

Child maltreatment prevention readiness assessment in Malaysia

Country Report

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Table of Contents

ACKNOWLEDGEMENT	3
LIST OF ABBREVIATIONS	4
LIST OF TABLES.....	6
LIST OF FIGURES	7
BACKGROUND.....	16
COUNTRY PROFILE.....	16
CHILD ABUSE IN MALAYSIA.....	19
OVERVIEW OF CHILD MALTREATMENT PREVENTION AND CHILD PROTECTION IN MALAYSIA.....	21
RATIONALE AND AIMS OF THE PROJECT	23
ETHICAL CONSIDERATION	24
TARGET AUDIENCE OF THE RESEARCH	24
METHODS.....	24
DEVELOPMENT OF INSTRUMENT.....	24
A) FOCUS GROUP DISCUSSION	25
B) TRANSLATION AND ADAPTATION OF INSTRUMENT	25
C) COGNITIVE TESTING.....	26
PILOT STUDY	27
FIELD TRIAL.....	27
PROCESS OF CARRYING OUT INTERVIEWS	28
CHALLENGES CONDUCTING THE RESEARCH.....	29
PROCESS OF CONDUCTING OBJECTIVE ASSESSMENT.....	29
DATA MANAGEMENT AND ANALYSIS.....	30
THE TEN DIMENSIONS OF RAP-CM QUESTIONNAIRE.....	32
FINDINGS	34
OVERALL.....	34
COMPARING SCORES FROM NATIONAL AND SUB-NATIONAL ORGANISATIONS	35
COMPARING SCORES FROM GOVERNMENT AND NON-GOVERNMENTAL ORGANISATIONS	37
QUANTITATIVE AND QUALITATIVE ANALYSIS FOR EACH DIMENSION	39
DIMENSION 1: ATTITUDES TOWARDS CHILD MALTREATMENT.....	39
DIMENSION 2: KNOWLEDGE OF CHILD MALTREATMENT PREVENTION	41
DIMENSION 3: SCIENTIFIC DATA ON CHILD MALTREATMENT	44
DIMENSION 4: CURRENT PROGRAMME IMPLEMENTATION AND EVALUATION.....	46
DIMENSION 5: LEGISLATION, POLICIES AND MANDATES	48
DIMENSION 6: WILL TO ADDRESS PROBLEM.....	50
DIMENSION 7: INSTITUTIONAL LINKS AND RESOURCES	53

DIMENSION 8: MATERIAL RESOURCES	54
DIMENSION 9: HUMAN AND TECHNICAL RESOURCES.....	55
DIMENSION 10: INFORMAL SOCIAL RESOURCES	56
COMPARISON OF 'SUBJECTIVE' AND 'OBJECTIVE' ASSESSMENT	57
RELATIONS OF SCORES WITH COUNTRY BACKGROUND CONDITIONS	73
STRATEGIES FOR INCREASING CMP READINESS.....	74
DISCUSSION	82
IMPLICATIONS FOR LARGE-SCALE CMP PROGRAMME IMPLEMENTATION	85
RECOMMENDATIONS AND CONCLUSIONS	85
REFERENCES	90
APPENDIX 1. KEY COUNTRY CONDITIONS.....	93
APPENDIX 2. CHILD MALTREATMENT STUDIES OF MALAYSIA – JOURNAL PUBLICATIONS	95
APPENDIX 3. ITEM ANALYSIS	98
APPENDIX 4. DETAILS OF SCORING FOR EACH DIMENSION FOR ALL RESPONDENTS.....	99
APPENDIX 5. QUALITATIVE ANALYSIS – ANSWERS GIVEN TO RAP-CM	100
APPENDIX 6. AVAILABLE PROGRAMMES FOR CHILD PROTECTION	103
APPENDIX 7. AVAILABLE PROGRAMMES FOR CHILD MALTREATMENT PREVENTION	104
APPENDIX 8. POVERTY REDUCTION PROGRAMME IN MALAYSIA	107
APPENDIX 9. AVAILABLE PROGRAMMES WHICH COULD ALLOW INTEGRATION OF CMP COMPONENTS.....	110
APPENDIX 10. COALITIONS OR NETWORKING OF ORGANISATIONS EXAMPLE.....	114
APPENDIX 11. MATERIAL RESOURCES IN SOME PROGRAMS	116
AUTHORS' BIODATA	117

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List of Abbreviations

CAN	Child abuse and neglect
CEA	Child Emotional Abuse
CIA	Central Intelligence Agency
CM	Child Maltreatment
CMP	Child Maltreatment Prevention
CMPR	Child Maltreatment Prevention Readiness
CN	Child neglect
CPD	Continuous Professional Development
CPT	Child Protection Team
CSA	Child Sexual Abuse
DSW	Department of Social Welfare
FRHAM	Federation of Reproductive Health Associations, Malaysia
GDP	Gross Domestic Product
GHO	Global Health Observatory
ICT	Information and Communication Technology
KEMAS	Department of Community Development (Jabatan Kemajuan Masyarakat)
LMIC	Low- or Middle- Income Countries
MCCW	Malaysian Council for Child Welfare
MOE	Ministry of Education
MWFCD	Ministry of Women, Family and Community Development
NFPDB	National Population and Family Planning Board
NGO	Non- Governmental Organisation
NMRR	National Medical Research Register
OECD	Organisation for the Economic Co-operation and Development
PLAN	Plan International

RAP-CM	Readiness Assessment for the Prevention of Child Maltreatment
RAP-CM-XD	Readiness Assessment for the Prevention of Child Maltreatment based on Expert Opinion using all available Data
SCAN	Suspected Child Abuse and Neglect Team
UK	United Kingdom
UNICEF	United Nations Children's Fund
VIP	Violence Intervention Prevention
WCC	Women Centre for Change
WHO	World Health Organisation

List of Tables

TABLE 1 : TOTAL CASES OF CHILD ABUSE AND NEGLECT REPORTED TO DEPARTMENT OF SOCIAL WELFARE, MALAYSIA FROM 1997-2010 ACCORDING TO TYPE OF ABUSE.....	19
TABLE 2 : DISTRIBUTION OF THE PARTICIPANTS IN FOCUS GROUP DISCUSSION	25
TABLE 3 : DISTRIBUTION OF THE PARTICIPANTS IN PILOT STUDY	27
TABLE 4 : DISTRIBUTION OF THE SAMPLES ACCORDING TO TYPE OF ORGANISATIONS FOR THE FIELD TEST	28
TABLE 5: OVERALL SUMMARY OF EACH DIMENSION SCORE FOR ALL RESPONDENTS	34
TABLE 6: SUMMARY OF EACH DIMENSION SCORE COMPARING NATIONAL AND SUB-NATIONAL ORGANISATION	36
TABLE 7 : SUMMARY OF EACH DIMENSION SCORE COMPARING GOVERNMENT AND NON-GOVERNMENT ORGANISATIONS..	37
TABLE 8: SCORES FOR OBJECTIVE ASSESSMENT BY RESEARCH TEAM AND COMPARING WITH SUBJECTIVE ASSESSMENT SCORE FOR ALL RESPONDENTS	57

List of Figures

FIGURE 1: NUMBER OF POPULATION BY SEX AND AGE GROUP FOR YEAR 2000 AND 2010, MALAYSIA	16
FIGURE 2: LEVEL OF URBANISATION, MALAYSIA, 1980, 1991, 2000 AND 2010	18
FIGURE 3 : LEVEL OF URBANIZATION ACCORDING TO STATES IN MALAYSIA, 2010	18
FIGURE 4: CASES OF CHILD ABUSE AND NEGLECT REPORTED BY STATE, MALAYSIA, 2010.....	18
FIGURE 5 : NUMBER OF SCHOOLCHILDREN INVOLVED IN GANGS AND BULLYING	20
FIGURE 6. DIMENSIONS OF THE CHILD MALTREATMENT READINESS MODEL	32
FIGURE 7 : OVERALL SUMMARY OF MEAN, MINIMUM AND MAXIMUM READINESS SCORE FOR EACH DIMENSION	35
FIGURE 8: COMPARISON OF SCORES PER DIMENSION FOR ALL RESPONDENTS, THOSE AT NATIONAL LEVEL AND SUB- NATIONAL LEVELS	36
FIGURE 9. COMPARISON OF SCORES PER DIMENSION FOR ALL RESPONDENTS, THOSE FROM GOVERNMENT OR NGOS.....	38
FIGURE 10. DISTINGUISH THE DIFFERENCE BETWEEN PREVENTION AND PROTECTION	39

EXECUTIVE SUMMARY

BACKGROUND

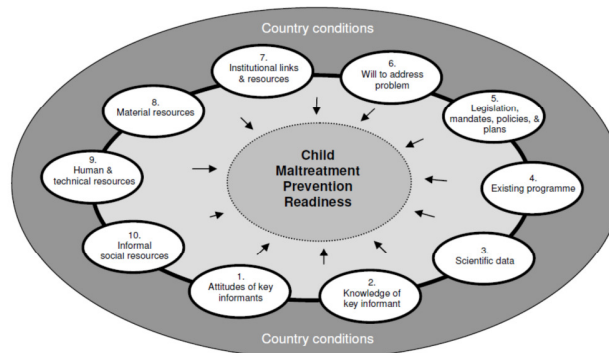
Child maltreatment (or child abuse and neglect) is a leading cause of morbidity, premature deaths and burden of disease worldwide. There is a substantial body of evidence identifying children being exposed to many different types of child maltreatment (CM), its damaging consequences to the children and also subsequent burden to the health and welfare system in many countries. Much work has been done to protect children from further maltreatment but prevention is more cost-effective in terms of resources and outcome. The field of child maltreatment underwent a major shift in response to the problem of child maltreatment worldwide, that is to prevent CM before it occurs termed “child maltreatment prevention (CMP)”, rather than responding to CM after it occurs termed “child protection” (such as to provide immediate safety, support and treatment to the children or prosecution of perpetrators). The success of child maltreatment prevention (CMP) strategies depends largely on individual and community readiness for behavioural change or to adopt a policy change or attitude, and national readiness especially with regards to capacity for implementation.

CHILD MALTREATMENT PREVENTION READINESS ASSESSMENT STUDY IN MALAYSIA

Malaysia was one of the six countries that participated in the development of the Readiness Assessment for the Prevention of Child Maltreatment (RAP-CM) instrument and measure of child maltreatment prevention readiness in low- and middle-income countries (LMIC), an initiative by the World Health Organisation (WHO). This information could be used to facilitate efforts at increasing and strengthening the ‘readiness’ of the country for the development of child maltreatment preventive programmes on a scale commensurate with the magnitude of the problem.

The Readiness Assessment for the Prevention of Child Maltreatment (RAP-CM) is an instrument to assess how “ready” a country, province or state, or community or municipality is, to implement evidence-based child maltreatment prevention programmes on a large scale. The development of the tools underwent five stages; 1) development of the conceptual model underlying the instrument via systematic review of literature; 2) development of the questionnaire (Version 1) based on the conceptual model, focus group discussion and cognitive testing in Malaysia (and other participating countries); 3) Revision of questionnaire (Version 2) and pilot testing of the version; 4) Revision of Version 2 and field testing of Version 3; 5) revision of Version 3 and development of Version 4 which is the final version presented in this report. The final semi-structured instrument assesses Child Maltreatment Prevention Readiness (CMPR) along ten dimensions as shown in the figure below.

Dimensions of the Child Maltreatment Readiness Model



The samples selection was purposeful in involving major stakeholders of child protection services or early child development programmes; key players or potential key players in CMP or in positions of some influence and decision-making power in the field. They included policy makers, high ranking officers or directors of government agencies that have child-related services (specifically MOE, MWFC, MOH), major service providers that have direct contact with children such as welfare officer, police, health staff, district leaders, spiritual leaders, and non-governmental organizations. Interviewees were from government, NGOs, community-based organizations, international organizations, donor agencies, universities and research institutes. Samples were selected to be representative of the national and state/sub-national levels. A total of 11 participants were involved in the focus group, 10 interviewees in cognitive interviewing, 20 in pilot study and 42 in the field test.

FINDINGS

The finding shows that Malaysia scored moderately in the overall readiness score (43.7/100) of CMP. Subgroup analysis suggests that respondents at national level (49%) tended to perceive the country as more ready for CMP compared to those at the sub-national level (38%). Almost similar figures were found when comparing perceived readiness between those from government and non-governmental groups respectively. This was an expected finding as a large proportion of the respondents in the sub-national level mostly comprised those from the NGOs. In general, two dimensions, that is, the 'Scientific data on CM' and 'Knowledge of child maltreatment prevention' are perceived by respondents as Malaysia's strengths in CMP readiness. Malaysia is viewed as less ready in terms of its 'human and technical resources', 'material resources' and 'current programme implementation and evaluation'.

When analysed further, government respondents perceived greater readiness of Malaysia in the aspects of availability of 'scientific data on child maltreatment', 'knowledge of child maltreatment prevention', and 'legislation, mandates and policies' in decreasing order while NGO respondents scored greater readiness for 'knowledge of child maltreatment prevention', availability of 'scientific data on child

maltreatment' followed by 'institutional links'. Notably, respondents from NGOs were less informative on legislation and policies and rated the country's readiness in terms of attitudes towards CMP lower compared to those from the government sectors. Sub-national respondents, including the government ones, felt more challenged than national respondents in terms of all forms of resources – material, human and technical resources and felt less supported in terms of political and public will to address CMP issues. Subnational and NGO respondents had a poorer impression of the CMP programme implementation and evaluation than national and government respondents.

Among the dimensions, the respondents rated the availability of scientific data in Malaysia as the dimension with the greatest CMP readiness. Many respondents were aware of the availability of data on CM in Malaysia particularly the magnitude and distribution of child physical abuse and sexual abuse. Access to scientific data though, was felt to be limited, and coupled by the lack of availability of large national prevalence studies, it is not surprising that many could not estimate the proportion of child maltreatment cases that are actually reported to the authorities.

Respondents were fairly knowledgeable about the types of child maltreatment and could give at least 2-4 consequences of child maltreatment. Health cost, social ills, rehabilitation costs, legal costs and cost of human resources were the main costs given by forty per cent of the respondents. Poverty, family dysfunction, cultural factors and lack of parenting skills were listed as the main risk factors. A "public health approach" would mean taking cognizance of risk factors and developing programmes to address the risk factors in order to improve the outcome of CMP. The majority of respondents were unaware of such an approach as called but half the respondents had heard of evidence based approach.

The understanding of the difference between child protection and child maltreatment among respondents appeared to be unclear and often these two terms were used interchangeably. It was generally agreed that CM is a serious problem in the country. Although the majority believed that CM could be prevented, 71% viewed that the priority given to child maltreatment prevention was low compared to that given to other health issues. In addition, "parental rights" was believed by many respondents to be as important as "child rights" and this can affect the attitude towards and the implementation of CMP or child protection policies.

Most respondents were aware of the major legislations related to children, in particular, the Child Act 2001. It was found that there is comprehensive legislation for the benefit of children. About sixty percent of respondents were aware of existing official policies on CMP that sets out the main principles and defines goals, objectives, prioritized actions and coordinated mechanisms for preventing child maltreatment, such as the National Child Protection Policy and the National Action Plan for Children. However the effectiveness of legislation and child related policies in protecting children remained questionable for forty-two percent of respondents, the reasons given being poor enforcement, lack of manpower and skills, and lack of coordination between agencies. While three quarters of the respondents knew of the existence of a mandatory system for reporting cases of child maltreatment to the welfare or police, it was found that some respondents were unclear of the group of professionals or persons who are mandated to report. About half the respondents felt that the reporting system was working poorly in protecting children, with some respondents perceiving the reporting system as one of prosecution and lack of confidentiality.

There is a general perception that the country is lacking in the will to address CMP, this being particularly felt by the NGO respondents. It was felt that the public is keen to help children but do not know how to translate that into action, allocating the responsibility to the Ministry for Women, Family and Community Development. Attention to CM issues accelerates when these issues are sensationalized in the media with huge public outcry for prosecution of the perpetrators and calls for harsher punishments, i.e. after the event. Otherwise advocacy efforts are intermittent and generally felt to be non-sustainable with current resources. Half of respondents were of the opinion that while political leaders do express commitment to CMP, they did not seem to be taking effective measures to address the problem and were not providing enough resources for long term CMP. Most felt the general public did not perceive CM as a serious problem and this may be inter-related to the lack of public knowledge on prevalence of CM, and available effective programs for CMP. Many felt that efforts at enhancing public information on CM and its prevention could be improved.

There are many programmes implemented in Malaysia to protect the children in accordance to the Child Act 2001, and in relation to CMP, programmes are available from the perspectives of child health, early intervention programmes, early childhood development, parenting skills and poverty reduction. However, many of these programmes have not undergone in depth evaluation, hence there is lack of evidence of their effectiveness in reducing the incidence of CM. Despite comprehensive national or state-focused strategies for the child maltreatment prevention as determined by our study's objective assessment, respondents perceived such programmes to be lacking in Malaysia. It was also felt that some of the programmes, while successful in pilot projects, were not sustainable due to lack of funding and staff, thus implementation at the sub-national level was an issue. Community projects were felt to be as important as national programmes as the high risk groups were more easily targeted. Universal programmes such as assessment of parenting and social issues by home visits was felt to be appropriate if done as part of the existing postnatal home visits by public health nurses, whilst prevention of inflicted head injuries by parent education in health clinics could be incorporated into existing public health programmes. Parenting education need to reach the poorly motivated, stressed parents or those who believe in corporal punishment.

Generally, respondents could name existing partnerships, coalitions, networks and alliances between institutions that involved working with children and perceived them to be effective. Those from NGOs had better awareness of existing networks or coalitions. About half the respondents felt that the corporate sector was generally supportive of CMP but required pointers regarding the services to be sponsored.

In terms of availability of material resources focused on CMP, many were not aware of dedicated budgets specifically for CMP. Respondents may not have been able to differentiate the budget allocation as specific to CMP such as funds under various programmes in public health, early childhood education, universal primary education or low-cost housing. These programs may not necessarily have been recognized as for activities for CMP. Specific budgets that were identified for child maltreatment actually came under child protection activities such as for Nur Alert hotline, Child Protectors, child interview units in Police Units.

Human and technical resources dimension had the lowest readiness score at both government and NGOs level. The number of professionals adequately trained in CMP was felt to be inadequate by the majority of the respondents, with many of the opinion that such acute shortage impeded the possibility of implementation of large scale CMP programmes. Education or training specifically dedicated to CMP needs to be improved. It was opined that there is a large pool of human resource available that could be targeted for training in CMP, such as teachers, school counselors and public health nurses. Resources outside the system, such as services and volunteerism of skilled expatriates in the country, remain to be tapped.

The majority of respondents felt that the single most important problem facing CMP in Malaysia was the lack of awareness and understanding towards CMP, which affects the other dimensions of CMP.

When an **objective assessment of CMP readiness** was conducted, CMP readiness scores were higher for the dimensions of 'current programme implementation', 'legislation', 'will to address the problem' and 'material resources' compared to the respondents' assessments. The difference between the two assessments differ due to lack of respondents' knowledge of the various available programmes, budgets and services offered by government agencies and NGO's, as well as due to gaps in delivery of services. The differences between the objective assessment and that of respondent perceptions were largest for the dimension of 'current programme implementation' followed by 'material resources' dimension. The respondents' perception of the "political will" and the "availability of policies to address CMP" were also lower than objective findings of the researchers.

