UNICEF/HQ01-0432. Claudio Versiani

Brazil, 2001, Maria (name changed), 6, hides her face in a pillow, in a room at CEDECA, the Centre for the Defense of Children and Adolescents, in a major city in Brazil. Maria was the victim of child abuse. Behind her is a six-year-old boy who is also being treated at the centre, to help him recover from abuse of his older sister.

3

VIOLENCE AGAINST CHILDREN IN THE HOME AND FAMILY

"With these two hands my mother holds me, cares for me, this I love. But with these two hands, my mother hits me – this I hate"

Girl, East Asia and the Pacific, 2005[1]

3

INTRODUCTION

Families, defined widely, hold the greatest potential for protecting children from all forms of violence. Families can also empower children to protect themselves. A basic assumption of the Convention on the Rights of the Child (CRC) is that the family is the natural environment for the growth and well-being of all its members – particularly for children – while the Universal Declaration on Human Rights and the International Covenant on Civil and Political Rights and the International Covenant on Economic, Social and Cultural Rights proclaim the family as being the fundamental group unit of society. The CRC requires the State to fully respect and support families.

But families can be dangerous places for children and in particular for babies and young children. The prevalence of violence against children by parents and other close family members – physical, sexual and psychological violence, as well as deliberate neglect – has only begun to be acknowledged and documented. Challenging violence against children is most difficult in the context of the family in all its forms. There is a reluctance to intervene in what is still perceived in most societies as a 'private' sphere. But human rights to full respect for human dignity and physical integrity – children's and adults' equal rights – and State obligations to uphold these rights do not stop at the door of the family home.

State responsibility to respect, protect and fulfill the rights of children extends beyond its direct activities and those of State agents, and requires the adoption of measures to ensure that parents, legal guardians and others do not violate children's rights. It is obliged to put in place a framework of laws, policies and programmes to prevent violence by providing adequate protection, and responding to violence if it occurs.

Younger children tend to be more vulnerable to violence in the home. In some industrialised States, where child deaths are most rigorously recorded and investigated, infants under one year of age face around three times the risk of homicide, almost invariably by parents, than children aged one to four, and twice the risk of those aged five to 14.[1] While all physical punishment is degrading, there are other cruel and degrading and potentially equally damaging non-physical forms of violence which children suffer within the family. These include enduring persistent threats, insults, name-calling or other forms of verbal abuse, belittling, isolation or rejection. In addition to the direct violence, many children witness violence between adult family members, which in itself has serious consequences, only very recently recognised.

Everywhere that sexual violence has been studied, it is increasingly acknowledged that a substantial proportion of children are sexually harassed and violated by the people closest to them. Forced sex within forced and early marriage is common in many States. So-called 'honour killings' of adolescent girls, regarded as having breached moral codes, occur in some countries. Despite legislation and advocacy efforts, female genital mutilation or cutting (FGM) remains widespread: in parts of North and Eastern Africa, over 90% of girls undergo this operation, usually at around the age of seven.[2,3]

"The Study marks a watershed in adult relationships with children. In just a few years time, we should be looking back with shame and bewilderment at the fact that in the early years of the second millennium, governments and individual adults were still justifying - even promoting - hitting and deliberately hurting babies and children as lawful and legitimate."

Peter Newell, Editorial Board of the UN Secretary-General's Study on Violence against Children

Sexual and gender-based violence has profound implications in the era of HIV/AIDS, and also compromises self-esteem, psychological and emotional health. The implications of all forms of home and family violence for future development, behaviour and well-being in adulthood, and for future parenting, are profound. In addition, home is the place where gender-based inequalities are first experienced by children, and where future power-imbalanced relationships are modelled, or challenged. Boys may be encouraged to become aggressive and dominant ('takers' of care), and girls are encouraged to be passive, compliant caregivers. These gender-based stereotypes support the use of violence and coercion that perpetuates gender inequalities.

This chapter discusses the various types of physical, psychological and sexual violence that occur in home and family settings, their impacts on children, and the wide range of responses that can be used to reduce and ultimately eliminate this violence.

HUMAN RIGHTS INSTRUMENTS

The adoption of the Convention on the Rights of the Child (CRC) in 1989 confirmed that children too are holders of human rights. The CRC claims, on the one hand, children's right to individuality and to have their views on all matters which affect them taken seriously; and on the other, in the light of their developmental state and vulnerability, rights to special care and protection. The CRC makes clear that wherever possible children should be raised within their family; and where the family is unable to care for and protect them adequately, an alternative family-type environment should be provided. Therefore the CRC uncompromisingly asserts that the family is the primary site for children's healthy, loving and safe upbringing. However, this role must be fully underpinned and supported by the State, including by stepping over the family threshold to intervene when necessary, in the best interests of the child.

The balance between the responsibilities and duties of families and of States to provide children with the necessary protections for their development is addressed in several articles of the CRC. Article 18 expresses the balance as follows: "…Parents or …legal guardians,

have the primary responsibility for the upbringing and development of the child," and in paragraph 2: "… States parties shall render appropriate assistance to parents and legal guardians in the performance of their child-rearing responsibilities." Article 3 requires that "the best interest of the child shall be a primary consideration in all actions concerning children." Article 9 states: "A child shall not be separated from his or her parents against their will" except when competent authorities determine that such separation is necessary in the best interests of the child, including in cases of violence.

The CRC therefore provides clear authorisation to the State to protect children against all forms of violence in the home and family, and establishes its role as final arbiter of child welfare in the domestic arena. Article 19 asserts children's right to protection "from all forms of physical or mental violence, injury and abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse, while in the care of parent(s), legal guardian(s) or any other person who has care of the child." Articles 20 and 21 address the State's obligations to make arrangements for alternative care where a child is parentless or has been separated from the family. Article 23 concerns special support for disabled children; articles 34 and 35 seek protection from sexual exploitation and abuse, and from sale and trafficking; article 37 states: "No child shall be subjected to torture or other cruel, inhuman or degrading treatment or punishment;" article 24 requires States to take action to end harmful traditional practices, including for example FGM and forced and/or early marriage.

The CRC requires States both to prevent all forms of violence and to respond to violence effectively when it occurs. While the State cannot be held directly responsible for individual acts of violence against children by parents or others, it is required to provide a framework of law and other necessary measures to supply adequate protection, including effective deterrence. Few States have put in place the necessary laws prohibiting all violence against children, together with policies, structures, and reporting and referral mechanisms to address violence in the home and family. Law enforcement officials in many countries remain reluctant to intervene even in cases of severe violence, child marriage, and incest. Violent forms of discipline remain legal and socially accepted in many States, despite the consistent interpretation of the CRC and other human rights instruments as requiring their prohibition and elimination (most recently, this has been underlined by the Committee's General Comment No. 8, 2006 on "The right of the child to protection from corporal punishment and other cruel or degrading forms of punishment and control," discussed later in this chapter).[4]

"I was forced to marry with an old man of over 30 years who had raped me."

Girl, 16, Eastern and Southern Africa, 2005 [11]

BACKGROUND AND CONTEXT

In most parts of the world, the family as an institution is itself changing or evolving in the light of social and economic pressures. The pace of urbanisation, especially in sub-Saharan Africa (nearly 6% a year) and in Asia (3–4%),[5] has important implications for family living patterns and make-up. One in three city dwellers – nearly one billion people – live in slums. Crowded living conditions, and the necessity for cash income to meet all family needs, create circumstances of stress very different from the life of rural subsistence.[6]

In industrialised countries, family make-up is less stable and also taking new forms, and the nature of 'family life' is undergoing change. Where income gaps have widened or there has been rapid social change, levels of interpersonal violence tend to rise.[7] In many parts of the world there has also been a loss of protection from kin, community and informal employers or 'patrons' that families traditionally relied upon.[8] Market-based social policy reforms of the 1990s and early 2000s have exacerbated pressures, especially on women, by reducing the already limited access of poorer families to health care, pensions, schooling, and care for small children and the elderly.

Economic pressures on low-income families in all regions have also led to significant levels of migration – seasonal, temporary or permanent – by one or other parent, either to town or another country, to earn and send remittances home.[9] Unprecedented levels of mobility lead to protracted periods of family separation, with negative effects for children, and often lead to permanent family break-up.[10] Single-parent households may also have the stress of economic disadvantage, and the added burden of child-care responsibilities, especially where other extended family support is not available.[11,12,13] In Southern Africa where HIV/AIDS also exerts stress on families, fathers are reported absent in 42% of households.[14,15,16] Heavily AIDS-affected countries have also seen the emergence of 'child-headed households' where orphaned children are left managing the home and struggling to provide for siblings.

NATURE AND EXTENT OF THE PROBLEM

Forms of violence to which a child will be exposed vary according to age and stage of development, especially as the child starts to interact with the world outside the home.[17,18] Infants and young children are more likely to be victimised by primary caregivers and other family members because of their dependence on adult caregivers and limited independent social interactions outside the home.[19] As children develop, they grow in independence and spend increasing amounts of time outside the home and away from family; therefore older children are more likely to be victimised by people outside their home and family. However, there are many overlaps in terms of age as well as forms of violence, and in terms of perpetrators.

In the home and family setting, children experience assaults and other acts of physical violence, sexual violation, harmful traditional practices, humiliation and other types

of psychological violence, and neglect. As well as assaults and other physical violence, these can include acts of omission, such as failure to protect the child from exposure to preventable violence at the hands of friends, neighbours, or visitors; acts of stigma or gross discrimination; and failure to utilise child health and welfare services to support the child's well-being. Perpetrators of violence in the home circle include parents and step-parents, and can also include alternative family carers, extended family, spouses (in the case of child marriage) and their in-laws.

PHYSICAL VIOLENCE

Homicide

In countries where homicide statistics are analysed according to age of the victim, 15–17-year-olds are the age group that is most at risk. The second high-risk group is infants. Data from OECD countries suggest that the risk of death is about three times greater for children under one year old than for those aged 1 to 4, who in turn face double the risk of those aged 5 to 14. The younger the child, the more likely their death will be caused by a close family member.[20,21]

The most frequent causes of death are injuries to the head or to the internal organs. Other causes include intentional suffocation, shaking, and more rarely, choking or battering. According to WHO estimates, the highest rates of homicide in children under the age of five are found in sub-Saharan Africa and Northern America, and the lowest in the high-income countries of Europe, and in Eastern and Western Asia.[22] Estimating the proportion of child homicides occurring in the home and family setting requires sophisticated surveillance systems of child deaths, which are lacking in most countries. Where deaths are not recorded or investigated, the extent of fatal violence to children is not accurately known, and may become obscured by the high rates of under-five mortality generally. It is assumed that violence in one form or another – including neglect – may often play a part in infant and young child deaths that are not recorded as homicides, or perhaps not recorded at all. It is widely agreed that violence against children by family members results in death far more often than official records suggest.[23]

Where sufficient reliable data exist (for example in New Zealand, Switzerland, and the USA), a few trends emerge.[24,25,26,27,28] In general, children under 10 are at significantly greater risk than children aged 10 to 19 of severe violence perpetrated by family members and people closely associated with the family. Age and sex are important risk factors. The majority of murders of children under the age of one are perpetrated by one or both of the child's parents, frequently the mother. While approximately 50% to 75% of murders of children aged under 10 are by family members, this proportion drops to about 20% of murders of children aged 10 to 14, and 5% of murders of children aged 15 to 19. A substantial proportion of homicides of children under 10 years of age are committed by a stepparent, by a parent's boyfriend or girlfriend, or by other people known to the victim.

A US study found that female victims were twice as likely as male victims to have been killed by family members.[29] Although girls' risk of murder by immediate family mem-

"One day I went to put the cows to graze and one cow got lost. When I returned home, my father beat me almost to death and I sustained wounds all over my body"

Boy, 17, Eastern and Southern Africa[III]

bers appears to decline after the age of 10, the data suggest that they face increased risk of murder by intimate partners (dating partners or spouses) or by the families of the intimate partner. Moreover, in regions where early marriage and so-called 'honour killings' against women are common, it is probable that the proportion of murders of girls by family members may remain stable or actually increase in the 10 to 14- and 15 to 19-year age groups. Further research is needed to confirm whether this is so.

In some parts of South Asia, high rates of murder of girls within a few days of birth have been reported, with these deaths often disguised and registered as a still birth. A study in India, interviewing 1,000 women regarding pregnancy outcomes, found that 41% of the early neo-natal female deaths are due to female infanticide. Although the practice is apparently not limited to India, one study in Tamil Nadu estimated that 8–10% of infant deaths in 1995 could have been due to female infanticide.[30] Further research is required to better understand the nature and extent of the phenomenon across countries.

Non-fatal physical violence

Physical violence is the intentional use of physical force against a child that either results in or has a high likelihood of resulting in harm to the child's health, survival, development or dignity. Children around the world experience hitting, kicking, shaking, beating, bites, burns, strangulation, poisoning and suffocation by members of their family. In extreme cases this violence can result in a child's death (as discussed above), in disability, or in severe physical injury. In other cases, physical violence may leave no outwardly visible sign of injury. In all instances, however, physical violence has a negative impact on a child's psychological health and development.

Surveys from around the world suggest that physical violence against children in the home is widespread in all regions. For example, in a survey of students aged 11 to 18 in the Kurdistan Province of the Islamic Republic of Iran, 38.5% reported experiences of physical violence at home that had caused physical injury ranging from mild to severe.[31] A review of research on physical victimisation of children in the Republic of Korea found that kicking, biting, choking and beating by parents are alarmingly common, with a high risk of physical injury – and for a small proportion, disability – as a result.[32] In the UK, a national survey found that mothers and fathers were most often responsible for physical violence, although violence by siblings was also reported.[33]

Corporal punishment is defined by the Committee on the Rights of the Child as "any punishment in which physical force is used and intended to cause some degree of pain or discomfort, however light."[34] While growing global concern over the prevalence of corporal punishment in the home – perpetuated by its widespread legality and social approval – has fostered interest in understanding its prevalence and forms, it has also generated debate. Most corporal punishment involves hitting ('smacking', 'slapping', 'spanking') children, with the hand or with an implement – whip, stick, belt,

shoe, wooden spoon, etc. But it can also involve, for example, kicking, shaking or throwing children, scratching, pinching, biting, pulling hair or boxing ears, forcing children to stay in uncomfortable positions, burning, scalding or forced ingestion (for example, washing children's mouths out with soap or forcing them to swallow hot spices). The Committee comments: "In the view of the Committee, corporal punishment is invariably degrading. In addition, there are other non-physical forms of punishment which are also cruel and degrading and thus incompatible with the CRC. These include, for example, punishment which belittles, humiliates, denigrates, scapegoats, threatens, scares or ridicules the child."[35]

There are considerable variations in popular views about the use and effectiveness of corporal punishment, according to available studies. While a Canadian study found that 59% of people believed that spanking is harmful and 86% that it is ineffective,[36] research in the USA found that 84% agreed "that it is sometimes necessary to discipline a child with a good hard spanking."[37,38] A study in the Republic of Korea found that 90% of parents thought corporal punishment 'necessary'.[39] In a report from Yemen, almost 90% of children said that physical and humiliating punishment is the main method of discipline in the family, with the most common form being beating.[40]

WHAT CHILDREN THINK ABOUT CORPORAL PUNISHMENT

The Save the Children Alliance conducted research on physical and humiliating punishment with children around the world as a special contribution to the Study. The resulting report found that overwhelmingly, the children disagreed with the idea that such punishment accomplished anything positive. The report suggested that while children may comply with adults' wishes immediately after being hit, "young children frequently do not remember why they are hit, and children will only refrain from the misbehaviour if they face an imminent threat of being hit. This sort of punishment frightens children into certain behaviours: it does not help children to want to behave, or teach them self-discipline or promote any alternative."[41] In a survey undertaken by UNICEF in Europe and Central Asia, over 75% of children said that 'hitting' was 'never' a good solution to problems at home.[42] In Regional Consultations for the Study, children repeatedly called for other methods of discipline, including being offered a proper explanation of what they had done wrong. They underlined how hurtful it was to be hit and humiliated by those who professed to love and care for them.

NEGLECT

Neglect is an important contributor to death and illness in young children. Neglect means the failure of parents or carers to meet a child's physical and emotional needs when they have the means, knowledge and access to services to do so; or failure to protect her or him from exposure to danger. However, in many settings the line between what is caused deliberately and what is caused by ignorance or lack of care possibilities may be difficult to draw. The degree to which neglect influences child mortality rates in many parts of the world is unknown (with exceptions, including the 'missing girls' phenomenon; see below).

Cases of neglect are difficult to interpret in circumstances of poor public health and undernutrition. In some industrialised countries, neglect constitutes the largest proportion of child maltreatment cases reported to the authorities. Studies in these countries confirm that forms of violence and neglect interconnect.[43] All of the Regional Consultations for the Study expressed concern about neglect of children with disabilities; although there is little quantitative evidence, it is known that these children are at high risk of neglect, from deliberate withholding of basic physical necessities to emotional isolation and lack of stimulation.

Research on sex differences in neglect in India suggests that girls suffer relatively more neglect than boys throughout early childhood. They are breast-fed less frequently than boys and for shorter duration; once weaned, they are given food of an inferior quality and quantity.[44] Girls are also taken to health services less often, and later in the course of any illness.[45] A study from Nepal into outcomes of polio infection in the population found that several years later, the survival rate of boys was twice that of girls, despite the fact that polio affects equal numbers of males and females, thus suggesting gender bias in care.[46] In China, the sex ratio is unbalanced in favour of boys (117 to 100), with this being contributed to by infanticide.[47]

SEXUAL VIOLENCE

The WHO estimates that 150 million girls and 73 million boys under 18 have experienced forced sexual intercourse or other forms of sexual violence involving physical contact,[48] though this is certainly an underestimate. Much of this sexual violence is inflicted by family members or other people residing in or visiting a child's family home – people normally trusted by children and often responsible for their care.

A review of epidemiological surveys from 21 countries, mainly high- and middle-income countries, found that at least 7% of females (ranging up to 36%) and 3% of males (ranging up to 29%) reported sexual victimisation during their childhood.[49] According to these studies, between 14% and 56% of the sexual abuse of girls, and up to 25% of the sexual abuse of boys, was perpetrated by relatives or step-parents. In many places, adults are outspoken about the risk of sexual violence their children face at school or at play in the community, but rarely do adults speak of children's risk of sexual abuse within the home and family context. The shame, secrecy and denial associated

"When I was like twelve, I thought I was pregnant by my father. I contemplated suicide because I was just saying to myself. "How am I going to explain this to people?" I mean, I was twelve years old. Nobody is going to believe me."

Young girl, North America, 2005 [IV]

3

with familial sexual violence against children foster a pervasive culture of silence, where children cannot speak about sexual abuse they have suffered, adults do not speak about the risk of sexual violence in the home, and where adults do not know what to do or say if they suspect someone they know is sexually abusing a child.

