, Child Rights Department, University Of Lahore, Lahore.
[3] Director, Globark Institute of Development and Training (GIDAT), Lahore.

Author's Contribution

[1,2] Conception of study
[1,2] Experimentation/Study conduction
[1,2] Analysis/Interpretation/Discussion
[1,2] Manuscript Writing
[3] Critical Review
[1,2] Facilitation and Material analysis

Corresponding Author

Dr. Mehek Naeem,
Director Programs Office,
PAHCHAAN (Protection and Help of Children Against Abuse and Neglect), Lahore
Email: mehek.pahchaan@gmail.com

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Abstract

Introduction: To set a base for a democratic society where the right to participation is meaningful and engaging, John Dewey argued that a school is a social agency for change. For this, the school needs to provide an enabling environment based on a more hands-on, problem-solving, and experimental approach.

Objective: The current study looks at how educational philosophy such as that of John Dewey and pragmatism is implemented in special schools in Lahore.

Materials and Methods: The study design was quantitative. A sample of 32 participants participated in this study from an NGO-based special school in Lahore. The participants included senior teachers who teach in the elementary section of the school, with at least five years of experience teaching children with disabilities. The sample was selected via convenient sampling. The instrument consists of 21 items that look at John Dewey's philosophy of education.

Results: 59.37% of teachers agreed that the teaching method utilized is based on problem-solving, dialogue, and self-learning. 71.71% of teachers responded that the school gives its students plenty of opportunities to learn via hands-on activities and 74.9% of teachers felt that adequate activities are provided to students so that they can learn through projects.

Conclusion: This study is just preliminary research looking at the implementation of John Dewey's philosophical approach in special schools. It is important to note that with children with disabilities, there is already a reliance on teaching and learning aids. While it may be seen that there is an inclination towards experimentation and experiential learning, there was a mixed opinion about how this approach can bridge the gap and make better, democratic citizens for the future where the rights of children, especially the right to participation is fulfilled.

Keywords: John Dewey, pragmatic, democratic society, children with disabilities.

Introduction

John Dewey is an American philosopher whose work has influenced social reforms and education. His work has contributed to pragmatism and has added value to the educational systems of various countries mainly those in Europe and the US. He believed that a democratic society's nature is to be dynamic and mobile. For this, teachers must understand individual differences between learners and that one strategy may work for a student which may not necessarily work for the other. Each student has his or her own experience. These experiences are not an internal mental state which is inside us but we are within the experience.[1,2]

Dewey's work emphasized a variety of pragmatism; Experimentalism or Instrumentalism. Via testing his early ideas at the Laboratory School, engaging students in a setting that was collaborative in nature, and engaging the learners in various problem-solving activities, Dewey believed that through a process of different social interactions, human intelligence arises. As pragmatism focuses on experimental learning it encourages a teacher to use instructional methods which focus on problem-solving and are process-oriented.

Dewey believed in "progressive education" which he felt would be possible by experiential learning or "learning by doing". In this critical thinking, problem-solving, dialogue, and collaboration play a very important part. Dewey felt that promoting experiential and collaborative learning lays the foundation of lifelong learning which not only contributes to individual growth but also lays a foundation for a truly democratic society.[3]

He moved from a traditional approach in education towards progressive education, with a focus on the present rather than the future. He argued that a traditional approach is essentially static as what is taught is taught as a finished product with little regard to the process and the future implication. The students do not have a chance to express or engage in a meaningful manner, not preparing them to think democratically. Alternatively, the education system needs to be progressive, which looks at each learner as a citizen of the society, preparing them for the adjustments and cultivation of individuality.[3]

Education has an important role in ingraining values and making the student differentiate between rights and wrongs, themselves. It is a tool for cultural transmission. Progressive education in a democratic society focuses on the transition or change in one's thoughts feelings and internal processes, which would help him/her to be a responsible and active citizen of the society. Hence, Dewey conceptualizes the school's role as a social agency that makes it simple for learners to understand the intricacies of social and cultural heritage, focuses on the positive aspects of society, and builds a link between heritage and culture.

To set a base for a democratic society, Dewey argues that a school is a social agency for change.[4] He focuses on experimentation and inculcation of multitasking and collaboration from an early start. To live in peace, within the learning community each member needs to be involved in each process.[5,6] As written by Ryan, "Dewey's Pragmatism was essentially a peacetime doctrine and credible only in a society that was in most respects harmonious, prosperous, and morally at ease with itself".[7]

With schools as an important social agency, Dewey focuses on bridging the gap between theory and practice. For this, the learner is taken as an active participant in the process. Dewey in his book "Democracy and Education" Dewey argues that educators need to be prepared for their lessons and reflect on how they can "acquire the capacity for wider, deeper and more organic experience and the capacity to communicate it?".[7]

This experience can be reflected in the curriculum. For pragmatics such as Dewey, the curriculum comes from the student's experiences rather than being made in advance by the teacher. The "complete act of thought" takes the person from the initial identification of the problem to acting on it and then testing a hypothesis to solve the issue, inculcated in the activities so that the child may polish his/her problem-solving skills in a scientific manner.[8]

In Pakistan, there are parallel systems of education; public, private, and Islamic. While each system has its own approach to teaching, the curriculum is mainly prepared by policymakers and is implemented via a top-down approach. There is less flexibility in the implementation of the curriculum and the experiences children have under the guidance of the teacher.[9]

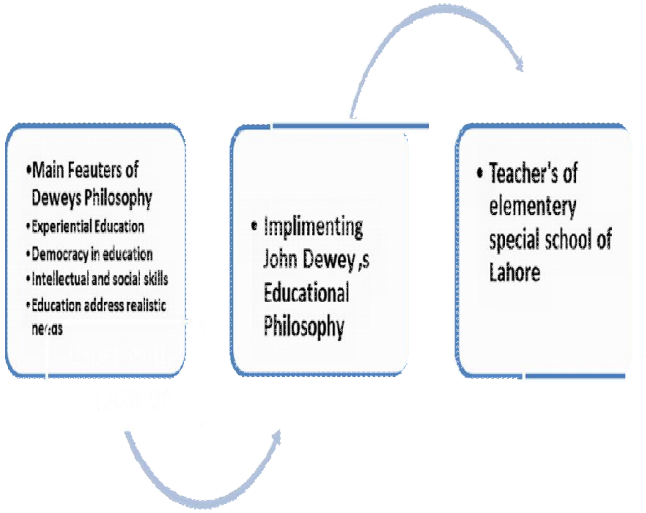
This gives little room for teachers and learners to experiment and experience skills revolving around critical thinking, hands-on approach, and dialogue and hence may not contribute to students who are well equipped to recognize their right to participation and contribute towards a truly democratic society. Implementation of Dewey's philosophy may be used as a tool to re-engineer educational systems.[10] Although students with special needs such as disabilities are marginalized and somewhat neglected

as compared to children in mainstream education implementation of curriculums is a little more flexible and education plans are created keeping individual differences in view.

This study looks at how educational philosophy such as that of John Dewey and pragmatism is implemented in special schools in Lahore. With an emphasis on special schools, which ought to look at their student as an individual, have individual education programs, and are student-driven, this study will see how Dewey's philosophy is implemented in their school.

Theoretical Framework

In this study, we examine the incidence of child marriage in Pakistan and the changes that have taken place over time in the profile of the women who marry before turning 18.



Research questions: The main research question of this study addresses:

- To what degree is the philosophy of John Dewey implemented in Pakistani NGO-run special schools?

Materials and Methods

Research Design:

The design of the study was quantitative and a survey research design was conducted to look at how Dewey's philosophy is implemented in schools.

Participants:

As a pilot, a sample of 32 participants participated in this study from an NGO-based special school in Lahore. The participants included senior teachers who teach in the elementary section of the school, with at least five years of experience teaching children with disabilities. The sample was selected via convenient sampling.

Instrument:

The instrument consists of 21 items that look at John Dewey's philosophy of education using a 5-point Likert scale (1-5) adapted from Khasawneh et al work.[11]

Results & Discussion

All teachers were females, had done special education training, and had at least 1 year of experience. However, when asked, the teachers did not recall Dewey and his philosophy.