IMPLICATIONS FOR LARGE SCALE PROGRAMMES

Factors to be considered:

- Political will is an important driving force for adequate funding and material resources in Malaysia and important determinant of legislation development and policies. There needs to be a repository of data such as a 'national clearing house' to assist political leaders and policy makers in making informed decisions.
- More than 95 percent of children and their families are accessible by public health staff in the newborn period and in primary school under existing programmes, thus providing ideal age groups for large scale universal CMP programmes
- Targeting of large-scale selective CMP program is not yet feasible until there is a large well-designed prevalence study including data on the risk factors and high-risk population groups. As a start, selective CMP programme should initially commence in the highly urbanized regions and poorer population based on the association between rapid urbanization and child maltreatment and local research data on social risk factors in urban areas.
- Priority for improving human and technical skills before implementation of any such programme
- The existing networking of government agencies for child protection can be the focal points at community and state levels for child maltreatment prevention

- Monitoring and evaluation packaged with dedicated budget and staff need to be built into CMP programmes

RECOMMENDATIONS

In order to address CMP, strategies are needed to tackle child maltreatment occurring at different development stages of development of the child, and to strengthen the various dimensions of CMP readiness.

Recommendation 1: Improving attitudes towards child maltreatment prevention

The enhancement of the community's awareness on issues relating early childhood development, good child care, childhood trauma and consequences of child maltreatment as well as children's rights is necessary to prevent child maltreatment. A child rights approach could be an additional strategy to a welfare approach.

Recommendation 2: Increasing knowledge of child maltreatment prevention

Media campaigns with emphasis to convey positive ideas on parenting and coping under difficult circumstances or the promotion of a respectful supportive child-rearing environment free from violence should be run on a regular basis. These could also include documentaries or dissemination through social media on issues such as the effects and causes, consequences of child maltreatment; awareness of risk to disabled children; discussions on child safety, criteria for good child care centres and dissemination of the Conventions of the Rights of the child. Sensationalism and criminalisation of child maltreatment in media should be discouraged to avoid ad hoc programmes and inaccurate public perception that CM is only perpetrated by "bad" parents, drug addicts or the mentally ill.

Recommendation 3: Increasing scientific data on child maltreatment prevention and the will to address the problem

A comprehensive and reliable national data collection system should be established to ensure systematic monitoring and evaluation of systems (impact analyses), services, programmes and outcomes. These outcomes should be based on indicators aligned with universal standards, and adjusted for and guided by nationally established goals and objectives.

A national clearing house for scientific publications is necessary for systematic reporting, analysis and dissemination of scientific literature related to fields of public health, mental health, social work, psychology, law enforcement and anthropology among others.

Recommendation 4 : Program implementation according to evidence based approach with monitoring and evaluation

A public health approach can be utilised – i.e. a review conducted on the capacity of CMP systems, structured program implementation, appropriate allocation of resources and monitoring and evaluation on the effectiveness of the programs in terms of outreach and impact. Existing programmes related to children is of sufficient breadth to allow review so as to include the integration of child maltreatment prevention into existing services. Existing CMP can be enhanced by increasing scope and target groups, after evaluation of such CMP programmes which are effective but under-resourced especially in the sub-national level requiring government or corporate assistance.

Dissemination of services should include outreach services according to epidemiological data of child maltreatment, and taking into consideration poverty and socio-economic discrimination, so that the most needy will be able to access the services provided.

Recommendation 5 : Legislation, mandates and policies for Child Maltreatment Prevention

Legal efforts should not only focus on the prosecution of perpetrators and enforcement of the Child Act 2001 but also on the enforcement of responsible parenting, satisfactory standards of child safety such as in schools, public transport, child care centres, child recreation centres, child care and city council planning and development in residential areas. Social policy measures should reflect government commitment to fulfilling child maltreatment prevention and provide for basic and targeted services. Malaysian programs are well placed to provide such services but require outreach services to vulnerable groups such as disabled children, urban poor and minority groups. Such social policy measures to be enhanced for CMP include poverty reduction strategies, housing and employment policies, “child friendly cities” implementation, and crèches at work.

Recommendation 6 : Improving human and technical resources

Programs cannot be successfully implemented without sufficient numbers of skilled personnel at all levels of implementation and this is a priority strategy as it is the weakest dimension of CMP readiness. There needs to be collaboration between academic institutions and professionals to develop model curricula for child development and maltreatment “literacy” for all relevant professional undergraduate training. As this will take time to mature, funding under continuous professional development programmes could be directed towards training in specific aspects of CMP such as home visiting programmes, for the training of trainers for parenting programmes; increasing the funding presently available from MWFCF for NGO-run programmes; as well as increasing the budget for outsourcing of manpower and technical experts.

Recommendation 7: Improving institutional links and resources

Multi-sectoral multi-agency networking and cooperation is required not only to facilitate the above recommendations but also to provide dialogue at the local level to identify appropriate services at each locality. There should be formalized support for systematic collaboration between NGOs, religious organisations and the corporate sector that have a shared goal of CMP.

The multi-dimensional model for assessment of CMP readiness in the country has been useful in elucidating the strengths and weaknesses of the country's conditions and to recommend strategies for addressing CMP with some degree of prioritization. According to this study, Malaysia is at the half-way mark in terms of readiness to implement large-scale CMP programmes. The lowest scoring dimensions would be rate limiting factors for successful CMP program implementation but obviously all ten dimensions are important just like the 'spokes of a wheel' for CMP to run smoothly. The goal for a safe and healthy childhood should be integrated into all major policy decisions with intersectoral collaboration at all levels of government and society. It is hoped that this report and recommendations by respondents who are workers in the field of CMP and protection will be useful in facilitating the promotion of child maltreatment prevention.

Child maltreatment prevention readiness assessment in Malaysia

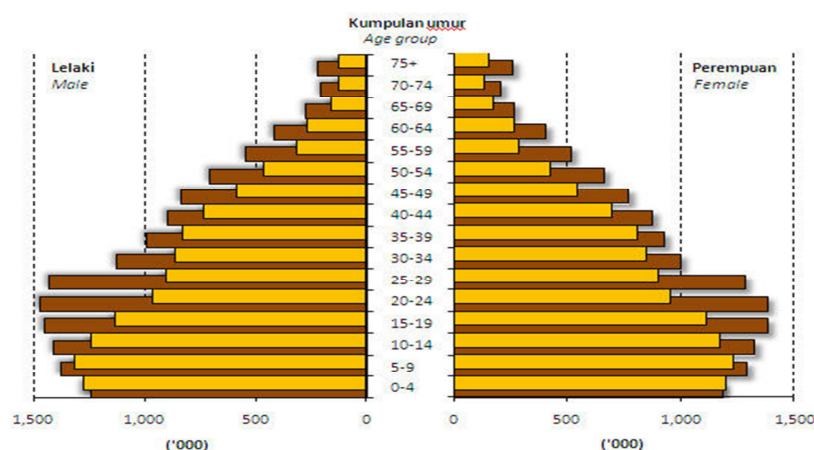
Country Report

BACKGROUND

Country profile

Malaysia is an upper-middle-income country situated in South- East Asia [1]. The country comprises of 13 states including Peninsular Malaysia, Sabah and Sarawak with a total land area of approximately 330,803 km square [2]. Currently, Malaysia is made up of 28.6 million people of different ethnic and cultural backgrounds. Malays formed the largest group (49.7 percent) of the total population, followed by the Chinese (22.84 percent) and the Indians (6.81 percent). The rest of the population comprise of the '*Orang Asli*' (the indigenous tribes) and people from other ethnic groups. Peninsular Malaysia accounts for 79.9 percent of the population, Sarawak 8.8 percent and Sabah 1.3 percent. Approximately, 11.3 million of the population are children below 18 years old. Of these children, 9.16 million are below the age of 15 and about 3.5 million are below 7 years old (i.e. non-schooling age) (see Figure 1). In addition, there are about 2.1 million non-citizens living in Malaysia [3]. More than two-thirds of the populace live in urban areas. Islam is the predominant religion in the country, practiced mainly by the Malays. Other ethnic groups embrace religions such as Buddhism, Hinduism and Christianity and are well represented in the Malaysian society.

FIGURE 1: NUMBER OF POPULATION BY SEX AND AGE GROUP FOR YEAR 2000 AND 2010, MALAYSIA



Reference: Population and Housing Census, Malaysia (2010)

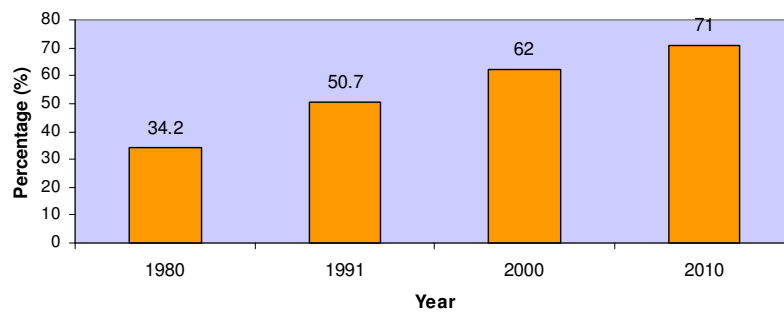
The Malaysian economy had traditionally been based on agriculture (rubber, palm oil and timber) and mining (tin and petroleum) but has experienced a major shift in its activities over the last 30 years to include manufacturing (electronic equipment, semi-conductor chips and vehicles), construction and services [1]. This transformation has made Malaysia achieve great economic and social progress over the past six decades since independence in 1957. In 2010, petroleum and natural gases, timber, service industries contributes 54.7 percent of the GDP and manufacturing approximately 27.7 percent) [1]. The per capita GDP is US\$8,194 and the economic growth has been sustained on an average of 8.0 percent a year [4]. Till July 2011, the unemployment rate is relatively stable at 3.0 percent [5]. Malaysia has set the target to achieve the status of a developed nation by 2020.

The rapid economic development over the last 20 years has improved the living standards of the people. Over the years, the government has devoted substantial amounts of national wealth in social infrastructure such as schools and health facilities to improve the health status and welfare of its populace. Primary school fees were abolished in 1962 and primary education was made compulsory in 2003 [6]. Near universal primary school enrolment had been achieved by 1990. In 2010, primary school enrolment was 96 percent with no appreciable differences between boys (97 percent) and girls (96 percent) [7]. In addition there are nearly 288,000 private kindergartens, 213,051 government run kindergartens under Ministry of Rural and Regional Development (KEMAS program), 78,623 under the Ministry of Education and 37819 kindergartens run by Ministry of Women, Family and Community Development (MWFC) [8]. Literacy rate is 92 percent amongst the total adult population [9]

On the health front, the public health care system has an extensive network of hospitals and clinics which provides highly subsidized health services to the population. Half of the population were reported in 1997 as living within 10 km of a public hospital and within 3 km of a public health clinic [10]. By 2009, many of the country's social indicators had reached levels close to those of countries in the developed world. For example, the literacy rate of adults was 92 percent while youths aged between 15 and 24 years was 98.6 percent with minimal differences between sexes [9]. Life expectancy at birth for females in 2010 was 77 years and for males was 72 years. Total fertility rate was 2.4 per couple and shows a decreasing trend. Infant mortality rate was 6.3 per 1,000 live births while stillbirth rate was 4.5 per 1,000 live births and again with minimal gender differences [4]. Child mortality under 5 years old was 8.5 per 1,000 live births in 2009 [11]. Maternal mortality ratio was 31 per 100,000 live births in 2009 [11]. This is a vast difference compared to the time of independence in 1957, where life expectancy at birth in Malaya was 58 years and 56 years, respectively, for females and males whilst infant mortality rate was 75.5 per 1,000 live births and maternal mortality ratio was 320 per 100,000 live births [11].

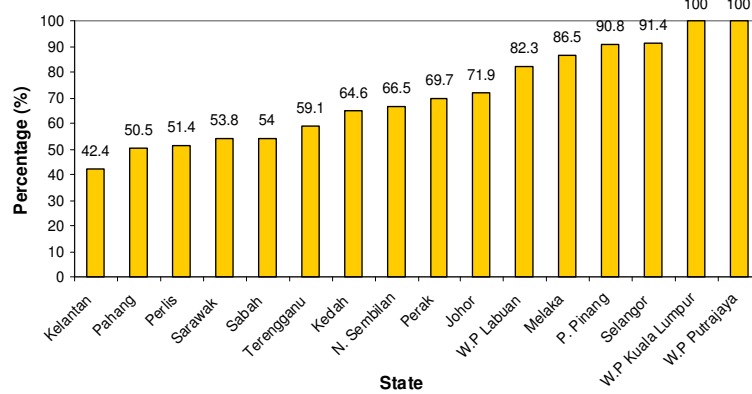
The relatively rapid urbanization in Malaysia as shown in Figure 2 has led to increased women workforce which accounted for 46.5 percent of the labour force in 2010 [3] and the sprouting of child care centres of up to 47,501 registered child care centres [8]. The states with the highest level of urbanization are Wilayah Persekutuan Kuala Lumpur (WPKL), Selangor and Johore where the incidence of child abuse reports are among the highest (see Figure 3 & 4).

FIGURE 2: LEVEL OF URBANISATION, MALAYSIA, 1980, 1991, 2000 AND 2010



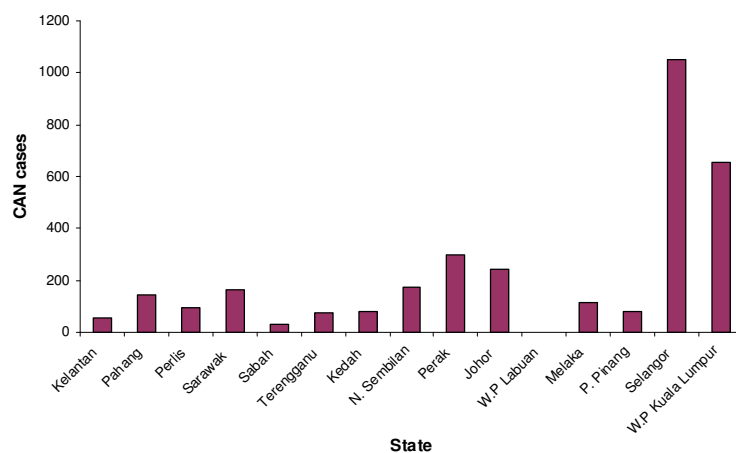
Source: Population and Housing Census, Malaysia (2010)

FIGURE 3 : LEVEL OF URBANIZATION ACCORDING TO STATES IN MALAYSIA, 2010



Source: Population and Housing Census, Malaysia (2010)

FIGURE 4: CASES OF CHILD ABUSE AND NEGLECT REPORTED BY STATE, MALAYSIA, 2010



Source: Department of Social Welfare, Malaysia (2010)

Child abuse in Malaysia

Prior to the late-80s, child maltreatment did not receive widespread attention in Malaysia. Child maltreatment has been recognised in Malaysia since 1985 whence the first Suspected Child Abuse and Neglect (SCAN) Team was set up in Hospital Kuala Lumpur, but only reached public awareness in 1989 following the death of a severely abused child.

National data on reported child abuse in Malaysia are compiled annually mainly by the Department of Social Welfare, the Royal Malaysian police, the Violence Intervention Unit in the Ministry of Health. There is presently no coordinated system of data collection between agencies, although an electronic database is being set up to link all state welfare centres with the eventual aim to link the Police and Health agencies in a comprehensive national database. Official reports from the ministries and child protection agencies are generally expected to underestimate the actual incidence due to underreporting. Table 1 shows cases of abuse and neglect in Malaysia reported by the Department of Social Welfare. Generally, there is an increase in the number of abuse cases reported over the years.

TABLE 1 : TOTAL CASES OF CHILD ABUSE AND NEGLECT REPORTED TO DEPARTMENT OF SOCIAL WELFARE, MALAYSIA FROM 1997-2010 ACCORDING TO TYPE OF ABUSE

Year	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Abandoned	n.a	n.a	n.a	71	70	121	98	26	68	53	63	58	62	115
Neglect	252	252	250	183	303	357	389	563	601	682	761	952	981	1250
Physical	476	489	413	362	287	354	410	445	431	495	586	863	895	846
Sexual *	219	270	291	258	251	324	430	529	566	679	754	733	728	937
Incest	n.a	n.a	n.a	n.a	n.a	n.a	n.a	30	57	49	21	72	n.a.	n.a.
Emotional	55	36	17	24	56	32	32	63	77	50	45	90	98	71
Others	147	104	136	36	69	54	31	0	0	0	49	12	25	38
Total	1149	1161	1107	934	1036	1242	1390	1656	1800	1999	2279	2780	2789	3257

Source: Department of Social Welfare, 2011

Note: * Excludes incest if figures for incest available

According to police statistics, there were 257 reports of child physical abuse in the year 2010 as compared to 146 reports in the year 2000. The number of child sexual abuse reports including rape has shown an increase from 1,710 cases in year 2006 to 2,658 cases in the year 2010.

Current evidence shows that there is still limited research documenting the problem of child abuse in Malaysia. Existing studies on this issue were mainly conducted among registered cases from hospitals [12-14] and these usually reflect severe cases resulting in death or disability that were brought to medical attention. Community surveys were relatively scarce. Two studies were found published in journals since 1996. The first study was a survey of college students in Ipoh, Malaysia which estimated

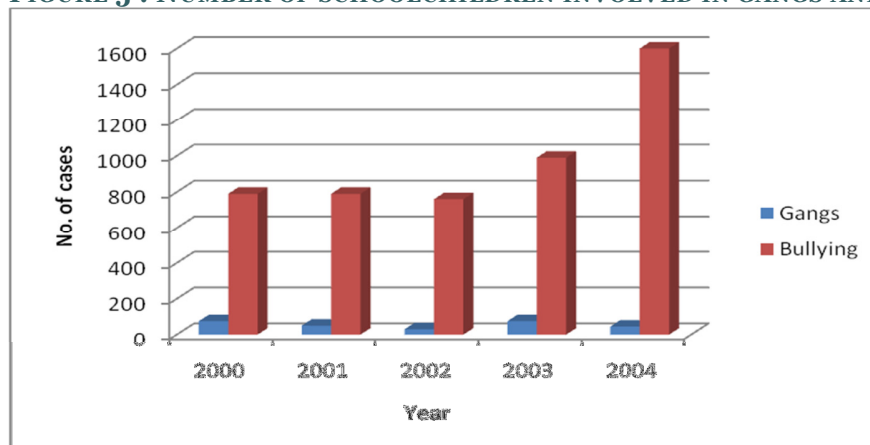
that 3.6 percent of females experienced contact CSA, with just 0.85 percent reporting unwanted sexual intercourse during childhood [15]. Among those who reported been sexually abused, about 38.1 percent of them reported being sexual abuse at aged 10 or younger. Two-thirds of them were repeatedly abused and one third of them had more than one abuser. About 71.4 percent of the abusers were persons known to the respondents. Small sample size and over-representation of Chinese respondents limit the generalisability of the findings.

The second study found was a cross-sectional survey conducted among 1,890 students in 2005 in the state of Selangor [16]. This survey found that emotional and physical maltreatment were the most common forms of child maltreatment reported. A significant proportion of adolescents (35.9 percent) were exposed to more than one type of maltreatment. There was no significant difference between male and female reporting penetrative sexual abuse (3.0 percent). Although adult males perpetrated the most abuse, female adults and peers were also found to contribute substantially to maltreatment experience.

In the highly urbanized Federal Territory of Putrajaya, there have been about 30 infant deaths per year reported from 2007-2009. These cases were suspected non-accidental head injury, choking, aspiration, and asphyxiation [17].

Schools are generally safe with minimal gangsterism (See Figure 5) [18]. The number of bullying cases in 2010 was reported at 0.05 percent of the total school population of about 5.2 million. However, it is on the rising trend from 1,600 cases in the year 2004 to 2,617 cases in the year 2010¹.