Most children do not report the sexual violence they experience at home because they are afraid of what will happen to them and their families, that their families will be ashamed or reject them, or that they will not be believed. Adults may also fail to report such abuse. In communities and families with rigid norms about masculinity, femininity and family honour, boys who disclose sexual violence may be viewed as weak and unmanly, and girls who disclose sexual violence risk being blamed – and frequently beaten and killed.[50,51] Both boys and girls are vulnerable to sexual violence, but comparison of international studies reveals that rates of sexual violence against girls are generally higher than those against boys.[52,53]

A recent WHO multi-country study interviewed more than 24,000 women in 10 countries (Bangladesh, Brazil, Ethiopia, Japan, Peru, Namibia, Samoa, the former Serbia and Montenegro, Thailand, and the United Republic of Tanzania), and asked if someone had touched them sexually or made them do something sexual they did not want to do, before the age of 15 years.[54] In some of these countries, the proportion of childhood sexual abuse perpetrated by family members is extremely high:

- In the two Brazil sites, city and province, 12% and 9% respectively of the women reported childhood sexual abuse. Of these, 66% and 54% reported that a family member was the perpetrator.
- In Namibia, 21% of the women reported childhood sexual abuse. Of these, 47% indicated that a family member was the perpetrator.
- In the two Peruvian sites, city and province, 19.5% and 18% of the women reported childhood sexual abuse, with 54% and 41% of the perpetrators being family members.

The most commonly reported perpetrators of sexual violence towards girls were male family members (brothers, uncles), followed by stepfathers, fathers and female family members. Male friends of family were also commonly named as perpetrators. Other research confirms that parents, caregivers, aunts and uncles, siblings, grandparents, cousins, and friends of the family perpetrate sexual violence against children. For example:

- In a study of women aged 15 to 49 in South Africa, 21% of women who reported being forced or persuaded to have intercourse against their will prior to the age of 15 years, reported that the perpetrator was a relative.[55]
- In a Romanian national study of 13- and 14-year-olds, 9% of the children reported they had been sexually violated in the family and 1% reported they had been raped by a family member.[56]
- In the Occupied Palestinian Territory, 19% of surveyed undergraduate college students reported at least one act of sexual violence against them by an

"I was just 15 years old and was studying in Grade 9 when my dreams shattered. I was attacked with acid for refusing a marriage proposal. You can imagine the physical pain of having acid thrown over your face and body, but the pain of social stigma is worse than physical pain and can last forever."

Acid victim, South and Central Asia, 2005 [v]

immediate family member prior to the age of 16. A further 36.2% reported sexual abuse by a relative at least once. Males and females reported similar rates of childhood sexual abuse.[57]

- In a study of university students in the Hong Kong Special Administrative Region of China, 4.3% of males and 7.4% of females reported experiencing one or more incidents of sexual violence before the age of 17 years. Perpetrators were strangers in less than one-third of cases.[58]
- An analysis of child protection files in Spain from 1997 and 1998 showed that 3.6% of abuse cases involved sexual abuse, and 96% of the perpetrators of sexual abuse were family members or relatives. Fathers and stepfathers accounted for the largest proportion of persons responsible for sexual abuse, followed by mothers and uncles or aunts.[59]
- In Somalia, 20% of the children reported to one study that they knew of a sexual assault against a child in their family.[60]

Violence related to sexual behaviour and perceptions of honour

In some circumstances, girls are regarded as complicit in cases of sexual violence against them and they, rather than their abusers, are held responsible for any sexual act, forced, violent or otherwise. In some countries, a girl older than 12 can be punished severely in cases of rape and other sexual assaults if the perpetrator denies it, and there is no witness.[61]

In some cultures, suspected loss of virginity of a female member of the family, including as a result of rape, is perceived as compromising family honour, and may lead to her murder by family members. In Pakistan, human rights organisations report that there were over 1,200 cases of so-called 'honour killings' in 2003 alone.[62,63] They also occur in Jordan, India, Libyan Arab Jamahiriya, the Occupied Palestinian Territory, Turkey, Iraq, and Afghanistan; and in countries with populations originally from Asia and the Middle East. UK data suggest that around 12 of these killings occur there every year.[64] These deaths are thought to represent only the extreme end of a much larger problem of intimidation and violence.[65]

Extreme violence may be perpetrated against girls and women who do not respond in stereotypical ways. Rejection of romantic overtures or marriage proposals, for example, may prompt a violent reaction. The proportion of acid attacks on women and girls in Bangladesh, currently estimated at around 120 every year,[66] related to refusal of a relationship or marriage proposal was reported as amounting to 17% in 2003.[67] Most of the girls come from poor households, and attacks often occur on the way to school or during collection of water or fuel.

SEXUAL VIOLENCE IN INTIMATE RELATIONSHIPS AND CHILD MARRIAGE

For a large number of girls – and some boys – the first experience of sexual intercourse in adolescence is unwanted and even coerced, and a proportion of these rapes occur in the context of intimate partnerships and under-

age permanent unions or marriages. There can also be violence in the context of dating, but this type of non-formal partnership relationships between adolescent boys and girls (and between same-sex young couples) tends to occur outside the home and family context. It is therefore primarily covered in the chapter on violence against children in the community.

In many societies, a marriage or permanent union is arranged – in the case of girls, usually at or soon after puberty – by parents and family elders. Sometimes these unions are forced on children, particularly girls, and result in early marriage.

While the justifications include protection of family honour and a girl's sexual purity, economic factors also play a role: girls may be viewed as an economic burden in poor families; dowry costs are commonly lower, and bride wealth gains are higher for younger girls; a young girl's marriage may be arranged to secure her and her family's economic future.

The Convention on the Elimination of All Forms of Discrimination against Women provides that the marriage of a child shall have no legal effect, and that all necessary action, including legislation, shall be taken to specify a minimum age for marriage. In its 1994 General Recommendation on equality and family relations, the Committee on the Elimination of Discrimination against Women (CEDAW) recommended that that the minimum age for marriage for both boys and girls should be 18. The Committee on the Rights of the Child has echoed this proposal, and frequently recommends to States that the legal age for marriage should be raised and equalised.

Early marriage of girls has significant negative consequences on their health, development and rights. It often ends their opportunities for formal education, and results in social isolation. Young wives are regarded as having consented to sexual relations with their husbands, and become pregnant when young, before their bodies are ready. They face higher rates of problems in childbirth and maternal mortality. The same applies to child marriage.[68]

In addition to other risks to their health and development, girls who marry before the age of 18 face significant risk of physical, sexual and psychological violence at the hands of their husbands, with existing evidence suggesting that girls who marry young are at higher risk of violence than other women.[69] Intimate partner violence against married girls is often a manifestation of unequal power relations between her and her husband, and indicative of underlying societal beliefs in the status and roles of men and women.

Prevalence of child marriage

Child marriage is common in South Asia, West Africa, and some countries in East and Southern Africa – especially Mozambique, Uganda and Ethiopia – as well as others in the Middle East, notably Yemen. In some countries – mostly in West Africa, but including Bangladesh and Nepal – about 60% of girls are married by the age of 18, and in at least 28 countries, the proportion is 30%.[70] Although the majority of countries have legislation which prohibits mar-

"I hate early marriage. I was married at an early age and my in-laws forced me to sleep with my husband and he made me suffer all night. After that, whenever day becomes night, I get worried thinking that it will be like that. That is what I hate most."

Girl, 11, married at 5, Eastern and Southern Africa, 2005 [VI]

riage of girls under the age of 16, and some forbid marriage under the age of 18, such laws are frequently ignored: marriages are not registered, customary or religious rules are accepted, with few cases resulting in court proceedings.

It is estimated that, globally, 82 million girls now between 10–17 years of age will marry before their 18th birthday.[71] This includes significant numbers of girls married at much younger ages. In Nepal, for example, 7% of girls are married by the time they are 10, and 40% by the age of 15.[72] In the Amhara region of Ethiopia, 40% of girls in rural areas are married by the age of 15,[73] in some cases following abduction and rape in order to avoid bride price. In all such cases, the notion of consent to the marriage by either partner, especially the girl, and to the sex within it, does not apply. In settings where a girl is sent to her in-laws once agreement between the families with respect to the marriage has been made, sex within the union often begins at the age of 10 or 11, before the girl has menstruated.

Physical, sexual and psychological violence

Married girls experience a significant amount of violence from their husbands. A recent analysis of Demographic and Health Surveys (DHS) data showed that spousal violence had been experienced in the previous 12 months by 4% of girls aged 15 to 19 in Cambodia, 15.4% in the Dominican Republic, 21.0% in Egypt, 25.4% in Haiti, 10.4% in India, 18.2% in Nicaragua, and 33.3% in Zambia.[74] In these countries, younger women and women who married at the earliest ages reported the most intimate partner violence.

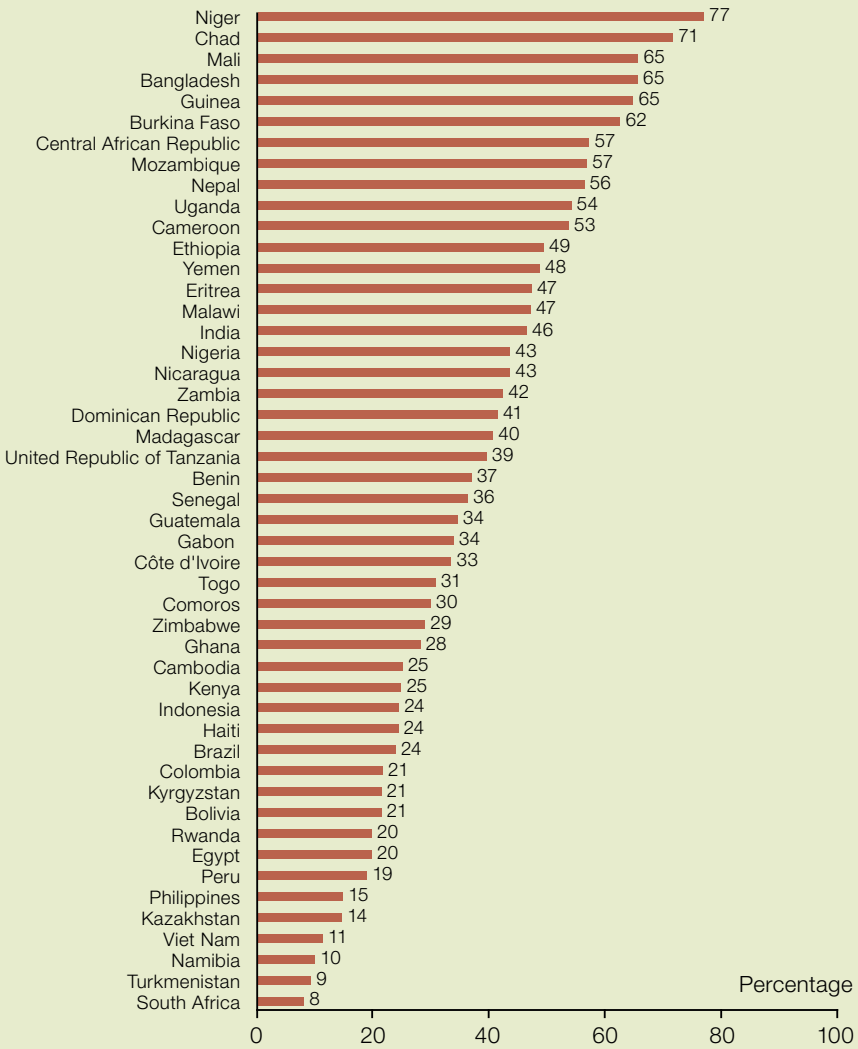
Physical violence against married girls by their spouses can include pushing, shaking, slapping, punching, biting, kicking, dragging, strangling, burning, and threatening/attacking with a weapon. In societies with a custom of dowry, intimate partner violence against the young bride can result from her family's failure to pay the dowry, or her husband's or in-laws' dissatisfaction with the amount.

Studies of domestic violence and dowry-related harassment show that close relatives, especially members of the husband's family, play important roles in perpetrating violence against women. Often the perpetrator is the husband, assisted by the mother- in-law.[75] However, in some cases the husband's relatives are the main perpetrators of violence and harassment against the young bride.[76,77,78] A study from India revealed that, among women who reported physical violence and harassment due to dissatisfaction with the dowry, the family member who most frequently harassed was the mother-in-law (95%), followed by the husband and father-in-law (72% each), sister-in-law (49%), and brother-in-law (14%).[79]

Many married girls experience sexual violence from their partners; they may be physically forced, or threatened into having sexual intercourse against their will, or they may have sexual intercourse because they are afraid of what their partner will do if they refuse, or they may be forced to do something sexual that they find degrading or humiliating. In societies where the cultural norm is for men to have unlimited sexual access to women upon marriage, married girls are likely to experience forced and traumatic sexual initiation.[80]

FIGURE 3.1

Percentage of women married by the age of 18 years



Source: UNICEF (2005). Early Marriage - a harmful traditional practice. A Statistical Exploration. New York, UNICEF. Data analysed from 1996 - 2003

Psychological violence, by spouses, against married girls includes humiliation, threats against her or someone close to her, and controlling behaviours. Where a girl flees a violent marriage and returns home, she may be rejected by her parents and beaten for inadequacy as a wife.

HARMFUL TRADITIONAL PRACTICES

In some settings, cultural traditions include practices which inflict pain and 'disfigurement' on children, such as scarifying, branding, or tattooing. Although the term 'harmful traditional practices' has been particularly associated with FGM of girls, there are many other harmful practices involving both boys and girls. In Ethiopia, a 1998 survey by the National Committee on Harmful Traditional Practices found that uvulectomy (removal of flesh from the soft palate at the back of the mouth) is carried out on 84% of children, and milk teeth extraction on 89%.[81] These operations may be performed with unsterilised instruments, leading to potential infection.

Participants in the West and Central African consultations for the Study expressed concern that in West African countries including Mauritania, Niger and northern Mali, the desire to marry their children at a very young age incites parents to force-feed their 5–10-year-old daughters to promote their physical development, make them as plump as mature women, and therefore pleasing to men. This may have tragic consequences, including rejection by husbands who find their wives have not menstruated and cannot produce children, as well as obesity which is associated with later serious health problems: cardiovascular disease, hypertension and diabetes.

Female genital mutilation/cutting (FGM)

The term 'harmful traditional practices' is most frequently used to refer to female genital mutilation, or 'cutting' as it is described in areas where it is practised. According to a WHO estimate, between 100 and 140 million girls and women in the world have undergone some form of FGM.[82] Girls from very young ages up to their mid or late teens undergo this form of genital excision, normally including the clitoris, as a precursor to marriage.[83] FGM is seen as a protection of virginity, a beautification process, and in a number of cultures is regarded as an essential precondition of marriage.

There are different forms of FGM, some of which involve more radical excisions in the genital area than others. In its most extreme form (infibulation), the internal labia minora and external labia majora are cut and the exposed edges sutured together, leaving the vagina almost shut. Following the procedure, the girl's legs are normally bound from foot to hip, immobilising her for days to enable scar tissue to form.[84] This form of the operation is endured by 90–98% of Somali girls, usually at the age of 7 or 8 years.[85] There are profound implications for a woman's experience of sexual relations and maternity. Prolonged labour and stillbirth are common. After delivery, the woman is usually 're-sewn'.

The most reliable and extensive data on the prevalence and nature of FGM are provided

"My grandmother arrived. She told me I was to be circumcised but I did not understand. She said: "Now you will be like everybody else, you will not be left behind." Then they got ready. They held me at my shoulders and at the knees, and I started crying and trying to close my legs. It was very terrible. I can never forget that."

Mother, who will still submit her daughters to the FGM due to pressure from her mother-in-law, Eastern and Southern Africa, 2005 [VII]

by DHS and Multiple Indicator Cluster Surveys (MICS). However, the practice varies considerably in degree of severity of mutilation, and some of the countries in which it is most frequently practised and in its severest forms have not been subject to DHS or MICS, notably Somalia and Djibouti (see Figure 3.2). Estimates from UNICEF published in 2005 suggest that in sub-Saharan Africa, Egypt and the Sudan, 3 million girls and women are subjected to FGM every year.[86]

The highest prevalence is in the countries in the Horn of Africa (Somalia, Ethiopia, Eritrea and Djibouti), followed by neighbouring Egypt and Sudan, East and West Africa, with some cases also occurring in other parts of the Middle East and in Asia. In many of the countries where it occurs, it is practised by certain peoples; for example in Nigeria, according to DHS data, the prevalence reaches almost 60% of girls in the southern provinces, but only 2% in the north. In a country such as Kenya, it is practised almost universally among Kenyan Somali, Masai, and some other groups, but reaches 32% in the country as a whole.[87] In Guinea, Mali and Mauritania, recent DHS have shown that rates of FGM are as high as 71–99%, and that some girls are nowadays 'cut' before the age of four.[88] There are also cases in the industrialised world among diaspora groups.

PSYCHOLOGICAL VIOLENCE

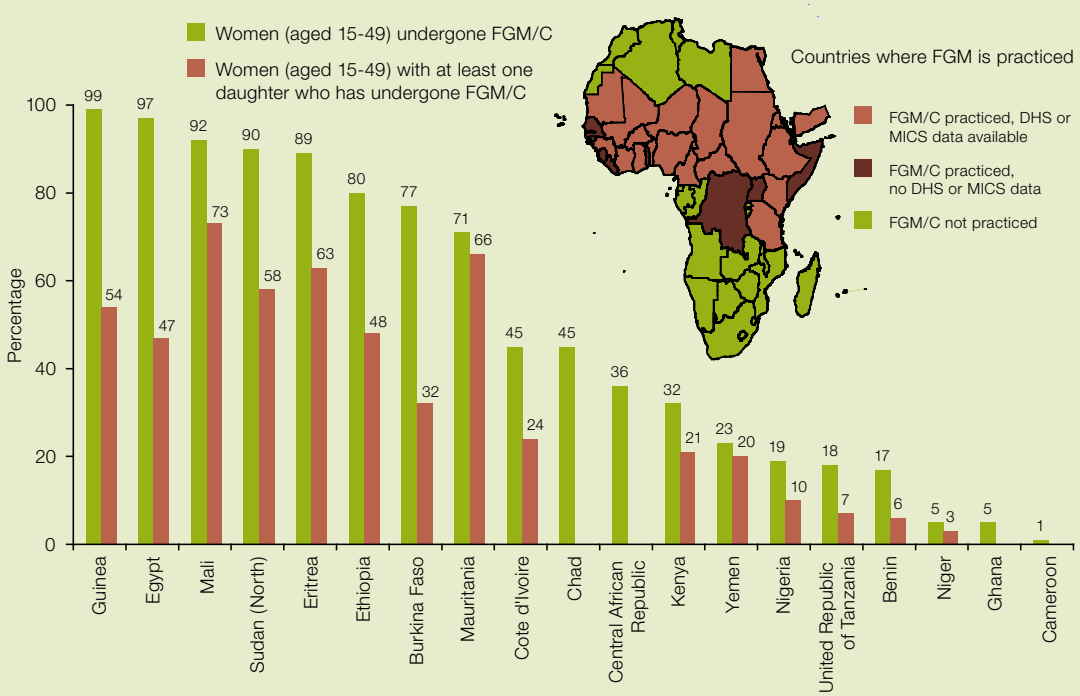
All physical and sexual violence involves some psychological harm; but psychological violence can also take the form of insults, name-calling, ignoring, isolation, rejection, threats, emotional indifference and belittlement – that can be detrimental to a child's psychological development and well-being. Standard definitions are lacking, and little is known about the global extent of this form of violence against children except that it frequently accompanies other forms: a strong coexistence between psychological and physical violence against children in violent households has been established.[89] In the violent family setting, there is constant fear and anxiety caused by the anticipation of violence; pain, humiliation and fear during its enactment; and, in older age groups, the loneliness of parental rejection, distrust, and at times self-disgust.