Special education is more student-driven, looking at the child's individual performance and potential. The teacher looks at how each student is different and has his/her own experiences which shape them.[12] 43.8% of teachers disagreed that individual differences are taken into account while raising individuals who are actively contributing to society. 37.5% agreed that individual differences are taken into account. Similarly, there was a mixed view about whether the schools neglect student needs. Around 56.25% of teachers believed that schools do not neglect the needs whereas around 40.93% believed that schools do neglect the needs of students. Around 43.43% of teachers believed that schools do not guide the student's expertise for him/her to achieve maximum growth, and 56.23% of teachers believed that elementary schools do not provide opportunities for students for decision making and expression of opinions.

Dewey believed that students should be active participants in the process. Hence, the teaching methodology should be such that it engages the student. 59.37% of teachers agreed that the teaching method utilized is based on problem-solving, dialogue, and self-learning. 71.71% of teachers responded that the school gives its students plenty of opportunities to learn via hands-on activities and 74.9% of teachers felt that adequate activities are provided to students so that they can learn through projects. These findings show that there is an inclination toward experiential learning or that more hands-on approach.

As Dewey believed in a strong relationship between human intelligence and the process of social interactions, a school provides a platform for these interactions.[3] 67.21% of teachers felt that the school provides its students with opportunities to acquire

intellectual and social skills. The other 33.55 % of teachers partially disagreed and 3.125% of the teachers strongly disagreed.

Dewey's philosophy focused on how students need to be given the space to experiment, experience, and discover themselves.[3] 59.37% of teachers reported that in school, teachers become more of a guide than a knowledge source. 59.36% of teachers believed that through experimenting teachers can discover knowledge. 43.76% of teachers believed that schools process themselves as an experimenting ground or laboratories rather than just lecture halls.

Dewey tried to build a link of how by guiding students in a way that encourages critical thinking, hands-on approach, and dialogue they can become better democratic citizens who may become agents of change and may help in working towards a better community.[8,10] In this research it was seen that there was a mixed opinion on how schools prepare students to move towards being better, more socially responsible, and democratic citizens. 56.25% of teachers felt that elementary schools in Lahore help their students to be good citizens whereas 40.6% of teachers felt that schools do not provide an adequate environment for students to become good citizens who are also disciplined.

Dewey believed in progressive education. 53.12% of teachers felt that the schools address realistic needs rather than be absorbed in the past.

Conclusion

This study is just preliminary pilot research looking at the implementation of John Dewey's philosophical approach in special schools. It is important to note that with children with disabilities, there is already a reliance on teaching and learning aids. While it may be seen that there is an inclination towards experimentation and experiential learning, there was a mixed opinion about how this approach can bridge the gap and make better, democratic citizens for the future. Future research needs to look at a more diverse group and how we can make students agents of the change via engaging school education.

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Original Article

Understanding teacher's perspectives related to Violence against Children in Schools

Mehek Naeem[1], Farhat Munir[2], Naeem Zafar[3], Uzma Ashiq[4], Neelam Zohaib[5], Muhammad Imran[6], Fatima Islam[7], Waseem Akram[8]

[1] Director Programs Office, PAHCHAAN (Protection and Help of Children Against Abuse and Neglect), Lahore.
[2] Assistant Professor, School of Social Science and Humanities, Technology, UMT, Lahore
[3] Head of Department, Child Rights Department, University Of Lahore, Lahore.
[4,5] Clinical Psychologist, PAHCHAAN (Protection and Help of Children Against Abuse and Neglect), Lahore.
[6] Population Science, Monitoring and Evaluation Officer, PAHCHAAN, Lahore.
[7] Public Health, Research Assistant at PAHCHAAN, Lahore.
[8] Finance, Academics & Operations Manager, PAHCHAAN, Lahore.

Author's Contribution
[1,2,3] *Conception of study*
[1,2,3,4,5,6,8] *Experimentation/Study conduction*
[1,2,3,4,5] *Analysis/Interpretation/Discussion*
[1,2,3,4,6,7] *Manuscript Writing*
[1,2,3] *Critical Review*
[1,2,3] *Facilitation and Material analysis*

Corresponding Author
Dr. Mehek Naeem,
Director Programs Office,
PAHCHAAN (Protection and Help of Children Against Abuse and Neglect),
Lahore
Email: mehek.pahchaan@gmail.com

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Abstract

Introduction: Children need to be protected from all forms of violence in schools. Teachers can play a very important role in early identification, management, and referrals. However, for this, it is important to understand teachers' perspectives related to violence against children.

Objectives: The objective of the study is to identify to explore teachers' own experiences related to violence, identify factors contributing to violence against children in schools, and identify gaps in system development and training according to teachers' perspectives.

Materials and Methods: Data was collected via focus group discussion which included note taking and participant observation during discussion. 8 government school teachers (6 males and 2 females) from primary level to high secondary levels from Sheikhupura district participated in the research.

Results: Analysis of the discussion revealed that violence against children is still very common in schools, including harsh psychological and physical punishment and bullying. Some of the factors contributing to violence against children include the influence of the intergenerational cycle of violence, inadequate support, classroom management issues such as high strength of students, and how teachers felt there was no formal training given to them related to issues such as prevention of child abuse and neglect, positive disciplining in school settings.

Conclusion: This study indicates that the teachers should be aware of school and child psychology, mental health awareness, consequences of corporal punishment along with aspects such as the intergenerational cycle of violence, and there needs to be a more systemic approach to protecting students in schools against violence.

Keywords: Violence against children, corporal punishment, intergenerational cycle of abuse, consequences of abuse, teachers, safe to learn, end violence.

Introduction

Children need to be protected from harm in all settings. A child spends most of the day in his/her school. A school needs to be provided with a safe, conducive, and enabling environment so that they can learn and grow. They need to be protected against all forms of violence including child physical abuse, emotional abuse, sexual abuse, neglect, and bullying. Violence against children is also perpetrated by peers including physical and emotional violence.[1]

Pakistan has signed and ratified the United Nations Conventions on the Rights of the Child (UNCRC) which makes it obligatory for children to be protected from all sorts of violence and neglect. Pakistan also has a number of laws and legislation pertaining to the rights of children and child protection including The Criminal Law (Second Amendment) Act, 2016 and the Sindh Prohibition of Corporal Punishment Act 2016.[2]

Looking at the INSPIRE Strategies and the need to work for ending violence, Pakistan is not adequately equipped to protect its children. There is a lot of work required in the implementation of law and legislation, change of general attitudes and awareness raising and creating systems for safe environments, parent and caregiver support, income and economic strengthening, education and life skills, and response and support services.[3] There is a need for a systematic approach to tackling cases of violence against children, proper databases and safeguarding policies, and training of key stakeholders to work towards protecting children from violence.[4]

In Pakistan, there are different types of educational institutes such as government, non-government schools (private), technical educational centers, and religious institutes (madrasas) that provide their services differently as per child's age and grades. Teachers of these school systems showed different teaching styles and behaviors towards students as well as students also showed different educational behaviors that further developed motivation, self-belief, and drive to learn and experience new things in their lives.[5]

There have been cases that have been highlighted in media related to violence against children over the past few years.[4] Khan and Amin identified the violence against children in school settings to be very common in Pakistani culture in which school teachers showed punitive behaviors toward students where they were reported to show their anger for no reason, most of the time. Physical violence and emotional abuse were highly reported in school settings where teachers bullied pupils in a humiliating way and make them guilty in front of their classmates causing emotional distress in their lives.[6] Teachers who bullied their students faced difficulty to manage their emotions later on and those students who experienced corporal punishment in their childhood showed multiple behavioral problems such as anger, fear, anxiety, and bullying others. Previous papers indicated that corporal violence caused a lack of socialization and difficulty to manage the interpersonal relationships with others.[7] In a similar study with educational managers and parents, it was also seen that child abuse and neglect are regularly seen in Pakistani schools where physical abuse happened moderately and emotional abuse happened frequently.[8]

Teachers play a very important role in providing this safe space for their students. They are in a unique position to identify and comprehend what is going on in a child's life as they interact with him/her on a daily basis. While looking at 270 teachers from private, public, Islamic schools, and NGO-run school settings, it was seen that only 15% of teachers had previously received any formal training on child abuse and neglect.[4] While most of them had received a reasonable qualification there were substantial gaps in knowledge related to child protection issues, especially in the areas of child physical abuse and sexual abuse.[4] There is also a lack of awareness at various levels in schools about child sexual abuse.[9] Most school teachers have no mental health awareness and they don't even know about emotional regulation.[10]