FIGURE 5 : NUMBER OF SCHOOLCHILDREN INVOLVED IN GANGS AND BULLYING



Source: Ministry of Education from the National Report on Violence and Health, Malaysia by WHO (2006)

¹ Personal communication from Ministry of Education

Overview of Child maltreatment Prevention and Child Protection in Malaysia

Malaysia has many programmes that were implemented for child protection and some for child maltreatment prevention. Several programmes had been instituted under the purview of Ministry of Women, Family and Community Development (specifically under the Department of Social Welfare) to protect the interest of the children by providing care and shelter or to rescue and provide assistance to those who have been abandoned by their family, mistreated or neglected. Social workers who are gazetted as Child Protectors look into the social needs and safety of the child; the health workers attend to emotional, psychological and physical health needs of the child, psychodynamics of the family and follow-up whilst the police and legal agencies focus into legal protection of the child and prosecution of perpetrators. There are multidisciplinary child protection teams and hospital-based Suspected Child Abuse and Neglect (SCAN) teams which aim to coordinate management and follow-up, as well as One-Stop Crisis Centres in hospitals and a dedicated police unit in major cities to attend to children suspected to have been sexually abused. The government initiated a hotline “*Teledera*”, which was launched in April 1998 [19]. Subsequently, this hotline combined with Healthline under the MWFCDC were consolidated and an integrated one-stop call centre was launched called the “*Talian Nur 15999*”, with the aim to enable early intervention for victims of domestic violence, child abuse, and natural disasters [20].

The main legislation to protect children from further maltreatment or to deter others from maltreating children is the Child Act 2001, which is a consolidation of three previous Acts –the Child Protection Act 1991, the Juvenile Offenders Act 1947 and the Women and Girls’ Protection Act 1973. In its enactment, there was also consideration to fulfill Malaysia’s obligations under the United Nations Convention on the Rights of the Child (CRC) 1989. Under the Child Act 2001, children are defined as those who are below 18 years old [21]. Family members, child care providers and doctors are subject to mandatory reporting of any suspected child abuse case to the relevant authorities. The Act provides for the setting up of Child Protection Teams to coordinate district based services to families and children in need of protection.

Malaysia has recognised that its legal and policy framework needs to be strengthened in the area of prevention and early intervention. This is also in line with a shift from the traditional focus on reactive protective interventions towards ones that are more proactive. This would include a clear continuum of prevention, early and rehabilitative interventions and restorative justice².

Malaysia has also ratified the Convention of the Rights of the Child with an initial 12 reservations. Eight of these reservations have been withdrawn leaving 5 remaining ones (articles 2, 7, 14, 28(1)(a) and 37³ due to incompatibility with existing domestic laws. These remaining reservations are on articles of CRC relating to non-discrimination; right to a name and nationality; freedom of thought, conscience and

² Beijing High Level Meeting, *Child Protection and Child Welfare services in Malaysia*. Nov 4-6, 2010

³ UNICEF Malaysia, http://www.unicef.org/malaysia/about_crc.html; Malaysia CRC Report 2006, http://mpaweb.org.my/file_dir/20092356204c7b2719c818c.pdf

religion; free and compulsory primary school education; freedom from torture and deprivation of liberty.

Universal child maltreatment prevention programs in Malaysia include maternal home visitation in the antenatal period upon registration with the health clinics, 4 to 6 postnatal visits and newborn check-up up to the first 30 days post-delivery.

There are family development and parenting programmes specifically on marriage and family life, reproductive health, child and adolescents' development delivered by centres of the National Population and Family Development Board under the auspices of the Ministry for Women, Family and Community Development. Religious organisations, both government and non-government, also provide counselling on marriage and family responsibilities.

Selective child maltreatment prevention intervention programs are on the drawing board or early phase of implementation— such as antenatal home visits for young or single mothers and outreach to those at risk for child neglect and substance abuse; training of home visiting nurses to recognise and refer families at risk for child maltreatment; parenting education programs in antenatal clinics for the prevention of inflicted traumatic brain injury and adolescent child health clinics and program with emphasis on abstinence, safe sex and prevention of teenage pregnancy.

Child sexual abuse prevention educational modules have been developed by non-government organisations and delivered in some preschool and primary schools. Although school authorities are open to the program, there is parental resistance to it similar to parental concerns towards sex education programs in schools.

Malaysia has the national policy framework, structural organisation and legislation to enhance and develop programmes for child maltreatment prevention (CMP). There is a “National Child Protection Policy” and “National Action Plan for Children” that are linked to the objectives and visions of the National Social Policy and the National Mission of Vision 2020”. The National Child Protection Policy drawn up by consensus with stakeholders from government, non-government and professional groups, has as its objectives:

- i) to increase the awareness and commitment of various sectors to have a shared responsibility towards protecting children,
- ii) creation of a safe and child friendly environment in the community,
- iii) to encourage organisations that have a direct or indirect contact with children to have child protection policies in place,
- iv) protection of children from neglect, abuse, violence and exploitation and to improve services for such children,
- v) to enhance research and development in the field of child protection.

The Coordinating Council for the Protection of Children was established as provided for under the Child Act 2001 to advise the Minister of MWFCD on all aspects of child protection and the development of

programmes to educate the public on the prevention of child maltreatment⁴. The National Advisory and Consultative Council for Children, which includes non-government stakeholders, chaired by the Minister for the MWFCDC then acts as a national focal point for children's wellbeing and development and to advise the Government.

Rationale and aims of the project

The success of child maltreatment prevention strategies depends largely on individual and community readiness for behavioural change or to adopt a policy change, and national readiness especially with regards to capacity for implementation. Assessment of community and national readiness requires a good and reliable measurement tool. Although there are some existing tools for this type of research, it is necessary to design a measurement tool that can be used internationally and cross-culturally. This would allow comparison on the level of community and national readiness across cultures. From the outset, experts working in child protection work in many countries and languages will need to participate in development of these tools.

As part of the initiative to develop an instrument to measure child maltreatment prevention readiness initiated by the World Health Organisation (WHO), the Malaysian team aimed to contribute on the following areas:

1. Develop an integrated multidimensional model for identifying community and national CMP readiness in collaboration with five other countries, specifically Brazil, China, The Former Yugoslav Republic of Macedonia, Saudi Arabia, and South Africa, that allows cross-country comparisons
2. Develop one standard instrument and pilot test the instrument to assess child maltreatment prevention readiness at community, sub-national and national level in Malaysia
3. Obtain quantitative and qualitative data that identify community and service strengths and gaps in community and national CMP readiness
4. To analyse findings of study to determine strategies and specify measures that can increase community and national CMP readiness
5. To disseminate study findings to national policy makers and stakeholders to develop stage-appropriate interventions and strategies that match the community readiness. This assists the development of national capacity and policy that facilitate child maltreatment prevention
6. To assist setting of benchmarks, so as to monitor improvement or change achieved in the future programs

⁴ National Child Policy, <http://www.kpwkm.gov.my/dasar1>

Ethical consideration

Permission to conduct the research was obtained from Economic Planning Unit, Prime Minister's Department (UPE: 40/200/19 JLD XVII). Ethics clearance was granted by Medical Review and Ethics Committee, Ministry of Health and University of Malaya Medical Institutional Review Board (IRB 830.12), and registered under the National Medical Research Registry (124-NMRR-11-124-875)

Target audience of the research

The outcomes of the study would be useful to:

- Policy makers, programme implementers, advocates and academics at the local and national level who are likely to have some influence over child maltreatment prevention policies in Malaysia
- Public opinion leaders, such as mass media opinion leaders, socially engaged professionals from the health, social, welfare and legal sectors who are responsible for shaping opinions and defining standards
- Community leaders, NGOs, and leaders of child advocacy groups
- Researchers interested in CM and CMP and child issues in general

METHODS

Development of instrument

Child Maltreatment Prevention Readiness (CMPR) interview schedule was developed based on a multi-dimensional model that involved a comprehensive systematic review of existing models and approaches relevant to the assessment of CMPR and expert consultation. The development of the multi-dimensional model started with defining the construct of CMPR and then delineating its construct domain, higher-order dimensions, and lower-order facets. The model specifically incorporates characteristics of CMP pertaining to LMIC based on earlier work on CMPR conducted in Malawi, Mozambique and South Africa. These include measuring awareness of the magnitude, distribution, and consequences of CM, their understanding on evidence-based public health approach to the prevention of CM especially primary prevention, resources for CMP and cultural specific forms of CM.

Following this, a one-day consultation meeting with 17 international experts was conducted to review the initial model. These experts are experts in readiness assessment, public health, instrument development, and child maltreatment, mainly from Brazil, China, The Former Yugoslav Republic of Macedonia, Malaysia, South Africa, the UK, the USA, and the World Health Organization (WHO). The multi-dimensional model was further refined and pilot tested in various countries. The following section discusses the three stages involved in the development of the CMP readiness instrument in Malaysia; i.e. focus groups, cognitive debriefing and pilot testing.

A) Focus group discussion

The focus group discussion was conducted with the aim to allow policy makers and key community leaders to contribute to the development of the CMP readiness instrument by providing constructive comments and suggestions on aspects of CMPR that may require country- or culture-specific adaptations.

A focus group discussion guide was developed to facilitate the discussion. The questions concentrated mainly on whether the model covered all important dimensions and facets of CMPR at the three levels of interest (i.e. national, sub-national/state and community) in Malaysia; the model's strengths and weaknesses; applicability and appropriateness of the proposed dimensions and facets to Malaysian culture and context.

A purposeful sampling was utilized to recruit representatives from governmental and university group. The detailed breakdown of the representatives is presented in Table 2. A total of 11 participants were involved in the focus group.

TABLE 2 : DISTRIBUTION OF THE PARTICIPANTS IN FOCUS GROUP DISCUSSION

Ministry /Agency Involved	No. of participants
Hospital	2
National Population and Family Development Board	2
Department of National Unity and Intergration	1
Ministry of Health	3
Ministry of Women, Family and Community Development	2
University	1

B) Translation and adaptation of instrument

The Readiness Assessment for the Prevention of Child Maltreatment (RAP-CM) interview schedule has a set of quantitative and qualitative items devised based on the multi-dimensional model and FGD inputs from various countries. The translation of the RAP-CM instrument was conducted using the forward-backward translation technique prior to field testing. The original English version was translated into

Malay language by two graduate research officers independently, bilingual users of the languages. The drafts of the instrument were then discussed and agreed on to a single Malay version by the researchers.

Backward translation on the Malay version was then performed by a bilingual public health specialist without referring to the original English version. The translated version was then compared with the original English version. The team discussed any inaccuracies or disaccords for the RAP-CM and rectified the items to ensure the Malay version retains the original meaning. The translated version focused on using direct words and expressions that were widely understood and cultural acceptable in the local context. The translated RAP-CM interview schedule was then pre-tested in the cognitive interviews. Training sessions were provided to the interviewers whereby a detailed step-by-step discussion of the RAP-CM interview schedule was described to and conducted with the interviewers. During the training itself, further revisions to the translated questionnaires were made.

C) Cognitive Testing

The cognitive testing for the RAP-CM questionnaire was aimed to assess: whether it generated the information required; the quality (e.g. clarity, intelligibility) of the interview schedule; how interviewee's elaborated on their answers; how they interpreted the questions; and identify any difficulties and problems in the conduct of the interview.

The interviewers were asked to note their own experiences administering the interview schedule and their respondents' experience of overall interview, including:

- i. acceptability of the overall interview;
- ii. clarity of overall layout;
- iii. order the dimensions, facets, and questions are presented in;
- iv. time required and time management;
- v. logistical problems - e.g. recording replies (in writing, tape-recording);
- vi. rapport with interviewee; questions or sections which may have made interviewer or interviewee uncomfortable;
- vii. interviewee's reaction to knowledge assessment and educational sections;
- viii. specifics of the interview schedule, such as introductory remarks, comprehension of question, motivation, social desirability, response process, scoring scheme; guidance and prompts for interviewer; explanations and clarifications for interviewee; instructions to interviewer to skip questions; and other relevant comments.

The cognitive interviews were conducted among 10 interviewees. The subjects of the cognitive interviews were specifically selected so that samples were similar to those who would be participating in the study. These interviewees consisted of officers from various ministries (mainly the Ministry of Health and Ministry of Women, Family and Community Development) and health service providers (e.g. clinics and hospitals). The interviews took an average of 90 minutes to complete.

Further modifications to fine-tune the translated questionnaire were made after the cognitive testing.

Pilot study

The main purpose of the pilot-testing phase was to assess the quality of the instrument and refine the protocol. The instrument was translated from English to Malay and field tested with personnel working in the area of child maltreatment or child related issues in both government and non-governmental organisations. These include policy makers, programme implementers, advocates, researchers, etc. in governmental, non-governmental and private organisations who have or are likely to have some influence and decision-making power over child maltreatment prevention in Malaysia, either at national, sub-national (state, district), or community level.

The questionnaire was pilot-tested with 20 individuals (see Table 3) using convenience sampling with the aim to check for acceptance of the protocol, question wording, order, and survey length to minimize respondent burden and maximize question clarity. A face-to-face interview was conducted. An information sheet for prospective interviewees, a consent form for interviewees and a sheet with a definition of child maltreatment on it, and the RAP-CM interview schedule was provided to the participants.

TABLE 3 : DISTRIBUTION OF THE PARTICIPANTS IN PILOT STUDY

Agency	No. of participants
Governmental organisation (ministry or department level)	12
Non-governmental organisation	6
International organisation	2
Total	20

Field trial

The field testing was conducted with 42 interviewees using the RAP-CM questionnaire. The purpose of the interview was to obtain respondents' view of the level of readiness of the country or state to implement large-scale evidence-based child maltreatment prevention programmes. A face-to-face interview was conducted using the semi-structured interview schedule. The final version of the RAP-CM interview schedule is divided into 10 dimensions including a concluding section (*For details of the interview schedule and its psychometric properties, please contact Christopher Mikton, Department of Violence and Injury Prevention and Disability, Non-communicable Diseases and Mental Health, World Health Organization*).

The target population in this proposed study was major stakeholders involved in the child protection services or early child development programmes; key players or potential key players in CMP or in positions of some influence and decision-making power in the field. They include policy makers, high ranking officers or directors of government agencies that have child-related services (specifically MOE,

MWFCD, MOH), major service providers that have direct contact with children such as welfare officer, police, health staff, district leaders, spiritual leaders, and non-governmental organisations. Interviewees came from government, NGOs, community-based organisations, international organisations, donor agencies, universities and research institutes. Samples were selected to be representative of the field at the national and state/sub-national levels. Participants interviewed for the pilot testing were not included for the field testing. Table 4 displays the distribution of the participants for the field test. Letters of invitations was sent out to 66 respondents to recruit 42 participants, giving a response rate 63.9 percent. The interviews took about 60-90 minutes to complete.

TABLE 4 : DISTRIBUTION OF THE SAMPLES ACCORDING TO TYPE OF ORGANISATIONS FOR THE FIELD TEST

Type of organisation		National level	State level	Local level (community)
International	- International organisations (e.g. UNICEF, WHO, etc.)	1	-	-
Government departments or ministries	- Health - Social welfare - National Unity - Education - Development - Criminal Justice	14	5	-
Civil society	- National NGOs - Community-based organisations - Faith-based organisations	5	10	4
Research	- Universities - Research institutes	3	-	-
Total		23	15	4

Process of carrying out interviews

A formal letter of approval to conduct the study was sent to various selected authorities. The researchers also visited the selected authorities and explained the purpose, content and nature of the study upon request. After approval was obtained from the selected authorities, all respondents were interviewed in private.

The study purpose was explained to the respondents. An information sheet about the study was provided to each participant together with a consent form. Participation was fully voluntary, and during the briefing session, participants were informed prior to commencing the interview that they may refuse to be interviewed or terminate the interview anytime and that such refusal or termination will not cause any disadvantage or unpleasant consequence to them. Informed consent from the respondents was obtained before conducting the interviews. Most of the interviews were conducted by the researchers (ICGS and CWY) with the assistance of two other research assistants. The interviews were conducted

either in Malay or English. Participants were given a souvenir as appreciation at the conclusion of the interview.

Where respondents were not clear as to the distinction between child protection and CMP, it was clarified to the respondent that CMP refers to measures taken to prevent CM before it occurs as compared to child protection which refers to measures taken after CMP has occurred.

Challenges conducting the research

During the course of conducting the interviews, the researchers faced with several issues. It was difficult to recruit participants at the ministerial level. Most officers that were involved directly in child protection work often needed clearance from their superiors to participate. Obtaining approval at the ministerial level took about 1-3 months and required a number of follow-ups. However, all ministries and departments were generally very cooperative. Once approved, the time gap between initial contact and the actual interview was on average shorter (between 1-2 weeks) depending on the availability of the respondents. Interviewing with participants from non-governmental organisations was relatively easier to organize and required shorter waiting time period. Legislators were the hardest group to recruit in the study.

From the outset of the study, the research recognized that participants might divulge sensitive information or negative views about child maltreatment issues and related policies during the interview. There was a danger that participants would not disclose their experiences or withheld their views. For this reason, an attempt was made to ensure that participants would feel able to disclose by emphasizing the confidentiality of their responses, and reminded them that their name (or their affiliations) remained anonymous.

Process of conducting objective assessment

The objective assessment responses were the outcome of a process of review of current literature, interviews, discussion and consultation. First, an extensive and comprehensive document analysis of existing laws, programs, resources and policies through reviewing governmental, non-governmental and international agencies' reports, documents, and websites as well as from interviews conducted with key informants.

The following data was collected for the objective assessment:

- Key country conditions which will have a significant bearing on the country's readiness and capacity to implement CMP: obtained from the Malaysian Housing and Population Census Data 2010, UNICEF country statistics, World Bank country statistics, CIA World Facts (see Appendix 1).

- Scientific data or study related to prevalence, risk factors, consequences, costs and related issues in Malaysia: journal articles (see Appendix 2), Ministry's annual report and other country reports such as the 3rd AIPA CAUCUS REPORT
- Information collected through interviews with key informants from Ministries and NGOs. Where interviews were not possible, the RAP-CM interview schedule was sent to the relevant Ministry to gather the information. The information was then compiled and call-back telephone interviews were carried out if required information was missing. Specific information collected (in addition to the above) from the Ministries and NGOs (including accessing their websites) are as follows:
 - Existing programmes on related to children
 - Existing laws and policies such as Child Act 2011, National Policy on Children and the National Policy on Child Protection.
 - Specific information on governmental or non-governmental organisations, institutions, networks, coalitions, on CMP; budget and human resources in each agencies;
 - Institutions providing education on child maltreatment or related curriculum

The following is the list of main agencies involved - The Ministry of Women, Family and Community Development (including Department of Social Welfare, National Population and Family Development Board); Ministry of Health; Ministry of Education; Department of National Unity; Ministry of Rural and Regional Development; Royal Malaysian Police; PS the Children; Yayasan Chow Kit; Women Centre for Change, Penang; Federation of Reproductive Health Associations, Malaysia (FRHAM) and UNICEF.

Finally, the research team then reviewed and discussed all available information gathered to reach consensus opinion for the objective assessment using the Readiness Assessment for the Prevention of Child Maltreatment based on Expert Opinion using all available Data (RAP-CM-XD) interview schedule *(For details, please contact Christopher Mikton, Department of Violence and Injury Prevention and Disability, Non-communicable Diseases and Mental Health, World Health Organization).*

Data management and analysis

Data management

To increase the accuracy of the data, a call-back to the interviewees were conducted in case of doubtful answers or incomplete filling of the questionnaire. All completed data was sent to University of Edinburgh for data entry. For the field test data, data was validated using a double entry method was used. Outliers were assessed and checked with the original questionnaire for accuracy and corrections were made where appropriate. Unknown values were treated as system missing values.