Psychological violence may be the product of uncontrolled frustration, or it may have a similar purpose to that of corporal punishment: to cow a child into obedience and 'retrain' his or her unruly behaviour. Although children may know the saying "words can never hurt me," the truth is that many children find the pain and anxiety of rejection, and the humiliation of an attack on their self-esteem, is also difficult to bear.[90]

Psychological forms of punishment occur in every region. A study across five countries conducted by the World Studies of Abuse in the Family Environment (WorldSAFE) project indicated that shouting or screaming at children was a punishment practised by parents in all five countries (Chile, Egypt, India, the Philippines, and the USA). The incidence of cursing children or threatening them was more varied; for example, in the Philippines no mother was reported as cursing her child, but 48% threatened abandonment; in Egypt 51% cursed the child, but only 10% threatened abandonment.[91]

FIGURE 3.2

The prevalence of FGM among women and their daughters



Data are from latest available years, 1996–2004. Adapted from UNICEF (2005). Changing a Harmful Social Convention: Female Genital Mutilation/Cutting. Innocenti Digest, No. 12. Florence, UNICEF Innocenti Research Centre; UNICEF (2005). Female Genital Mutilation/Cutting: A Statistical Exploration. New York, UNICEF.

The most reliable and extensive data on prevalence and nature of FGM are provided by DHS and MICS. However, the surveys do not capture the degree of severity of mutilation, which varies considerably between and within countries. In addition, some of the countries in which FGM is known to be most frequently practised in its severest forms, such as Somalia and Djibouti, have not been subject to DHS or MICS.

One type of punishment may give way to another, depending on age. A study conducted among 2,000 children aged six to 18 in Swaziland found that humiliating psychological punishment was more common against older children, and corporal punishment more common among younger ones.[92]

THE CONSEQUENCES OF VIOLENCE AGAINST CHILDREN

The consequences of violence against children include both the immediate personal impacts and the damage that they carry forward into later childhood, adolescence and adult life. The violence that children experience in the context of home and family can lead to lifelong consequences for their health and development. They may lose the trust in other human beings essential to normal human development. Learning to trust from infancy onwards through attachments in the family is an essential task of childhood, and closely related to the capacity for love, empathy and the development of future relationships. At a broader level, violence can stunt the potential for personal development and achievement in life, and present heavy costs to society as a whole.

DEVELOPMENTAL CONSEQUENCES: PHYSICAL AND PSYCHOLOGICAL

The most apparent immediate consequences of violence to children are fatal and non-fatal injury, cognitive impairment and failure to thrive, and the psychological and emotional consequences of experiencing or witnessing painful and degrading treatment that they cannot understand and are powerless to prevent. These consequences include feelings of rejection and abandonment, impaired attachment, trauma, fear, anxiety, insecurity and shattered self-esteem. When a parent deliberately inflicts pain on a child, whether for punishment or for some other reason, part of the child's lesson is that the parent is a source of pain to be avoided; even at two years old, physically punished children distance themselves from mothers compared to children who are not physically punished.[93]

Impacts and consequences are complicated by the fact that, at home, children are victimised by people they love and trust, in places where they ought to feel safe. The damage is particularly severe in the context of sexual abuse, particularly as the stigma and shame surrounding child sexual abuse in all countries usually leaves the child dealing with the harm in solitude. Loss of confidence and belief in the human beings closest to the child can instil feelings of fear, suspicion, uncertainty, and emotional isolation. He or she may never again feel safe or secure in the company of the parent or family member who perpetrated the violence.

A growing body of evidence suggests that exposure to violence or trauma alters the developing brain by interfering with normal neuro-developmental processes.[94] Where family violence is acute, children may show age-related changes in behaviour and symptoms consistent with Post-Traumatic Stress Disorder (PTSD) and depression. Physical and sexual victimisation are associated with an increased risk of suicidal thoughts and behaviour, and the more severe

"Violence against children in the home and family is a serious problem in itself and has been strongly associated with health risk behaviours later in life… In turn, these behaviours contribute to some of the leading causes of disease and death.… Preventing violence against children in the home and family should therefore be a public health priority."

Dr Alexander Butchart, Editorial Board of the UN Secretary-General's Study on Violence against Children

the violence, the higher this risk.[95,96] The effects may also be influenced by how adults respond to children if they try to talk about what they have experienced. Other variables will include how long the violence has gone on, where it has taken place, and whether the child is suffering from repeated violence from the same person, or whether he or she is being 're-victimised' by another perpetrator.[97]

According to WHO, the negative effects to children of living in a violent household are similar across culturally and geographically diverse settings. Based on studies of women in Bangladesh, Brazil, Ethiopia, Japan, Namibia, Peru, Samoa, Thailand and the United Republic of Tanzania, children living in violent households (where the mother reported physical abuse from the father) were more likely to have behavioural problems such as bed-wetting, nightmares, and excessively aggressive behaviour or timidity, than those in non-violent households.[98] The results suggest that exposure to violence in the home is a warning sign for damage to children, and care services need to factor this into prevention and response.

CONSEQUENCES OVER THE LONGER TERM

A growing body of research shows that violence perpetrated against children, or the experience of living in a household where violence against loved ones is frequently witnessed, can be a significant contributing factor in adult illness and death. Childhood experience of violence has been linked to alcohol and drug abuse, cancer, chronic lung disease, depression, and a number of other conditions including liver disease, obesity and chronic reproductive health problems.[99,100,101] The links may result from harmful behaviours adopted as coping mechanisms such as smoking, drinking, substance abuse, bingeing or other poor dietary habits.

Violence against children can also have a lasting impact on mental health.[102] A study comparing data from around the world shows that a significant proportion of adult mental disorders are connected to sexual abuse in childhood (see Table 3.1).[103] Although the prevalence of abuse varied in different regions, the impacts appeared similar, with mental health effects being worse in relation to the period over which abuse continued and degree of severity.

Findings are similar regarding physical punishment and other degrading forms of treatment. Corporal punishment is a predictor of depression, unhappiness and anxiety, and feelings of hopelessness in children and youth. Even a low frequency of corporal punishment may lead to psychological distress in young people.[104,105,106,107] In a group of adolescents in the Hong Kong Special Administrative Region of China, those who had been physically punished in recent months were more likely to consume alcohol, smoke cigarettes, get into fights, be anxious and stressed, and perceive difficulties in their ability to cope with everyday problems.[108] The relationship with poorer mental health continues into adulthood according to studies in Canada and the USA, which found a higher level of anxiety disorders and alcohol dependence.[109]

"I am 8 years old and was raped when I was 6. My parents made a complaint to the police and he was sent to jail. But I cannot stay where I live anymore. You know what they call me here? They have nicknamed me the "tainted" (la déchirée)…even when I go to the well to get water the kids call me that. I want to run away from here".

Girl, 8, Eastern and Southern Africa, 2006 [VIII]

3

TABLE 3.1 – Global burden of mental disorder attributed to child sexual abuse

MENTAL DISORDER	PERCENTAGE OF GLOBAL DISEASE BURDEN ATTRIBUTED TO CHILD SEXUAL ABUSE (CSA)	
	FEMALES (%)	MALES (%)
Depression, alcohol and drug abuse	7–8	4–5
Post-Traumatic Stress Disorder	33	21
Suicide attempts	11	6
Panic disorders	13	7

Source: Andrews G et al. (2004). Child Sexual Abuse. In: Ezzati M et al. (2004). Comparative Quantification of Health Risks: Global and Regional Burden of Disease Attributable to Selected Major Risk Factors, Vol 2. Geneva, World Health Organization, pp 1851–1940.

FURTHER VICTIMISATION

Experiencing violence as a young child also increases the risk of further victimisation, and an accumulation of violent experiences. This reinforces the importance of recognising and preventing violence against children as early as possible. Similarly, child sexual abuse has been clearly established as a risk factor for sexual victimisation in adulthood, and the risk is compounded when it includes intercourse and other forms of violence.[110] The extent of continued victimisation in the home has only been assessed in a few countries where registers and databases are routinely updated. In the UK and the USA cases where violence to the child has been referred to official child protection agencies, rates of re-referral range from between 5% and 24% within a 1–4 year follow-up.[111,112,113] In cases where a child has been referred on at least two occasions, risk rises significantly.

Family violence against children is believed to be associated with increased risk of violence in other settings. A study in the UK found that children witnessing domestic violence are also more likely to be victims of bullying,[114] and similarly a study of elementary and middle school-aged children in Italy showed that being bullied at school was associated with witnessing parents' violence at home, especially for girls.[115]

Children who have been sexually abused, or extremely neglected, or who have experienced violence at home, may run away or drift into a street life which exposes them to the risk of sexual abuse or exploitation. This happens to boys as well as girls: according to a report from

"It could appear a feeling of guilt. The victim and even people around who don't know the situation could consider that the abused child is responsible for the abuse. If close people believe this, then slowly the victim will believe the same thing."

Girl, 11th grade, Europe, 2005 [ix]

Canada, almost all boys involved in prostitution there have been sexually abused at home.[116]

A number of studies have focused on the intergenerational nature of violence.[117] Recent data from an international study in Australia, Costa Rica, the Czech Republic, Poland and the Philippines indicates that the problem is common across cultures and regions.[118] Women in all countries who have experienced physical violence from their parents in childhood are considerably more likely to report physical violence from an intimate partner as an adult, supporting the notion of a life-course perspective of violence[119] (see Figure 3.3).

In the case of traditional practices, and of child marriage, there is a consistent intergenerational link in that mothers (and fathers) who regard them as mandatory customs inflict them on daughters and sons. The main predeterminant of FGM is ethnic affiliation; some ethnic groups carry out the practice in almost their entire population, whereas others living in the same area do not do so.[120] Education of girls, especially to secondary level, can break the intergenerational link and reduce the prevalence of FGM.[121]

SOCIAL AND ECONOMIC CONSEQUENCES

In addition to its negative impact on a child's rights, health and development, family violence against children has economic consequences for families and society. These include direct costs such as the cost of medical care for victims, legal and social welfare services, and the placement of child victims in care. Indirect costs include possible lasting injury or disability, psychological costs or other impacts on a victim's quality of life; the disruption or discontinuation of education; and productivity losses in the future life of the child or young person.[122] The potential financial burden is illustrated by data from a few industrialised societies. The financial costs associated with child abuse and neglect, including future lost earnings and mental health care, were estimated in the USA in 2001 at US$ 94 billion.[123] In the UK, an annual cost of US$ 1.2 billion has been cited for immediate welfare and legal services alone.[124]

FACTORS CONTRIBUTING TO VIOLENCE

The risk of home and family violence arises from the interaction between the quality of family relationships, and stress or pressure upon the family from external factors or from characteristics of family members. Some factors stem from the individual characteristics of the child (e.g. stage of development, sex) and the characteristics of the parent or caregiver (e.g. mental disorders, substance abuse). Others derive from the family setting and the roles and relationships of people within it; these may enhance vulnerability, or on the contrary, may offer protection. Dysfunctional family relationships and poor parent–child interactions have a critical bearing on whether children experience violence in the home. Other factors derive from the environment, as in the case of emergency situations, but may also be related to the availability of social networks, or loss of livelihood. Of course, a negative outcome is

not inevitable; for example, where parent and sibling relationships are good, this will provide children with protection and foster resilience against external shocks.

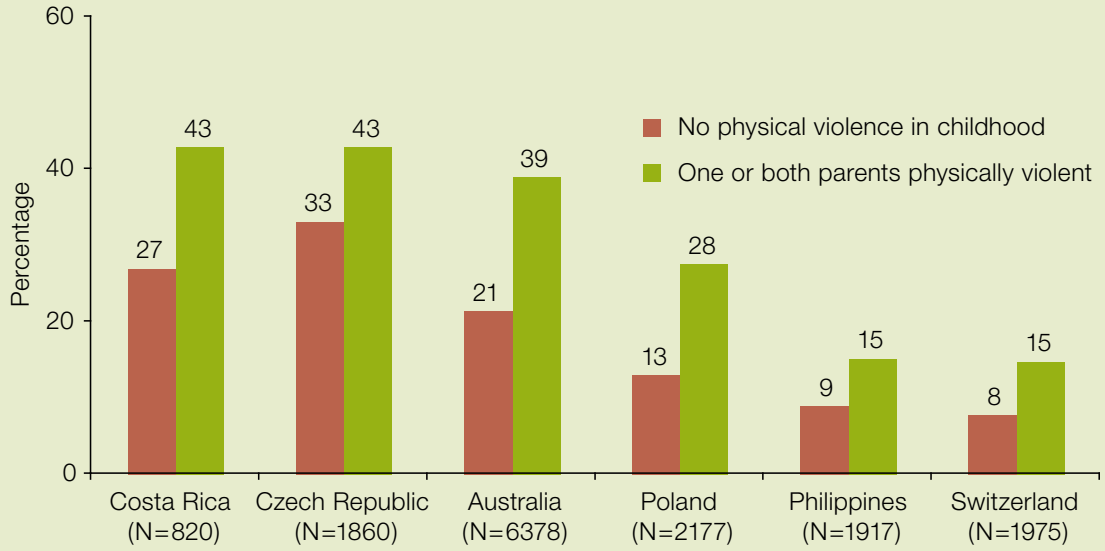
Violence is likely to result from a combination of personal, familial, social, economic and cultural factors, and the interrelationship amongst these factors can be difficult to disentangle. Moreover, some children are exposed to several types of violence from multiple sources over many years.

CHILD-RELATED FACTORS

Age: At a very early age, the physical frailty of the infant and state of dependence on the mother or immediate carer is the key to vulnerability. Apart from the risks of injury or death from physical violence, infants are vulnerable to as a result of omission and neglect. Infants are most vulnerable in the time immediately after birth; they remain extremely vulnerable, but become decreasingly so, throughout their first year and early childhood (0 to 4 years).

FIGURE 3.3

Women's experience of intimate partner violence after the age of 16 and its association with childhood victimisation



Source: Johnson H et al. (forthcoming). Violence Against Women: An International Perspective. New York, Springer.

"When the head of the household has a bad day, the dog cries."
From an Asian proverb, Regional Consultation, South Asia

Sex: A child's sex may also be a factor which raises his or her risk of victimisation. Although sexual violence is frequently directed against boys, girls are more likely to suffer such abuse. Daughters are more likely to be severely neglected in societies where son preference is pronounced, while in some societies sons are more likely to experience severe violence than daughters.

Other characteristics: Children with disabilities are at heightened risk of violence for a variety of reasons, ranging from deeply ingrained cultural prejudices to the higher emotional, physical, economic, and social demands that a child's disability can place on his or her family.[125] In the USA, children with physical, sensory, intellectual or mental health disabilities endure almost double the number of violent incidents compared to their non-disabled peers.[126] Similarly, the Caribbean Regional Desk Review undertaken for the Study reported that children with disabilities were at heightened risk for all types of violence (physical, sexual, emotional and neglect), much of it in the home.[127] In some regions disabled children are viewed as cursed; for example in West and Central African such children are likely to be exposed from birth to tacit or open neglect, and violence may be accepted or even encouraged by the family.[128] (Violence against children with disabilities is also discussed at some length in the chapter on violence against children in care and justice systems.)

In addition to disability, certain other characteristics heighten children's risk of experiencing violence in the home. Characteristics that hinder parent–child attachment or make a child more difficult to care for can affect susceptibility.[129,130,131] For example children who are unwanted, born prematurely or are of low birth-weight or part of a multiple birth, and children with chronic illness or serious behavioural problems may be at increased risk of maltreatment.

FAMILY-RELATED FACTORS

Parent characteristics and socio-economic status: While violence in the home is found in all social and economic spheres, studies from a range of different settings show that low parental education levels, lack of income, and household overcrowding increase the risk of physical and psychological violence against children.[132,133,134] Physically violent parents are also more likely to be young, single and poor.[135] These associations are likely to be related to stress caused by poverty, unemployment and social isolation. Children living in families with these factors are most at risk when there is inadequate social support and the family is not part of a strong social network. Lack of extended family support may exacerbate existing problems.[136]

Stress and social isolation: Studies from both industrialised and developing countries show that many of the personality and behavioural characteristics of violent parents are related to poor social functioning and diminished capacity to cope with stress.[137] Parents with poor impulse control, low self-esteem, mental health problems, and substance abuse (alcohol and drugs) are more likely to use physical violence against their children and/or to neglect them.[138] Parents who use violence against their children may well have experienced violence as children.[139]

UKRAINE,2005, Sasha, 5, holding a stuffed animal, sits with his sister Nastya, 4, at a state institution in the village of Kopylov, near Kyiv. Six months earlier, Sasha had witnessed his father killing his mother.

Research on the links between socio-economic conditions and violence against children suggest that efforts are needed to alter the underlying conditions that put extreme economic, social and emotional stress on families. Greater attention must be given to supporting families who live in communities characterised by high levels of unemployment, overcrowded housing, rapid population turnover and low levels of social cohesion.

Parental loss or separation: Orphanhood, which has increased with the HIV/AIDS pandemic, heightens vulnerability. A study by World Vision in Uganda, where an estimated 1.7 million children have been orphaned by AIDS, argues that the deliberate stigmatisation suffered by these children from guardians, teachers and relatives causes psychological harm and is itself a form of violence.[140] Placing these orphans into the homes of extended family or local community is a common and preferred practice over institutionalisation or the phenomenon of child-headed households; however, community leaders in Uganda reported that corporal punishment was more violent and common against orphans than against other children in the household who were more closely related to adult carers or to the head of the household. In Zambia, a study by Human Rights Watch found that orphans who were taken in by extended family members were frequently subjected to sexual violence from uncles, stepfathers and cousins. With a rate of around 20% cases of HIV infection in the population, such violence can be deadly. Girls rarely attempted to disclose the abuse: they were too aware of their dependency, and

"Some of our parents fight in front of us, causing us a lot of pain and distress. Some of our parents always come back home drunk and do not care for our physical, emotional and nutritional needs. Some children are looking after their parents and siblings because their parents are not responsible."

Child, Eastern and Southern Africa, 2005 [x]

that they might be silenced or lose essential support.[141] Orphanhood can also increase the risk of violence in community settings.