It is seen that violence against children may be a major cause of dropout of students and that harsh treatment including physical punishment is not an effective way to increase the student's compliance with completing tasks such as homework.[11] The current norms of society along with the intergeneration transmission of abuse can contribute to the acceptance of violence against children. Researches showed that the transmission of violence is stronger among teachers, parents, and children implying that parents and teachers who had an abusive childhood were more likely to show aggressive behavior to their children.[12]

Violence against children in schools is a major problem all over the world in which the child experienced punishment by their teachers that caused many short-term and long-term problems in children. Short-term consequences include emotional behavioral problems which further consist of; isolation, crying, sadness, lack of interest in studies, truancy, dropping out of school,

fear of teacher, poor academic performance, non-disciplining, and bullying. In the long-term problems, the child may experience anger, substance use, and lack of socialization, juvenile tendencies, and the child may not forget such experiences in their lives.[13]

The current study aimed to identify the teacher's perspectives on violence against children. The objectives of the study are:

- To explore teacher's own experiences related to violence in their childhood
- To identify factors contributing to violence against children in schools
- To identify gaps in improving school systems to protect children from violence

Materials and Methods

Participants:

A total of 8 government school teachers were selected from Sheikhupura District. All participants belonged to different schools spread across the district. The participants were 6 males and 2 females who were currently working as teaching professionals teaching from primary level to high secondary levels, with an experience of 15-25 years.

Data collection:

The main method of data collection was qualitative in nature with a focus group discussion. This included note-taking and participant observations against their responses.

Procedure:

Data was collected through focus group interview-based discussion that took approximately 40-50 minutes. To begin with, facilitators gave the participants a brief orientation about definitions and types of abuse that are usually highlighted in schools along with a briefing on ethical considerations including the right to leave, anonymity, and confidentiality. After explaining the initial information, facilitators asked the following open-ended questions and noted the participant's responses:

- What kind of issues related to violence against children did you see while you were growing up, as a child?
- What kind of issues related to violence against children do you now see in your everyday practice, as a teacher?
- How can we protect children in schools from violence?

Analysis:

Focus group discussion consisting of both qualitative and observational records that would be used accordingly[14] in which their note taking used to share their experiences. Through these focus group interviews, multiple themes were identified from their teachers and their childhood perspectives such as an intergenerational cycle of violence, consequences of violence, and causes of violence.

Results

Intergenerational Cycle of Violence:

Participants identified their personal childhood experiences have had an impact on their current personality, especially in their profession. A teacher reported that "humari teacher humay baghair kisi waja ke punish kerti thi aur class mien se nikaal deti thi aur kaan maroorti thi" (our teachers punished us without reason and sent us out of the class and used to pull our ears in the classroom). Whereas they also reported that the behavior they are showing to students is the reflection of their teachers who showed strict teaching styles in their childhood. The individual who had healthy childhood experiences reflects the same attitudes to the next generation. Most of the teachers shared their experiences that they had experienced emotional and physical violence from their teachers. One teacher reported, "meri teacher b bila waja saza deti thien aur sara din class k samne negative comments deti thy. Aur ab lgta hai k jese main b aisa hy behave krta hu apne student's k sath" (my teacher used to punish me without any particular reason and used to keep saying negative comments in front of the class. And now it feels like I behave in the same manner with my students).

Some teachers spoke about emotional punishment which they feel is transferred and is reflected via uncontrolled anger. For example, a teacher reported, "mujhy bohot jaldi gussa ajata hai jese meri aik teacher ko ata tha aur wo hmain dant'ti rehti thien" (I get angry very quickly just like one of my teachers who used to keep shouting at us).

Most of the teachers reported that they experienced corporal punishment, and physical violence in their childhoods such as "hitting, hair pulling, and hair cutting, slapping, ear pulling, and beating with sticks and cruel practices in and outside the classroom" which somehow caused for harsh teaching and parenting towards their own children and students. This supports the intergenerational cycle of violence which is transferred from one generation to the other. The discussion also revealed that there is no difference between male and female staff members as both are

showing the same level of violence against children in their classrooms and schools as well.

Forms of Violence in schools:

While most of them understood that hitting or physical punishment is not the solution, and with the slogan "maar nahi pyaar" (don't hit, only love) - a slogan which discourages corporal punishment, various forms of violence were shared by participants in their school settings. For example, a teacher reported, "aik teacher ne bachi k sar k baal jarh se ukhair dye" (a teacher pulled the hair out from the roots of a student) and another reported, "aik teacher ne sabaq na sunane ki waja se bachi k baal kat dye" (a teacher cut a girls hair because she had not learned her lesson), reflecting how physical punishments were not only limited to hitting the child with a stick only. Teachers also shared that emotional abuse via name calling, insulting behaviors, passing negative comments, asking the child to leave the classroom for long periods of time (to embarrass him/her) and discrimination along with bullying is also very common in their schools.

Understanding the consequence of violence in schools:

Most of the teachers showed a reasonable understanding of the consequence of various forms of violence in schools. For example, a teacher reported, "Jb bacho ko bachpan me saza milti hai to unk dil me sari zindagi k lye khof beth jata hai" (when a child gets punishment in his/her childhood, they have fear instilled in their heart for life). They also shared that adverse childhood experiences cause a lack of confidence and that the child doesn't know how to regulate his/her emotions properly in a productive way.

Factors related to Violence in schools:

While most of the teachers shared their perspectives related to the intergenerational cycle and how if an individual experienced violent behavior in his childhood there are more chances to repeat such behavior with pupils, there were some other factors that contributed to acts of violence. Reasons reported by school staff included "frustration, class strength, workload, staff internal rivalry, comparison among staff, low salary packages and other incentives that caused lack of motivation to work enthusiastically". One of the teachers stated that "teachers ko extra incentives na milai to wo fatigue ka shikar ho jaty hain"

(Teachers do not get any extra incentives (for overwork) and they become fatigued). Another stated that "relax kernay ke liyay koi extra holiday accept nahi hoti" (no extra holidays are accepted to get some relaxation time). Most of the teachers agreed that "aik teacher ziada bacho ko handle nahi kr sakta jiski waja se wo ziada gussa krta hai" (one teacher cannot handle a lot of children which causes him/her to get angry very quickly).

Need for a systematic approach toward protecting children in schools:

While most teachers knew about the legal framework pertaining to ending corporal punishment, some of the teachers felt that this law and its awareness among students has only caused issues for them. For example, a teacher stated "bacho ko saza na dene wale law pass hone ki waja se bachy bat nahi manty to teachers phir kia krian" (due to the law pertaining to not punishing children, children do not listen to us so what can we do). They felt that a more holistic approach is needed which looks at various stakeholders (not just teachers) where teachers are facilitated. They stated that they struggle with their own stresses and there is no form of psychological help for staff members, which sometimes makes it hard to keep their own anger and frustrations in check.

They also reported not having any formal training related to identification and management of child abuse and neglect, positive disciplining, and general child rights frameworks. It was not included in their preservice or in-service teacher training. They also stated that they don't know what to do or where to refer a child who has been bullied or has faced violence at home or school and how a more systemic approach is needed to protect children in schools.

Discussion

Focus group discussion is a useful and adaptable technique of research that provides an opportunity to explore issues that are not well in the particular setting or society. Moreover, focus group discussion builds on group dynamics to explore issues in detail for conceptual clarity and to share their views in discussion. Through this focus group discussion, teachers shared their issues firstly lack of mental health awareness caused all kinds of problems in a school setting.

Secondly, this focus group discussion reflected how most teachers struggled with their personal childhood experiences and traumas which when unresolved also caused unsatisfactory class management. The intergenerational cycle plays an important role to develop a child and making a society productively same as most teachers share their own experiences that are the reason for their experiences.[15]

Thirdly, while teachers were aware of slogans and legal frameworks related to the use of corporal punishments, they felt that without much teacher support and a holistic & systematic way to deal with violence against children in schools, these only add to their challenges in the classroom management and their mental health issues. They also reported that there was little awareness or no formal training that they received as teachers related to violence against children, types of abuse, as well as its impact on child mental health and academic performances. Teacher training programs need to address issues related to the basics of child abuse and neglect along with how teachers can be equipped to detect and manage cases of child abuse and neglect in schools.[16]

This calls for a need for the development of child protection systems where the admin, teacher, parents, and students all work towards devising identification, management, and reporting systems, and a multidisciplinary, multi-sector approach needs to be taken to tackle violence against children in all settings, including schools.[16]

Conclusion

The current study provides basic and important information about the knowledge of school teachers on violence against children and how their own childhood experiences are relatable to the current situation in schools. This study shows how important it is to address and break the intergenerational cycle of violence for teachers by providing them psychological support, administrative support, and adequate training in child protection.