Quantitative Analysis

The Readiness Assessment for the Prevention of Child Maltreatment (RAP-CM) interview schedule has 10 dimensions and each dimension may consist of 4-12 core questions. Each item in the RAP-CM has a score ranging from 0 to 2, with several exceptions. Score for items related to a single dimension were summed up and then divided by its maximum possible score to obtain a raw score for that dimension. The calculated raw score were subsequently standardized to a 10-point scale by multiplying them by 10. For example, if the total score for Dimension 1 is 12 out of a maximum possible score of 14:

$$12/14 = 0.86 \times 10 = 8.6$$

The calculated total score for all dimensions were summed up to obtain a total score on CMP readiness. The total score of CMP readiness ranged from 0 to 100. A higher score indicates greater perceived readiness for CMP.

A further analysis was performed to examine data for national and sub-national level, as well as government and non-government organisations (NGOs) separately. This helps to identify the country's strengths and gaps in terms of readiness to implementing child maltreatment prevention programmes. As the sample size from the community based level was small, we categorized them into sub-national level taking into consideration that community-based activities are usually limited to districts or state level.

The scoring for the objective assessment was done using Readiness Assessment for the Prevention of Child Maltreatment based on Expert opinion using all available Data (RAP-CM-XD) scoring system. A higher score indicates greater readiness for CMP from expert opinion using all available data.

All quantitative data were processed and analysed by using the SPSS Version 16. Descriptive analysis will be performed to obtain frequency, proportions and mean (SD) (where appropriate).

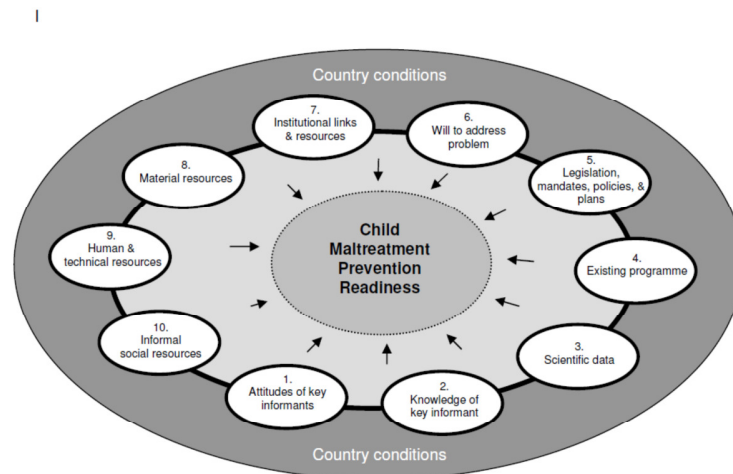
Qualitative Analysis

Qualitative data was collected from respondents' comments to the open-ended question sections in the RAP-CM interview schedule, observations, views and reflections about the interviews noted by the interviewers. The results from the qualitative data were utilized with a focus to further understand the nuances underlying the quantitative responses and enhance interpretation of the overall results. The data was analysed and classified to identify the most common themes. These categories were then quantified. Quotations were included in sections to highlight common and/or interesting themes.

The ten dimensions of RAP-CM questionnaire

RAP-CM is based on a model of readiness for CMP made up of the following 10 dimensions as shown in Figure 6:

FIGURE 6. DIMENSIONS OF THE CHILD MALTREATMENT READINESS MODEL



Dimension 1 - key informants' attitudes towards child maltreatment and its prevention;

Dimension 2 - key informants' knowledge of child maltreatment and prevention;

Dimension 3 - scientific data on child maltreatment and its prevention

Dimension 4 - existing programmes and their evaluation

Dimension 5 - legislation, mandates, policies and plans

Dimension 6 - will to address the problem

Dimension 7 - institutional links and resources - focuses on assessing existing partnerships, coalitions, networks, and alliances between institutions in Malaysia dedicated to child maltreatment prevention and the extent to which they involve different sectors

Dimension 8 - material resources for child maltreatment prevention, both in terms of financial resources and infrastructure and equipment

Dimension 9 - human and technical resources dimension which aims to gain an indication of the availability of personnel with specialized technical, administrative, and managerial skills, knowledge, and expertise in child maltreatment prevention; and the existing institutions in for education and training in child maltreatment prevention in Malaysia

Dimension 10 - informal social resources dimension which focuses on measuring interviewee's perceptions on the quality of social interactions and social bonds within a community or society.

The Conclusion section focuses on gauging interviewees' views on the most important problem facing child maltreatment prevention work in Malaysia and the multidimensional model.

FINDINGS

Overall

The following section presents data on the assessment of child maltreatment prevention readiness in Malaysia. The data were all drawn from the 42 interviewees' responses to the WHO CMP interview schedule questionnaire. The results are presented in 10 dimensions on the basis of the multi-dimensional model.

Based on the responses given by the respondents in this study, through the application of the RAP-CM survey, the total CMP general readiness score for Malaysia is 43.73/100, with a minimum value of 23.43 out of 100 and a maximum score of 79.5 out of 100.

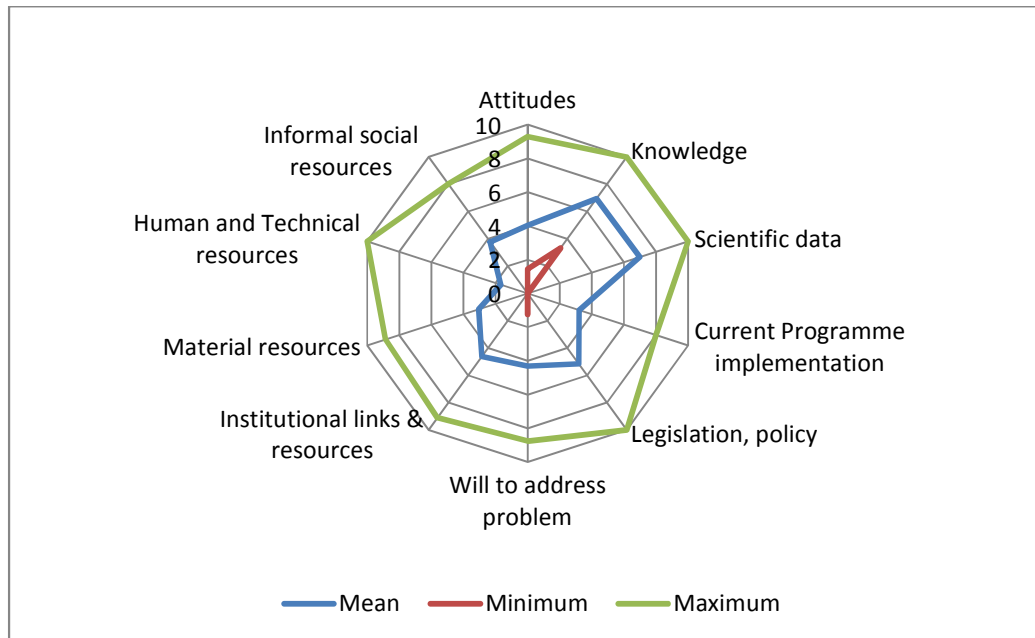
Total CMP Readiness for Malaysia = 43.73/100

There was a general perception that Malaysia was more ready for CMP from the aspects of 'scientific data on CM', 'knowledge of child maltreatment prevention' scoring above 60 percent, whilst there was a low perceived readiness score for 'human and technical resources' (17 percent), 'material resources' (31 percent) and 'current programme implementation and evaluation' (32 percent) (see Table 5). There is a wide difference between the minimum and maximum score for the majority of dimensions indicating the wide differences in perception or knowledge of readiness between respondents (see Figure 7 and Appendix 4).

TABLE 5: OVERALL SUMMARY OF EACH DIMENSION SCORE FOR ALL RESPONDENTS

Dimension	Mean score (1-10)
Dimension 1: Attitudes towards child maltreatment prevention	4.03
Dimension 2: Knowledge of child maltreatment prevention	6.94
Dimension 3: Scientific data on child maltreatment prevention	6.99
Dimension 4: Current programme implementation and evaluation	3.21
Dimension 5: Legislation, mandates, and policies	5.16
Dimension 6: Will to address the problem	4.30
Dimension 7: Institutional links and resources	4.61
Dimension 8: Material resources	3.05
Dimension 9: Human and technical resources	1.67
Dimension 10: Informal social resources (non-institutional)	3.76
Total	42.97/100

FIGURE 7 : OVERALL SUMMARY OF MEAN, MINIMUM AND MAXIMUM READINESS SCORE FOR EACH DIMENSION



Comparing scores from National and Sub-national organisations

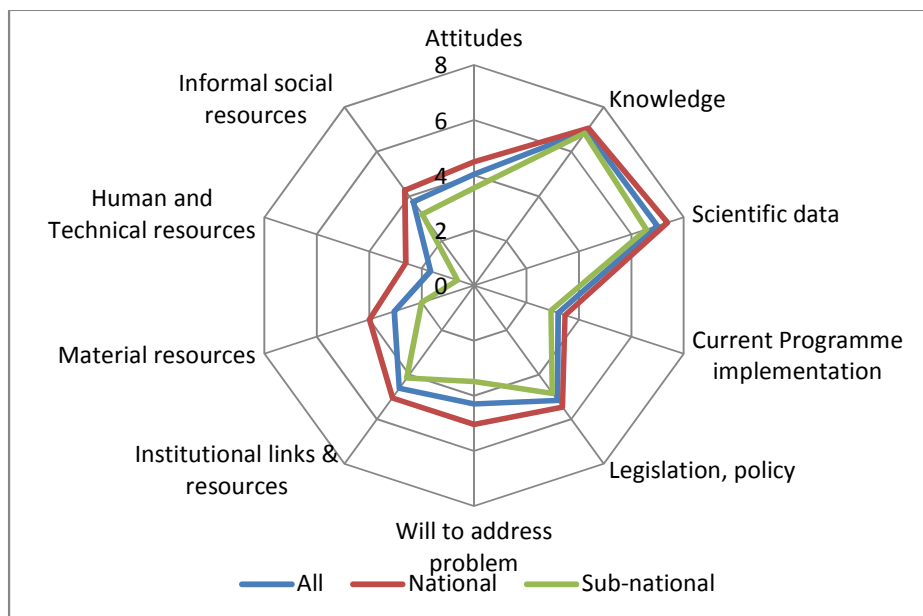
On comparing the scores on CMP based on the responses of those in national and sub-national organisations, the total scores were higher for the national group at 49 percent compared to 38 percent for the sub-national group. On further analysis, the scores were similar for the dimensions of 'knowledge for CMP' and 'scientific data for CMP' as well as availability 'legislation, mandates and policies', scoring between 48-74 percent. Both national and sub-national groups scored 'scientific data availability' and 'knowledge of CMP' as the two strongest dimensions for the purposes of CMP, and 'human and technical resources' as the weakest link in CMP, the latter particularly felt at the sub-national level (see Table 6 & Figure 8). Respondents from the district levels were grouped under the sub-national level as the numbers were rather small.

Notably, the difference in scores between national and sub-national levels was greatest for the dimension of 'material resources' followed by 'human and technical resources', 'will to address problem' and 'informal social resources' in decreasing order. This is not surprising as workers in the sub-national level would be expected to receive fewer resources if the resource capacity is perceived to be insufficient even at the national level.

TABLE 6: SUMMARY OF EACH DIMENSION SCORE COMPARING NATIONAL AND SUB-NATIONAL ORGANISATION

Dimension	National	Sub-national
Dimension 1: Attitudes towards child maltreatment prevention	4.48	3.54
Dimension 2: Knowledge of child maltreatment prevention	7.05	6.83
Dimension 3: Scientific data on child maltreatment prevention	7.38	6.57
Dimension 4: Current programme implementation and evaluation	3.47	2.93
Dimension 5: Legislation, mandates, and policies	5.45	4.83
Dimension 6: Will to address the problem	5.04	3.48
Dimension 7: Institutional links and resources	5.04	4.15
Dimension 8: Material resources	4.00	2.00
Dimension 9: Human and technical resources	2.61	0.63
Dimension 10: Informal social resources (non-institutional)	4.27	3.20
	48.79	37.92

FIGURE 8: COMPARISON OF SCORES PER DIMENSION FOR ALL RESPONDENTS, THOSE AT NATIONAL LEVEL AND SUB-NATIONAL LEVELS



Comparing scores from Government and Non-governmental organisations

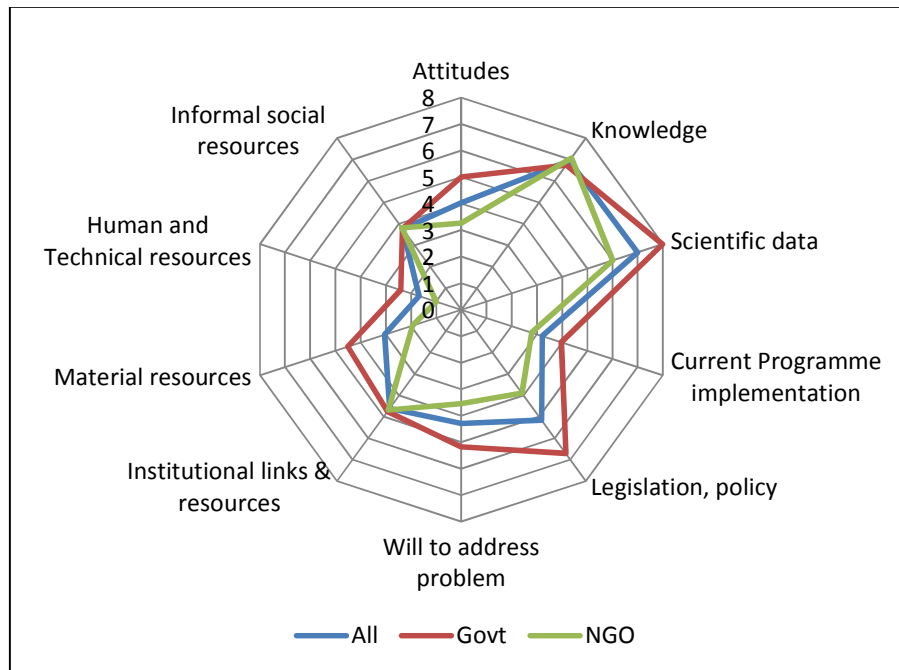
Government respondents gave higher scores for CMP from aspects of 'scientific data availability', 'knowledge of child maltreatment prevention' and 'legislation' whilst the NGO respondents assessed 'knowledge of child maltreatment prevention', followed by 'scientific data availability' and 'institutional links' as the dimensions with the highest CMP readiness. Total overall score from government respondents was 51 percent as compared to total score of 38 percent from NGOs responses (see Table 7 and Figure 9).

Both government and NGO respondents assessed the level of readiness similarly for 'knowledge' regarding CMP, 'institutional links and resources' and 'informal social resources'. Both groups scored the dimension of 'human and technical resources' as lowest. The widest disparity in assessment was in the perception of how readily 'legislation, mandates and policy' prevent CM with a score difference of 2.82, followed by 'material resources' (2.57) and 'attitudes towards CMP' (1.73). Respondents from government agencies had higher readiness assessment scores for these three dimensions.

TABLE 7 : SUMMARY OF EACH DIMENSION SCORE COMPARING GOVERNMENT AND NON-GOVERNMENT ORGANISATIONS

Dimension	Governmental	Non-governmental
Dimension 1: Attitudes towards child maltreatment prevention	5.00	3.27
Dimension 2: Knowledge of child maltreatment prevention	6.74	7.08
Dimension 3: Scientific data on child maltreatment prevention	7.99	6.00
Dimension 4: Current programme implementation and evaluation	3.96	2.79
Dimension 5: Legislation, mandates, and policies	6.71	3.89
Dimension 6: Will to address the problem	5.18	3.55
Dimension 7: Institutional links and resources	4.75	4.69
Dimension 8: Material resources	4.51	1.94
Dimension 9: Human and technical resources	2.41	0.99
Dimension 10: Informal social resources (non-institutional)	3.79	3.81
	51.05	38.01

FIGURE 9. COMPARISON OF SCORES PER DIMENSION FOR ALL RESPONDENTS, THOSE FROM GOVERNMENT OR NGOS



Quantitative and Qualitative Analysis for Each Dimension

Dimension 1: Attitudes towards child maltreatment

OVERALL DIMENSION SCORE (DIMSCORE) = 4.03/10

National DIMSCORE = 4.48/10, Subnational = 3.54/10

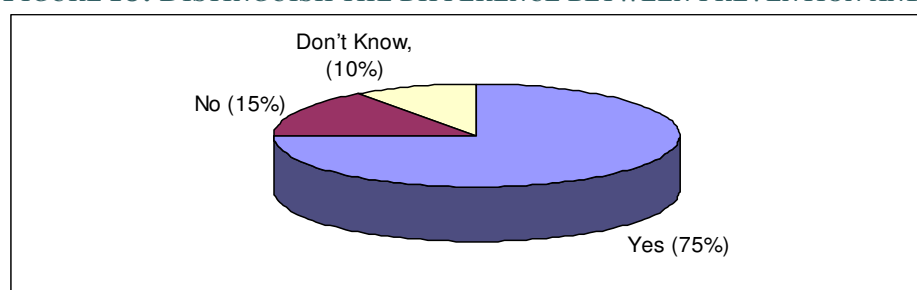
Government DIMSCORE = 5.00/10, NGO = 3.27/10

Difference between child maltreatment prevention (CMP) and child protection

Some time was spent with most of the respondents in differentiating the difference between CMP and child protection. WHO defines “child protection” as measures to substantiate reports of suspected child maltreatment and either directly or refer to appropriate support, care and treatment for the child victim, i.e. intervention after the child maltreatment has occurred. “Child maltreatment prevention” as defined by WHO, refers to measures taken to prevent child maltreatment before it occurs by addressing the underlying causes and risk and protective factors.

In differentiating child protection from child maltreatment prevention, one respondent said that “Protection is action that is taken for the best interest of the child” and “prevention is preventing the need for protection to be done”. Some from the non-government sector felt that ‘child protection’ was a broader issue than ‘prevention of child maltreatment’ in the sense that the former “*could be protection against harm such as accidents or malnutrition*”. Seventy-five per cent said that they knew the difference between child protection and child maltreatment prevention (See Figure 10). However, in the qualitative responses they used the two terms interchangeably. Respondents felt strongly that CMP and child protection is strongly interconnected and that prevention responses should address both CMP and child protection.

FIGURE 10. DISTINGUISH THE DIFFERENCE BETWEEN PREVENTION AND PROTECTION



Perceived priority

Sixty-four percent of respondents felt that CM was a serious problem and felt that CMP is possible. However, 71 percent of respondents were of the opinion that CMP was generally considered to be of low or extremely low priority compared to other health issues such as childhood infections and HIV, or social issues such as abandoned babies and single mothers. Nineteen percent did feel that it was of high priority whilst 45 percent felt that CMP was less of a priority compared to child protection. The majority (62 percent) felt that the measures taken so far to prevent CM have been inadequate. Only 10 percent felt that the measures taken so far were adequate and the rest were equivocal.

Protection of child rights

Whilst 52 percent of respondents said that the rights of children were moderately to extremely well-protected under the legislation, the majority 67 percent perceived that the legislation was lacking in implementation and that the rights of children were inadequately or not well protected at all by this legislation. Many respondents commented on the use of '*budi bicara*' (own valued judgement and resultant action or inaction) in the enforcement of the Child Act 2001. There is social acceptability of physical punishment and there is lack of youth participation in policies that affect children. Corporal punishment is allowed in school but to be meted out only by the principal, discipline teacher or other designated teachers. "Parental rights" was believed by many respondents to be as important as "child rights".

Those from NGOs ranked the attitudes promoting CMP to be lower than those from government, particular in terms of priority and implementation of child rights. Those from sub-national level placed the readiness level lower than those from the national level.