Exposure to intimate partner violence in the home: It is estimated that 133 to 275 million children witness violence between their parents/carers annually on a frequent basis, usually fights between parents, or between their mother and partner (see Table 3.2).[142] Children can be psychologically and emotionally damaged by witnessing violence against another family member.[143] Evidence from a range of studies shows that witnessing of this violence over a long period of time can severely affect a child's well-being, personal development and social interactions both in childhood and adulthood; such children may exhibit the same behavioural and psychological disturbances as those who are directly exposed to violence (see below).[144,145,146]

Violence against women in the home often is linked with violence against children; in the USA, inter-partner violence (also known as domestic violence) may be the most important precursor to child maltreatment fatalities.[147] The same association has been observed in a variety of geographically and culturally distinct settings and countries: in China, Colombia, Egypt, India, Mexico, the Philippines, and South Africa a strong relationship between these two forms of violence has been found.[148] In one study from India, inter-partner violence in the home doubled the risk of direct violence against children in the household.[149] Children living in circumstances of inter-partner violence among parents/caregivers in their home are not only at risk of physical violence themselves, but may suffer psychological and emotional disturbances; without intervention they may go on to be future perpetrators or victims of violence.[150,151]

Since they spend more time at home, children in the early years – when they are most subject to influence by external factors and liable to be more overwhelmed by fear – are at particular risk of witnessing intimate partner violence. Such children may also learn powerful lessons about aggression in interpersonal relationships which they carry with them into their future. Child development specialists suggest that hostile styles of behaviour, emotional regulation and the capacity for personal conflict resolution are shaped by parent–child and inter-parental relationships.[153] However, not all children who grow up in violent homes suffer long-lasting consequences; given support, children have remarkable capacities for coping, and resilience in the face of violence.

SOCIETAL AND CULTURAL FACTORS

Legal and policy framework: Weak legal frameworks contribute both directly and indirectly to family violence against children. The laws of some countries still condone, either explicitly or implicitly as a result of interpretation, some level of violence against children if it is inflicted by the child's own parents or guardians as a means of behavioural correction. Many countries lack legal protection against harmful traditional practices and child marriage, and in some countries laws against child sexual abuse apply only to men's sexual violence against girls or may not address sexual violence against children by family members.

TABLE 3.2 – Estimated number of children who witness violence at home annually

MDG REGION	ESTIMATED NUMBER OF CHILDREN WITNESSING VIOLENCE IN THE HOME*
South Asia	40.7–88 million
Western Asia	7.2–15.9 million
Sub-Saharan Africa	34.9–38.2 million
South-eastern Asia	No estimate
Oceania	548,000–657,000
Northern Africa	No estimate
Latin America and the Caribbean	11.3–25.5 million
Eastern Asia	19.8–61.4 million
Commonwealth of Independent States	900,000 to 3.6 million
Developed countries	4.6–11.3 million
Global estimate	**133–275 million**

**Estimates based on: UN Population Division Data for Global Population under 18 Years for 2000; Domestic Violence Studies from 1987 to 2005; analysis conducted by the Secretariat of the United Nations Secretary-General's Study on Violence against Children (2005).*[152]

Laws and policies relating to access to family planning services, alcohol availability, acceptable levels of environmental toxins, access to mental health and substance abuse treatment, and access to birth, death and marriage registration, have an indirect but substantial impact on the risk of child maltreatment in homes and families. Policies regarding education, child care, parental leave, health care, unemployment and social security that leave children and families without economic and social safety nets exacerbate family stress and social isolation and contribute to higher rates of violence against children.

Authoritarianism: Where parent–child relationships are excessively controlling and afford a low status to children, this is likely to increase violence, particularly when coupled with the belief that corporal punishment or

other humiliating forms of punishment are a necessary means of discipline. Several studies have suggested that a culture in which children are expected to submit without question to the injunctions of older family members and adults in authority contribute to children's vulnerability.[154,155] Where parents believe they 'own' children and have the right to do to them whatever they think best, there is resistance to State involvement in child protection. Belief in the sanctity of the family makes authorities, neighbours and members reluctant to speak up when they know children are being victimised.[156,157,158,159,160] This should not be confused with *authoritative* parenting, which balances warmth and support with setting and enforcing clear limits on behaviour, and blends setting high standards with being responsive to the child's needs and developing capacities.[161]

Patriarchal attitudes: Patriarchal attitudes – particularly when they perpetrate the entrenched inferior status of women in many cultures – are also associated with increased risk of violence. In some societies, extremely violent acts may be inflicted by boys or men if the girls or women in question do not comply with their wishes. Seeking a girl's consent in such matters as sexual relations and marriage may not be considered necessary. Girls may also be blamed for male violence against them. In these settings, male children may be exposed to violence as punishment for behaving in a manner inconsistent with stereotypical roles for men and women.

Membership in ethnic minority or indigenous groups: Children in ethnic minority groups are often at high risk of violence because of a confluence of other risk factors associated with the social exclusion of these groups. These include high rates of substance abuse and alcoholism, poverty, bad housing, and unemployment.

PROTECTIVE FACTORS WITHIN THE HOME

Just as certain factors increase the likelihood of family violence against children, other factors can reduce its likelihood. Not every family with the risk factors described above becomes a violent environment for children. Unfortunately, there has been little systematic research on protective factors and they are not well understood. Where research has been conducted, the focus is on identifying factors that mediate the impact of violence once it has occurred, for example those that might protect a victim from developing long-term mental disorders or that seem to be associated with breaking the cycle of violence. Factors that appear through common sense and research to facilitate resilience include higher levels of paternal care during childhood,[162] fewer associations with substance-abusing peers, or peers engaged in criminal activity,[163] a warm and supportive relationship with a non-offending parent,[164] and lower levels of violence-related stress.[165]

Little is known about what prevents families from becoming violent. A few studies have shown that communities with strong social cohesion, thriving social networks and neighbourhood connections have a strong protective effect and can even lessen the risk of violence when other family risk factors are pres-

ent.[166,167,168] Based on current understanding of the risk factors for violence and the evidence of prevention strategies that are effective, it is clear that families can be a powerful source of protection and support for children. Good parenting, strong attachment between parents and children, and positive non-violent relationships with children are clear protective factors. This highlights the importance of providing support to families to encourage these factors to flourish, especially families situated in communities with low levels of social cohesion.

RESPONSES TO VIOLENCE AGAINST CHILDREN IN THE HOME AND FAMILY

Under the CRC and other human rights treaties, States have an obligation to provide a comprehensive and multi-sectoral response to all forms of violence against children in families. These should comprise policies and services for both prevention of violence and protection to assist child victims.

CHILD SAFETY: A PIONEERING MODEL IN JORDAN

The Jordan River Foundation (JRF) was set up in 1997, with the support of Her Majesty Queen Rania Al-Abdullah, to promote the protection of Jordanian children, strengthen the family unit, and enhance positive child–parent relationships and healthy family dynamics. The Foundation has established itself as a pioneer in building an Arab child safety model.

The Child Safety Programme carried out under the JRF umbrella provides awareness, prevention and intervention services in relation to the sensitive issue of child abuse, by addressing legal, medical, psychological educational and social needs of the child in an integrated manner. The programme is unique to Jordan and the Arab world, and has pioneered the opening up of a complex issue and bringing it to the awareness of the Jordanian public and decision-makers.

The Child Safety Centre – Dar Al-Aman – set up by the Foundation is the first therapeutic centre in the Arab world for rehabilitating abused children and their families. Children and families attending the centre are able to gain from a variety of services and education programmes. Mothers are assisted with child care techniques, fathers familiarised with alternative means of discipline, young people instructed in conflict resolution and basic life skills, and children empowered with techniques for self-protection.[169]

To date, States' responses have focused primarily on child protection services or alternative systems of care, rather than on prevention. Prevention and protection strategies should be developed in tandem, balanced within the framework of an overall strategy which considers issues of social policy; legal reform; programmes and services for prevention and care; and strategies to bring about changes in attitudes and behaviours.

LEGAL REFORM

Fewer than 20 countries have reformed their laws to prohibit physical chastisement in the family, but more have committed themselves to doing so as the Study has progressed. All States have laws making assault a criminal offence and many Constitutions prohibit cruel, inhuman or degrading punishment; many have laws which prohibit cruelty, maltreatment or 'abuse' of children. But these laws are not interpreted as prohibiting all violence against children, and in many States legislation contains justifications or defences for corporal punishment. Most countries prohibit incest, rape and other sexual assaults; many also specify a minimum age of sexual consent and of marriage, although this is often below the age of 18. Most countries where FGM is practised now have laws against it.[170] However, laws on violence against children are not effectively implemented in many places because of the strength of traditional attitudes and in some cases because of the existence of religious or customary legal systems.

Laws on corporal punishment and other forms of cruel or degrading punishment

Laws on criminal assault, as has been noted by the Committee on the Rights of the Child, are seldom interpreted as prohibiting physical chastisement, corporal punishment and all other forms of cruel or degrading punishment of children in the family. In over 70 countries, the English common-law defence of 'reasonable' or 'moderate' chastisement of children has remained following periods of colonisation. In order to prohibit all corporal punishment, any such defences must be removed and prohibition of corporal punishment and other forms of cruel or degrading punishment made explicit.

Between 1996 and 2006, the Committee on the Rights of the Child has recommended to 130 countries that they take steps to prohibit all corporal punishment. In 2006, the Committee adopted a General Comment – a statement of its authoritative interpretation of the CRC – on the right of the child to protection from corporal punishment and other degrading forms of punishment.[171] The Committee emphasises that the first purpose of law reform to prohibit all corporal punishment within the family is preventive: "to prevent violence against children by changing attitudes and practice, underlining children's right to equal protection and providing an unambiguous foundation for child protection and for the promotion of positive, non-violent and participatory forms of child-rearing." [172]

The Committee also emphasises that the principle of equal protection of children and adults

from assault, including within the family, does not mean that all cases of corporal punishment of children by their parents that come to light should lead to prosecution of parents: "The *de minimis* principle – that the law does not concern itself with trivial matters – ensures that minor assaults between adults only come to court in very exceptional circumstances; the same will be true of minor assaults on children. States need to develop effective reporting and referral mechanisms. While all reports of violence against children should be appropriately investigated and their protection from significant harm assured, the aim should be to stop parents using violent or other cruel or degrading punishments through supportive and educational, not punitive, interventions."[173]

For legal reform to fulfil the purpose intended, advice and training will be needed for all those involved in child protection systems, including the police, prosecuting authorities and the courts. Guidance should emphasise that support for the family and for constructive and non-violent upbringing is vital, and that any question of separating a child from his or her family must fully respect the best interests of the child.

Other areas for legal change

Some countries have introduced measures to criminalise abuse by intimate partners; measures which broaden the definition of rape have been introduced, thus dispelling the notion that violence among intimates is a private matter, thereby helping to shift social norms.[175]

However, legal change does not guarantee social change where it is not backed up by public and professional education. Laws passed to reflect CRC obligations which are not linked to widespread public education and which clash with cultural norms and accepted practices may be systematically ignored. Combating harmful traditional practices such as FGM, for example, cannot be achieved by legal change alone, even though legal systems should and must condemn them. Legal change must be accompanied by education programmes directed at officials, parents and children.

In some cases, legislation exists but is insufficient; imprecise or insensitive implementation of it can compound children's victimisation rather than relieve it. Some existing legislation is so inadequate that it penalises child victims instead of family perpetrators; in these circumstances, it may actually reinforce the possibility of violence against children. In many settings in Africa, Asia and the Middle East, when a young girl below the age of consent or marital union has been raped and become pregnant, marriage to the rapist can be imposed upon her by the courts and her parents.[176] Legislation against so-called 'honour killings' may impose more lenient sentences than on other homicides, or perpetrators may be exonerated by traditional justice systems; and children sold into prostitution may bear the brunt of social disapproval or be treated as criminals.

Preventing violence against children in the home and family setting requires legal reform to reach beyond laws directly concerned with violence. To achieve large-scale reductions in violence against children, legal and policy frameworks must address the underlying risk

THE SWEDISH EXPERIENCE WITH PROHIBITION OF CORPORAL PUNISHMENT

Sweden was the first State to prohibit all corporal punishment. In 1957, a provision was removed from the Criminal Code which excused parents who caused minor injuries in the course of 'discipline'. In 1979, Sweden explicitly prohibited corporal punishment in its Parenthood and Guardianship Code: "Children … may not be subjected to corporal punishment or any other humiliating treatment."

Sweden's experience shows that when progressive law reform is linked to comprehensive public education, substantial changes in attitude and reductions in violence against children can be achieved within decades. In 2000, a parliamentary committee enquired into the experiences of parents and children with corporal punishment since the ban. The data indicate that its use has decreased dramatically, particularly in relation to beating children with fists or with an implement, or 'spanking' them. In national parental studies in 1980, 51% of parents said that they had used corporal punishment during the previous year; 20 years later, in 2000, this figure had decreased to 8%.[174]

factors and strengthen protective factors. Factors such as alcohol availability, family planning services, pre- and post-natal care, social security, mental health and substance abuse treatment, birth, death and marriage registration, and levels of environmental toxins are just a few examples of important factors that are sensitive to legal and policy reform.

PREVENTION STRATEGIES

What many do not realise, but which research continues to show, is that a variety of interventions can prevent violence: violence against children in the home and family setting can be reduced significantly by the implementation of laws, policies and programmes which strengthen and support families, and that address the underlying community and societal factors that allow violence to thrive.

To maximise effectiveness, prevention strategies should be based on the best available scientific evidence, aim to reduce factors contributing to risk and strengthen protective factors, include mechanisms for evaluating the impact of the strategy, and be carried out within a broader framework for addressing violence against children. Promising strategies to prevent violence against children in the home and family context are many and varied, ranging from programmes with a direct impact, such as parenting training, to policies with a more indirect impact, such as those governing alcohol availability or access to family planning services.

Support for parents and families

Maternal and child health services

Services for reproductive and maternal and child health are the first line of action to reduce neglect and violence against children from their earliest moments of life. These services not only provide the possibility of preventing unwanted pregnancies and improving access to prenatal, post-natal and early childhood health care, but can also help strengthen early attachment and reduce the risk of parental violence against young children. Most countries provide maternity services and some have home visitation programmes for newborns by health or community workers/volunteers. Therefore, the early identification of parents who need support can be achieved without stigma or labelling by the routine checks on mothers and children through maternity services, promoting safe pregnancy and childbirth, and through home visits by health workers. These give an opportunity to provide parent education, and to direct resources to 'high priority' families by identifying known risk factors and offering additional services.

USA, 1997, Tiffany, 10, her mother, Letisha and her step-father, Billie, sit on a sidewalk bench in the city of Daytona Beach. After months of homelessness, they have decided to send Tiffany and her sister, Tonya, 13, to live with their grandmother in another state.

Home visitation and parent education programmes

Programmes focusing on family functioning, particularly on family management, problem-solving, and parenting practices, have existed for several decades. There is strong and consistent evidence showing them to be effective in reducing home and family violence against children, as well as other negative child health and development outcomes. The most successful programmes address both the internal dynamics of the family and the family's capacity for dealing with external demands. Caregiver education can also pre-empt the evolution of poor parent-child relationships, and provide a context in which to teach parents non-violent methods of discipline. The earlier these programmes are delivered in the child's life and the longer their duration, the greater the benefits.

Home visitation involves health professionals, social workers or trained volunteers in the assessment of infants and young children's needs and their parents' capacity to meet those needs, given the family's current social and economic situation. Personalised home visits aim to provide emotional support and training to promote positive parental knowledge, skills and behaviour, and to a certain extent to assess

the family. Home visits also offer an opportunity to link a family with other community services as needed.

In the USA, the value of home visits by nurses to young first-time mothers in socio-economic difficulty, for the first two years of the child's life, were evident 15 years later.[177] In a randomised trial, the benefits to the visited families included a significant reduction in child abuse and neglect, as well as reductions in maternal alcohol/drug problems. Current evidence indicates that the most successful home visitation programmes focus on families with an elevated risk of violence against the child, and begin in pregnancy and continue to at least the second year of the child's life, actively promote positive health behaviours, support the family in stress management, and address a range of issues that are important to the family.[178,179] Programmes should be flexible in order to adjust to the changing needs of families.

Parenting education, another successful and widely used prevention strategy, can be offered either in the context of home visitation programmes or independently. Programmes usually educate parents about child development and aim to improve their skills for behaviour management. Parents' and caregivers' positive behaviour management skills can be improved by developing an understanding of the importance of follow-through and consistency, rewarding and reinforcing positive behaviour, strategically ignoring minor negative behaviours, giving effective instructions, and implementing non-violent consequences for misbehaviour.[180] Parenting programmes should strive to strengthen the skills of both mothers and fathers.

Parenting programmes are increasingly being implemented in middle- and low-income countries. For example, at the instigation of the All China Women's Federation, over 200,000 Chinese communities organised 'Parents' Schools' to help people adapt to parenting in the one-child family.[181] In Eastern Europe, the Republic of Moldova is mainstreaming parent education in the primary health care system. Health workers are trained to provide parents with the knowledge and skills needed to meet the survival, growth, development and protection needs of their young children, and also to know when and where to go for specialised services. The initiative started in 2002; already it is clear that family doctors and nurses who attended the training programme are more likely to engage in parent education. This initiative includes a specific focus on protecting children from all forms of violence, including physical punishment and other humiliating forms of discipline.[182]

In developing countries, parenting courses are offered by community-based parents' centres. For example, services offered by The Parent Centre in Cape Town, South Africa include the following:[183]

- Parent groups for mothers and babies, mothers and toddlers, and single parents
- Post-natal depression support
- Training on effective discipline for toddlers
- Training for parents of under-5s, under-12s, and teenagers
- Counselling for parents and caregivers

- Home visitation specifically to prevent family violence against children
- Training for professionals and para-professionals who work with children.

Early education and child care programmes

Many families need help in providing not only basic care but also stimulation and education for their children. Early Childhood Care and Development (ECCD) programmes are designed to achieve both of these objectives, and there is evidence that they can be effective in reducing the factors that engender violence in the home. In the UK, for example, a review of day-care programmes for pre-school children of economically disadvantaged parents found that the effects on the mothers' interaction with their children were positive, and that the mothers' gains in education or employment were beneficial for their families. Long-term benefits to children included improved behavioural development and school achievement, higher levels of employment, lower teenage pregnancy rates, higher socio-economic status, and decreased criminal behaviour.[187]

TRIPLE P: POSITIVE PARENTING PROGRAMME

Since the risk factors that shape the risk of family violence occur at several levels, some of the most effective prevention strategies involve interventions at more than one level. An example is the Positive Parenting Programme (Triple P) originally devised in Australia, and now also used in Canada, Germany, the Hong Kong Special Administrative Region of China, New Zealand, Singapore, Switzerland, the USA and the UK. Triple P has been shown to be effective in promoting positive parenting behaviour and is likely to reduce the risk of violence against children. The US Centers for Disease Control and Prevention is currently funding an outcome evaluation study to assess the impact of Triple P on child maltreatment.[184]

Level 1 of the programme is aimed at the whole population. For selected parents, two further levels offer consultation sessions in primary care settings such as health centres. For parents in difficulty, with mental health problems or where there may be a high risk of violence in the family, more intense parent training programmes are available, with 8–10 sessions (level 4) or 10–16 sessions (level 5).

The core principles of Triple P are:
- Safe engaging environment for the child
- Responsive learning environment for the child
- Assertive (non-aggressive) and consistent discipline from the parent
- Reasonable expectations of the child
- Parent taking care of self.[185]

Support for families of children with disabilities

There is little research on the effectiveness of programmes aimed at reducing family violence against children born with disabilities. However, the Expert Consultation on Children with Disabilities held for the Study noted that promising approaches from various parts of the world include community-based rehabilitation and early stimulation programmes, either at centres or through home visits.