Recommendations

The current study found gaps in conceptualization that would be covered in the future and the following are high recommendations;

- Awareness sessions on violence against children in school should be taught including awareness sessions on child rights and violence against children.
- Early identification, prevention, and child psychology should be delivered to the staff.
- The staff should be taught about positive teaching styles and refresher courses to guide them to multiple techniques to manage a child.
- Teachers should remain in contact through parent-teacher meetings with pupils' Parents/guardians and monitor students' friendship patterns and observe their changes in behaviors in the classroom and school.
- A systematic, multi-stakeholder approach to protecting children in schools from violence is needed in schools that focus on early detection, management, and referrals.

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Original Article

Sexual Abuse in Children: Shocking Figures in Pakistan

Sadaf Ijaz[1], Muhammad Iqbal[2]

[1] Senior Registrar, Paediatric Medicine, Benazir Bhutto Hospital, Rawalpindi.

[2] Assistant Professor, General Surgery, Benazir Bhutto Hospital, Rawalpindi.

Author's Contribution

[1] *Conception of study*
[1] *Experimentation/Study conduction*
[1,2] *Analysis/Interpretation/Discussion*
[1,2] *Manuscript Writing*
[1,2] *Critical Review*

Corresponding Author

Dr. Sadaf Ijaz,
Senior Registrar,
Paediatric Medicine,
Benazir Bhutto Hospital,
Rawalpindi
Email: sadiqbal60@gmail.com

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Abstract

Introduction: Sexual abuse is an alarming issue in children of Pakistan1 which has not only physical but also mental implications.[2,3] It is common globally but many cases are not reported because of fear, feeling of self-blame, guilt, or many other reasons.[4,5,6]

Pakistan is still in the infancy period to deal with and protect child abuse cases although legislation has been passed and needs to work a lot on this issue. This article gives an idea of the current situation in Pakistan so that policies can be made and protective measures were done at the grass root level.

Objective: To determine the frequency of sexual abuse in children of Pakistan.

Materials and Methods: A cross-sectional study with retrospective analysis from the data of SAHIL Non–governmental Organization (NGO) for the year 2017.

Results: In the data analyzed a total of 1002 cases of child sexual abuse were reported in 2017 out of which 414 cases (41%) were of sodomy and 588 cases (58.6%) were of rape. Almost all the age groups were the victims in which boys were more affected in the 6-10 years age group while girls were more affected in the 11-15 years of age group. The data shows that 74% of cases were reported from Punjab, 18% from Sindh, 4% from KPK (Khyber Pakhtoon Khwa), and 2% from Islamabad's capital territory. Also, 17% were from urban areas and 83% were from rural areas.

Conclusion: Alarmingly high figures of child sexual abuse are noted in Pakistan mainly in the province of Punjab and serious efforts are needed for its prevention in terms of public legislation as well as awareness of parents and teaching staff.

Keywords: Sexual child abuse, prevention.

Introduction

Sexual abuse is an alarming issue in children of Pakistan[1] which has not only physical but also mental implications.[2,3] It is common globally but many cases are not reported because of fear, feeling of self-blame, guilt, or many other reasons.[4,5,6] Although a multidisciplinary approach should be applied Pediatricians have the main role in detecting sexual abuse by local examination, sampling, assessing the trauma, and mental health of a child[7] so they should know about the child protection agencies and law enforcement organizations to protect the child.[7,8] It is also a great threat for mentally disabled children and can be prevented by increasing awareness in children as well as parents.[9]

Pakistan is still in the infancy period to deal with and protect child abuse cases although legislation has been passed and needs to work a lot on this issue. This article gives an idea of the current situation in Pakistan so that policies can be made and protective measures were done at the grass root level.

Objective: To determine the frequency of sexual abuse in children of Pakistan

Materials and Methods

A cross-sectional study was conducted with retrospective analysis from the data of SAHIL Non–governmental Organization (NGO) for the year 2017.

Definitions:

Child Sexual Abuse: The World Health Organization (WHO) defines CSA (child sexual abuse) as a coercive act by a child who is unable to comprehend or provide consent, leading to serious physical or psychological damage[10]

Sodomy: it is the forced sexual intercourse between two males

Rape: it may involve sexual intercourse which is initiated against a female without her consent

Results

In the data analyzed a total of 1002 cases of child sexual abuse were reported in 2017 out of which 414 cases (41%) were of sodomy and 588 cases (58.6%) were of rape.

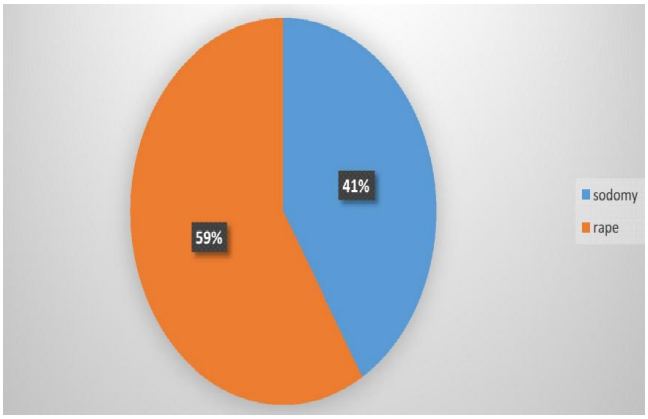

Figure 1: Categories of Child Sexual Abuse

Almost all the age groups were the victims in which boys were more affected in the 6-10 years age group while girls were more affected in the 11-15 years of age group. The data shows that 74% of cases were reported from Punjab, 18% from Sindh, 4% from KPK (Khyber Pakhtoon Khwa), and 2% from Islamabad's capital territory. Also, 17% were from urban areas and 83% were from rural areas.

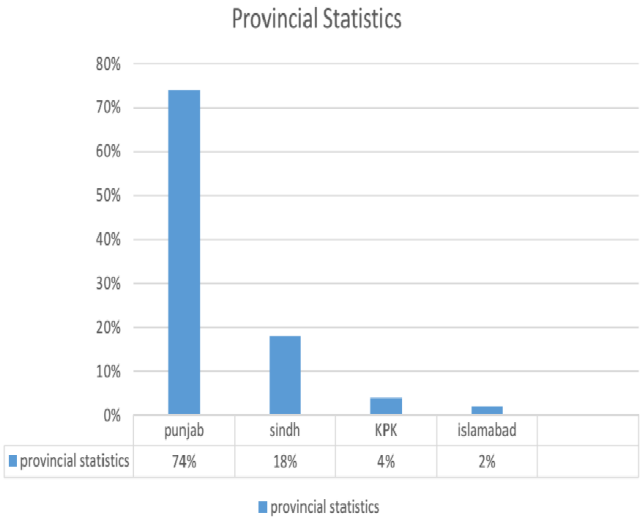

Figure 2: Provincial Statistics

Discussion

Child sexual abuse is a problem with both a national and worldwide prevalence.

Globally, 5 million to 1.5 million children suffer violence every year and 73 to 150 million girls are subjected to abuse every year.[11]

In Pakistan, no official data exists on various types of Child abuse and neglect. In our study, 41% were boys while 58.6% were girls. According to an unofficial report, 15-25% of children are sexually abused in Pakistan. In our study, 74% were from Punjab, 18% from Sindh, 4% from KPK, and 2% from Islamabad. While in another study in Karachi 88.7% of school children reported physical abuse; 17% of 300 school children in Rawalpindi/ Islamabad were sexually abused (1 in 5 boys and 1 in 7 girls), and 72% of the victims/survivors who were abused were below the age of 13 years.[11]

Prevalence rates of Child Sexual Abuse range from 8% to 31% for females and 3% to 17% for males.[10] The highest rates have been reported for boys (<18 years) in Africa, i.e., 19.3%, and for girls, in Australia, i.e., 21.5%. Asia has the lowest rates both 11.2% for girls and 4.1% for boys.[10]

A study in Iran showed that 20.9% of the children had been sexually abused. Depressed children were 3.2 times more likely to be sexually abused than non-depressed children. Furthermore, 8.7% of girls and 48.2% of boys suffered from depression.[12]

Conclusion

Alarmingly high figures of child sexual abuse are noted in Pakistan mainly in the province of Punjab and serious efforts are needed for its prevention in terms of public legislation as well as awareness among parents and teaching staff.