Dimension 2: Knowledge of Child Maltreatment Prevention

OVERALL DIMSCORE = 6.94/10

National DIMSCORE = 7.05/10, Subnational = 6.83/10

Government DIMSCORE = 6.74/10, NGO = 7.08/10

Dimension 2 had the second highest score for a single dimension in CMP in Malaysia, showing an intermediate level of knowledge on the forms of child maltreatment, risk factors for and its consequences. There was minimal difference in the scores between government and non-government respondents, with individual minimum score of 3.3 and highest individual score of 10.0 in terms of knowledge on CMP.

Forty percent of the respondents could name at least 4 types of child maltreatment, i.e. physical, sexual and emotional abuse and neglect (see Appendix 5, Tables I and II). Two respondents mentioned child labour and malnutrition as additional forms.

The majority of respondents (61.3 percent) could give at least 2-4 consequences of child maltreatment (see Appendix 5, Tables III and IV). Psychological and emotional trauma, low self-esteem, withdrawal and violent behavior, lack of trust in relationships were listed by respondents as the most common consequences of child maltreatment. Surprisingly drug abuse as a consequence was given by only one respondent. According to a Ministry of Education officer, many of the school students involved in disciplinary problems had a history of child abuse or neglect. Sixty percent of participants did not know the percentage of the current population of adults who were mistreated as children.

Health costs, social ills, rehabilitation costs, human resources costs and legal costs to society were the main costs from child maltreatment given by 40 percent of respondents, apart from the health and social consequences to the victims themselves (see Appendix 5, Table V).

Poverty was given as the main risk factor for child abuse, followed by dysfunctional family, cultural factors and lack of parenting skills. Fifty percent of respondents could list 3-4 risk factors with one person naming 21 risk factors (see Appendix 5, Table VI). Exposure to pornographic media which is readily available in the city, and other negative influences such as parental drug abuse or alcoholism as well as lack of religious knowledge were other risk factors cited.

Evidence-based prevention programmes

Little more than half of respondents (56.5 percent) had heard of evidence based approach to CMP but the majority of these were unaware of a 'public health approach' to child maltreatment prevention. When asked about the appropriateness of selected evidence based programmes, most agreed that the programmes were appropriate in Malaysia.

Early home visitation, especially for high risk groups, was felt to be appropriate by 66 percent of respondents. There were some concerns with implementation since it is resource intensive and requires dedicated and skilled personnel. As such, some expressed that it may not be as useful for mass intervention. It was felt that home visitation would be acceptable to the community if done as part of a normal health screening such as in the postnatal home visits for newborn and mothers or early childhood health programme.

Parenting education was deemed to be appropriate by all except one participant, with 72 percent rating it as extremely appropriate. There was a recommendation to make such parenting education free. Parenting education could also be given through religious groups or residents' associations.

A frequent response was that parenting courses did not reach high risk families and that innovative ways were required to reach high risk groups, such as providing incentives to attend parenting classes. One NGO respondent remarked that *"Parents, guardians and professionals, should be sensitized and educated on their roles, functions and responsibilities towards the child. At the same time, positive, non-violent and participatory methods of child rearing should be promoted."* Existing parenting courses had a small charge other than those conducted by NGOs and religious bodies. A few participants felt that having parenting courses through Neighbourhood Committees (such as *"Rukun Tetangga"*) also enables the community to be more closely knit and help to prevent child maltreatment within community.

All but one felt it was appropriate to have *child sexual abuse prevention education*. However, many from NGOs and professional groups felt that implementation was a problematic issue as it was generally interpreted by the teachers and public as giving sexual education in schools instead of a programme to teach safety and for the child to say "no" to unsafe touches. Common responses were that teachers are not willing or trained to implement the Reproductive, Health and Social Education curriculum in schools where sex education is incorporated. Some respondents felt that the implementation of the curriculum had been hindered by cultural and religious influences. Several respondents reported that teachers and parents were concerned about such education being perceived by the school children as promoting sexual promiscuity. One social worker quoted a teacher as saying that *"sex education was just like handing out condoms"* to the school children and that it *"could encourage prostitution"*.

The lack of knowledge of sexual education is exemplified by the fact that the *"majority of adolescent girls who have been admitted to hospital for alleged sexual abuse are not aware of the risk of sexually transmitted infections, HIV or pregnancy"* according to a paediatrician respondent. Police respondents stated that about half of all "rape" reports are actually consensual acts but reported as "rape" to avoid rebuke from parents. The majority of those girls who were pregnant were not aware of the possibility of getting pregnant, the meaning of contraception or safe sex.

Programmes for abusive head trauma prevention was rated to be appropriate by 95.1 percent of respondents, with medical and health staff gauging such programmes to be extremely appropriate.

Media campaigns to raise public awareness of CMP were felt to be 'very appropriate' by 61 percent and 'appropriate' by 32 percent of respondents. A minority felt that media campaigns were not as appropriate as the past media coverage had tended to be sensationalized and one-off.

Dimension 3: Scientific Data on child maltreatment

OVERALL DIMSCORE = 6.99/10

National DIMSCORE = 7.38/10, Subnational = 6.57/10

Government DIMSCORE = 7.99/10, NGO = 6.00/10

This dimension had the highest score for a single dimension in terms of CMP, showing a perception of data on CM in Malaysia being fairly readily available. There was concordance in the assessment of CMP readiness amongst the various subgroups.

The majority, 88 percent, of respondents are aware of available data on the magnitude and distribution of child maltreatment and more specifically for the magnitude and distribution of child physical abuse and sexual abuse. However, only 33 percent are aware of data being available for emotional abuse and 50 percent of all respondents felt that data on child neglect is not available. Furthermore, 83 percent said that information on consequences of child maltreatment in Malaysia is not available or they are not aware of such information.

There are official legal definitions for child abuse and neglect and most were aware of this. The definitions of the various types of child maltreatment used were consistent amongst the respondents except for that of 'child neglect' which varied from one agency to another.

Seventy-six percent of respondents knew about the existence of a mandatory system for reporting instances of child maltreatment to the welfare or police. For those who knew about the mandatory reporting system, there was a lack of clarity about who, other than doctors, was mandated to report CM. Three respondents thought there was no official definition of CM – two were from NGOs and one was from a government department. Some did not know that family members are mandated reporters while some thought that teachers are already mandated to report CM. Eight out of nine respondents, who thought the existing system was a non-mandatory system, were from NGOs or an international organisation.

Thirty-two percent gave an estimated data of only 5-10 percent of CM cases being reported to the authorities. About a third did not know the actual percentage of CM cases that were being reported. This is primarily due to the lack of availability of large national prevalence studies.

Only 24 percent felt that system was working well whilst 43 percent felt reporting system was working poorly in terms of enforcement of the mandatory reporting system. From the experience of these latter group, people close to the family are very hesitant to report especially to the police due to various reasons: perceived inefficiencies and lack of clarity of the reporting process; prolonged process after reporting assuming the case was being brought to Court; lack of trust in the effectiveness of the system to prosecute the perpetrator or protect the child after all the 'trouble of reporting' ; not wanting to put the family into trouble with the police; feeling sympathetic to the alleged perpetrator who is a relative,

neighbor, friend or bread winner; or feeling that it is not their business to report. Despite the law protecting the identity of reporters of child maltreatment, respondents commented that many relatives or potential reporters who knew the family feel afraid of being harassed and are actually threatened by the alleged perpetrators after reporting. In addition, many victims in school had to switch schools after reporting due to lack of confidentiality and resulting stigma.

Half of respondents (52 percent) were aware of procedures being in place for compiling data for regular publication. The ones knowledgeable about the procedures were mainly the senior government officials.

Slightly less than half of respondents (44 percent) strongly felt that scientific evidence does shape the thinking and decisions of those involved in CMP. However, the impact of the scientific evidence was felt to be greater on the thinking of clinicians, other professionals and scientists as compared to the thinking of political leaders who also have to consider the pressure of public opinion and whether the evidence is “in line with their political agenda”.

Dimension 4: Current Programme Implementation and Evaluation

OVERALL DIMSCORE = 3.21/10

National DIMSCORE = 3.47/10, Subnational = 2.93/10

Government DIMSCORE = 3.96/10, NGO = 2.79/10

This dimension has the third lowest score of the various dimensions in readiness for CMP. Current efforts in CMP appear to be disproportionately less widespread compared to the significant efforts undertaken for child protection (see Appendices 6-8). Comprehensive national or state-focused strategies for the child maltreatment prevention were perceived to be lacking in Malaysia.

Approximately 73 percent of the respondents in the study could name at least one child maltreatment programme that had been implemented currently or in the past in the country. Most participants did not initially differentiate between preventative or protection programme but could do so after further reminder.

About slightly half of the participants (56.9 percent) were aware of existing programmes where child maltreatment components could be integrated. Respondents had cited several problems with CMP programme implementation with parenting skills education and sex education in schools. A module for Reproductive Health and Sex education was developed by the MWFCF under ministerial leadership but could not be implemented in schools due mainly to parental objections under religious and cultural grounds, citing such module promotes promiscuity. As another example, the 'Safe touch' program taught by NGOs such as PS the Children to children in secondary schools and in nurseries could only be conducted on an ad hoc basis with the approval of the Parent teachers' association of individual schools. According to the Association of Early Childhood Development, many parents objected to the safe touch program.

Secondly, many programmes could not be sustained due to lack of resources and funding. Sub-national government respondents lamented that the same number of staff was expected to carry out additional programs. They felt under-resourced and unclear on the process of implementation of programmes which were at times ad hoc and where target groups change from time to time.

Sub-national and some NGO respondents commented that programmes were introduced as a reactive response to headline news and strong public opinion, such as when a child dies from CM. This meant that some of these hurriedly introduced programmes were not as well-structured as they could have been and had to be implemented with no increase in funding or manpower. Thirdly, many programmes have been implemented but evaluations of their effectiveness are very inadequate. One social worker and a paediatrician commented that activities held in Child Activity Centres, such as having a Children's Day celebration, tuition classes and religious classes, may be involving children who are already attending paid classes elsewhere and this may result in a lack of impact on reducing or preventing CMP.

"Are the children in the high risk groups such as those loitering in the streets or shopping complexes, the socially isolated children or disabled children attending the Child Activity Centres? Are there any classes for the children on building self-esteem?" were some of the issues raised.

Dimension 5: Legislation, policies and mandates

OVERALL DIMSCORE = 5.16/10

National DIMSCORE = 5.45/10, Subnational = 4.83/10

Government DIMSCORE = 6.71/10, NGO = 3.89/10

The fifth dimension measures the level of awareness of the respondents on the availability of existing laws, mandates and policies related to CMP. Overall, the score for this dimension was lowered by a general perception that the existing policies, related laws and mandated organisation were not that effective in CMP. The respondents from the national level (mainly government organisations) were more aware of policies and legislation than the sub-national and NGO groups.

Ninety percent of respondents were aware of legislation in force relevant to CM, mainly ascribing to the Child Act 2001. Other legislation given by a few respondents were Convention of the Rights of the Child, Penal code, Child Care Act. The following legislation was only named by one or two respondents each – Domestic Violence Act, Commercial Act (to prevent child labour and prostitution), Child Evidence Act, Child Trafficking Act, Employment Act. However, nearly half of respondents (49 percent) felt that the legislation is not effective or extremely ineffective in preventing CMP, that is, in deterring CMP for fear of prosecution. Nearly half (41 percent) of this group was from government sector, 7 from NGOs, and 3 from other sectors. Seven respondents, who felt that it was effective or extremely effective in preventing CM, were all from government departments.

Sixty two percent stated the Department of Social Welfare (DSW) as being the agency officially mandated with CMP, whilst the rest mentioned that there was no mandated agency with that role. Some quoted the Ministry of Education as having an important role in CMP although it was not the mandated organisation for CMP. Of the 26 respondents who said there was a mandated organisation for CMP, the effectiveness of the Department of Social Welfare (DSW) in CMP was rated as effective by 38.4 percent, ineffective or extremely ineffective by 30.8 percent and nearly another one-third (30.8 percent) was equivocal.

About fifty nine percent of the respondents agreed that there existed official policies on CMP that sets out the main principles and defines goals, objectives, prioritized actions and coordinated mechanisms for preventing child maltreatment. Several from government sectors or NGOs who could name the policies as the National Child Protection Policy and the National Action Plan for Children were those who were directly or indirectly involved in the development of such policies. In assessing the effectiveness of these policies, 42 percent, of whom the distribution was equal in terms of government or NGO respondents, felt that the policies are ineffective or extremely ineffective to protect children. Some of the reasons given for this were implementation issues, lack of coordination between agencies and lack of capacity in terms of manpower and training. Thirty-one percent was unaware of the level of effectiveness due to lack of published reports or mention of any evaluation exercises. Slightly more than

half (57 percent) was of the opinion that CMP should be done at national level whilst 29 percent felt that CMP implementation at the community level was more important. At the community level, a particular CMP can be “tailor-made” for the needs of the children and families of that particular community, and the relevant target groups can be more readily identified.

Dimension 6: Will to address problem

OVERALL DIMSCORE = 4.30/10
National DIMSCORE = 5.04/10, Subnational = 3.48/10
Government DIMSCORE = 5.18/10, NGO = 3.55/10

This dimension tries to gauge the strength of the will to address CMP (i.e. before child maltreatment occurs) in Malaysia and focuses on five different facets: leadership, political will, public will, advocacy and communication. Notably, the dimension score was significantly lower in those in working in the sub-national level compared to those in the national level.

LEADERSHIP

About a third (38 percent) of respondents felt that there was some level of concern about preventing CM amongst the country's leaders be they political, religious, business leaders or civil society. NGO and professional respondents were of the opinion that these concerns for CMP were generated by media news on CM such as sexual abuse, severe physical abuse, baby dumping or child deaths from abuse. The concern from political leaders and general public were at times misplaced and directed more towards improving moral standards and punishment of perpetrators rather than looking at a systemic review of risk factors for such happenings.

Several respondents expressed their frustration that political or public opinion concern was often transient, and politicians "*paying lip service*", before public attention was distracted onto other topics of discussion in the mass media. Respondents lamented that there is a gap between verbal expression and readiness to act on behalf of children and in reality, there may be no change in public or political will despite the "*hue and cry*" every time a child is reported as being abused in the media. There is also public expectation of government to take care of the problem rather than a review of how the community cares for children. As an illustration, caning and slapping is accepted by a large section of the community, including schools, and not necessarily regarded as child maltreatment [22].

Other comments were that the public is generally keen to help children but they do not know how to translate that into action. Generally, leaders are more concerned about physical and sexual abuse which are perceived to be a bigger problem in Malaysia than neglect and emotional abuse. This may be because neglect is associated with poverty and other societal factors whilst emotional abuse is less readily apparent.

The Department of Social Welfare was mentioned by 62 percent of respondents as being the national organisation which takes a leadership role in CMP. There was varying opinions regarding the political leadership on the issue of CMP with 24 percent of respondents assessing the leadership as "overall

good” while 30 percent gave it a “poor” evaluation. More respondents from government sector rated the overall leadership as being good compared to NGO respondents.

POLITICAL WILL

About half (54 percent) of respondents were of the opinion that political leaders do express commitment to CMP but not taking effective measures to address the problem. It was felt by 67 percent that organisations headed by the political leaders were not providing enough resources for CMP, especially for investing in long-term CMP programmes.

PUBLIC WILL

Only 21 percent of the respondents felt that the general public perceived CM as a serious problem and that CM is something that can be prevented before it occurs. Almost two thirds of respondents felt that public support for CMP was good especially if there was political will or a media campaign for CMP. A third of respondents felt that CM was something that cannot be prevented.

ADVOCACY

Half of respondents considered advocacy efforts to be moderately intensive. In contrast, another 35 percent felt that advocacy efforts for CMP have been weak, although there has been more progress seen in the last few years. There has been proliferation of articles on CMP and child rights in the media recently. Most were aware of the recent UNICEF child abuse prevention campaign in Malaysia in contrast to other advocacy programmes which were sporadic. Advocacy efforts were generally felt to be non-sustainable. Respondents were vaguely aware of localized community efforts for high risk groups for CM.

COMMUNICATION

There was a vast difference of opinion in terms of communication efforts concerning CM in Malaysia with 43 percent stating that it was moderately intensive while almost an equal proportion, 40 percent, felt that it was weak or very weak.

Two thirds of respondents felt that information on CMP is not readily accessible or extremely inaccessible. Only data on incidence and some demographic details is available in printed forms or official websites. Various studies have been conducted but the publications are not known or readily accessible as many NGOs and the public do not ready access to professional publications. Researchers looking for data on child maltreatment issues need to obtain the data through recommended contacts

or apply formally to the various government institutions. Hence it was felt that information on CMP requires an immense effort to find.

Dimension 7: Institutional links and Resources

OVERALL DIMSCORE = 4.61/10

National DIMSCORE = 5.04/10, Subnational = 4.15/10

Government DIMSCORE = 4.75/10, NGO = 4.69/10

This dimension focuses on partnerships, coalitions, networks and alliances between institutions dedicated to CMP and the resources and efficiency within the main institutions currently involved or which might become involved in CMP. Scores were similar across subgroup analysis with a higher score for NGO respondents probably implying better awareness of existing networks or coalitions. Administrative efficiency of the coalitions was perceived as good by 74 percent of respondents.

While eighty percent of respondents are aware of the existence of some forms of partnerships or coalitions that are wholly or in a large part dedicated to CMP, they were generally unable to name more than two of the organisations in any of the alliances. More than 90 percent of the respondents did not know the number of people working in each of the institutions mentioned.

Dimension 8: Material Resources

OVERALL DIMSCORE = 3.05/10

National DIMSCORE = 4.00/10, Subnational = 2.00/10

Government DIMSCORE = 4.51/10, NGO = 1.94/10

This dimension has the second lowest score as assessed by respondents especially those at the sub-national and from NGO groups. There was a low awareness of the availability of material resources such as dedicated budgets for CMP in the various government ministries such as health, social welfare, education, early childhood development programmes, local government or community safety.

Respondents were not familiar with budgets available according to the various ministries. Forty-two per cent of respondents did not know if there were dedicated budgets for CMP or not whilst about a third, (37 percent) stated that there were dedicated budgets. It was difficult to differentiate the budget allocation that is specific to CMP as it is managed under various programmes within the same ministry or department rather than specifically for CMP.

The majority of those in government organisations felt the facilities within the departments addressing CMP to be adequate whilst this was felt to be lacking by the NGO respondents.

Almost half of respondents (48 percent) felt that potential funders are generally supportive of CMP. Many said that it was dependent on the amount of publicity regarding CM. Corporations would fund child related programme under the auspices of their corporate social responsibility if there was a specific activity that was brought to the respective company's attention. NGOs respondents said that sufficient justification was required for funding and smaller-scaled NGOs may not equipped technically at writing such justifications in a formal way.

Dimension 9: Human and technical resources

OVERALL DIMSCORE = 1.67/10

National DIMSCORE = 2.61 /10, Subnational = 0.63/10

Government DIMSCORE =2.41/10, NGO = 0.99/10

This dimension which looks at technical, administrative and managerial skills, knowledge and expertise, is by far the lowest score for overall as well as subgroups. The lack of human and technical resources is expressed by both the government and NGO level. This issue is strongly felt especially among the NGOs as implied by the lower score for sub-national in which NGOs made up a significant proportion of respondents (see Table 4 Field Test section). One recurrent theme in the interviews was the acute shortage of welfare officers and the heavy workload faced by these officers. One respondent from NGO who worked closely with the welfare officers in her area expressed:

“Like the welfare officer we, we, we feel sorry for the welfare officer, because that welfare officer is handling the child cases. The welfare officer also handles our domestic violence cases. Then the sexual abuse, then there’s banjir (literally meaning floods), then there’re ... you know? This and there’s that. You can have a designated child protection officer. It’s not enough to have one. We need to have more. Then they can do their work well.”