Providing short-term respite care for parents of children with disabilities can reduce stress on the family as a whole, but also act as a preventive strategy against violence. Support mechanisms that allow parents to take a break from child care, organised through religious bodies, NGOs, or through a State agency, may help prevent violence against disabled children.[188]

Programmes for and with children

Life-skills-based education, which enables children to recognise and avoid risky situations, has produced promising outcomes in a number of school- and community-based settings. This type of intervention usually teaches children about appropriate and inappropriate touching, saying 'no' to an adult when they feel uncomfortable, and who they can talk to if they experience violence. While some programmes have improved children's knowledge and skills regarding threatening situations, longer-term evaluations are not generally available. Such programmes work best as part of a more comprehensive strategy, rather than as stand-alone programmes. (See the chapter on violence against children in schools and educational settings.)

In a number of countries, stimulated by the child rights movement, children's and adolescents'

FATHERING

Since 2003, Save the Children Sweden in South and Central Asia has included working with men and boys in its regional strategy, in the belief that many males are uncomfortable with constructs of masculinity which tolerate violence against women and children. Working to support alternative constructs with men and boys as partners is now being explored in the region. Workshops on working with men and boys have been conducted to enlist them in efforts to reduce violence against girls, boys, women and other men. Input has been sought from the White Ribbon Campaign, the longest-standing organisational effort among men to reject violence against women, which today has a network in 47 countries throughout the world, including South Africa, South Asia, New Zealand, Tonga, Brazil, Germany, and the Nordic countries. Country-based workshops have also been held, and in Bangladesh, a non-governmental organisation (NGO) network on the issue has been formed. Increasing the focus on the socialisation of boys is now seen as the challenge.[186]

"We are at a disadvantage because of our age. Adults don't believe what we say when something like this happens. That's why we don't say anything. I have a girlfriend whose stepfather touches her and she was even punished when she told her mother about it"

Boy, 15, Latin America

own organisations have developed and become active during the past decade. These organisations have enabled many of their members to gain confidence, articulate their problems, and in solidarity with others, undertake actions designed to reduce acts of violence that have either been threatened or carried out against themselves or other children. Some, such as the Girls' Advisory Committees in Ethiopia, target specific problems such as child marriage (see box on next page). Although there is evidence that these school-based programmes can reduce the risk of childhood sexual victimisation in the community, it is not clear whether this embraces family-related sexual abuse.[189] Child participation activities based on schools and community settings need to be supported, as peer groups can have a major role to play in helping identify at-risk children and undertaking proactive initiatives.

Breaking the silence

One of the cornerstones of any strategic response must be to break down the silence in which most children endure episodes of physical, psychological or sexual violence at home. Consultations and reviews repeatedly demonstrate that children – however much they fear and dislike the violence they experience – do not feel they have any place to make their feelings known, or they may even consider that such feelings are 'legitimate'. Many feel shame or blame themselves, while others stay silent for fear of provoking further violence, or insensitive interventions which could make their overall situation worse.

Within the general trend to lay more emphasis on child consultation as an integral component of programme planning and interventions with children, child-friendly methodologies for consultation and action-research have been developed. These, coupled with counselling and communications skills, have also been used to enable children to open up to adults they regard as safe about their intimate and painful experiences. In some small-scale examples, notably in India and Brazil, children who have been trafficked by their families and have few trusting relationships with adults have organised themselves to provide mutual support and avoid further exposure.[191]

Child helplines are gradually becoming more common: as already noted, discussion in confidence with a counsellor by phone allows some children to report what is happening to them and seek help. Helplines or hotlines have been set up by various NGOs in order to help children escape from abusive situations; they are used in the Philippines and Cambodia by children experiencing violence as domestic helpers in the homes of those who are not their parents.[192] (See the chapter on violence against children in the community.)

Social policy

Strong social policy is essential for supporting families and enabling them to thrive despite economic, social and psychological stress. Improvements in these areas address some of the major risk factors for family violence against children and should therefore lead to reductions in the rate of child maltreatment. Relevant policies include support for employment, minimum wages, rural livelihoods, equitable land reform, equitable compensation in case

of forced displacement, women's income generation, and equitable access to facilities such as water supplies, roads and paths, transport systems, drainage, and sanitation. Other social policies with a proven positive effect on family life include access to social protection systems, such as social security benefits for people who suffer from disabilities or who care for children with disabilities; unemployment benefits; health insurance or free care for the indigent; income or food supplementation for those in extreme need. (Social policy interventions are discussed in greater detail in the chapter on violence against children in the community.)

Other strategies

Although the direct impact of these interventions on violence against children has not been well researched, general health initiatives at the community level can reduce levels of violence.

GIRLS' ADVISORY COMMITTEES: A CHILD-LED ACTIVITY IN RURAL ETHIOPIA

Primary schools are the one location in rural Ethiopia that bring together girls (and boys) who might be vulnerable to forced early marriage. The creation of Girls' Advisory Committees (GAC) is an innovation in Ethiopian primary schools aimed at preventing child marriage and other forms of gender discrimination.

The Girls' Advisory Committee is not a club, but a school committee linked to the Parent–Teacher Association. GACs work to create a more positive environment for children at home and at school, by awareness-raising and other means. They vary in composition, but include male and female students, sometimes a community member, and a female teacher as advisor. The student members act as links between families in the community and the school, reporting on upcoming child marriages, abductions, teasing, harassment, and extended absence of girls from school.

Where an impending marriage of a young girl is reported, the GAC visits the parents to attempt to dissuade them. If they refuse to listen, the GAC asks the parents to come to the school. The teachers then ask the parents to cancel the marriage, explaining that it is illegal. This is normally successful. Mothers are reported as saying they are glad that their daughter has escaped the life they were forced into, but they would not be able to protest the marriage without the backup of the school.

This example of child-led activity illustrates the necessity of an integrated approach, whereby children's efforts are backed up by authority figures such as schoolteachers, and the law.[190]

For example, environmental health initiatives that remove lead and other environmental toxins from communities can lead to less physical violence against children by reducing the rate of foetal brain damage and subsequent cognitive disorders such as Attention Deficit Disorder (ADD) and hyperactivity, thereby decreasing the number of children with high-risk characteristics. Similarly, limiting access to alcohol, for example through controlling the number of alcohol outlets or raising prices, may help prevent child maltreatment.[193] Similar efforts in developing countries could reduce alcohol-related violence against children, although these measures should be considered carefully, as they might prompt people who drink to switch to cheaper and less regulated home-brewed alternatives.[194]

Although few formal evaluations have been conducted, other promising interventions include providing shelters and crisis centres for battered women and their children, training health care workers to identify and work with adults who have experienced violence in childhood, as well as strengthening the linkages between mental health services, substance abuse treatment and child protection services.

INTERVENING WHEN VIOLENCE BECOMES KNOWN

When violence against children is suspected or disclosed, action must be taken to protect the children at risk. The content and legislative foundation of child protection services vary from country to country and often include mechanisms for reporting, referral, investigation and follow-up. Ideally, legal measures should be implemented in tandem with health and social support approaches. Support and assistance without adequate protection can endanger the child's well-being and development; but a legal focus on investigation and protection with insufficient follow-up and parallel treatment can lead to severe and lasting damage both to the child and to the family.

Research is urgently needed to identify effective support, help and treatment-oriented approaches to child protection and how they might be implemented in both high- and low-resource settings. Although rooted in human rights and a clear framework of legislation, child protection systems operating at community level need to evolve in consultation with communities. While aiming for acceptance and trust, child protection workers must be made fully accountable within the context of the overall system and its accountabilities.

Detection of violence against children in the family

The potential for damage to the child increases with increasing frequency and severity of victimisation over time. It is therefore important to identify violence as early as possible and intervene to stop it. Health professionals have an important role in child protection because, except in very remote rural areas, infants and small children are usually taken to the health centre on a routine basis. In countries with social service networks, they may also be seen occasionally or on a regular basis by social workers.

These occasions and contacts provide an opportunity to detect violence against children that parents and caregivers may try to disguise as unintentional injury or illness. Given the pressure on health-clinic staff, they need training and capacity-building, as well as improved facilities. Since detection is not always straightforward, standardised guidelines and tools to assist professionals with assessments are essential. Training health workers to detect and manage violence against children appears particularly promising for pre-verbal infants who cannot describe what has happened, and for all cases where detection depends upon observation rather than a first-person account.

In many developing country settings, community-based mechanisms are being established for monitoring violence in the home and the need for child protection. Most of these are in experimental stages, and structured evaluation is required before clear conclusions can be drawn. For example, in the Philippines, UNICEF has supported the establishment of 6,500 *barangay* (village) councils for the protection of children. The Councils set up a database and monitoring system on children, including those who are at risk or who are victims of exploitation and violence.[195] In the United Republic of Tanzania, an organisation called Kivulini whose primary target is to reduce physical, emotional and sexual violence in the home, works closely with leaders at the lowest structure of local Government – ward executive officers and street leaders. Street leaders are elected by community members, and have a right of access to people's homes.[196]

Treatment for victims of violence

Children who have experienced family violence have a wide range of treatment needs. Health workers need to be trained to detect cases of violence against a child, and the procedures to follow in documentation and reporting, as well as treatment and follow-up.[197] In some cases, the collection of forensic specimens may be required; whenever possible, this should be done at the same time as the physical examination. Trained professionals are needed for interpretation of injuries, forensic examinations and forensic interviewing of children. Victims of sexual violence should be given preventive prophylaxis for sexually transmitted infections, including HIV/AIDS, as appropriate. Health workers have a responsibility to prioritise the child's physical health and to refer the child for psychosocial support services and social welfare or child protection services. Cases of violence detected outside the health sector should be referred to a health worker for proper assessment and care.

All forms of family violence have significant impact on a child's emotional health and development; psycho-social support is therefore crucial. A supportive, non-offending caregiver is an important facilitator of a child's recovery. The most effective mental health interventions employ behavioural and cognitive techniques, and work with both the child and the family. Key skills for children include skills to identify, process and regulate emotion; anxiety management skills; skills to identify and alter inaccurate perceptions; and problem-solving skills. Trauma-specific cognitive behavioural

interventions appear to be particularly effective in reducing victims' anxiety, depression, sexual concerns and symptoms of PTSD.[198,199]

Reporting by professionals

When professionals such as nurses, doctors, social workers and teachers identify a suspected case of family violence against children, they may be required by law to report their suspicions to the authorities, or expected to do so irrespective of legal obligation. To be effective, reporting structures must always be matched with equally well-developed structures for protection, support and treatment for children and families. Countries with mandatory reporting laws should consider systems reforms that allow children and families access to confidential services where they can receive support on a voluntary basis.

Mandatory reporting can establish an adversarial relationship between families and child protection authorities, and may even deter families from seeking formal support. However, the reluctance of professionals and the general public in most parts of the world to report violence in the home suggests that without mandatory reporting laws applying at least to defined groups of professionals, large numbers of children in need of protection will never be identified and given the protection they need. Whatever approach is chosen, it should present itself as a help-oriented service offering public health and social support rather than as being primarily punitive. Some experts urge that children and their representatives should have access both to services which they know have an obligation to report violence and take action (usually social services, law enforcement), and also to services that are confidential and will not take action except with the agreement of the child unless the child is perceived as being at risk of death or serious injury.

Intervention in the best interests of the child

Once a child has been identified as being in danger of family violence, a coordinated response is needed to guarantee the protection of the child. Assessment of the child and the child's family requires input and participation from service providers in different sectors who have had contact with the child and/or family. To minimise the risk that a child will 'fall through the cracks' of a system, the various sectors with responsibilities for child protection must share information about individual cases of family violence against children, as already noted. But there must also be clear lines of responsibility for taking action, and accountability for failures in protection.

Some middle-income countries are experimenting with innovative ways of building protective environments for children in local communities. In Serbia, Mobile Outreach Teams for Child Protection were initially developed in four municipalities in 2001 with the cooperation of governmental social work centres and NGO mobile teams. In Montenegro, pilot Operational Multidisciplinary Teams were formed in 2003, with technical assistance from UNICEF, to provide teams of professionals who would identify cases involving violence and neglect and respond in a coordinated way. Various protocols were adopted on collaborative working, on communication with the media, and on interviewing child victims of

A MULTISECTORAL APPROACH TO COMPREHENSIVE SERVICE PROVISION: THE CHILD PROTECTION UNIT OF THE PHILIPPINES GENERAL HOSPITAL

The Child Protection Unit (CPU) of the Philippines General Hospital uses a multisectoral approach towards comprehensive medical and psychosocial services for maltreated children and their families. The aim is to prevent further maltreatment and to start the process of healing. In 2005, the CPU cared for 972 new cases of maltreated children, 81% of whom had been sexually abused.

From the first point of contact through a long follow-up, the CPU provides quality care using a multisectoral approach which coordinates the actions of the health, legal and social sectors through CPU's case management system. The CPU provides legal and police services, judicial hearings, medical services, guidance and support to the child and next of kin, as well as therapy or referral to other specialised medical services, when necessary. The CPU also provides other social services to very poor families, including grants for the child's school-related costs and interest-free loans for livelihood assistance. Parenting classes help parents manage their expectations of their children, help them to better understand their children's behaviour, and adjust their methods of discipline accordingly.

Each child has a CPU case manager to coordinate all services received by the child and the family, and to facilitate and monitor child safety placement, legal assistance and mental health care. Case managers work with the children and families for as long as is necessary.[200]

violence. The Ministry of Labour and Social Welfare has since adopted these protocols, and decided to establish teams in all Social Welfare Centres by 2009.[201]

Child protection service agencies may investigate and try to substantiate reports of suspected violence. If the reports are verified, then the staff of the child protection services choose the appropriate course of action. Such decisions are often difficult, since a balance has to be found between various potentially competing demands – such as the need to protect the child and the wish to keep a family intact. The least detrimental alternative to the child and the least intrusive alternative for the family should be employed, as long as the child's safety can be assured. Consideration must be given to the concerns and desires of the child in all decisions about interventions, taking into account the context of the child's developmental stage, emotional health, and

"I remember being a foster child on another reserve as a child. I had been strapped…never understood the reasons why or what I had done wrong, I do remember the fear and pain."

Youth leader, North America, 2005 [XI]

the healthy or unhealthy bonds between the child and other family members.

When alternative care is necessary

Removing a child from the family should be a last-resort intervention. Ideally, services should be available to support those parents who are failing to cope with the demands of parenting. Only when the child appears to be at immediate risk of significant harm, the parent is assessed as not responding to other interventions, or appears unable to change within the developmental time frame of the child, should long-term alternatives (i.e. long-term fostering or adoption) be considered.

A child who is separated from the family environment for his or her own best interest is entitled to special protection and assistance; furthermore, States are obliged to ensure some suitable form of alternative care for a child in these circumstances, giving due regard to maintaining continuity in a child's upbringing and to the child's ethnic, religious, cultural and linguistic background (CRC article 20). Alternative care can be provided both formally – through foster-care placement (*kafalah* care under Islamic law), and adoption – and informally, such as the placement of a child with the extended family. Three principles should guide decisions about alternative forms of care for children:[202]

- Family-based solutions are generally preferable to institutional placements
- Sustainable solutions aimed at permanency in the best interests of the child, but including regular review, should take precedence over temporary solutions
- National solutions are generally preferable to those involving another country (e.g. international adoption).

All forms of alternative care involve risk for the child, including risk of further violence, exploitation and other violations of the child's rights. It is therefore important that States register and regulate all forms of alternative care, with continuous monitoring of children's placement and treatment, and with the full participation of the child. (See also the chapter on violence against children in care and justice systems.)

ADVOCACY AND PUBLIC EDUCATION

Violence against children in the home and family receives little media and research attention worldwide compared to issues such as commercial sexual exploitation of children, or child labour. The media play a central role in shaping opinions and influencing social norms that can also affect behaviour. Violence against children in the home and family should be brought into the public sphere in every region; space must be created to discuss the issues and to find solutions. Without raising awareness, it will be difficult to achieve large-scale and lasting prevention, and behavioural change.

An important development of recent years, and one promoted by the Study process, has been the involvement of children themselves in research, and in advocacy based on such research. Children pointed out in Regional Consultations that they normally had no opportunity to articulate

"I think child abuse happens a lot more than we think it does. Kids get beaten at home and are afraid to tell anyone. It's hard to stop something that happens behind closed doors."

Child, 12, North America[XII]

their views and feelings about the violence they had experienced at home. In all regions, NGOs have begun to undertake participatory research into violence against children in the family, in which boys and girls are involved not only as respondents but as co-researchers. Besides giving children the opportunity to talk about the punitive behaviour of parents and other caregivers, such exercises challenge the silence surrounding family violence, and contribute to the understanding of the nature and dimensions of child abuse and its effects. These exercises are of primary importance in providing a basis for awareness-raising campaigns and workshops.[203,204]

At every Regional Consultation, adults and children alike expressed the urgent need for advocacy strategies to change cultural norms in order to end violence against children. Outcome documents from the consultations and thematic working groups emphasised that advocacy should target policy-makers, parents, and children, and that advocacy on the following themes would help prevent family violence against children:

- Children's rights, including their right to protection from all forms of violence
- Harmful consequences of corporal punishment and other forms of cruel or degrading punishment, and the need for parents to develop positive, non-violent relationships with their children and ways of child-rearing
- Breaking the culture of silence around sexual violence in the family
- Addressing traditional stigma and prejudicial beliefs concerning inability to reduce the vulnerability of disabled children to violence
- Harmful traditional practices
- Gender-based violence
- The role of men and boys in preventing violence
- The effects of HIV on the stigmatisation of children and their increased vulnerability to violence.

Children and adolescents have a very important part to play in advocacy on issues that concern them. (See the chapter on violence against children in the community.)

Eliminating harmful traditional practices

Efforts to eliminate harmful traditional practices have illustrated the importance of intervening at multiple levels – parents and families will find it hard to change their behaviour if the norms and behaviour in the wider community do not change. Bringing an end to FGM requires clear prohibition, education and awareness-raising within families and communities, and community mobilisation (see box). Triggering changes in community knowledge, beliefs, attitudes and practices is the key to success.[205] This requires an advocacy strategy in which religious and community leaders, health professionals and a variety of actors participate; persuading individual parents or mothers is not sufficient. Where social standing and eligibility for marriage are dependent on girls having undergone FGM, mothers are unlikely on an individual basis to refuse the operation for their daughters, however terrible the experience was in their own case. The decision needs to be made by a community as a collective, and that community needs to know

TOSTAN'S APPROACH

In November 2005, representatives of 70 villages in Senegal's northeastern region of Matam participated in a public declaration that they were ending the practice of FGM and forced child marriage. Matam is a very conservative region, where a few years ago these subjects could not even have been discussed. Thousands of villagers from up to 300 km away witnessed the ceremony. Dignitaries, officials and the media were also in attendance. Rural women, adolescents, chiefs, religious leaders and Government officials pledged their commitment. This declaration, the 19th of its kind in Senegal, is the final stage in a programme of public education and advocacy at village level.

This programme was undertaken by the Tostan Community Empowerment Programme, in a drive for the collective abandonment of FGM and early marriage throughout the country. Since 1997, 1,628 communities have committed themselves to abandoning these practices. The Tostan strategy consists of the formation of village committees, setting up classes on women's health and rights at village level, and social mobilisation by class members. At the end of the programme, a public declaration is made at a major ceremony. This is seen as a vital part of the process, since it marks collective social endorsement of change.