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Review Article

Pakistan's National Policy for Persons with Disabilities and National Plan of Action – A Critical Review

Nabila Chauhdry[1]

[1] Chief Executive Officer, Rising Sun Education & Welfare Society, Lahore.

Author's Contribution

[1] *Conception of study*
[1] *Experimentation/Study conduction*
[1] *Analysis/Interpretation/Discussion*
[1] *Manuscript Writing*
[1] *Critical Review*
[1] *Facilitation and Material analysis*

Corresponding Author

Ms. Nabila Chauhdry,
Chief Executive Officer,
Rising Sun Education & Welfare Society,
Lahore
Email: nabilachauhdry@yahoo.com

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Abstract

Introduction: Fifteen years have passed since the National Plan of Action (NPA) was developed for the implementation of the National policy for persons with disabilities (NPPWDs). This policy and plan of action provided a much-elaborated road map to ensure that persons with disabilities get access to their basic rights.

Objectives: This study was conducted to a) Find notional shortcomings b) explore developments made & c) identify inherent biases present in both NPPWDs and NPA.

Materials and Methods: A desk review was carried out to identify gaps & discrepancies in National policy and NPA, and to examine developments and grey areas regarding achievements of the objectives. BIAS FREE framework was used to identify inherent biases in the documents.

Results: Findings of the study indicate that there were clear gaps in what Policy theoretically claimed and what its structure portrayed in reality. Based on BIAS FREE framework all three types of inherent biases (H: Maintaining an existing hierarchy, F: Failing to examine differences, and D: Using double standards) were found.

Conclusion: Legislative cover is now available for a few recommendations; these legislations are either result of direct implementation on NPA while few developments are indirect. A reasonable number of objectives remain unachieved.

Keywords: National plan of action, national policy for persons with disabilities, legislation, persons with disabilities, Pakistan.

Introduction

At the time of independence in 1947, there were very few institutes of special education in Pakistan. It was not till the 1980s that systematic care of children with special education was taken very seriously on Govt. the level.[1] With the proclamation of 1981 as "International Year of disabled persons" by the United Nations, govt. and civil society felt that along with other required measures, a full fledge policy should be formulated for persons with disabilities.[2]

Literature Review: Consistent and data-driven policies play an important role in the development of different sectors.[3]. In order to ensure that persons with disabilities get their rights, the first national policy was developed in 2002. Early efforts were made in 1986 when a draft of national policy was prepared and circulated in close circles. In 1988, the early draft was refined and spread in wider circles. But even then, only federal special education institutes were involved in the consultation process through the circulation of policy drafts.[4] In 2000 a task force on disability was formed, which was headed by Justice (Retd.) Amir Raza (a prominent social worker). This team developed the first draft of the National Policy for persons with disabilities. After detailed deliberations and consultations, with the experts in the field and ministries involved, the policy was formulated. The policy was built upon the data gathered in the 1998 census, and a 2.49% ratio of disability was used as a reference point.[5]

A national plan of action was developed in 2006 to implement National policy for persons with disabilities (2000). The main focus areas remained the same. In the foreword, Ms. Zubaida Jalal, federal minister of social welfare & special education stated that "strong commitment of all level of govt. non-govt. departments & ministries, international organizations, and institutions were required to make this policy and plan of action a success".

A plan of action was developed after detailed consultations at different levels, including national-level consultative meetings and a situational analysis carried out in 2004 (National Plan of Action, 2006). This document also incorporated actions required to achieve targets of the UN-ESCAPE document named "Biwako millennium framework for action towards an inclusive, barrier-free and right-based society for persons with disabilities in Asia and the Pacific". The Plan of action stressed that the goals of the policy and plan of action could not be achieved in isolation therefore; integrated and collaborated efforts of different actors at govt. level (ministries, departments, institutes, etc.), as well as the generation of funds from multiple sources, were required to realize the targets set in the plan of action.[5]

Significance: National Policy for Persons with Disabilities – NPPWDs (2002) and National Plan of Action – 2006 (NPA) were important milestones in the history of Pakistan as these were expected to open new avenues for empowerment and successful inclusion of Persons with Disabilities in society. As more than 15 years of NPA have passed, this study was an attempt to explore the extent to which NPPWDs and NPA, 2006 have been successful in achieving their goals and objectives.

Objectives: This study was conducted to a) Find notional shortcomings b) explore developments made & c) identify inherent biases present in both NPPWDs and NPA.

Materials and Methods

Desk review of secondary sources available at the National and provincial levels was done to investigate the implementation of NPPWDs and NPA. BIAS FREE framework was used as a tool to explore inherent biases in the NPPWDs and NPA. Document analysis of both NPPWDs and NPA was also done to identify notional/academic shortcomings in these documents. The desk review was aimed at answering these questions:

a) What were the notional/academic shortcomings of the NPPWDs and NPA?
b) What important developments have been made in the NPPWDs and NPA?
c) What are the inherent biases present in the NPPWDs and NPA?

Data Collection: Data collection was primarily dependent on secondary data sources. For developments on NPPWDs & NPA-related legislations, notifications, reports, etc. were reviewed. Resources available online were searched using keywords according to each article and action area. Document analysis of both NPPWDs and NPA was done to identify discrepancies between both documents.

BIAS FREE framework (Building an Analytical System for Recognizing and Eliminating in-Equalities) is a relatively new and innovative tool. It is used to spot biases in policy programs, legislation, and policies.[6]. This tool was used to identify inherent biases in both NPPWDs and NPA.

Findings & Discussion

NPPWDs (2002) and NPA (2006) were well-elaborated and well-thought documents. Although many shortcomings and discrepancies existed in these documents, proper implementation of the action areas might have resulted in more favorable conditions to ensure that children and adults could enjoy their rights like typically developing children.

Notional / Academic Shortcomings:

There were visible differences between what NPPWDs and NPA theoretically claimed and what their structure portrayed in reality.

National policy for persons with disabilities did not clearly define "Persons with Disabilities" (PWDs). In the preamble of the policy document, insane and handicapped were quoted. In the same preamble, it was stated that the statistics given in the national census 1998[7] include," mild or temporary conditions" while there are "2 - 4% persons who have severe disabling conditions". These statements made it quite confusing how policy defined "disability or disabling conditions" and whether these terms were used interchangeably or had some difference. Therefore, the National Policy for persons with disabilities and NPA did not clearly define who the direct beneficiaries of the policy were.

One Guiding principle of the national policy was "Right based approach" rather than charity or welfare concepts in program planning and implementation, but in reality, most of the actions were spelled out and sequenced in such a way that they reflected the charity or welfare approach. Many actions suggested under "estimates of disability (action 1), prevention (action 2), medical rehabilitation (action 4), special education (action 5), etc." depicted a welfare model. Even action 7 which is about "women with disabilities" included "protect them from discrimination" and "give them priority in receiving training opportunities", this is a clear depiction of the welfare model.

One guiding principle given in the policy document was "non-discrimination" while discrimination was inherent in many steps suggested in NPA e.g. in vocational training & employment (action 9) much stress was laid on the "quota system (action 9.13)" and "Disability specific vocations (action 9.12)" which in the long run promoted discrimination and even hindered competitive development of persons with disabilities.

A vision of national policy stressed "mainstreaming" while under "aims and objectives" and focus area of "education & training" mainstreaming & integration were discussed. While NPA was based upon the actions required for "inclusive, barrier-free and right-based society". It was not just difference in nomenclature but rather perspectives, because road maps required for integration & mainstreaming and Inclusion are quite different and require different strategies altogether.

It was noticeable that few action areas in NPA were very well elaborated while few remained under-discovered. Such as area related to prevention of disability was very well elaborated while the area of "medical rehabilitation" remained under elaborated and focused primarily on physical disabilities.

The possible reasons for these shortcomings can be; first, the NPA came after four years of formulation of national Policy, and the rapid changes in research and approaches towards persons with disabilities impacted the NPA. The second possible reason could be that different consultative groups were working on different areas for action, therefore, the difference in the very structure and deliberative process of those sub-groups reflects in the way actions plans were spelled out and described under different areas of action.