The number of professionals adequately trained in CMP for large scale implementation of CMP programmes was felt to be inadequate by 73 percent of respondents, who feel that the current resources only allow national small scale pilot programmes in several areas of country. The number of institutions that provide training and education on child maltreatment prevention was perceived to be inadequate or absent by a large majority of 71 percent. Two respondents commented that there are many expatriates in Malaysia who are highly skilled in CMP but this resource has been largely untapped. One paediatrician had organised trainings on family health assessment with a senior British social worker trainer who happened to be an expatriate wife in Malaysia and had kindly volunteered her services. There have also been enquiries to hospitals by expatriates, such as child psychologists, who were seeking to volunteer their services. Although language and licensing are issues in direct contact with the children, it was felt that these expatriates or local retirees could be a useful training resource.

Twenty- three percent thought that there was some undergraduate and postgraduate curriculum in educational institutions dedicated to CMP. Another 24 percent did not know if the availability of such institutions. Only a third of the respondents were aware of other non-university institutions that offer training in related skills or felt there were opportunities for CPD in CMP.

Dimension 10: Informal social resources

OVERALL DIMSCORE = 3.76/10

National DIMSCORE = 4.27/10, Subnational = 3.20/10

Government DIMSCORE = 3.79/10, NGO = 3.81/10

The 'Informal social resources' is an important dimension in CMP as it indicates respondents' perception of the nature of social interactions, social cohesion and sense of community. The perception of these informal social resources was one of moderate readiness, with the lowest score at the sub-national level.

The level of citizens' participation to address health and social problems was rated high to moderately high by 59 percent of participants. About half of respondents agreed with the statement that "people are generally dishonest and they want to take advantage of others" implying lack of trust amongst those respondents. Forty-four percent agreed that "If I help someone, I can anticipate that they will treat me just as well as I treat them", implying a sense of social reciprocity.

The majority 68 percent of respondents thought that most people do not belong to any civic group, with 14.5 percent saying that all or most people belong to a civic group.

Respondents were not in agreement about joint effort effectiveness in Malaysia with 46 percent of the opinion that people living in Malaysia are good at getting things done through joint effort while 31 percent perceive that people are poor at getting things done through collective effort, and therefore most likely not cohesive in effecting social change as a community.

Respondents' opinion about the single most important problem facing CMP in Malaysia

The majority of respondents felt that the single most important problem facing CMP in Malaysia was the attitude towards CMP. Several reasons were given by the various respondents – these being lack of recognition of CM and child rights and lack of awareness of the size of the problem and consequences of CM leading to an attitude of low priority for CMP; lack of reporting of CM due to fear of stigma, distrust in implementation of child protection or lack of knowledge and hence an underestimation of the size of CM in the country. This subsequently may lead to lack of advocacy and political will. This in turn will affect distribution of resources, the structure and impact of programme implementation, development of expertise, and joint efforts in prevention work.

Comparison of ‘Subjective’ and ‘Objective’ Assessment

The objective assessment responses were the outcome of a process of review of current literature and websites, interviews with expert opinion or officers-in-charge of various programmes involving children, and discussion amongst the research team members to reach a consensus for dimensions involving perceptions. The scores obtained for objective assessment is given below (Table 8, see Appendix 4-Table II for raw scores) and compared to subjective assessment scores, i.e. the scores by the study respondents. The objective assessment scores are much higher than the subjective assessment scores in dimensions 4, 5, 6, 8, lower for the dimension 9 on institutional links and similar for dimensions 1, 2, 3, 9 and 10.

TABLE 8: SCORES FOR OBJECTIVE ASSESSMENT BY RESEARCH TEAM AND COMPARING WITH SUBJECTIVE ASSESSMENT SCORE FOR ALL RESPONDENTS

Dimension	Objective Assessment Score on a scale of 1-10	Subjective Assessment Score on a scale of 1-10
Dimension 1: Attitudes towards child maltreatment prevention	4.2	4.03
Dimension 2: Knowledge of child maltreatment prevention	6.7	6.94
Dimension 3: Scientific data on child maltreatment prevention	6.4	6.99
Dimension 4: Current programme implementation and evaluation	8.3	3.21
Dimension 5: Legislation, mandates, and policies	7.5	5.16
Dimension 6: Will to address the problem	6.7	4.30
Dimension 7: Institutional links and resources	3.3	4.61
Dimension 8: Material resources	5.7	3.05
Dimension 9: Human and technical resources	3.3	1.67
Dimension 10: Informal social resources (non-institutional)	4.0	3.76
Total child maltreatment prevention readiness score	56.0 /100	43.73 / 100

DIMENSION 1. ATTITUDES TOWARDS CHILD MALTREATMENT

The consensus was that CMP as a specific programme was of low priority in Malaysia. Programmes involving child protection exists and it was found that CMP and child protection are not usually distinguished.

There are some measures taken to prevent CM such as the promotion of child rights, compulsory education, promotion of child health and early childhood development. However, it was found that these measures are equivocal in terms of adequacy in CMP.

The government is committed to the complete ratification of the Convention of the Rights of the Child and is in the process of adjusting legislation to be fully compatible with the CRC. Therefore, the rights of children are well-protected from the legal perspective, but in practice, the rights of children are not as well protected since public opinion often favours the parents' rights over the child's rights in situations other than moderate-to-serious child maltreatment. There would be much public debate if there was a proposal for a total ban on all forms of corporal punishment in all settings. Many would protest against it as an infringement of parenting autonomy. There was a move to ban corporal punishment in schools in the year 2006 but with the increase in bullying and indiscipline in schools, corporal punishment in schools was revived in 2009 as disciplinary action to control students who gang fights and bullying [23].

DIMENSION 2. KNOWLEDGE OF CHILD MALTREATMENT PREVENTION

Scientific data on child maltreatment in Malaysia are limited and not available to the general public. The older studies were mainly retrospective studies looking at mortality from child abuse and social factors that lead to child maltreatment. The media has reported intermittently on findings by local researchers done on small samples of victims of abuse or perpetrators in prison. Studies on consequences of CM other than mortality are not available or not easily retrievable. Studies have been done by police officers doing psychology degrees, social work students and others looking at aspects pertinent to the field of child maltreatment but there is no national clearinghouse to keep track of these studies that may have useful data for policymakers.

A recent study from University Malaya reports on prevalence of child maltreatment in children of school-going age [16]. This cross-sectional survey of 1870 students conducted in 20 randomly selected secondary schools, revealed that one in every three adolescents in Selangor schools has had multiple experiences across types of victimization and one in 10 experienced three or four types of child maltreatment, i.e. physical, sexual, emotional and neglect. Emotional and physical abuse was found to be most prevalent (ranging from 1.8 percent to 72.3 percent depending on the type of abusive acts), while at least 3 percent of the adolescents reported having experienced penetrative sexual abuse. The most important factors associated with all four types of victimization were male gender, poor quality of parent-child relationship, and perceived low quality of school and neighborhood environments.

Much of the knowledge of the respondents, general public and policy makers are obtained from the mass media which reports on opinions of available experts, religious leaders and the World Wide Web.

Evidence based prevention programs such as Triple P parenting program, abusive head trauma prevention program and home visitation are known to some health professionals but not as yet publicized.

DIMENSION 3. SCIENTIFIC DATA ON CHILD MALTREATMENT

Data on incidence and demographics of child abuse victims are available from the Department of Social Welfare (DSW) from 1997 till 2010 in terms of type of abuse, ethnicity and distribution across states as well as according to various types of abuse. Data on the magnitude and distribution of various types of child maltreatment are compiled by DSW and reported on an annual basis available on the Web. This national registration of children who have been abused, neglected, trafficked or abandoned or used for begging is overseen by the Registrar General of Children in need of Protection, as provided for under the Child Act 2001. As there are no large scale prevalence studies, the percentage of reported CM cases in Malaysia is not known. Demographic details on the convicted perpetrators, risk factors and conviction records of child abusers are kept by the Police Department. Re-offence and outcome of prosecution data are not available unless the perpetrator is found guilty on both occasions. Case based information is available from some SCAN teams in government hospitals and epidemiological data from one stop crises centers based in hospitals. The Ministry of Education disclosed that the number of cases reported for bullying was 2,617 in year 2010 (0.048 percent of all school children)⁵.

In Malaysia, there are legal definitions for the children “in need of protection” under the Child Act 2001 covering the various forms of child maltreatment including abandonment and neglect by parents who have failed in their parenting roles. The medical definition for child maltreatment is that given by WHO in 1999, whereby the act of child maltreatment is one such as to result in actual or potential *harm*, to the child’s *health, survival, development or dignity* in the context of a *relationship* of responsibility, trust or power.

Reporting is legally mandated of doctors, family members and nursery workers for all cases of suspected child maltreatment under the Child Act 2001 in Malaysia. Although teachers are not as yet legally mandated reporters, they are compelled by the MOE to report abuse cases to the relevant authorities. However, not all cases are presently reported to DSW as the decision to report is that of the school principal. A survey conducted among 668 primary school teachers showed that only 44.4 percent of the survey respondents supported legislation requiring teachers to report child abuse [24].

Cases reported from schools are those disclosed by the abused students, teachers’ observations and reports from peers. School counselors will investigate and report to the school principal who will then verify and endorse the report. The findings will be reported to the Police or DSW and the child victim sent to hospital as required. Data on all cases of CM are collated by the Public Relation and Complaints Unit under each State Education Department. There is a system (SSDM online) to record children who have faced disciplinary action and referred to school counselors.

⁵ Personal communication, Ministry of Education (2011)

The National Institutes of Health and the Social Institute of Malaysia are the bodies that serve as a repository of relevant studies in the Ministry of Health and Ministry of Women, Family and Community Development respectively. There is a policy for Institutes of Higher Learning to send a copy of all related publications to these centres. The Ministry of Health (MOH) has a National Medical Research Registry for studies conducted in government health centres but would only be able to capture studies conducted in the MOH or by MOH personnel.

DIMENSION 4. CURRENT PROGRAMME IMPLEMENTATION AND EVALUATION

A substantial number of programmes are available for child protection and to a smaller extent, programmes for CMP are also available in the urban areas. Almost all the programmes have not been evaluated in terms of effectiveness in reducing or preventing CM. It is reported that evaluation of parenting programs and Child Activity Centres are being started. Evaluation of the programme's cost-effectiveness is a new policy direction that is to be implemented in government departments. However, it is unclear if there is any budget allocation specifically for the evaluation of such programmes.

The objective assessment score for this dimension is much higher than the subjective assessment score implying that there are many more programmes available than the respondents were aware of. There is as yet no comprehensive database or directory of services for CMP or child protection. There is a directory of services for the MWFCF whilst NGO services are available on individual web pages. The lower subjective scores could also imply a perception of lack of evaluation for the programmes.

Child Protection Programmes

The Malaysian Government has implemented a series of services or programmes to fulfill her obligations under the Convention on the Rights of the Child based on four core principles of protection, survival, development, survival and participation of children. The National Child Action Plan and Protection Policy guide the mechanisms, processes, and services to build a comprehensive child-based protection system. Earlier programmes on child maltreatment generally focused on secondary prevention or early interventions services, as well as tertiary interventions that aim to protect the interest of the children by providing care and shelter or to rescue and provide assistance to those who have been abandoned or harmed by their family. The MWFCF and Ministry of Health are the main service providers for these services with its efforts focusing on providing emergency intervention to children who have been abused or neglected. Various initiatives and resources have been put forward in the form of childcare homes and institutions, emergency medical services including the One-Stop Crisis Centres and Suspected Child Abuse and Neglect (SCAN) teams under the Ministry of Health, and establishment of the Child Protection Unit under the Royal Malaysian Police and the Child Protection Teams under the DSW. A summary of these programmes are listed in Appendix 6.

Children's Activity Centres & Child Protection Teams

The Child Activity Centres (CAC) and Child Protection Teams (CPT) at both state and district levels were set-up to mobilize community participation in the implementation of preventive programs and coordinate multiagency protective services respectively. The centres were set up as a proactive action by the MWFCDD to provide support services to help families overcome their social problems. The functions of these Child Activity Centres are to organise programmes which will provide care and protection to children at risk of being abused; provide different activities to cater to the needs of parents and children; and to conduct child development and parenting courses for the community. It is also meant to act as a resource centre, provide counselling and crisis intervention services, educational support services, child development activities, lectures, seminars, workshops on parenting and other family-oriented topics as well as motivational camps for children and youths. To date, there are 142 Child Activity Centres established throughout Malaysia. Many of these CACs were set-up in densely populated areas or those with many social problems such as child abuse, child neglect, school dropout, truancy and moral decadence. The aims of the Child Activity Centres are also to serve as a platform to foster community relations and the caring spirit where the local community interact, exchange ideas and work together towards a common goal of improving the well-being of the child and family.

Childline Malaysia and NUR Alert

Malaysia established a toll free line known as *Talian NUR* (NUR Alert) 15999 in 2005 with the aim of encouraging members of the public to report child abuse cases or missing children directly to the Department of Social Welfare for immediate action. The gazetted Child Protectors role is to investigate, evaluate and take appropriate actions when the public lodges a report. In 2010, through mutual partnership and close collaboration, the MWFCDD and several NGOs, started the Childline Malaysia, which is a dedicated outreach service for children under 18 years old in need of care and protection. Childline Malaysia is a child-friendly confidential 24-hour hotline service. The operators for the Childline are trained to handle calls from children and help them seek services for their needs.

Children's Homes and Institutions

Children's Homes are gazetted as a substitute home for children in need of care and shelter. Children are admitted into one of the Children's Homes if they are orphans, abandoned, abused or neglected. Behaviour rehabilitation schools and probation hostel provide care and rehabilitation for Children who are involved in crime, those who are "beyond control" or those who are under remand. The *Tunas Bakti* School provides rehabilitation for a maximum period of 3 years. The probation hostels host children under remand until the issuance of court order, probation cases of not more than 12 months, or who are in transit to *Tunas Bakti* School for a period of not more than 2 weeks. The *Taman Seri Puteri* schools are institutions established under the provision of child Act 2001 to rehabilitate specifically girls below the age of 18 years old who are exposed or forced into prostitution or engaged in illegal activities. Children gain entry to these schools either through court order or formal application to the District

Welfare department office nearest to the parents' place of residence. These are among the initiatives targeted for children at risk or children vulnerable to all forms of abuse and exploitation. There are many children's homes run by NGOs spread throughout the country, supported by the private sector and partially by the government. In terms of CMP in these institutions, there is a child protection policy for government welfare homes for children but not in the numerous NGO-run welfare homes in the country. There are minimal fostering programmes in the country as most individuals are more interested in adoption rather than fostering.

One Stop Crisis Centres & SCAN teams

Rape crisis services and a related management protocol were available since late 1986 [25]. However, a more comprehensive health sector response to violence against women was started with the first One-Stop Crisis Centre (OSCC) established in 1996 and subsequently introduced to all general hospitals nationwide, after intense lobbying by women's groups [26]. It provides victims of violence access to comprehensive treatment and services such as medical treatment, lodging a police report, legal support and counseling at one centralized location. This spares the victim from having to go around seeking help from different departments or agencies, thus minimizing the trauma and stress for the victim. Many NGOs in several urban settings play an active role in supporting the OSCC service by provide counseling, emotional support and assistance where needed.

The first SCAN Team (Suspected Child Abuse and Neglect Unit) established since 1985 at the Paediatric Institute of Hospital Kuala Lumpur (HKL) provides medical care, treatment and services to children who have been maltreated. The team comprise of paediatricians, gynaecologists, child psychiatrists, emergency physicians, forensic doctors, medical social worker and nurses in the hospital, as well as social workers from the Welfare Department, police, and NGOs. Presently there are OSCC centres in all government hospitals and SCAN teams in the major government hospitals in Malaysia. Maltreated children from more remote communities have to be referred to the hospitals with specialists for management and rehabilitation.

Child Maltreatment Prevention Programmes

As stated above, child protection programmes are relatively well developed in contrast to current efforts in CMP (see Appendix 6). A substantial amount of resources and funding have been channeled for activities, such as the setting up and sustaining Children Activity Centres and child care homes and deployment of child protectors. Although some organised efforts to mobilize community participation on CMP have been carried out across different governmental agencies (see Appendix 7- Table I & II), these efforts remained scattered and localized except for the Child Activity Centres and the long-term impact of these CMP activities need to be evaluated. Several agencies offer programmes for early childhood development that are often overlapping in its objectives and functions. For example, several ministries (MWFC, MOE, National Unity and Integration Department, Ministry of Rural Development) and private Sector provide pre-school education to children below 7 years [8].

Among the government agencies, National Population and Family Development Board (NPFDB)⁶ developed a number of family development programme initiatives in line with the government's emphasis on strengthening the family institution. For instance, the SMARTSTART Premarital Programme was developed since 2006 with the aim to raise awareness among married couples on parenting skills and aspects of family relationships. The programme is conducted through NGOs or religious bodies who apply funding from the NPFDB to run the programme. Respondents' comments in relation to this programme were that they run on ad hoc basis and a payment of RM50 (USD17) is chargeable to the participants. As a consequence, the programme mainly reached motivated parents and not the target groups likely to have poor parenting skills. A similar programme but targeted at working places called 'Parenting at Work' is available but only upon invitation by Government agencies or private sectors to hold it for their staff. The impact of these programmes remain unknown as no evaluation has been conducted. However, it is noted that an evaluation is being planned by the NPFDB for these programmes.

Poverty is one of the important risk factors for CM. Although not undertaken as a program for CMP, there have been many poverty reduction programmes under the Ministry of Rural Development for the hardcore poor as well as National Economic Plans by the Economic Planning Unit for anti-poverty developments (see Appendix 8)

A number of initiatives and resources that promote children's well-being could allow integration of CMP components (See Appendix 9). These initiatives are directed at reducing risks and enhancing key protective factors for children's development. Among these, the most salient investments were those aimed at the provision of the child's basic needs, enhancing child's social and emotional development, and creation of more supportive relationships and safe environment for children.

As children spend most time in schools receiving formal education, schools become an important focal point for active prevention efforts. Under the common law doctrine of *loco parentis*, schools in Malaysia have a legal responsibility to ensure the safety of students. The Ministry of Education developed a blueprint known as Safe School Concept and Manual: Implementation Guide to Create a Safe School, Community and Family for Children (2002). This was developed in response to a study on gangsterism (Gangsterism in Daily Secondary Schools 1999) where it was found that gangsterism occurred amongst children who came from low parental income families living in densely populated areas (such as new villages, apartments or temporary public housing). At risk students were found to have low academic achievement, receive little parental attention, show a tendency to rebel and break rules, like to be at the center of attention and to be susceptible to negative peer influence and they would be the target group by the schools.

The MOE has an anti-bullying program and policy since the year 2010 – where children are made aware of factors promoting bullying in school such as lack of moral or religious teaching at home, lack of supervision in school, schooling difficulty, low self-esteem, media violence and peer pressure. Signs of being bullied and consequences to the bully, responsibilities of children to report bullying are listed in a pamphlet together with the hotline number for reporting. Anti-gangsterism and school safety programs

⁶ The National Population and Family Development Board is under the jurisdiction of the Ministry of Women, Family and Community.

have also been introduced in the schools. In 2010, the MOE piloted a Safety Standard in 321 primary schools and 321 secondary schools and surroundings. It was found that 78.3 percent of these schools were safe, 21 percent required some improvement and 0.5 percent need special attention⁷. The aims of the school safety program are for the safe management of social issues, to promote racial harmony in school and to reduce the risks of accidents, as well as the safe management of handling crises and disasters and in facing threats. The school safety program looks into promotion of physical safety at the time of children going to and from school, during co-curricular activity, sports and play times, during school visits, during camping as well as safety in hostels. This helps to promote active involvement and cooperation between communities, teachers, parents and students. It also informs the school administrators and teachers about their responsibilities with regard to safety management and planning. In addition, counsellors from schools visit homes and talk to parents of students who are at risk of dropping out of school.