An evaluation by the Population Council in 2004 found that Tostan's programme significantly affected the knowledge and beliefs of the people who participated in the classes, and of those in their circles. For example, the proportion of girls aged 10 and under who had not been cut increased from 46% to 60% among intervention participant families, but remained unchanged at 48% in the comparison group. Approval of FGM and intent to cut girls decreased significantly, and the intention to cut among participating women fell from nearly 75% at baseline to less than 25%. Another encouraging finding was that knowledge about human rights increased significantly among study participants. The proportion of women who were aware of their rights to health, education, and a healthy environment increased from 11% to 94%, while knowledge among men increased from 41% to 92%.[208]

that other communities are similarly abandoning the custom (see box).

Child marriage requires similar efforts to change social and cultural norms. Up to now the number of advocacy initiatives to influence and reduce child marriages directly have been very few. The tendency has been to regard the custom as susceptible to the wider enrolment of girls in education, and to the legislative enforcement of marriage laws. However, more concerted attention to women's and girls' rights in marriage has led in new directions. Some programmes specifically directed at child marriage reduction are now underway, and targeted advocacy against the practice is beginning.[206] For example, a campaign against child marriage has recently been launched by civil society organisations in Yemen, on the basis of research undertaken by the University of Sana'a.[207]

Many other practices which cause violence and harm to children need the benefit of exposure and campaigning as part of the efforts to prevent them. These include the sale of children into sexual or other work; the stigmatisation of disabled children, children without families, or children orphaned by HIV/AIDS; child victims of sexual abuse; children accused of sorcery; children who have been dedicated by their parents to priests and shrines.

IMPROVING INFORMATION FOR POLICY DEVELOPMENT AND ACTION

Accurate and reliable data on the magnitude and consequences of family violence against children are essential to evidence-based advocacy, policy development, resource allocation and programme implementation. The lack of data has been a constant refrain throughout the Study, and nowhere has this been more acute than in the home and family context, particularly because of the already described inhibitions to reporting, but also because of the lack of investment in scientific research on the topic. On the one hand, no effective systems of response can be developed without proper data; on the other, the development of programmatic responses to children suffering violence cannot await the development of systematic data-gathering systems where country or State capacities in this context are limited or under-resourced.

Ongoing data collection and analysis of officially reported cases can be useful for identifying trends in service utilisation and, in some instances, prevalence. However, as these systems rely only on cases brought to the attention of the authorities, and given that children most often suffer family violence without telling anyone, surveillance systems based on official records will always underestimate the extent of the problem. Surveillance of officially reported cases must be supplemented by population-based surveys that document exposure to childhood violence and its lifelong consequences. Similary, true understanding of fatal violence against children can only be gained through comprehensive death registration, investigation and reporting systems (see box).

Small qualitative studies and studies using convenience sampling – of families referred to social services, for example – are important for documenting the problem of violence against children and how to manage it. However, to begin to understand fully the patterns of family

"It is time we moved beyond qualtiative explorations of violence against children. In South-East Asia, population-based surveys are needd urgently to shed light on the full extent of violence against children. We must invest in better research and systematic data collection on this issue."

Dr Samlee Plianbangchang, Regional Director for South-East Asia, WHO

violence against children, studies that survey a large subset of the general population and which are repeated over time are necessary.

Confidential interview studies with children, parents and other close carers can also contribute to understanding all forms of violence in the home and family. There must, of course, be ethical safeguards to ensure the necessary protection of the children involved. Retrospective studies, interviewing young adults about their childhood experiences, are also valuable, but disclose nothing about what is happening to children now, and may distort understanding of experiences in early childhood when some forms of violence are most common.

One of the important purposes of data collection, especially in countries and regions where home and family violence is denied or not publicly debated, is advocacy. Policy-makers need to be persuaded that violence against children is more prevalent than they believe or care to admit, and that responses are urgently needed. Efforts by NGOs and international support agencies to collect information and publish analyses of children facing violence are often the first step towards enabling a culturally or politically sensitive issue to emerge, become locally owned up to, and taken up.

CHILD FATALITY REVIEW TEAMS (CFRT)

Most children who die from violence are young. About 40% are infants and 80% are under six. The most common cause of death is head trauma, followed by blunt force trauma to the body. It is sometimes difficult to detect how a child has died when he or she is reported as having had 'a fall'.

The first Child Fatality Review Team (CFRT) was formed in Los Angeles in 1978, sponsored by the Los Angeles County Interagency Council on Child Abuse and Neglect (ICAN). Members included the coroner, police, social services, courts, health and public health workers. ICAN later became the National Center for Fatality Review (NCFR) and other teams followed, some adding teachers, mental health workers and occasionally community members. The team meets to discuss cases of young child death where medical evidence is inconclusive; thus different types of evidence come together, and a mystery can conceivably be solved.

By 2001, an estimated 1,000 teams existed in Australia, Canada, New Zealand and the USA. The Philippines recently added a hospital-based model that may better fit developing countries. An international working network has begun connecting ICAN with contacts and start-up programmes in China, Estonia, Iceland, the Islamic Republic of Iran, Japan, Jordan, Lebanon, the Netherlands and the UK.[209]

IMPROVING THE KNOWLEDGE BASE IN INDIA - THE NATIONAL STUDY ON CHILD ABUSE

India has taken a proactive approach to the issue of child protection. Initiated by the Department of Women and Child Development in 2005, the National Study on Child Abuse involved an enormous network around the country. One of the first major activities undertaken was a National Level Consultation on Child Abuse, held in New Delhi in April 2005, to discuss various issues related to project formulation, including defining the concept of child abuse and methodology for the project, developing instruments for data collection and identifying the various categories of respondents. This Consultation involved experts from all over India and from various disciplines to exchange views on the common theme of child abuse. The experts included academics, social workers, activists, NGO representatives, teachers, researchers, police, judiciary, representatives from funding agencies like UNICEF, Save the Children, USAID, US Agency, Plan International, Catholic Relief Services, SARI Equity, etc.

The sample size of 17,500 included children (n=12500), young adults (n=2500), and other stakeholders (n= 2500). The child respondents included children living on the streets, working children, children in schools, children in institutional care, and children in family groups not attending school. Part of the methodology involved focus group discussions with children in the context of children's workshops, through which all indicators of various forms of abuse were elicited, and confidentiality and ethical considerations taken into account.

From its inception, the project emerged as an advocacy and awareness opportunity, which was extremely useful from the standpoint of a country where child abuse was known to exist, and yet so little about the issue was discussed publicly. The participation of so many experts had a multiplier effect, in that it increased awareness and more open discussion about the previously neglected issue of child abuse ensued. Analysis of results are expected at the end of 2006.[210]

RECOMMENDATIONS

The following recommendations are guided by the human rights obligations of Governments under the CRC and other instruments, and are also based on evidence from research and existing practice. They recognise that, while the primary role in childrens' upbringing is accorded to the family, Governments have obligations to ensure that in all places – including in the home – children are protected from actions constituting violence against them, and that there is an effective response when violence occurs. In addition, Governments are required to provide appropriate support and assistance to parents.

"In the consultations all over the world, it was as if everyone had been waiting for permission to talk about this - waiting for violence against children not to be a secret any more."

Karin Landgren, Chief, Child Protection, UNICEF

3

Prioritise prevention

1. **Ensure that comprehensive systems to prevent violence and protect children are implemented at scale, in ways that respect the whole child and their family, their dignity and privacy, and the developmental needs of girls and boys.** Governments should ensure that response systems should be coordinated, aimed at prevention and early intervention, linked to integrated services that extend across sectors – legal, education, justice, social, health, employment and other necessary services. Respect for the views of the child in all matters and decisions which affect them should be assured. Governments have the obligation to develop evidence-based standards to facilitate effective and sensitive service delivery for children in all parts of the country.

Societal level

2. **Assess the impact of public policies on children and their families.** Governments should conduct social impact assessments which give particular attention to the potential impact of public policies on violence against children – especially discrimination, social and economic stress, and other risk factors relevant to family violence against children. The results should be used to prioritise economic and social safety nets which directly benefit families.

3. **Increase economic and social safety nets for families.** These should include family support centres which can provide assistance, including that provided in emergency situations; and they should help to develop supportive networks through providing quality child care facilities and pre-school enrichment programmes; and through respite programmes for families facing especially difficult circumstances; and also by giving attention to underlying factors such as education, housing, employment, and social policies and opportunities.

4. **Implement evidence-based advocacy programmes on violence prevention.** At the society and community level, Governments should support strategies that aim to raise awareness of child rights, and promote change in social and cultural norms, gender equity/equality, and non-discrimination. Such programmes should target Government sector workers, including police and justice system staff, educators, health workers, and the private sector, as well as parents and the general public. Governments have the obligation to initiate and support awareness campaigns that promote non-violent relationships and communication with children, as well as the positive involvement of men and boys in family life.

Legal measures

5. **Develop an explicit framework of law and policy in which all forms of violence against children within the family are prohibited and rejected.** Governments have the obligation to prohibit and eliminate all forms of violence against children in the home as well as in other settings. This includes all harmful tradi-

tional practices, sexual violence, and all corporal punishment, in accordance with the CRC and other human rights instruments (see the Committee's General Comment on corporal punishment, No. 8, June 2006). Clear guidance and training should ensure that the law is implemented sensitively, in line with the best interests of the child. Legal reform should be linked with advocacy and awareness-raising activities to promote positive, non-violent relationships with children.

6. **Ensure that family courts and other parts of the justice system are sensitive to the needs of children and their families.** Governments should ensure that child victims of family violence are not re-victimised during the justice process, nor subjected to extended or drawn-out legal processes. Child victims should be treated in a caring and sensitive manner throughout the justice process, taking into account their personal situation and immediate needs, age, gender, disability and level of maturity, and fully respecting their physical, mental and moral integrity.

   In particular, Governments should ensure that investigations, law enforcement, prosecution and judicial processes take into account the special needs of the child, bearing in mind the Guidelines on Justice for Child Victims and Witnesses of Crime (ECOSOC Resolution 2005/20). In this regard, the child should be accompanied by a trusted adult throughout his or her involvement in the justice process, if it is in his or her best interests; the child's identity and privacy should be protected; confidentiality should be respected; and the child should not be subjected to excessive interviews, statements, hearings and unnecessary contact with the judicial process.

   Consideration should be given to the use of pre-recorded video and other testimonial aids, such as the use of screens or closed circuit televisions, as well as to eliminating unnecessary contacts with the alleged perpetrator, or their defence. In particular, if compatible with the legal system and with due respect for the rights of the defence, professionals should ensure that the child victim of violence is protected from being unnecessarily cross-examined, that the general public and the media are excluded from the courtroom during the child's testimony, and that guardians *ad litem* are available to protect the child's legal interests. Speedy trials should also be ensured, unless delays are in the child's best interests.

Strengthen coordinated responses

7. **Provide pre-natal and post-natal care, and home visitation programmes for optimising early childhood development.** These measures should be aimed at building on the strengths of the family and the community to promote healthy child development, and the early detection and support of families with problems. Governments should ensure that such programmes include information on the importance of attachment and the physical, emotional, and cognitive development

of infants and young children as well as attention to cultural factors.

8. **Implement culturally-appropriate and gender-sensitive parenting programmes and programmes that support families to provide a violence-free home.** Governments should ensure that important components are included in these programmes such as: the importance of attachment bonds between parents and their children, and increasing understanding of the physical, psychological, sexual, and cognitive development of infants, children and young people in the context of social and cultural factors; expanding child-rearing and parenting skills for fathers and mothers, including promoting non-violent relationships and non-violent forms of discipline, problem-solving skills, and the management of family conflicts; addressing gender stereotypes, and emphasising the involvement of men and boys in family life. Governments must develop such programmes in compliance with human rights norms, and also with reference to scientific evidence regarding the effectiveness thereof.

9. **Protect especially vulnerable children in the family, and address gender issues.** Governments should ensure a focus in all research, prevention, and response initiatives dealing with the family, on the situation and risks of children who are especially vulnerable to violence; for example, children with disabilities, refugee and other displaced children, children from minority groups, children without parental care, and children affected by HIV/AIDS. Special efforts are required to understand and respond to the differing risks which may be faced by girls and boys, and to pay attention to the concept of masculinity and gender stereotypes on violence experienced by girls and boys.

Build capacity

10. **Build capacity among those who work with children and their families.** Governments should ensure that professionals and non-professionals who work with and around children and their families receive adequate training and ongoing capacity building which includes basic information on children's rights and the law, violence against children, its prevention, early detection and response, non-violent conflict management, and children's rights. In addition, workers must have a clear understanding of the physical, sexual, emotional and cognitive development of children and young people, and the links between gender and violence. Specific skills in communicating with and involving children in the decisions affecting them should also be promoted.

Build information systems

11. **Implement civil registration universally, including the registration of births, deaths, and marriages.** Governments should ensure free and accessible civil registration with free certification, and should remove penalties for late registration. The process must be advocated widely, and facilitated and implemented in coopera-

tion with local government, hospitals, professional and traditional birth attendants, police, religious and community leaders, and other partners in order to ensure universal uptake.

12. **Develop a national research agenda on family violence against children.** Governments should put in place a set of national priorities for research that can supplement information systems with in-depth qualitative and quantitative research. Guided by international indicators and standards, Governments and their partners should strengthen information systems through improved surveillance of reported cases of family violence against children, and also through population-based research which includes estimates of the prevalence of childhood victimisation. Risk and protective factors related to violence can also be assessed by retrospective studies of childhood, and by interviewing young adults.

    Data should be disaggregated to make visible the scale and scope of the experiences of girls and boys of different ages that are related to violence and overcoming it, their situations, and their risk and protective factors. Such efforts should include confidential interviews with the children themselves, with special attention given to vulnerable groups and their families, as well as to parents and other caregivers and adults, and appropriate ethical safeguards should be put in place. The information gathered should be shared widely to inform public policy and related action.

REFERENCES

1 UNICEF (2003). A League Table of Child Maltreatment Deaths in Rich Nations. *Innocenti Report Card*, No. 5. Florence, UNICEF Innocenti Research Centre.

2 Yoder PS et al. (2004). *Female Genital Cutting in the Demographic Health Surveys: A Critical and Comparative Analysis*. Calvertion, ORC Macro.

3 UNICEF (2003). *Female Genital Cutting in Somalia: Reasons for Continuation and Recommendations for Eradication*. UNICEF Somalia. Cited in: UNICEF Somalia (2003). *From Perception to Reality: A Study on Child Protection in Somalia*, Ch. 3. UNICEF Somalia.

4 Committee on the Rights of the Child (2006). *General Comment No. 8. The Right of the Child to Protection from Corporal Punishment and Other Cruel or Degrading Forms of Punishment* (articles 19, 28(2) and 37, inter alia), CRC/C/GC/8.

5 UN Habitat (2006). *State of the World's Cities Report 2006/7.* Nairobi, UN Habitat. Available at: http://www.unhabitat.org/mediacentre/ documents/sowcr2006/SOWCR%201.pdf.

6 UN Habitat (2006). *State of the World's Cities Report 2006/7.* Nairobi, UN Habitat. Available at: http://www.unhabitat.org/mediacentre/ documents/sowcr2006/SOWCR%201.pdf.

7 Krug EG et al. (Eds) (2002). *World Report on Violence and Health*. Geneva, World Health Organization.

8 Molyneux M (2004). *Poverty Relief Programmes and the 'New Social Policy in Latin America': Women and Community Carework*. UNRISD Project on Gender and Social Policy, Mimeo, Geneva, UNRISD. Cited in: UNRISD (2005). *Gender Equality: Striving for Justice in an Unequal World*. United Nations Research Institute for Social Development.

9 UNRISD (2005). *Gender Equality: Striving for Justice in an Unequal World.* United Nations Research Institute for Social Development.

10 Asis MMB et al. (2004). When the Light of the Home is Abroad: Female Migration and the Filipino Family. *Singapore Journal of Tropical Geography*, 25(2): 198–215.

11 National Research Council (1993). *Understanding Child Abuse and Neglect.* Washington DC, National Academy of Sciences Press.

12 Straus MA et al. (1998). Identification of Child Maltreatment with the Parent–Child Conflict Tactics Scales: Development and Psychometric Data for a National Sample of American Parents. *Child Abuse & Neglect*, 22: 249–270.

13 Zununegui MV et al. (1997). Child Abuse: Socio-economic Factors and Health Status. *Anales Españoles de Pediatria*, 47: 33–41.

14 Kelly MJ (2005). *The Power of Early Childhood as a Healing Force in the AIDS Crisis*. Paper for Presentation to the World Forum on Early Care and Education, Montreal, 19 May 2005.

15 UNICEF (2003). *Africa's Orphaned Generations*. New York, UNICEF..

16 United Nations (2000). *The World's Women: Trends and Statistics*. New York, United Nations.

17 Boudreaux MC, Lord WD (2005). Combating Child Homicide: Preventive Policing for the New Millennium. *Journal of Interpersonal Violence*, 20(4): 380–387.

18 Finkelhor D, Berliner L (1995). Research on the Treatment of Sexually Abused Children: A Review and Recommendations. *Journal of the Academy of Child Adolescent Psychiatry*, 34: 1408–1423.

19 Boudreaux MC, Lord WD (2005). Combating Child Homicide: Preventive Policing for the New Millennium. *Journal of Interpersonal Violence*, 20(4): 380–387.

20 UNICEF (2003). *Innocenti Report Card No. 5: A League Table of Child Maltreatment Deaths in Rich Nations*. UNICEF Innocenti Research Centre, Florence.

21 Dean PJ (2004). Child Homicide and Infanticide in New Zealand. *Int J Law Psychiatry*, 27(4): 339–348; Romain N et al. (2003). Childhood Homicide: A 1990–2000 Retrospective Study at the Institute of Legal Medicine in Lausanne, Switzerland. *Medicine, Science and the Law*, 43(3): 203–206; Collins KA, Nichols CA (1999). A Decade of Pediatric Homicide: A Retrospective Study at the Medical University of South Carolina. *American Journal of Forensic Medicine and Pathology*, 20(2): 169–172.

22 WHO (2006). *Global Estimates of Health Consequences Due to Violence against Children*. Background Paper to the UN Secretary-General's Study on Violence against Children. Geneva, World Health Organization.

23 Runyan D et al. (2002). Child Abuse and Neglect by Parents and Other Caregivers. In: Krug EG et al. (Eds). *World Report on Violence and Health*. Geneva, World Health Organization, pp 59–86.

24 Collins KA, Nichols CA (1999). A Decade of Pediatric Homicide: A Retrospective Study at the Medical University of South Carolina. *American Journal of Forensic Medicine and Pathology*, 20(2): 169–172.

25 Lyman JM et al. (2003). Epidemiology of Child Homicide in Jefferson County, Alabama. *Child Abuse & Neglect*, 27(9): 1063–1073.

26 Romain NK et al. (2003). Childhood Homicide: A 1990–2000 Retrospective Study at the Institute of Legal Medicine in Lausanne, Switzerland. *Medicine, Science and the Law*, 43(3): 203–206.

27 Moskowitz HD et al. (2005). Relationships of US Youth Homicide Victims and Their Offenders, 1976–1999. *Archives of Pediatrics & Adolescent Medicine*, 159(4): 356–361.