Developments on National Policy for PWDs and NPA:

Following developments and grey areas were identified regarding achievements of overall objectives of NPPWDs and NPA during the study. Developments were either result of direct implementation of NPA goals or indirect in the sense that different legislations and plans had been developed over the years that helped in achieving the overall objectives of NPPWDs and NPA.

Extent and distribution of disabilities (action 1):

It was recommended in action 1.1 that ICF (International classification of functioning, disability & health)[8] should be used for the classification and identification of disabilities, and sample surveys should be conducted in selected districts to get a clear picture of the prevalence of disabilities (action 1.2). In order to make these statistics readily available it was also suggested that such data banks should be developed online (action 1.3 and 1.4).

The availability of reliable statistics for making informed policies for persons with disabilities remains an underdeveloped area. Few surveys were conducted by private organizations or under donor-funded projects but they lacked systematic collaboration with govt. departments, therefore, the information gathered through those surveys remained under-utilized.[9]

Most recently, a provincial level multiple indicator cluster surveys has been conducted in Punjab and a

dimension on functional difficulties faced by children 2 to 17 years was included in it. Two questionnaires were used, one for children under age five and the second for children and adolescents aged 5 to 17. The questions inquired about functional problems in hearing, seeing, moving, learning & remembering, accepting change, making friends, focusing attention, etc.[10] More collaborative efforts are required at an inter-provincial level to make these data collection tools more culture friendly, comprehensive and use the same tools across provinces to get comparative data.[11]

It was said in action 1.5 (NPA) that modules based on ICF should be included in the national census, ironically even counting a simple number of persons with disabilities was included in the 2017 census, only after a voice was raised by DPOs (Disabled person organizations), while no other details were included.[11]

Prevention of Disability (action 2):

Considerable efforts have been made by the govt. to improve immunization (action 2.1, 2.2) in Pakistan. An expanded program on immunization (EPI) was launched in 1978. It targets 7.5 million children annually to protect them from infectious diseases including childhood tuberculosis, poliomyelitis, diphtheria, pertussis, tetanus, and measles.[12] Pakistan remains among the last countries failing to eradicate Polio, therefore, more concentrated efforts are required to improve the immunization program specifically for the eradication of polio.[13].

Pakistan is also among the top six priority countries for M&RI (measles and Rubella Initiative) collaboration. VPD surveillance report (2016) reported that out of a sample of 3,380 suspected cases of measles, 36% were found positive. 61% of cases were from Sindh, while the second highest reported cases i.e. 37% were from KPK.[14]

Action 2.5 of the NPA was regarding improving the nutritional status of children. National Nutrition Survey (2018) indicated that wasting has increased in Pakistan over the years. 15.1% of children were wasted in 2011 and this percentage increased to 17.7% in 2018. The concurrence of wasting and stunting is as high as 5.9%, which makes malnutrition more complex and threatening to the survival of the children.[15] These statistics can give us a clear indication that children with special needs face nutrition and development problems at the same scale if not more.[16]

Early detection & intervention (action 3):

Even after 15 years, early detection and early intervention remain highly neglected areas. Only a few institutes such as Lahore, Karachi, Quetta & Multan children's hospital are reported to be equipped enough to provide early intervention facilities while the rest of the population has no access to such specialized services.[17] However, there has been a thrust towards developing the workforce and availability of allied health professionals (action 3.7). Many universities private & public have designed and launched degree programs in physical therapy, speech & language therapy, audiology, optometry, etc.[18]

Medical Rehabilitation Services (action 4):

This area was not well elaborated on in NPA. Its major focus was on physical disabilities and even among physical disabilities paraplegia was especially focused (action 4.1, 4.2). Therefore, the scope of work was already quite limited, which in itself is a grey area in terms of policy development.

Action 4.5 was about establishing rehabilitation medicine departments in major public hospitals. Progress on this goal has been slow as there are very few state-of-the-art rehabilitation medicine departments in public hospitals in Karachi, Lahore, and Rawalpindi.[19]

Special education for Severe and moderately severe children (action 5):

The overall situation of establishing new special education schools (action 5.12) has been quite encouraging, in Punjab alone there are more than 300 public special education schools.[20] In Sindh 62 institutes are being run by the department of empowerment of persons with disabilities which is quite encouraging.[21] Govt. and private institutes have increased in number, especially in urban areas, but access to such schools, especially in rural areas, remains on the lower side.[22]

NPA stressed the need for standardizing classification criteria for disabilities (action 5.1). Keeping in view recent changes in the way disability is defined in terms of interaction between impairment and environment, this action requires revisiting to adopt a more functional approach towards disability.[23]

Quality of services in special education schools was emphasized in action 5.8 of NPA. Tassawar and Khurshid (2019) found out that many special education institutes lack the required facilities, non-teaching and teaching staff, and the infrastructure is also not according to the needs of students.[24] School enrolment is usually used as a key indicator of the performance of a special school. Much work needs to be done to ensure that more detailed quality indicators are developed to improve the quality of services in special education schools.[25]

NPA called for a standardized core curriculum for persons with special needs (action 5.3). With the

development of single national curriculum guidelines, it has become more feasible to use the same student learning outcomes and adapt or modify the delivery of instruction, formative and summative assessment according to the requirements of special children.[26]

For intellectual impairment, there is no standardized core curriculum. And there has been a lack of consolidated development toward any sort of alternative academic certification for these students.

Inclusive Education (action 6):

NPPWDs and NPA supported the concept of inclusive education for children and adolescents with special needs. Recommended legislation regarding "education for all" (action 6.1) originated in form of a constitutional amendment and addition of 25A which proclaims education as a basic right for every child aged 5 to 16. Ever since many legislations have been enacted by federal and provincial governments. Few significant legislations include; the federal free and compulsory education act 2012, Baluchistan persons with disabilities act 2017, KPK free and compulsory primary and secondary education act 2017, Sindh empowerment of persons with disabilities act 2018, and Sindh right of children to Free and Compulsory Education Act 2013.[27]

Formulation of an "inclusive education policy" (action 6.2) was discussed in NPA. Over the years, there has been a paradigm shift in terms of approaching education as a facility for all children, therefore, instead of a separate inclusive education policy, it is more preferred and required to have an education policy that is diversity-friendly and has an inclusive spirit. This commitment is quite visible in the Punjab education sector plan (2019-2020) which talks about making schools more accessible for marginalized communities and children with special needs.[28]

Several initiatives have been taken by the govt. for implementation of inclusive education in the country. In the recent past two such initiatives were taken by govt. of Punjab. Punjab inclusive education project (PIEP) was launched in 2014 in two districts of south Punjab and the Punjab education foundation's inclusive voucher schemes started in 2016 in six districts of the province. The major challenges faced included training of teachers, availability of required adaptations, and mostly the administrative ownership of the project. Inclusive education projects were launched in the school education department but administrating responsibilities vested with the special education department.[29] Research indicates that teachers working in inclusive classrooms in Pakistan consider modifications in the assessment and grading system the most difficult. At times, the strict policies of regular schools regarding methods of assessing learning make inclusion more difficult.[30]

We are still lacking orientation and training of inclusive education in Pre-service & in-service training of regular school teachers (action 6.5). Chaudry (2019) indicated in her study that a major barrier to the successful inclusion of students with neurodiversity is teacher training, both pre-service and in-service. If they are equipped with proper teaching strategies, outlook and have access to appropriate resources, students with special needs can more successfully be included in regular classrooms.[31]

As for the accessible physical structure of school buildings is concerned (action 6.7), guidelines exist but it is a common observation that many most private and public school buildings are not accessible for children with disabilities. The long-term goal under this area of action recommended "at least one inclusive education unit per union council", we are far from reaching this goal by 2025.

Women with disabilities (action 7):

Women with disabilities still face double challenges for being women and also PWDs. There has been a gradual increase in awareness and voicing of the rights of women with disabilities.[32] It was stressed in NPA that women role models should be portrayed through media to create a positive image of women with disabilities (action 7.2). We do see some good examples such as Muniba Mazari, Abia Akram, and Zahida Qureshi[33] who are working as activists and being portrayed very positively by mainstream and social media.