Schools and nurseries have also been targeted to receive child sexual abuse prevention programmes such as “safe touch” programmes wherein young children are taught about their body parts and that it is “OK” to say “No” to what is perceived as uncomfortable touches from the child’s perspectives. NGOs and professionals in early childhood development who have tried to run this program in nurseries and schools have faced objections from parents who equated it to teaching sexual education. Some schools have organised the programme after obtaining agreement from the Parent Teachers Association.

According to various publications, sex education in schools has been taught in “bits and pieces”, such as in co-curricular activities or incorporated into various other subjects from the primary level to secondary level, in the absence of a proper structured course [27-28]. According to the Ministry of Education, modules on sexual health had been incorporated into the Health, Reproductive and Social Education Curriculum since 2005.

Many teachers surveyed in a recent local study had reported that there were inadequate references to refer to as to how best to convey the information to students and there was no specific time/subject allocated for sex education to be taught in schools [24]. While teachers in this study agreed that it was important to introduce sex education in schools, the issue on which schooling year it should be introduced in the curriculum remained debatable as far as the teachers were concerned. Many teachers felt that primary school children were ‘too young’ to be taught and to discuss sexual matters. In addition, there have been objections from many parents and religious groups who protested strongly against sex education in schools.

Our adolescents have been found to be very naïve with respect to sexual matters and are unaware of the risks of pregnancy or sexually transmitted infections without protection. There are presently no programs that specifically target groups that have been found to be at high risk of teenage pregnancy or sexual promiscuity or abuse, i.e. young people in or leaving care, homeless young people, school drop-outs, truants and young people underperforming at school and children of teenage mothers. A module jointly developed by the MWFC, the United Nations Population Fund and various NGOs, called “I’m in Control” had been piloted in five schools in 2009 and was planned to be implemented in schools by the

⁷ Personal communication, Ministry of Education, 2011

government in 2010 but was finally not approved due to objections from conservative religious groups [29]. This module which includes pointers like assertive techniques to avoid premarital sex and how to identify and avoid high-risk situations, has been tested by the NPFDB from mid-2009 until the end of 2011 and to be evaluated in 2012. Responses from participating students, teachers and parents have been positive according to the Minister of MWFC in a news report [30]. This module is currently being applied to students undergoing National Service Training at the age of 17 to 18 years.

Police officers conduct school tours to talk about the dangers of substance abuse to school children below 10 years old as it has been found that children around the age of 10 have been targeted as illicit drug carriers⁸.

Within the present health system, home visits are conducted by public health nurses if the mothers-to-be who have registered with the health clinics defaulted follow-up. There are at least 4 home visits during the first month of life of a newborn baby. During these visits, the newborn babies are evaluated by the nurse visitors who are trained in newborn health and to evaluate for any postnatal issues regarding mother and baby dyad. Parents are guided in newborn health care by home nurse visitors and this service is available to all parents but may not be accessed by the urban poor and high risk families. There is an informal policy to train public health nurses on assessing families for risk of CM in that they are included as participants in seminars on child maltreatment organised by the hospital or public health staff on an annual basis. There is as yet no structured training module for public health nurse visitors.

Free immunization is available at all government health centres and schools for most of the common childhood illnesses except pneumococcal and rotavirus disease which is available in the private health sector. There is preventative health screening scheduled at the time of immunization for children under 6 years of age and an annual health and dental check for school-going children in primary schools. An early intervention programme for disability has been in place for many years. The Family Health Division of the Ministry of Health has also recently produced a video for the increasing parents' awareness for the prevention of inflicted head trauma in infants. It is meant to be shown to parents or potential parents waiting in antenatal clinics, maternal and child health clinics as well as paediatric clinics. Implementation is still presently up to the initiative of the respective health clinics and hospitals.

NGOs play a major contributing role in primary prevention work particularly in urban areas. International organisations such as UNICEF and NGOs like P.S. the children and Women Centre for Change have been actively involved in primary prevention work on child maltreatment besides the support services provided to the victims of abuse. Some type of programmes conducted by non-governmental organisations was presented in Appendix 7.

Since the late 90s, Women Centre for Change (WCC) has been very active in outreach work to reach out to children and youth, mainly focusing on personal safety and sexuality. Three main sections in their outreach work including child sexual abuse programmes ('Towards a Violence Free Society: Say No to Sexual Violence') for primary schools, RESPEK (Knowing Yourself, Respect Yourself) programme for

⁸ Presentation at Convention of Rights of the Child Round Table Conference, Kuala Lumpur, 2004

youth, and outreach talks to the public. However, the WCC work has mainly focused in the state of Penang and northern parts of Peninsular Malaysia. Another NGO, P.S. The Children provides support to victims of child sexual abuse and also organises talks, workshops and training to create awareness on the prevention of child sexual abuse. They provide 'Safe touch prevention programme' to schools which agree to the programme, as mentioned above. OrphanCare and some other NGOs have started a Baby Hatch programme equivalent to enable mothers who feel stigmatized to send their newborn babies for adoption, to "drop" their babies with "no questions asked". This is an effort to reduce the number of abandoned babies or "baby dumping".

In 2011, UNICEF Malaysia worked with the media, NGOs, celebrities, youth and the private sector to promote greater protection for children and their rights through campaigns such as "Stop Child Abuse Now" and "No to Violence". In 2010, UNICEF together with Childline Malaysia produces public service announcements on child abuse and to set-up a child rights resource centre for the PJ City Council. To encourage the incorporation of children's right into media practices, the Minister of Women, Family and Community Development, engaged a dialogue with media professionals from print, TV, radio and advertising to examine realistic approaches to enhance child protection. In addition, the Human Rights' Commission of Malaysia (SUHAKAM) has embarked with MOE on a pioneer project in schools to highlight and increase awareness of human and child rights (*Amalan terbaik hak asasi di sekolah*).

Media programmes have not been sustained in increasing public awareness especially with regards to television and radio. It is costly with limited slots provided for health or social development campaigns by the government at peak viewing times. There have been video features promoting close community and family ties sponsored by Petronas and local dramas highlighting social issues but they are few and far between. There are minimal media programmes highlighting child rights. Some radio programmes have put aside some time slots for increasing public awareness on health issues and the prevention of shaken baby syndrome.

DIMENSION 5. LEGISLATION, MANDATES AND POLICIES

From the objective assessment, Malaysia has a very comprehensive set of legislation aimed at protecting children and the system is in place to revise legislation if needed. The subjective assessment score for readiness for this dimension is lower than the objective score primarily due to the respondents' evaluation of the lack of effectiveness of legislation to protect children or their lack of information on the level of effectiveness of legislation in CMP.

The relevant legislation pertaining to children are Child Act 2001 (which replaces the Child Protection Act 1991, Women and Girls Protection Act 1973 and Juvenile Courts Act 1947), Education Act 1996 (amendment 2002), Child Care Centres Act 1984 (amendment 2007), Registration of Adoptions Act 1952, Children and Young Persons Employment Act 1966 (revised 1988), and Anti-Trafficking in Persons Act 2007. In addition, there is legislation aimed at protecting the survivors of domestic violence – Domestic Violence Act 1994. Malaysia has a separate set of family laws for Muslims, i.e. the Syariah Legal system. This includes the Islamic Family Act 1984 which spells out rights of the child.

The Child Act 2001 covers 12 categories of children in need of protection. The 12 categories include situations where there is substantial risk that child will be physically/emotionally/sexually injured or exploited by parent/guardian/member of his extended family; where the parent or guardian of child has neglected or is unwilling to provide for him adequate care, food, clothing & shelter or to exercise proper supervision of child and the child is falling into bad association; the child has been abandoned or allowed to beg or gamble, requiring medical attention that is not being provided by the parent or guardian or left without proper supervision or suffering from emotional injury where family relationships are severely disrupted from conflict between parent/guardian and child. The Act allows provision for the protection of another child of the same household as the child victim. However, it retains the option of corporal punishment for child offenders [31].

Under the Child Act 2001, the DSW under the MWFC is the major agency looking into child protection, i.e. tertiary protection after CM has occurred, and families with domestic violence. The MWFC is the key agency that coordinated the development of the National Child Protection Policy and Action Plan for the Protection of Children as mentioned above.

Under the National Technical Subcommittee for Social Issues concerning Children, the Ministry of Health chairs the subcommittee which comprise all stake holders from other Ministries, professional organisations like Malaysian Paediatric Association, media and NGOs looking into policy matters related to CMP like provision of parenting education, home visitors at postnatal visits, prevention of abusive head trauma, child care services, adequate and timely provision of resources for abused children and their families and as well as social services for the disabled.

Under the Education Act 1996, every Malaysian parent has to ensure that their children attend primary school failing which they are “liable to a fine not exceeding five thousand ringgit or to imprisonment for a term not exceeding six months or to both” [32]. Two studies in 2009 conducted by the MOE showed that lack of proper citizenship documents was the main reason for children’s inaccessibility to formal education. Procedures have been established to enable undocumented Malaysian children to be admitted to government and government aided schools^{9,10}. There is a recent programme to provide undocumented non-citizen children in Sabah with access to alternative education by the state government in collaboration with UNICEF¹¹.

The Child Care Centres Act seeks to control the minimum standards of care based on the Child Care Act 1984 and Regulation TASKA (in institutions 1985) Amendment Act 1993. It aims to ensure that all children obtain quality care from their caregivers. Child minders require to be trained in a course called Basic Child Care as specified in the TASKA Regulation, within one year of registration. This basic child care covers basic physical care of children but currently does not cover any training in child development or coping with fretful or difficult young children. New staff employed after registration of a child care centre may be working without having attended the basic child care course as there are presently insufficient enforcement staffs for monitoring the implementation of the Act. Childminders running

⁹ Personal communication, Ministry of Education, 2011

¹⁰ http://www.unicef.org/malaysia/media_news11-news-alert-launch-of-school-in-sabah-for-refugee-children.html

¹¹ http://www.unicef.org/malaysia/media_news12-back-to-school-for-undocumented-children-in-Sabah.html

home-based nurseries are encouraged to register but are not legally compelled to, depending on the number and age of children they cared for. The current Act requires a ratio of one childminder to 3 infants below one year of age, one childminder to five children between 1-3 years of age and one childminder to 10 children between 3-4 years of age. There is a lack of implementation of this Act even for those centres with more than 9 children due to lack of manpower and prioritisation. In Putrajaya, when the high infant mortality in these child care centres was investigated, it was found that only 25 percent of such centres were officially registered as the registration fees were said to be high. With frequent checks assisted by the public health staff and enforcement, the registration rate of the home-based child care centres rose to 60 percent in the past year.

The main policy pertaining specifically to CMP is the National Child Protection Policy which has been described at the start of this report. The National Action Plan for Children details strategies to meet the policy objectives with short and long term plans till the year 2020 and the key agencies responsible for or involved in the various strategies for CMP and child protection. The [National Action Plan](#) reinforces the importance of prevention via advocacy initiatives to cultivate and promote awareness among all segments of society of the importance of protecting children and awareness of the CRC, by establishing smart partnership with the media, NGOs, private sector and community organisations. This includes encouraging the setting up of safe and healthy environment for children such as:

- working with the local authorities to have safe and child-friendly facilities
- to recognise and monitor the care of children from at-risk families
- the provision of quality child care centres and “after school care” in school
- to have guidelines on child protection policies for all corporations and institutions that deal directly with children. The policy also includes having a review committee to develop and enforce guidelines on employment screening and certification as being safe to work directly with children.

As the actual prevalence of child maltreatment in the country is unknown, it is difficult to ascertain objectively the impact of legislation, mandates or policies impact on CMP. The incidence rate of CM is expected to rise as more reports are made with increasing public awareness irrespective of prevalence.

DIMENSION 6. WILL TO ADDRESS PROBLEM

Generally, the public and policy makers are not aware of the level of seriousness of CM in the country. The public perception is that children are valued in Malaysian society and no one but a ‘bad’ person would purposefully hurt children and that it is within the control of individuals not to harm children. Hence, there is usually a short and intense reaction to media highlights of cases of CM by both public and politicians, and the response is usually one of punishment to the perpetrator, barring extenuating circumstances. Public support for CMP is strong as long as there is a constant reminder in the media.

Political leaders do express strong commitment but the political will for CMP is not sustained once the political leaders get distracted by other social or political issues. The measures for CMP are seen to be

short-term in nature, variable in implementation from state to state and dependent on the availability, motivation and skill of the ground staff.

The MWFC is the Ministry that has been allocated to lead the other stakeholders in CMP, with the Department of Social Welfare as being its key department involved in CMP. Two of the other main organisations looking into CMP are National Population and Family Development Board and Ministry of Health.

Under the Corporate Social Responsibility programme, a Malaysian listed company Sime Darby Berhad launched its own child protection policy in March 2010 to ensure that the rights of all its employees' children remain strictly protected. Many other companies have shown willingness to help in CMP. Charitable funding from private sector is fairly easily attainable for victims of CM but may be more difficult to access for CMP unless there are provisions for tax incentives. An example of current tax incentives is that of one for having crèches at the workplace. There is a start-up government funding of RM200,000 per institution to have a crèche at the workplace. This serves to promote mother-child bonding, promote breastfeeding and reduce the problem of finding good child care centres.

The objective assessment score for the will to address the problem is higher than the subjective assessment. This may be due to the variation in experiences and perceptions of the respondents. The objective assessment is also dependent on the perceptions of the researchers from their own experiences and findings during the research process.

DIMENSION 7. INSTITUTIONAL LINKS AND RESOURCES

There are several coalitions of NGOs and networking between various Ministries and agencies working with children whose focus are addressing the children's needs. The Malaysian Council for Child Welfare (MCCW) or *Majlis Kebajikan Kanak-Kanak Malaysia* (MKKM) is the main national NGO coalition with the aim in promoting the well-being of children. It complements and supplements Government efforts in the welfare and development of children and promotes the general principles embodied in the Convention on the Rights of the Child. The list of organisations in MCCW is given in Appendix 10. There is also a Malaysian Coalition for the Prevention of Sexual Abuse which is a coalition of NGOs dedicated to advocating for the prevention of child sexual abuse.

There are several Ministerial links dedicated to child maltreatment prevention. The Coordinating Council for the Protection of Children is chaired by the Director General of MWFC with representatives from various agencies responsible for child protection, social welfare, health, education, human resources, information, legal division, police prison, and persons with appropriate experience, knowledge and expertise on matters related to the welfare and development of children. The Technical Subcommittee for children under the Inter-Ministerial Council looking at CMP chaired by the Chief Secretary and Director General of the Ministry of Health, has representatives from Education, Health, MWFC, Social welfare, NGOs and universities. The National Advisory and Consultative Council for Children, which includes non-government stakeholders, is chaired by the Minister for the MWFC. These three committees form a close high level and technical link with all the stakeholders involved in CMP.

In addition, there are many informal links such as between NGOs and MWFC who work together for the Child Helpline, and between UNICEF, government bodies and NGOs in working together to ensure the implementation of the Convention of the Rights of the Child. There are presently some websites with government services but not a one-stop website that has a comprehensive list of NGOs and government services for children other than some for child care or children with disabilities.

Research has also been conducted across various agencies such as collaborative research on child maltreatment between National Institute of Health, UNICEF and universities.

DIMENSION 8. MATERIAL RESOURCES

There is no dedicated budget for CMP other than for Child Activity Centres and the Child Protection teams as required under the Child Act 2001. Budgets are available through government departments that incidentally do CMP as part of child health and development programmes (see Appendix 11). Budgets specific to CM were related to child protection.

To enable families to obtain more access to quality child care since many women are entering the work force, there is a subsidy for childcare centres' fee to be extended to civil servants whose monthly household income is RM3,000 and below from the year 2010. In the same year, the launching grant for the establishment of the childcare centre at the workplace has increased from RM80,000 to RM200,000.

There are existing subsidies for poverty and school age children to promote educational compliance such as free textbooks, transport subsidies and tax subsidies (see Appendix 11).

The objective score for this dimension is higher than the subjective score. This is probably due to the lack of knowledge of the participants on the budgets, infrastructure and equipment of various government departments. Also, respondents may not perceive these budgets as meant for CMP purposes.

DIMENSION 9. HUMAN AND TECHNICAL RESOURCES

This dimension is by far the least ready of all the dimensions as scored objectively and subjectively.

Human resources

Overall there is insufficient number of professionals trained in the area of CM. Between 1994-2006, there were multidisciplinary training courses conducted by the Suspected Child abuse and Neglect team, Hospital Kuala Lumpur and the Malaysian Association for the Protection of Children in collaboration with UNICEF, Department of Social Welfare and Police. A minimum of 90 people from hospitals, 20 from police and welfare departments had been trained annually in awareness of CM and child protection.

Since then, training on CM is conducted by the various agencies of health, welfare, police and legal divisions but the emphasis is on child protection rather than CMP. About 200-300 health workers from

community clinics and hospitals are trained per year by the One Stop Crisis Centres or SCAN teams in the recognition and management of child maltreatment after it has occurred, as well as to recognise risk factors and about the response procedures for child protection. Child Protectors and police officers working in the division for child sexual offences attend formal courses as part of their post basic training, whilst exposure to CM is part of a course on family related issues by the Judicial and Legal Training Institute. Training is often conducted by a multidisciplinary group of trainers. However, the numbers trained is still insufficient in terms of child protection services.

Human resource development is one of the key features of the 10th Malaysia Plan. The number of staff trained in the agencies for areas related to CMP such as public health nurses in home visitation skills or teachers/ carers in early childhood development would be potentially a larger number to start with but they need to be trained in the aspects of CMP. As mentioned above, there are district public health nurses distributed throughout Malaysia, who review newborn babies and mothers in their home environment for at least four visits in the first month after birth. At the Ministry level, there is a unit of Violence Intervention Program at the Ministry of Health that acts as a Focal Point that coordinates all activities that relate to CMP in MOH such as data collection of the incidence of child maltreatment. Under the MWFC, there is a Children's Division in charge of the Child helpline and issues related to CM and CMP. The secretariat for CM matters for the MWFC is in this division. The Ministry of Education has a counseling division with many school counselors who have been trained in assisting school children who have family problems, educational difficulties, and another division with a few officers involved in policy and implementation issues related to prevention of bullying and other conduct disorders in schools.

In the field of CM, most of the professionals are working in child protection in addition to other areas of their profession, i.e. they are not dedicated workers in child protection per se. These would be the majority of social workers, hospital staff and police. Social workers cover all aspects of social work in the community and very often only have time to attend to reported cases of child abuse for an initial visit. There are some police officers trained to give talks on child safety issues. The vice squad also goes into schools regularly to give talks on substance abuse prevention to children in upper primary schools. Kindergarten teachers in the Klang valley have undergone some training in teaching young children about "safe touch" in the prevention of sexual abuse. Most of the school counselors have been exposed to aspects of child maltreatment and are involved in promoting the emotional development of school children.

Institutions that enable the acquisition of required skills, knowledge and expertise in CMP

Modules of "safe touch program" are taught to some workers in KEMAS which runs government supported preschool centres. Child care centres are newly expected to have their workers trained in child development and this is being reviewed to become a legal requirement.

Some NGOs underwent training to run parenting skills course and then conduct such courses for a minimal fee. Parenting skills courses are also taught by the National Family Planning and Development Board (NFPDB).