28 Dean PJ (2004). Child Homicide and Infanticide in New Zealand. *International Journal of Law and Psychiatry*, 27(4): 339–348.

29 Moskowitz HD et al. (2005). Relationships of US Youth Homicide Victims and Their Offenders, 1976–1999. *Archives of Pediatrics and Adolescent Medicine*, 159(4): 356–361.

30 George S (1995). Female Infanticide in Tamil-Nadu, India: From Recognition Back to Denial? *Reproductive Health Matters*, 10: 124–132. Cited in: Naved RT (2003). A Situation Analysis of Violence against Women in South Asia. In: *Violence against Women in South Asia: A Regional Analysis*. Bangkok, Asian Forum of Parliamentarians on Population and Development/Kathmandu, UNFPA.

31 Stephenson R et al. (2006). Child Maltreatment among School Children in Kurdistan Province, Iran. *Child Abuse & Neglect*, 30: 231–245.

32 Hahm HC, Guterman NB (2001). The Emerging Problem of Physical Child Abuse in South Korea. *Child Maltreatment*, 6(2): 169–179.

33 May-Chalal C, Cawson P (2005). Measuring Child Maltreatment in the United Kingdom: A Study of the Prevalence of Child Abuse and Neglect. *Child Abuse & Neglect*, 29: 969–984.

34 Committee on the Rights of the Child (2006). *General Comment No. 8. The Right of the Child to Protection from Corporal Punishment and Other Cruel or Degrading Forms of Punishment* (articles 19, 28(2) and 37, inter alia), CRC/C/GC/8, para 11.

35 Committee on the Rights of the Child (2006). *General Comment No. 8. The Right of the Child to Protection from Corporal Punishment and Other Cruel or Degrading Forms of Punishment* (articles 19, 28(2) and 37, inter alia), CRC/C/GC/8.

36 Durrant JE (2003). Maternal Beliefs about physical punishment in Sweden and Canada. *Journal of Comparative Family Studies*, 34:586-604. Cited in: Durrant JE (2005). Corporal Punishment: Prevalence, Predictors and Implications for Child Behaviour and Development. In: Hart SN (Ed) (2005). *Eliminating Corporal Punishment.* Paris, UNESCO.

37 Lehman BA (1989). Making a Case against Spanking. *The Washington Post*, 23 March 1989. Cited in: Straus MA, Mathur AK (1996). *Social Change and Trends in Approval of Corporal Punishment by Parents from 1968 to 1994*. In: Frehsee D et al. (Eds). *Violence against Children*. Berlin and New York, Walter de Gruyter, pp 91–105.

38 Durrant JE (2005). Corporal Punishment: Prevalence, Predictors and Implications for Child Behaviour and Development. In: Hart SN (Ed) (2005). *Eliminating Corporal Punishment.* Paris, UNESCO.

39 Kim D-H (2000). Children's Experience of Violence in China and Korea: A Transcultural Study. *Child Abuse & Neglect*, 18: 155–166. Cited in: Durrant JE (2005). Corporal Punishment: Prevalence, Predictors and Implications for Child Behaviour and Development. In: Hart SN (Ed) (2005). *Eliminating Corporal Punishment.* Paris, UNESCO.

40 Habasch R (2005). Physical and Humiliating Punishment of Children in Yemen. Save the Children Sweden. Cited in: International Save the Children Alliance (2005). *Ending Physical and Humiliating Punishment of Children. Making It Happen*, Part 2. Global Submission to the UN Secretary-General's Study on Violence against Children. Stockholm, Save the Children Sweden.

41 International Save the Children Alliance (2005). *Ending Physical and Humiliating Punishment of Children. Making It Happen*, Part 2. Global Submission to the UN Secretary-General's Study on Violence against Children. Stockholm, Save the Children Sweden.

42 UNICEF (2001). *Young Voices Opinion Survey of Children and Young People in Europe and Central Asia*. Geneva, UNICEF.

43 Dong M et al. (2004). The Interrelatedness of Multiple Forms of Childhood Abuse, Neglect, and Household Dysfunction. *Child Abuse & Neglect*, 28(7): 771–784.

44 Government of India (2005). *India Country Report on Violence against Children*. New Delhi, Department of Women and Child Development, Ministry of Human Resource Development, Government of India.

45 Klasen S, Wink C (2003). Missing Women: Revisiting the Debate. *Feminist Economics*, 9(2–3): 263–299.

46 Helander E (1999). *Prejudice and Dignity: An Introduction to Community-based Rehabilitation*, 2nd Edition. New York, United Nations Development Programme. Cited in: United Nations Secretary-General's Study on Violence against Children (2005). *Summary Report of the Thematic Meeting on Violence against Children with Disabilities.* 28 July 2005, New York.

47 UNICEF (2002). *UNICEF 2002 China Annual Report.* UNICEF China.

48 WHO (2006). *Global Estimates of Health Consequences Due to Violence against Children*. Background Paper to the UN Secretary-General's Study on Violence against Children. Geneva, World Health Organization.

49 Finkelhor D (1994). The International Epidemiology of Child Sexual Abuse. *Child Abuse & Neglect*, 18(5): 409–417.

50 United Nations Secretary-General's Study on Violence against Children (2005). *Regional Desk Review: South Asia*. Available at: www.violencestudy.org/r27.

51 Haj-Yahi MM, Tamish S (2001). The Rates of Child Sexual Abuse and Its Psychological Consequences as Revealed by a Study among Palestinian University Students. *Child Abuse & Neglect*, 25(10): 1303–1327.

52 Finkelhor D (1994). The International Epidemiology of Child Sexual Abuse. *Child Abuse & Neglect*, 18(5): 409–417.

53 Andrews G et al. (2004). Child Sexual Abuse. In: Ezzati M et al. (2004). *Comparative Quantification of Health Risks: Global and Regional Burden of Disease Attributable to Selected Major Risk Factors*, Vol. 2. Geneva, World Health Organization, pp 1851–1940.

54 WHO (2005). *WHO Multi-country Study on Women's Health and Domestic Violence against Women*. Geneva, World Health Organization.

55 Jewkes R et al. (2002). Rape of Girls in South Africa. *Lancet*, 359(9303): 319–320.

56 Browne KD et al. (2002). *Child Abuse and Neglect in Romanian Families: A National Prevalence Study*. Denmark, World Health Organization Regional Office for Europe.

57 Haj-Yahi MM, Tamish S (2001). The Rates of Child Sexual Abuse and Its Psychological Consequences as Revealed by a Study among Palestinian University Students. *Child Abuse & Neglect*, 25(10): 1303–1327.

58 Tang CS (2002). Childhood Experience of Sexual Abuse among Hong Kong Chinese College Students. *Child Abuse & Neglect*, 26(1): 23–37.

59 Queen Sofia Centre for the Study of Violence (2003). *Child Abuse in Spain 1997/1998: A Statistical Report Based on Field Research*. Valencia, Queen Sofia Centre.

60 UNICEF (2003). *From Perception to Reality: A Study on Child Protection in Somalia.* UNICEF Somalia, Ch. 3.

61 Naved RT (2003). A Situation Analysis of Violence against Women in South Asia. In: AFPPD/UNFPA (2003). *Violence against Women in South Asia: A Regional Analysis*. AFPPD/UNFPA.

62 AFPPD/UNFPA (2003). *Violence against Women in South Asia: A Regional Analysis*. AFPPD/UNFPA. Cited in: United Nations Secretary-General's Study on Violence against Children (2005) *Regional Desk Review: South Asia*. Available at: www.violencestudy.org/r27.

63 Irinnews (2002). *Special Report on Elections, 3 October 2002*. Cited in: Home Office (2004). Pakistan Country Report. United Kingdom, Country Information & Policy Unit, Immigration & Nationality Directorate Home Office.

64 Wainwright M (2006). Honour Murders Leave Thousands of Women Living in Fear. *The Guardian*, 21 July 2006.

65 Wainwright M (2006). Honour Murders Leave Thousands of Women Living in Fear. *The Guardian*, 21 July 2006.

66 Bangladesh Human Rights Commission (2001). *Acid and Trauma Victims.* Available at: http://www.bhrcbd.org/victims.htm.

67 Farouk S (2005). *Violence against Women: A Statistical Overview, Challenges and Gaps in Data Collection and Methodology and Approaches for Overcoming Them.* Expert Paper prepared for Expert Group Meeting of the UN Division for the Advancement of Women. 11–14 April, 2005, Geneva.

68 UNICEF (2001). Early Marriage, Child Spouses. *Innocenti Digest*, No. 7. Florence, UNICEF Innocenti Research Centre.

69 Outtara M et al. (1998). Forced Marriage, Forced Sex: The Perils of Childhood for Girls. *Gender and Development*, 6(3). Cited in: UNICEF (2001). Early Marriage, Child Spouses. *Innocenti Digest*, No. 7. Florence, UNICEF Innocenti Research Centre.

70 UNICEF (2001). Early Marriage, Child Spouses. *Innocenti Digest*, No. 7. Florence, UNICEF Innocenti Research Centre.

71 Forum on Marriage and the Rights of Women and Girls (2003). *Early Marriage and Poverty: Exploring the Links for Policy and Programme Development.* London, Forum on Marriage and the Rights of Women and Girls/IPPF.

72 UNICEF (2001). Early Marriage, Child Spouses. *Innocenti Digest*, No. 7. Florence, UNICEF Innocenti Research Centre.

73 Erulkar A et al. (2004). *The Experience of Adolescence in Rural Amhara Region of Ethiopia.* Accra, The Population Council.

74 Kishor S, Johnson K (2004). *Profiling Domestic Violence: A Multi-Country Study.* Calverton, ORC Macro.

75 Marcus R (1993). *Violence against Women in Bangladesh, Pakistan, Egypt, Sudan, Senegal and Yemen*. Report prepared for Special Programme WID, Netherlands Ministry of Foreign Affairs (DGIS). Brighton, Institute of Development Studies.

76 Minnesota Advocates for Human Rights (1998). *Domestic Violence in Nepal*. Minnesota Advocates for Human Rights, MN.

77 Marcus R (1993). *Violence against Women in Bangladesh, Pakistan, Egypt, Sudan, Senegal and Yemen*. Report prepared for Special Programme WID, Netherlands Ministry of Foreign Affairs (DGIS). Brighton, Institute of Development Studies.

78 Fernandez F (1997). Domestic Violence by Extended Family Members in India. Interplay of Gender and Generation. *Journal of Interpersonal Violence*, 12(3): 433–455.

79 Panda KP (2004). *Domestic Violence against Women in Kerala*, Discussion Paper No. 86. Thiruvananthapuram, Kerala Research Programme on Local Level Development, Centre for Development Studies.

80 Naved RT (2003). A Situation Analysis of Violence against Women in South Asia. In: *Violence against Women in South Asia: A Regional Analysis*. Bangkok, Asian Forum of Parliamentarians on Population and Development/Kathmandu, UNFPA.

81 NCTPE (1998). *Baseline Survey on Harmful Traditional Practices in Ethiopia*. Addis Ababa, National Committee on Harmful Traditional Practices.

82 WHO (2000). *Female Genital Mutilation*, Factsheet No 241. Geneva, World Health Organization.

83 UNICEF (2005). Changing a Harmful Social Convention: Female Genital Mutilation/Cutting. *Innocenti Digest*, No. 12. Florence, UNICEF Innocenti Research Centre.

84 UNICEF (2003). *Female Genital Cutting in Somalia: Reasons for Continuation and Recommendations for Eradication*. UNICEF Somalia. Cited in: UNICEF Somalia (2003). *From Perception to Reality: A Study on Child Protection in Somalia.* UNICEF Somalia, Ch. 3.

85 UNICEF Somalia (2003). *From Perception to Reality: A Study on Child Protection in Somalia.* UNICEF Somalia, Ch. 3.

86 UNICEF (2005). Changing a Harmful Social Convention: Female Genital Mutilation/Cutting. *Innocenti Digest*, No. 12. Florence, UNICEF Innocenti Research Centre.

87 UNICEF (2005). Changing a Harmful Social Convention: Female Genital Mutilation/Cutting. *Innocenti Digest*, No. 12. Florence, UNICEF Innocenti Research Centre.

88 Stanley YP et al. (2004). *Female Genital Cutting in the Demographic and Health Surveys: A Critical and Comparative Analysis.* DHS Comparative Reports, No. 7. Calverton, ORC Macro. Cited in: United Nations Secretary-General's Study on Violence against Children (2005). *Regional Desk Review: West and Central Africa.* Available at: http://www.violencestudy.org/r27.

89 Dube SR et al. (2002). Exposure to Abuse, Neglect, and Household Dysfunction among Adults Who Witnessed Intimate Partner Violence as Children: Implications for Health and Social Services. *Violence and Victims*, 17(1): 3–17.

90 International Save the Children Alliance (2005). *Ending Physical and Humiliating Punishment of Children. Making It Happen*, Part 1. Global Submission to the UN Secretary-General's Study on Violence against Children. Stockholm, Save the Children Sweden.

91 Runyan D et al. (2002). Child Abuse and Neglect by Parents and Other Caregivers. In: Krug EG et al. (Eds). *World Report on Violence and Health*. Geneva, World Health Organization, pp 59–86.

92 International Save the Children Alliance (2005). *Ending Physical and Humiliating Punishment of Children. Making It Happen*, Part 2. Global Submission to the UN Secretary-General's Study on Violence against Children. Stockholm, Save the Children Sweden.

93 Crockenburg S (1987). Predictors and Correlates of Anger towards and Punitive Control of Toddlers by Adolescent Mothers. *Child Development*, 58: 964–975. Cited in: Durrant JE (2005). Corporal Punishment: Prevalence, Predictors and Implications for Child Behaviour and Development. In: Hart SN (Ed) (2005). *Eliminating Corporal Punishment.* Paris, UNESCO.

94 Perry BD (2001). The Neurodevelopmental Impact of Violence in Childhood. In: Schetky D, Benedek EP (Eds). *Textbook of Child and Adolescent Forensic Psychiatry*. Washington DC, American Psychiatric Press, pp 221–238.

95 Evans E et al. (2005). Suicidal Phenomena and Abuse in Adolescents: A Review of Epidemiological Studies. *Child Abuse & Neglect*, 29(1): 45–58.

96 Thompson R et al. (2005). Suicidal Ideation among 8-Year-olds Who Are Maltreated and At Risk: Findings from the LONGSCAN Studies. *Child Maltreatment*, 10(1): 26–36.

97 Hamilton CE, Browne KD (1998). The Repeat Victimization of Children. *Aggression and Violent Behavior*, 3: 47–60.

98 Analysis provided to the Study by the WHO Multi-country Study on Women's Health and Domestic Violence against Women (2006). Geneva, World Health Organization.

99 Felitti VJ et al. (1998). The Relationship of Adult Health Status to Childhood Abuse and Household Dysfunction. *American Journal of Preventive Medicine*, 14: 245–258.

100 Dube SR et al. (2005). Long-term Consequences of Childhood Sexual Abuse by Gender of Victim. *American Journal of Preventive Medicine*, 28(5): 430–438.

101 Dong MRF et al. (2004). The Interrelatedness of Multiple Forms of Childhood Abuse, Neglect, and Household Dysfunction. *Child Abuse & Neglect*, 28(7): 771–784.

102 Turner HA et al. (2006). The Effect of Lifetime Victimisation on the Mental Health of Children and Adolescents. *Social Science and Medicine*, 62(1): 13–27.

103 Andrews G et al. (2004). Child Sexual Abuse. In: Ezzati M et al. (2004). *Comparative Quantification of Health Risks: Global and Regional Burden of Disease Attributable to Selected Major Risk Factors*, Vol. 2. Geneva, World Health Organization, pp 1851–1940.

104 Turner HA, Finkelhor D (1996). Corporal Punishment as a Stressor Among Youth. *Journal of Marriage and the Family*, 58: 155–166. Cited in: Durrant JE (2005). Corporal Punishment: Prevalence, Predictors and Implications for Child Behaviour and Development. In: Hart SN (Ed) (2005). *Eliminating Corporal Punishment.* Paris, UNESCO.

105 Thompson R et al. (2005). Suicidal Ideation among 8-Year-olds Who Are Maltreated and At Risk: Findings from the LONGSCAN Studies. *Child Maltreatment*, 10(1): 26–36.

106 Evans E et al. (2005). Suicidal Phenomena and Abuse in Adolescents: A Review of Epidemiological Studies. *Child Abuse & Neglect*, 29(1): 45–58.

107 Csorba J et al. (2001). Family and School-related Stresses in Depressed Hungarian Children. *European Psychiatry*, 16: 18–26.

108 Lau JTF et al (1999). Prevalence and Correlates of Physical Abuse in Hong Kong Chinese Adolescents: A Population-based Approach. *Child Abuse & Neglect*, 23: 549–57. Cited in: Durrant JE (2005). Corporal Punishment: Prevalence, Predictors and Implications for Child Behaviour and Development. In: Hart SN (Ed) (2005). *Eliminating Corporal Punishment.* Paris, UNESCO.

109 MacMillan HL et al. (1999). Slapping and Spanking in Childhood and Its Association with Lifetime Prevalence of Psychiatric Disorders in a General Population Sample. *Canadian Medical Association Journal*, 16: 805–809. Cited in: Durrant JE (2005). Corporal Punishment: Prevalence, Predictors and Implications for Child Behaviour and Development. In: Hart SN (Ed) (2005). *Eliminating Corporal Punishment.* Paris, UNESCO.

110 Classen CC et al. (2005). Sexual Revictimisation: A Review of the Empirical Literature. *Trauma Violence and Abuse*, 6(2): 103–129.

111 Fryer G, Miyoshi T (1994). A Survival Analysis of the Revictimization of Children: The Case of Colorado. *Child Abuse & Neglect*, 18(12): 1063–1071.

112 Creighton SJ (1992). *Child Abuse Trends in England and Wales 1988–1990: And an Overview from 1973–1990*. London, NSPCC.

113 Hamilton CE, Browne KD (1999). Recurrent Maltreatment During Childhood: A Survey of Referrals to Police Child Protection Units in England. *Child Maltreatment*, 4(4): 275–286.

114 Bradshaw J, Mayhew E (Eds). *The Well-being of Children in the UK*, 2nd Edition. London, The University of York/Save the Children UK.

115 Baldry A (2003). Bullying in Schools and Exposure to Domestic Violence. *Child Abuse & Neglect*, 27(7): 713–732.

116 International Save the Children Alliance (2005). *10 Essential Learning Points: Listen and Speak Out against Sexual Abuse of Girls and Boys.* Global Submission to the UN Secretary-General's Study on Violence against Children. Oslo, Save the Children.

117 Ertem IO et al. (2000). Intergenerational Continuity of Child Physical Abuse: How Good is the Evidence? *Lancet*, 356 (9232): 814–819.

118 Johnson H et al. (forthcoming). *Violence against Women: An International Perspective*. New York, Springer.

119 Williams LM (2003). Understanding Child Abuse and Violence against Women: A Life Course Perspective. *Journal of Interpersonal Violence*, 18(4): 441–451.

120 UNICEF (2005). Changing a Harmful Social Convention: Female Genital Mutilation/Cutting. *Innocenti Digest*, No. 12. Florence, UNICEF Innocenti Research Centre.