Vocational training, employment & economic rehabilitation (Action 9):

It was recommended in NPA that more vocational training opportunities should be created for persons with disabilities. Sajjad et. al. discovered in their study that very few schools were offering vocational training to students with special needs in Karachi, mostly focus was only on developing pre-vocational skills and there was a lack of standardized curriculum for vocational training.[34] At govt. level different organizations such as technical education and vocational training authority (TEVTA) provide technical education, although there is a fixed quota for persons with disabilities, yet unavailability of trained staff and lack of physical accessibility makes it difficult for PWDs to avail such training opportunities.[35]

The government has announced a 3% quota in jobs for persons with disabilities.[36] A common observation, however, is that employers hesitate in hiring a PWD as an employee out of fear that they may not be able to

work as efficiently as other typical workers and prefer to pay the financial penalty instead. The awareness component has not been worked upon rigorously.[37] Women with disabilities report that they face constraints in accessibility and in-service training while being employed.[38] Arsh and colleagues (2019) found out in their study that in KPK no department was fulfilling the required 2% quota of job opportunities for persons with disabilities, mostly persons with disabilities are hired in the education department (0.68%) and agriculture and livestock department 90.48%).[39]

It was recommended that the Annual labor force survey should include data on PWDs (action 9.20) but the labor force survey of 2018 -19 and prior surveys, do not include persons with disabilities; only statistics regarding occupational injury cases are provided.[40]

Barrier-free physical environment (action 12)

In response to NPA "The Accessibility Code Pakistan, 2006" was developed by the Directorate general of special education. It's a very good document that provides guidelines for a barrier-free environment & buildings. The accessibility code of Pakistan was developed and enacted in response to requirements mentioned in National Policy for PWDs and NPA. In big cities awareness regarding accessible buildings is gradually improving but in periphery and rural areas it remains a big challenge.[41]

Support to the NGOs (action 16):

Action 16 included establishing an autonomous board for funding NGOs and enabling good stature NGOs to train small community-based organizations (CBOs). In Punjab, Punjab Welfare Trust for Disabled is playing quite an active role in this regard but nationally such coordinated efforts are not seen.[42]

Linkages at federal, provincial, and district levels (action 17):

Concerned line ministries and departments are mentioned against every short-term and long-term goal. But it does not describe which ministry will have the ownership or should be responsible for the initiation of the task e.g. prevention (action 2) and early identification of disability (action 3) are relevant to the health ministry, but we do not see any mechanism how these collaborated efforts will be initiated and carried out. Another important aspect is the funding of actions, it is mentioned that inter-sectoral collaboration and funding from multiple sources will be required but we cannot see any clear explanation about who will fund the specific actions and under what mechanism this fund allocation will be done.

Inherent Biases in NPPWDs and NPA:

We can see that in every society, social services and resources are not equally distributed. Certain biases and hierarchies place certain segments of society higher than others. BIAS FREE framework was used to identify inherent biases in National Policy for PWDs and NPA. BIAS FREE stands for "Building an Integrative Analytical System for Recognizing and Eliminating in-Equities". The system is based on a three-dimensional matrix. Basically, three types of problems are studied:

H: Maintaining an existing hierarchy
F: Failing to examine differences
D: Using double standards

Overall National Policy for PWDs and NPA indicate the following inherent biased based on the Bias-Free framework:

H3 or Dominant Perspective is inherent in the very basic design of the Policy as all the deliberations and decision-making has been done by the dominant typical or normal population with a very little if not any representation of the concerned population i.e. persons with disabilities (PWDs).

H4 or Pathologization is functioning when the definition of disability is provided in National Policy for PWDs. All focus is on the "disability" of PWDs because they differ from the normative behavior of the majority of the population while no attention is laid on environmental constraints that limit mobility and accessibility. Action 1.1 "using ICF for measuring disabilities" and Action 5.1 "criteria for classifying disability in four categories" are a few examples of H4 type of bias as the major focus is laid on classification, identification of causes of disabilities, and trying to fix disability.

F1 or insensitivity seems to be functioning when action 9.13; "5% quota in existing mainstream vocational training programs" is recommended without realizing the fact that the physical environment and training material needs to be adapted in order to be made accessible for all users.

D1 or overt double standards seem to be working when, concession in bus fares, quota in employment, and other special treatments are mentioned.

D6 or stereotyping is working when we observe a generalized perspective adopted in both documents that PWDs should be "Helped and facilitated" and they should be "taught to realize their rights".

Recommendations

Based on the study following recommendations are made:

- There has been a paradigm shift in the way disability is defined (UNCRPD, 2006), therefore the way disability is defined should be revised.
- Words play important role in forming ideas, therefore terminology used in policy and NPA should be revised.
- After the 18th amendment to the constitution and devolution of powers to provinces, many recommendations of NPA require reviewing.
- Social media was not that much active when National Policy for PWDs and NPA was formulated, further strategies could be adopted to achieve desirable results regarding awareness and advocacy.
- Electronic media is now far more active and has a wider range of audiences. Public and private sector channels should be utilized to promote awareness about disability and also to promulgate the rights of persons with disabilities.
- All big corporate houses have their "Corporate social responsibility programs", these programs could be used to raise awareness about the capabilities of PWDs in the corporate sector.

Conclusion

The legislative cover is now available for a few recommendations; these legislations are either result of direct implementation on NPA while few developments are indirect. A reasonable number of objectives remain unachieved.

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Case Report

A Case of Munchausen by Proxy: A form of Child Abuse

Syeda Sobya Owais[1], Hafiz Asim Ali Qaiser[2], Khawaja Junaid Mustafa[3]

[1] Consultant Pediatrician ER, Shifa International Hospital, Islamabad, Pakistan.
[2] Consultant Pediatric ICU, Shifa International Hospital, Islamabad, Pakistan.
[3] Director Clinical Risk Management, Consultant ER, Shifa International Hospital, Islamabad, Pakistan.

Author's Contribution

[3] *Conception of study*
[1,2] *Experimentation/Study conduction*
[1,2,3] *Analysis/Interpretation/Discussion*
[1] *Manuscript Writing*
[2,3] *Critical Review*

Corresponding Author

Dr. Syeda Sobya Owais,
Consultant Pediatrician ER,
Shifa International Hospital,
Islamabad, Pakistan
Email: sobya.owais@gmail.com

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Abstract

Munchausen syndrome by proxy (MSBP), also known as medical child abuse, is a special form of child abuse in which a parent or caregiver fabricates an illness in their child in order to meet his or her own emotional needs via the treatment process. MSBP was first described in 1977 by paediatrician Roy Meadows, who identified parents who invented illness stories about their children and even made up physical signs.[3] MSBP has been termed as a factitious disorder by proxy in the Diagnosis and Statistical Manual of Mental Disorders, 5th edition (DSM-V).[4]

Since diagnosing MSBP is a difficult task for any health professional, diagnostic criteria have been defined by Meadow and Rosenberg.[5] Family members or caregivers, usually, the mother of the child can make up for almost any disease, leading to multiple hospital visits, various treatments, and a high recurrence of the illness.

The perpetrator is usually a mother with mental disorders.[5] Once the diagnosis is made, it is important to start psychiatric treatment as early as possible while separating the child from the perpetrator.

Keywords: Case; Munchausen syndrome by proxy; child abuse.

Case

We describe the case of a 2-month-old boy who presented to our hospital, suspected of being a victim of Munchausen syndrome by proxy of his mother.

His first visit to our hospital was to the paediatrician's clinic. His mother was 37 years old, with two previously healthy girls. She was a qualified paediatrician herself, who was currently on maternity leave, while the father worked abroad. The mother gave the history that he was born at term via a spontaneous vaginal delivery, with a normal postnatal course. He was described as having nasal congestion since the second day of life for which she self-prescribed antibiotics. On the 9th day of life, he developed a staring gaze for which he was taken to the hospital and treated for meningitis after a lumbar puncture. He was well in between till 3 weeks before his presentation to our hospital. He again had upper respiratory illness symptoms for which he visited several paediatricians and had received multiple oral antibiotics while being treated for pneumonia. For the last 1 week, he reportedly ran a high-grade fever and a croupy cough with stridor. He received intravenous 3rd generation cephalosporin as well as inhaled and intravenous corticosteroids without much improvement. He was currently on three intravenous antibiotics.

In the paediatrician's office, his vital signs were within normal range, heart rate of 151 beats/min, oxygen saturations (SpO2) 98%, and he was not in distress. Weight was 5.8kg, length 61.5cm, and head circumference 41cm, all plotted on the growth curve between 50-75th centile for age. The rest of his physical exam was normal, except for oral thrush noted. The paediatrician's impression was a viral illness. Chest X-ray and laboratory investigations including a complete blood count, C-reactive protein, and blood culture were advised.

The next day the mother came to the ER complaining that the child was lethargic and edematous. She was concerned that his current symptoms could be a manifestation of cardiac failure. On examination, a playful child was seen, with the same weight as the previous day, 5.8kg. His vital signs were normal, heart rate of 125 beats/min, respiratory rate of 40 breaths/min, SpO2 97%, and blood pressure of 120/65 mmHg. There were no signs of respiratory distress or heart failure. Laboratory investigations from the previous day were reviewed which were all within normal limits, pending blood culture. Chest X-ray showed mild hilar infiltrates on the right side. The mother was reassured about her concerns, and admission to the hospital was offered for observation of the child.

At the mother's insistence, the child was admitted to Pediatric ICU (PCIU) for close monitoring. Echocardiography and electrocardiogram were done which were normal for age. Overnight, the mother called the staff and doctors almost hourly with one concern or another, which was documented by them. According to the mother, during her PICU stay the child had cyanotic spells, cold and clammy skin, drug reaction, abnormal readings of heart rate, and blood pressure on the monitor, none of which was corroborated by the staff who repeatedly examined the patient. At 3.30 am, the PICU consultant on call examined the child due to maternal concerns. However, the mother remained unsatisfied. Her behaviour became increasingly disruptive. She even confiscated the medical chart of the patient and documented her findings. She demanded self-prescribed medications for her child.

On further enquiry from the father, it was revealed that the mother had a history of postpartum depression after the delivery of one of her previous children. She also had a history of panic attacks. Her concern for the child had worsened since the departure of the father who returned to his workplace abroad. The case was discussed with the hospital Psychiatry team and a formal assessment was planned, as well as separation of the child from the mother while in hospital. However, the mother refused to cooperate and had the child discharged against medical advice.

Discussion

Munchausen syndrome by proxy (MSBP), also known as medical child abuse, is a special form of child abuse in which a parent or caregiver fabricates an illness in their child in order to meet his or her own emotional needs via the treatment process.[1,2] MSBP was first described in 1977 by paediatrician Roy Meadows, who identified parents who invented illness stories about their children and even made up physical signs.[3] MSBP has been termed as a factitious disorder by proxy in the Diagnosis and Statistical Manual of Mental Disorders, 5th edition (DSM-V).[4]

Although rare as compared to other types of child abuse, the incidence of MSBP is reported as 2-2.8/100,000 in children younger than 1 year of age with the average age at diagnosis between 20 months

to 3.25 years.[6] The reported mortality rate is as high as 6-10%.[5,6]

Diagnosing MSBP can be a challenging task for any health professional. Family members or caregivers, usually the mother of the child, can make up for almost any disease, leading to multiple hospital visits, various treatments, and a high recurrence of the illness. The most common method is misleading the health professionals about the child's symptoms. The most common symptoms are haemorrhage (44%), loss of consciousness (19%), apnea (15%), recurrent diarrhea (11%), recurrent vomiting (10%), and redness (9%). In severe cases, the child may even be poisoned or suffocated.[5] These assaults are typically compounded by painful procedures and expensive treatment in an effort to diagnose and treat an apparently complicated and elusive medical condition.[2]

The symptoms at presentation of the child can occur in the course of an actual illness, however, the suspicion of MSBP usually occurs in the setting of a misalignment in the cause, severity, and persistence of the child's symptoms. This requires a detailed history from the caregiver, to try and elucidate an understanding of the underlying concerns. Paediatricians'' diagnoses are dependent on the detailed medical story from the child's caregiver, but in these cases, this most important is invalidated.

To aid the diagnosis, criteria have been defined by Meadow and Rosenberg as follows[5]:

1) The disease must have been made up by parents or by those who replace the parent
2) Symptoms are often presented to require more than one recognition. The parent does not accept the etiology of the disease
3) Disease indications and acute symptoms end when the child leaves the parent.

Warnings signs that may point towards a diagnosis of Munchausen syndrome by proxy include[2]:

1) Persistent or recurrent illness that cannot be explained.
2) Discrepancies between clinical findings and history
3) Symptoms occur only in the presence of the perpetrator
4) Symptomatology or treatment course is clinically inconsistent
5) The diagnosis of Munchausen syndrome by proxy is more likely than any other clinical working diagnosis
6) The perpetrator encourages painful medical tests for her child, has previous medical experience, yet may seem less concerned about the actual health of the child
7) Family history of sudden or unexplained infant death

The perpetrator is usually a mother with mental disorders.[7] Chronic somatoform disorders or personality disorders have been implicated.[7] Evaluation of previous medical records of the patient and other siblings, as well as a detailed social history, may help identify an illness pattern.[2]

Once the diagnosis is suspected, it is important to separate the child from the perpetrator. This is both diagnostic and therapeutic. The child should be placed in a different setting, with a separate caregiver, while the perpetrator receives appropriate psychiatric treatment as early as possible. A multidisciplinary team, including psychiatry, pediatrics, and child protection groups, is instrumental in further assessing the situation. Where appropriate, the child may require psychological support as well.

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Report

CPU Report

Tanzeela Rani[1]

[1] Senior Registrar, Rawalpindi Medical University, Rawalpindi.

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Children are the future of any nation. The healthy development of children is the base of the success and prosperity of any nation. Child rights are the basic human rights of children. The convention on child rights (international agreement adopted in 1989 with 196 signatory parties) includes four main pillars: the right to survival, the right to protection, the right to development, and the right to participation. Each and every child deserves to be given these rights and to be treated equally, fairly, and with dignity.

To promote awareness of child rights and protection, measures are taken at different levels in society. For this noble cause, a CHILD PROTECTION UNIT (CPU) has been established in the Paediatrics department at Benazir Bhutto Hospital Rawalpindi on 27 Feb 2021. It was inaugurated by the Vice Chancellor of Rawalpindi Medical University, Professor Muhammad Umar. This unit has been established in collaboration with PAHCHAAN (Protection And Help of Children Against Abuse and Neglect).

Our child protection unit aims to identify cases of child abuse and neglect. Once identified, these cases are investigated and proper follow-up is done. Medical treatment and psychosocial support is provided and attendants are counselled. Our unit also has a liaison with 12 sister hospitals from Rawalpindi and Islamabad. One focal person is appointed in each hospital who can report cases from the respective hospital.

Various activities have been conducted since the establishment of the child protection unit in collaboration with PAHCHAAN and UNICEF.

- Workshop on Positive Parenting
- Inclusion of Child Rights Module in MD Pediatrics and Diploma in Child Health Curriculum
- Training Session on Early Detection and Management of Cases of Child Abuse and Neglect
- Training Session of Teachers of Various Schools Located in Rawalpindi to Prevent and Detect Child Abuse and Report Suspicious Cases to Child Protection Unit (CPU)
- Liaison with Child Welfare Protection Beaureau for Referral of Child Abuse Cases Who Require Legal Support or Residential Care
- Provision of Medical Care and Support to Children Under Shelter of Child Protection Bureau
- Initiation of Students Body to Promote Child Protection in Collaboration with VCAN-Pakistan (Voices of Children Aspirations and Needs), the Youth Wing of PAHCAHAAN.
- Launching Of Children Rights Journal of Rawalpindi Medical University.

Progress Report of CPU	
Total Patient Registered	103
Child Neglect	50
➢ Poisoning	34
➢ Drowning	07
➢ Snake Bite	08
Physical abuse	03
Sexual Abuse	01

In near future, our goal is to further develop our unit in collaboration with various societies to provide more services for child safety and protection.

Inauguration Ceremony of Child Protection Unit

Launching Ceremony of Children Rights Journal of Rawalpindi Medical University

Launching Ceremony of Child Rights Module in MD & DCH Curriculum Inauguration

Few Cases seen in Child Protection Unit

Few Cases seen in Child Protection Unit

Training Session on Early Detection & Management of Child Abuse & Neglect Cases 1st June 2021

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Address:
Research Cell,
Paediatrics Department,
Benazir Bhutto Hospital,
Rawalpindi.

Principal Contact:
Assistant Editor CRJRMU
Benazir Bhutto Hospital
editor@crjrmu.com