121 Stanley YP et al. (2004). *Female Genital Cutting in the Demographic and Health Surveys: A Critical and Comparative Analysis*. DHS Comparative Reports, No. 7. Calverton, ORC Macro. Cited in: UNICEF (2005). Changing a Harmful Social Convention: Female Genital Mutilation/Cutting. *Innocenti Digest*, No. 12. Florence, UNICEF Innocenti Research Centre.

122 Waters H et al. (2004). *The Economic Dimensions of Interpersonal Violence*. Geneva, World Health Organization.

123 Fromm S (2001). *Total Estimates of Cost of Child Abuse and Neglect in the United States – Statistical Evidence*. Chicago, Prevent Child Abuse America.

124 National Commission of Inquiry into the Prevention of Child Abuse (1996). *Childhood Matters: The Report of the National Commission of Inquiry into the Prevention of Child Abuse*, Vol. 1. London, Her Majesty's Stationery Office. Cited in: Runyan D et al. (2002). Child Abuse and Neglect by Parents and Other Caregivers. In: Krug EG et al. (Eds). *World Report on Violence and Health*. Geneva, World Health Organization, pp 59–86.

125 United Nations Secretary-General's Study on Violence against Children (2005). *Summary Report of the Thematic Meeting on Violence against Children with Disabilities*, 28 July 2005, New York. Available at: http://www.violencestudy.org/r180.

126 American Academy of Pediatrics (2001). Assessment of Maltreatment of Children with Disabilities. *Pediatrics*, 108(2): 508–552.

127 United Nations Secretary-General's Study on Violence against Children (2005). *Regional Desk Review: the Caribbean*. Available at: http://www.violencestudy.org/r27.

128 United Nations Secretary-General's Study on Violence against Children (2005). *Regional Desk Review: West and Central Africa*. Available at: http://www.violencestudy.org/r27.

129 Wolfe DA (1999). *Child Abuse: Implications for Child Development and Psychopathology*, 2nd Edition. Thousand Oaks, Sage.

130 Leventhal JM (1996). Twenty Years Later: We Do Know How to Prevent Child Abuse and Neglect. *Child Abuse & Neglect*, 20: 647–653.

131 National Research Council (1993). *Understanding Child Abuse and Neglect*. Washington DC, National Academy of Sciences Press.

132 Sariola H, Uutela A (1992). The Prevalence and Context of Family Violence against Children in Finland. *Child Abuse & Neglect*, 16: 823–832.

133 Zununegui MV et al. (1997). Child Abuse: Socioeconomic Factors and Health Status. *Anales Españoles de Pediatria*, 47: 33–41.

134 Turner HA et al. (2006). The Effect of Lifetime Victimisation on the Mental Health of Children and Adolescents. *Social Science & Medicine*, 62(1): 13–27.

135 Runyan D et al. (2002). Child Abuse and Neglect by Parents and Other Caregivers. In: Krug EG et al. (Eds). *World Report on Violence and Health*. Geneva, World Health Organization, pp 59–86.

136 United Nations Secretary-General's Study on Violence against Children (2005). *Regional Desk Review: South Asia*. Available at: http://www.violencestudy.org/r27.

137 Sidebotham P, Golding J (2001). Child Maltreatment in the 'Children of the Nineties': A Longitudinal Study of Parental Risk Factors. *Child Abuse & Neglect*, 25: 1177–1200.

138 Klevens J et al. (2000). Risk Factors and the Context of Men Who Physically Abuse in Bogota, Colombia. *Child Abuse & Neglect*, 24: 323–332.

139 Ertem IO et al. (2000). Intergenerational Continuity of Child Physical Abuse: How Good Is the Evidence? *Lancet*, 356 (9232): 814–819.

140 World Vision (2005). *Violence against Children Affected by HIV/AIDS: A Case Study of Uganda*. A contribution to the UN Secretary-General's Study on Violence against Children. Nairobi, World Vision International–Africa Office.

141 Human Rights Watch (2002). *Suffering in Silence: The Links Between Human Rights Abuses and HIV Transmission to Girls in Zambia*. New York, Human Rights Watch.

142 The Body Shop/UNICEF (2006). *Behind Closed Doors. The Impact of Domestic Violence on Children*. London, The Body Shop International Plc.

143 Edleson JL (1996). Children's Witnessing of Domestic Violence. *Journal of Interpersonal Violence*, 14 (8): 839–870.

144 McClosky LA et al. (1995). The Effect of Systematic Family Violence on Children's Mental Health. *Child Development*, 66: 1239–1261. Cited in: Krug EG et al. (Eds) (2002). *World Report on Violence and Health*. Geneva, World Health Organization.

145 Dube SR et al. (2002). Exposure to Abuse, Neglect, and Household Dysfunction among Adults Who Witnessed Intimate Partner Violence as Children: Implications for Health and Social Services. *Violence and Victims*, 17(1): 3–17.

146 UNICEF (2005). Submission to the United Nations Secretary-General's Study on Violence against Children. UNICEF New Zealand.

147 Family Violence Prevention Fund (2006). Programs: Children and Domestic Violence. Family Violence Prevention Fund. Available at: http://endabuse.org/programs/children/.

148 Runyan D et al. (2002). Child Abuse and Neglect by Parents and Other Caregivers. In: Krug EG et al. (Eds). *World Report on Violence and Health*. Geneva, World Health Organization, pp 59–86.

149 Hunter WM et al. (2000). Risk Factors for Severe Child Discipline Practices in Rural India. *Journal of Paediatric Psychology*, 25: 435–447.

150 UNICEF (2005). Submission to the United Nations Secretary-General's Study on Violence against Children. UNICEF New Zealand.

151 The Body Shop/UNICEF (2006). *Behind Closed Doors. The Impact of Domestic Violence on Children.* London, The Body Shop International Plc.

152 The Body Shop/UNICEF (2006). *Behind Closed Doors. The Impact of Domestic Violence on Children.* London, The Body Shop International Plc.

153 Ehrensaft MK et al. (2004). Clinically Abusive Relationships in an Unselected Birth Cohort: Men's and Women's Participation and Developmental Antecedents. *Journal of Abnormal Psychology*, 113(2): 258–271.

154 Naved RT (2003). A Situation Analysis of Violence against Women in South Asia. In: *Violence against Women in South Asia: A Regional Analysis*. Bangkok, Asian Forum of Parliamentarians on Population and Development/Kathmandu, UNFPA.

155 Lalor K (2004). Child Sexual Abuse in Sub-Saharan Africa: A Literature Review. *Child Abuse & Neglect*, 28(4): 439–460.

156 Haj-Yahi MM, Tamish S (2001). The Rates of Child Sexual Abuse and Its Psychological Consequences as Revealed By a Study among Palestinian University Students. *Child Abuse & Neglect*, 25: 1303–1327.

157 Chen J et al. (2004). Child Sexual Abuse in China: A Study of Adolescents in Four Provinces. *Child Abuse & Neglect*, 28(11): 1171–1186.

158 United Nations Secretary-General's Study on Violence against Children (2005). *Regional Desk Review: South Asia.* Available at: http://www.violencestudy.org/r27.

159 United Nations Secretary-General's Study on Violence against Children (2005). *Regional Desk Review: East Asia and the Pacific.* Available at: http://www.violencestudy.org/r27.

160 United Nations Secretary-General's Study on Violence against Children (2005). *Regional Desk Review: Middle East and North Africa.* Available at: http://www.violencestudy.org/r27.

161 Luster T et al. (2004). Family Advocates' Perspectives on the Early Academic Success of Children Born to Low-income Adolescent Mothers. *Family Relations*, 53: 68–77.

162 Fergusson DM, Lynskey MT (1997). Physical Punishment/Maltreatment During Childhood and Adjustment in Young Adulthood. *Child Abuse & Neglect*, 21 (7): 617–630.

163 Fergusson DM, Lynskey MT (1997). Physical Punishment/Maltreatment During Childhood and Adjustment in Young Adulthood. *Child Abuse & Neglect*, 21 (7): 617–630.

164 Spaccarelli S, Kim S (1995). Resilience Criteria and Factors Associated with Resilience in Sexually Abused Girls. *Child Abuse & Neglect*, 19: 1171–1182.

165 Spaccarelli S, Kim S (1995). Resilience Criteria and Factors Associated with Resilience in Sexually Abused Girls. *Child Abuse & Neglect*, 19: 1171–1182.

166 Hunter R et al. (1978). Antecedents of Child Abuse and Neglect in Premature Infants: A Prospective Study in a Newborn Intensive Care Unit. *Pediatrics*, 61: 629–635.

167 Korbin J et al. (2000). Neighborhood Views on the Definition and Etiology of Child Maltreatment. *Child Abuse & Neglect*, 24(12):1509–1527.

168 Runyan D et al. (2002). Child Abuse and Neglect by Parents and Other Caregivers. In: Krug EG et al. (Eds). *World Report on Violence and Health*. Geneva, World Health Organization, pp 59–86.

169 WHO (2003). *Violence and Health. Brief Report on the Situation of Violence and Health in Jordan*. World Health Organization.

170 UNICEF (2005). Changing a Harmful Social Convention: Female Genital Mutilation/Cutting. *Innocenti Digest*, No. 12. Florence, UNICEF Innocenti Research Centre.

171 Committee on the Rights of the Child (2006). *General Comment No. 8. The Right of the Child to Protection from Corporal Punishment and Other Cruel or Degrading Forms of Punishment* (articles 19, 28(2) and 37, inter alia), CRC/C/GC/8.

172 Committee on the Rights of the Child (2006). *General Comment No. 8. The Right of the Child to Protection from Corporal Punishment and Other Cruel or Degrading Forms of Punishment* (articles 19, 28(2) and 37, inter alia), CRC/C/GC/8, para 38.

173 Committee on the Rights of the Child (2006). *General Comment No. 8. The Right of the Child to Protection from Corporal Punishment and Other Cruel or Degrading Forms of Punishment* (articles 19, 28(2) and 37, inter alia), CRC/C/GC/8.

174 International Save the Children Alliance (2005). *Ending Physical and Humiliating Punishment of Children. Making It Happen*, Part 1. Global Submission to the UN Study on Violence against Children. Stockholm, Save the Children Sweden.

175 Heise L, Garcia-Moreno C (2002). Violence by intimate partners. In: Krug EG et al. (Eds). *World Report on Violence and Health*. Geneva, World Health Organization.

176 UNICEF (2001). Early Marriage, Child Spouses. *Innocenti Digest*, No. 7. Florence, UNICEF Innocenti Research Centre.

177 Olds DL et al. (1999). Prenatal and Infancy Home Visitation by Nurses: Recent Findings. *Future of Children*, 9(1): 44–65.

178 Centers for Disease Control and Prevention (2003). First Reports Evaluating the Effectiveness of Strategies for Preventing Violence: Early Childhood Home Visitation. Findings from the Task Force on Community Preventive Services. *MMWR*, 52: 1–9.

179 Holzer PJ et al. (2006). The Effectiveness of Parent Education and Home Visitation Child Maltreatment Prevention Programmes. *Child Abuse Prevention Issues*, No. 24. Australian Institute of Family Studies.

180 Saunders BEL et al. (Eds) (2004). *Child Physical and Sexual Abuse: Guidelines for Treatment.* Revised Report: April 26, 2004. Charleston, SC, USA. National Crime Victims Research and Treatment Center.

181 UNICEF (2003). *Meeting Basic Learning Needs.* New York, Consultative Group on ECCD, UNICEF. Cited in: Black M (1996). *Children First: The Story of UNICEF Past and Present.* New York, New York and Oxford University Press.

182 UNICEF (2004). *Moldova Annual Report 2004*. UNICEF Moldova. Cited in: United Nations Secretary-General's Study on Violence against Children (2005). *Violence in the Home and Family. Regional Desk Review: Europe and Central Asia.* Available at: www.violencestudy.org/r27.

183 Butchart A, Hendricks G (2000). The Parent Centre. In: Butchart A (Ed). *Behind the Mask: Getting to Grips with Crime and Violence in South Africa*. Pretoria, HSRC Publishers.

184 CDC (2006). *Child Maltreatment: CDC Activities.* Atlanta, National Center for Injury Prevention and Control. Available at: http://www.cdc.gov/ncipc/factsheets/cmactivities.htm.

185 Hoath F, Sanders M (2002). A Feasibility Study of Enhanced Group Triple P – Positive Parenting Programme for Parents of Children with Attention Deficit/Hyperactivity Disorder. *Behaviour Change*, 19(4): 191–206.

186 Karlsson L, Karkara R (2006). How to End Violence. *CRIN Newsletter*, No. 19. Child Rights Information Network.

187 Zoritch B et al. (2000). Day Care for Pre-school Children. *Cochrane Database of Systematic Reviews*, 3: CD000564.

188 United Nations Secretary-General's Study on Violence against Children (2005). *Summary Report of the Thematic Meeting on Violence against Children with Disabilities*, 28 July 2005, New York. Available at: www.violencestudy.org/r180.

189 Gibson LE, Leitenberg H (2000). Child Sexual Abuse Prevention Programmes: Do They Decrease the Occurrence of Child Sexual Abuse? *Child Abuse & Neglect*, 24(9): 1115–1125.

190 Gurevich R, Gero T (2005). *Using Schools to Reduce the Incidence of Early Marriage among Girls: A Case Study from Ethiopia*. Paper by World Learning Ethiopia, presented at Early Marriage Technical Consultation, IPPF Kenya, October 2005, Nairobi.

191 International Save the Children Alliance (2005). *10 Essential Learning Points: Listen and Speak Out against Sexual Abuse of Girls and Boys.* Global Submission to the UN Study on Violence against Children. Oslo, Save the Children.

192 Anti-Slavery International (2005). *Child Domestic Workers: A Handbook on Good Practice in Programme Interventions*. London, Anti-Slavery International.

193 Markowitz S, Grossman M (1998). Alcohol Regulation and Domestic Violence towards Children. *Contemporary Economic Policy*, XVI: 309–320.

194 Room R et al (2003). *Alcohol in Developing Societies: A Public Health Approach*. Helsinki, Finnish Foundation for Alcohol Studies/Geneva, World Health Organization.

195 United Nations Secretary-General's Study on Violence against Children (2005). *Regional Desk Review: East Asia and the Pacific.* Available at: http://www.violencestudy.org/r27.

196 Anti-Slavery International (2005). *Child Domestic Workers: A Handbook on Good Practice in Programme Interventions*. London, Anti-Slavery International.

197 WHO (2003). *Guidelines for Medico-legal Care for Victims of Sexual Violence*. Geneva, World Health Organization.

198 Saunders BEL et al. (Eds) (2004). *Child Physical and Sexual Abuse: Guidelines for Treatment.* Revised Report: April 26, 2004. Charleston, SC, USA. National Crime Victims Research and Treatment Center.

199 Cohen JA et al. (2005). Treating Sexually Abused Children: 1-Year Follow-up of a Randomised Controlled Trial. *Child Abuse & Neglect*, 29: 135–145.

200 WHO/ISPCAN (2006). *Preventing Child Maltreatment: A Guide to Taking Action and Generating Evidence*. Geneva, World Health Organization/International Society for the Prevention of Child Abuse and Neglect.

201 United Nations Secretary-General's Study on Violence against Children (2005). *Violence in the Home and Family. Regional Desk Review: Europe and Central Asia.* Available at: http://www.violencestudy.org/r27.

202 UNICEF/Inter-parliamentary Union (2004). *Handbook on Child Protection.* Inter-parliamentary Union.

203 United Nations Secretary-General's Study on Violence against Children (2005). *Regional Desk Review: South Asia*. Available at: www.violencestudy.org/r27.

204 Save the Children (2004). *So You Want to Involve Children in Research? A Toolkit Supporting Children's Meaningful and Ethical Participation in Research Relating to Violence against Children.* Stockholm, Save the Children Sweden.

205 UNICEF (2005). Changing a Harmful Social Convention: Female Genital Mutilation/Cutting. *Innocenti Digest*, No. 12. Florence, UNICEF Innocenti Research Centre.

206 Forum on Marriage and the Rights of Women and Girls/IPPF (forthcoming). *Taking Action to End Child Marriage A Guide for Advocacy by Programmers and Activists.* London, Forum on Marriage and the Rights of Women and Girls/IPPF.

207 Forum on Marriage and the Rights of Women and Girls and IPPF (forthcoming). *Taking Action to End Child Marriage A Guide for Advocacy by Programmers and Activists.* London, Forum on Marriage and the Rights of Women and Girls/IPPF.

208 Diop NJ et al. (2004). *The Tostan Programme: Evaluation of a Community-based Education Programme in Senegal*. Population Council, GTZ/Tostan.

209 WHO/ISPCAN (2006). *Preventing Child Maltreatment: A Guide to Taking Action and Generating Evidence*. Geneva, World Health Organization and International Society for the Prevention of Child Abuse and Neglect.

210 Kacker L (2006). *National Level Study on Child Abuse. Submission to the UN Secretary-General's Study on Violence against Children*. India.

QUOTES

I International Save the Children Alliance (2005). *Ending Physical and Humiliating Punishment of Children. Making It Happen*. Part 2. Global submission to the UN Secretary-General's Study on Violence against Children. Stockholm, Save the Children Sweden, p 78.

II Save the Children Alliance (2005). *10 Essential Learning Points: Listen and Speak Out against Sexual Abuse of Girls and Boys*. Global Submission by the International Save the Children Alliance to the UN Secretary-General's Study on Violence against Children. Oslo, Save the Children Norway, p 54.

III Naker D (2005). *Violence against Children: The Voices of Ugandan Children and Adults.* Raising Voices and Save the Children Uganda, p 21.

IV United Nations Secretary-General's Study on Violence against Children (2005). *Regional Desk Review: North America*, p 7. Available at: www.violencestudy.org/r27.

V International Save the Children Alliance (2005). *Voices of Girls and Boys to end Violence against Children in South and Central Asia*. In preparation of UN Secretary-General's Study on Violence against Children. Kathmandu, Save the Children Sweden Regional Programme for South and Central Asia, p 49.

VI Erulkar A et al. (2004). *The experience of adolescence in rural Amhara region of Ethiopia*. Accra, The Population Council.

VII UNICEF (2003). *Somali children and youth: Challenging the past and building the future*. UNICEF Somalia.

VIII L'Observatoire des droits de l'enfant de la région océan indien (2006). *La violence contre les enfants dans la région de l'océan indien.* Annual Report of the Observatoire des droits de l'enfant de la région océan indien. Mauritius, l'Observatoire des droits de l'enfant de la région océan indien, p 29.

IX International Save the Children Alliance (2005). *10 Essential Learning Points: Listen and Speak out against Sexual Abuse of Girls and Boys.* Global Submission to the UN Secretary-General's Study on Violence against Children. Oslo, Save the Children, p 66.

X United Nations Secretary-General's Study on Violence against Children (2005). *Regional Desk Review: Eastern and Southern Africa*, p 1. Available at: www.violencestudy.org/r27

XI United Nations Secretary-General's Study on Violence against Children (2005*). Regional Desk Review: North America*, p 10. Available at: www.violencestudy.org/r27.

XII United Nations Secretary-General's Study on Violence against Children (2005). *Regional Desk Review: North America*, p 19. Available at: www.violencestudy.org/r27.