There is a training module developed by the Ministry of Health for use by the public health staff to assist the assessment for child maltreatment risk. The emphasis for the home visitor training is on the general health and screening of the newborn infant and there is presently no training on reviewing the family psycho-social aspects of care during the home visits. However, a pilot project has been started in Putrajaya focusing at the prevention of infant deaths and shaken baby syndrome by the public health nursing staff. For child protection, there is a national guideline for the management of child maltreatment in hospitals.

Some training in CMP has been implemented at teacher training institutions like Teachers' Training College, Penang and University of Malaya in bachelor degrees of early childhood education. School counselors are trained in behavioural modification and the handling of bullying in schools. Only three medical schools in Malaysia are incorporating training on CM in their medical training syllabus albeit a small component. CM and child protection issues are taught at police academy and at the social welfare officers' post-basic training.

The objective assessment score is still low for this dimension due to the lack of capacity in terms of numbers of trained people in CMP as well as the relatively few sources of training organisations to cope with the number to be trained. Trainers with technical skills are also limited. Therefore current human and technical resources would allow only small-scale CMP programmes in a few states.

DIMENSION 10. INFORMAL SOCIAL RESOURCES

The objective assessment score is similar to the subjective assessment score of the respondents for this dimension. In Malaysia, there is a strong sense of community bond in smaller towns and villages and less so in the cities. There have been news reports of the use of social networking sites like Twitter in some suburbs to communicate with their neighbourhood. *Rukun Tetangga*, which is a community watch and default neighbourhood committee, vary in their success rate of building a community spirit. It is likely to be more active in areas which feel threatened by crime, environmental issues or lack of safety.

There is a perception that people join civic groups for an ulterior motive such as enjoying side benefits with awarded contracts. However, there are those who are in civic groups for their belief in a cause. People are generally helpful to those in need unless they are worried about their own safety. The public response to aid of children in need has been generally good.

Relations of Scores with Country Background Conditions

Readiness in the dimensions with higher scores is probably related to the developments in child protection in the country. The key country conditions (see Appendix 1) in terms of child health, economic development, compulsory education, social and communication infrastructure are also suitable for the development of CMP programmes. With improving socio-economic development, higher life expectancy at birth and low childhood mortality, there are higher expectations for the quality of life for children to enable them to reach their maximum potential. A maternity leave allowance of 300 days in 5 years and for the government sector, an option for a further 3 months 'unpaid breastfeeding leave' as well as a paternity leave of one week, shows government and society's recognition of the importance of parental bonding from birth as well as the economic status allowance for staff time-off from work. There is good health care access and the public health machinery is potentially able to be mobilized for some CMP programs, using a similar mechanism as with the highly successful immunization program¹². The government provides for 44 percent of total health expenditure in Malaysia and has a low percentage of health expenditure relative to other OECD countries. In the year 2007, the Malaysian government expenditure was 6.9 per cent of GDP, i.e. USD 218 compared to an average of USD 1,987 and 8.5 per cent of average GDP spending among the 34 OECD countries [33]. The health expenditure by the government increased to USD353 per capita in year 2011 [2]. Health, social services and education is where government spending should be increased as the dimensions of material, human and technical resources were the lowest dimensions for CMP readiness.

The cultural norm is that children are still perceived to have fewer rights than adults and expected to show filial piety and conformance. This places children at risk of maltreatment when they do not conform to family or supervisors' expectations or they could easily fall prey to sexual abuse by known persons. In terms of CMP, this could affect the attitude to CMP as well as the will to address prevention work. There has been some sensitization to child rights by various NGO groups and UNICEF but more needs to be done in this respect for attitudinal changes to increase the will to address CMP.

Since primary school education enrolment is at least 96 per cent and enrolment rate to last primary grade is 98 percent, CMP programmes which are to be delivered in schools can be expected to reach most children with proper implementation.

¹² immunization rate of 95-98 percent

STRATEGIES FOR INCREASING CMP READINESS

This section presents the strategies identified by respondents to improve CMP readiness in the respective key areas under each respective dimension. The recommended strategies are made more than once under different dimensions and this is not surprising since the dimensions are abstract constructs and often overlap.

Dimensions 1, 2 and 3 “Attitudes, Knowledge and Scientific data on child maltreatment prevention”

Strategies are required to increase the level of scientific data especially with regards to the country scenario, to improve the knowledge of the general public, policy makers and country leaders so as to generate increased priority for CMP and to have reliable data available to determine programme priority areas in relation to CMP. This is in line with the National Child Protection Policy which directs for increased research on child maltreatment. These were the dimensions felt to be most important by the respondents to increase political will and resources. Recommendations given by the respondents were :

- To promote awareness of CRC as well as review the implementation of corporal punishment in schools. Ineffectively practiced corporal punishment is counter-productive as it can be degrading and imply permission to use violence or cause pain in others to change behavior
- To increase scientific data
 - on prevalence of child maltreatment in Malaysia and risk factors,
 - on cost and consequences of CM such as association of past maltreatment and high-risk behavior, current health status, socio-economic status, crime and social ills
 - by Universities, National Social Institute and other research grant bodies prioritising funding for such research in the fields of social sciences, public health, mental health and criminology
 - To add more details on child maltreatment in the National Morbidity Study that is conducted every 10 years
- To improve collation of reported data
 - To have a centralized reporting database, which currently is available only to DSW . This would reduce costs of collecting data on abused children, duplication of work and reduce problems of linking data such as system incompatibility across police, welfare and health agencies. This has been suggested under the National Action Plan for Children and various other networking meeting. Annual reports with non-identifiable data should be made readily available for policy makers and programme implementers, advocacy bodies, academics and media. This registry data can provide basic information to launch research priorities on CM and CMP.

- To have a national and state child fatality review for investigating all known and suspected child deaths due to injuries or suicide
- To have a collaborative effort with various Ministries and NGOs involved with children in having joint research and conferences regarding CM
- To increase knowledge :
 - on cost and consequences of CM via the mass media so that there is impetus for public opinion and political will to invest more on CMP
 - on reporting process for CM and outcome after reporting as well as the to inform the public as to who are mandated reporters so as to increase reporting rate of CM
 - by having a National Clearinghouse for research with a public website to be the central repository for all local publications on CM and related issues and to publicise the availability of this clearinghouse to researchers, policy makers , media and other stakeholders . The Violence Intervention Unit at the Ministry of Health, as the focal point for the Ministry of Health CMP activities or a National Library, could take up this role.
- Successful programs that are evidenced based should be made known to policy makers and programme developers as well as funders.

Dimension 4 “Current Programme Implementation and Evaluation”

From the comparison between the objective and subjective assessment scores, it appears that some of respondents are not fully aware of the available programmes for CMP. Available programmes for CMP in Malaysia are relatively fragmented and isolated in implementation compared to the more comprehensive child protection programmes currently available. The effectiveness of the CM or CMP programmes have not been well evaluated and respondents felt that implementation of programmes is an issue. Once the programmes are in place, there should be media campaigns and information disseminated in print or on-line regarding available services. Recommendations include:

- To increase awareness of stakeholders on the services and programmes available for CMP such as by having a website or directory of government, NGOs and available corporate programs or available funding for CMP activities
- To enhance the existing CMP programmes such as:
 - the parenting skills program by NFPDB in terms of outreach services to parents in districts with high incidence of physical abuse, and to develop modules teaching alternative means of discipline other than corporal punishment

- the anti-bullying campaigns in schools with emphasis on positive peer relationships, gender sensitivity, and respect for privacy in information and communication technology (ICT) use
- programs enhancing parents' child rearing capacities such as introducing micro-credit schemes to urban poor, priority allocation of low-cost housing to the very poor with children
- National programmes related to CMP should be evidence based as with most public health programmes and the proposed programme should be implemented initially as pilot projects at community level. Respondents felt strongly that isolated, fragmented and reactive initiatives to address CMP in response to public outcry should be avoided.
- To ensure sustainability of programs by:
 - Reviewing existing programmes in terms of adequacy of manpower, training in implementation, skill development and technical expertise, and to have standard operating procedures in place at sub-national level before commencement – comments from sub-national level respondents
 - Having dedicated budget inclusive of training and development of human resources
- To improve the monitoring and evaluation of programmes by:
 - Surveying available programmes to monitor the appropriateness and sustainability of these programmes
 - Having a national coordinated agency which is mandated to monitor programme implementation and enforcement, besides ensuring minimal overlapping of programmes. Where they do overlap, a review should be done to avoid conflict or mal-distribution of services.
 - Having a separate budget and staff for programme evaluation so as to outsource programme evaluation until such skill is available
 - Providing training to increase technical resources for programme evaluation

Special note is made of the need for child sexual abuse prevention programmes and prevention of teenage pregnancies where it is strongly felt (97.6 percent of respondents) that there should be a comprehensive sex education program either in schools and children's homes or by parents. The Centers for Disease Control USA reported that research on programs that cover both the abstinence and comprehensive sex education methods found that *"not all sex and AIDS education programs had significant effects on adolescent sexual risk-taking behavior but specific programs did delay the initiation of sexual intercourse, reduce frequency of intercourse or increase the use of condoms or other contraceptives"* [34]. The same report commented that teachers, who have the opportunity to reach large numbers of young people before they become sexually active, have a responsibility to act in partnership with parents and communities to participate actively in reducing high risk sexual behaviour

and to give accurate information without being uncomfortable with the topic of sexuality or being judgemental.

Unplanned pregnancies and teenage pregnancies increases health risks and poorer life outcomes for both mother and the foetus or newborn baby [35]. With the stigma associated with unwed pregnancies, there is increased risk of abandonment of babies. Respondents recommended:

- To modify the existing Curriculum to have modules which are age-appropriate and easily accessible providing information on life-skills, self-protection and specific risks, including those relating to information technology such as persuaded into meeting strangers off-line, being “groomed” for sexual activities or exposure to pornography.
- To have programs targeted towards adolescents in the high risk groups mentioned above especially those who are not involved in school, have other social or family problems, poor school performance or missing classes
- To have video based programs produced by educationists together with psychologists, counselors, adolescent paediatrician or other personnel trained in the area of sexuality and reproductive health that can be placed on Facebook, MyHealth Portal (Ministry of Health website for public health education)
- Getting the parenting adolescent back to school which remains a key element for long-term success for the adolescent and her child. Quality school-based child care programs can facilitate the participation of the adolescent in school, provide support and education to the parent, and can assist in improved health and development in their children [36]

Dimension 5 “Legislation, mandates and policies”

The main measures that were recommended by the respondents to improve legislation, mandates and policies for CMP were:

- To implement the National Child Protection Policy at the sub-national level and increase awareness of the policy amongst stakeholders and the public
- To enhance enforcement of the Child Act 2001 through
 - Training of Child Protectors (gazetted welfare officers) to feel more empowered to protect children using the Act
 - Promotion of inter-agency cooperation and to train professionals in existing protocols for collaboration
 - Training of professionals to change their attitude to reporting and to have clear publicised procedures for public and mandated reporters for reporting. Social stigma and fear of consequences inhibits disclosure and to a lesser extent, failure of

professionals to recognize and report child maltreatment, are major contributing factors to underreporting

- Judicial use of the Child Act 2001 to compel caregivers to bring the child survivor and the perpetrator(s) for assessment and follow-up including rehabilitative and social services
- To fully enforce the Child Care Centre Act as the care of young children are substandard and to enhance parents' knowledge of the standard of care to be expected of child care centres.
- Coalition between all child care providers and other stakeholders to look at problems in registration of Child Care centres and improving standard of care
- To mandate the availability of child protection policies within organisations or institutions dealing with children
- To have all stakeholders, including NGOs and youth participants, involved in policy and legislation development rather than to make adjustments to policies and legislation later which would be difficult and take time. The government is usually inclusive of as many stakeholders as possible for new legislation but some NGOs still felt that they did not have a voice to say which policies are not practical and for that dialogue to be taken into consideration before policy decisions or legislation are made.
- To have a policy that allows government funding of projects aimed at CMP proposed by the community, NGO or sub-national government level and not only from top-down approach.

Dimension 6 "Will to address child maltreatment prevention"

Recommendations to strengthen the will to address CMP included

- Having a continuous intensive media campaign with strong advocacy on the issue using supportive data on incidence and consequences to build up public and political awareness.
- To highlight to the politicians that CMP is in keeping with the objectives of the National Social Policy. Advocacy should be on building successful healthy families i.e CMP rather than on promoting fear of prosecution after the event.
- To use the proposed central repository on all data regarding CM in Malaysia to allow easy access by the public, media and politicians so that data to advocate and in terms of risk factors can be readily available when necessary.
- To have a celebrity or more than one celebrity who champions the cause of CMP by raising public awareness but he or she would need to be provided with correct information. Collaboration between such a figure, government and NGOs was thought to be potentially helpful.

- To advocate for a change in mindset by promoting the rights of the child and the public to treat the child as an individual rather than as a property of the parents. A common saying is that *“a parent has a right to do as he will to or for his child”* which can lead to abuse of the child as well as a failure to report on the part of the community who feels that *“it is not their business to report”* when they suspect CM. Hence advocacy for child rights and improving parenting skills were also thought to be important means of increasing the public and political will to address CMP.

Dimension 7 “Institutional Links and Resources”

It was stated by respondents that the institutional links are mainly at the national level and that these links should also be forged at the sub-national and district levels with a focal point at each level, with clearly defined protocols on inter-agency work. The Child Protection Teams, comprising welfare, officer and police, could be such a focal point at the district level for community or national level programs. Through such links there can be:

- Development and implementation of policies and sharing of data and research
- Dissemination of policies involving multi-agencies for implementation at the sub-national and district levels since communication was not as efficient as at the national level.
- Promotion of better networking and understanding. Some respondents also commented that there should be no “one upmanship” amongst agencies. Networking for CMP is important as the issues relating to CMP are complex and multi-sectoral and cannot be easily implemented by a single agency.
- Increased advocacy efforts, efficient use of resources and a shared political agenda.
- Development of standards of care for all childcare services and settings such as daycare centres, schools, hospitals, residential institutions

A known and easily accessible directory of NGOs and government services for children should be available online.

Dimension 8 “Material resources “

Measures suggested to generate more material resources for CMP were:

- To have data on CMP to generate political will and to justify distribution of funding in an evidenced based manner.
- To have more funding especially for NGOs – some suggestions were to have a foundation for CMP or a ‘community chest’ where corporations could donate as part of corporate social responsibility, with joint funding by the government. There could also be specific quantum revenue into the community chest from large corporations on an annual basis.

- To have training for NGOs to write justification to apply for funding from corporate and government sectors.
- To have a dedicated budget for CMP in every related Ministry or to have a Ministry/ Department for Children to improve coordination across all sections of various Ministries that are involved in children services. Having a Ministry or Department for Children would mean a pooling of government resources and coordination of resources from the various sections of other Ministries involved in other activities involving children but not necessarily focused on children. This would provide for specific funding and allocation for material and human resources from government which is focused efficiently on the needs of children, and allow for institutionalized networking with other Ministries and agencies.
- To expand the Children's Division in the Social Welfare Department to be a Department in itself with separate budget allocations according to the various CMP activities.

Dimension 9 "Human and technical resources"

This dimension requires impetus to improve rapidly as it is the weakest link. Some of the measures suggested to improve the availability of human and technical resources in CMP were:

- To increase overall number of personnel working in programs for CMP and in enforcement agencies especially in densely populated areas such as new suburbs, low-cost flats or temporary public housing
- To increase technical skills
 - to have modules on relevant aspects of CMP for all undergraduate courses dealing with children
 - to have more specialized training on CMP in undergraduate and post-graduate course in institutions, especially in health, social sciences and educational related fields
 - to implement existing modules for public health nurses or to use the modules in developed countries like the United Kingdom where nurse health visitors have been trained in CMP
 - to enable access to informational resources for media and for self-learning
 - to have dedicated funding for organisations that provide training, including NGOs
 - to look into the possibility of expatriates specialist or retired experts to be involved in providing technical skills in CMP as there is a severe shortage of trainers in CMP
- to consider outsourcing for provision of services where human resources are limited

- to use information technology such as videos, blogs, website information to improve parent education and awareness on CMP to increase the amount of time available to staff to personalise time spent with parents
- to have funding for technical materials related to evidence based programs such as Triple P parenting program
- to increase training-of-trainers for specific programs of CMP where available

Other suggested measures were to provide incentives to social workers and teachers to attend postgraduate courses on CMP as part of their continuous professional development.

It was suggested that NGOs can also play a greater role in providing technical and human resources for CMP, but they need fund-raising skills or a government initiative to provide for public or private funding as a constant feature of NGO programmes.

In schools, MOE officers commented that capacity building for technical and human resources can be enhanced under the Safe School Programs and through in-service and pre-service teacher training.

Dimension 10 “Informal Social resources”

To improve informal social resources, some of the suggestions were:

- to strengthen interaction between races which was still sectoral as in schools, community interactions in line with 1Malaysia policy
- to develop programs on promoting social cohesiveness at the community level especially in the urban areas especially in promoting child safety, healthy environment in the community
- evaluate effectiveness of existing community programmes such as *Rukun Tetangga*
- promote volunteerism and community work amongst school children

DISCUSSION

From the objective assessment and feedback of respondents, child protection rather than child maltreatment prevention has been the focus in Malaysia. About 75 percent of the study respondents had been working for many years in child protection rather than CMP. Hence the distinction between child protection and child maltreatment was not easy and respondents had to be constantly reminded of the distinction.

From the quantitative analysis of our findings, the objective assessment scores shows that Malaysia's child maltreatment prevention readiness is at a moderate level, with greater readiness in current programme implementation and evaluation, legislation and policies on CMP, knowledge on CMP and the will to address problem. The subjective assessment scores were almost similar, being highest for scientific data on CMP, knowledge on child maltreatment, legislation, mandates and policies, and institutional links and resources. The lower score for the subjective assessment compared to objective scores is most likely related to the lack of awareness of respondents as well as the perceptions of the respondents on the lack of implementation and resources. Much of the data for objective assessment was compiled from many sources.

As for the respondents, whilst the majority knew about the reporting system, many of those from NGOs were not aware who are mandated to report. Despite the mandated reporting requirement since 1991, in a study on 1,870 adolescents in schools [16], the prevalence of "having been physically hurt or beaten with a stick, belt or hard object" for at least three times, was 16.7 percent and of having been "forced to have sexual intercourse" was 3.0 percent. Extrapolating from a Malaysian population of about 5 million adolescents and the incidence rate of all types of reported CM to be 3,257 in the year 2010, the grossly estimated reporting rate for CM could be as low as 2 percent.

From the point of legislation in CMP, the Childcare Centres Act is probably the one which should be well enforced. There have been many cases of infant deaths and injuries at home based child care centres. Women comprise 46.5 percent of the labour force in year 2010 therefore the standard of care in Child Care Centres must be adequate in terms of skilled staff in child development and child care in addition to safety standards.

The existing multiagency coalitions such as the Coordinating Council for the Protection of Children and the Malaysian Council for Children or National Technical Subcommittee for Social Issues concerning Children could serve as the core committee for work on CMP instead of only child protection. However, there will need to be similar committees at the state and community levels for two-way communication in programmes and services for CMP at the community level, monitoring and evaluation.

Most respondents could give information about only 1 or 2 programmes for CMP. One of the reasons for this is probably because not many available programmes are being addressed as being specifically for CMP, but rather for the overall health, educational and social well-being of the child and family. Almost all respondents felt that the given examples of CMP programmes given in the study were appropriate for Malaysia, except for some concerns about problems in implementation. It was generally felt that

more priority would be given by the public and political leaders to expand existing programmes if the data concerning CM, risk factors and cost and consequences to our children and society were available from local research. Whilst demographic data and increasing amounts of research has been done on this topic, the information is not readily available to mass media, public and stakeholders.

The dimension with the least readiness is that of human and technical resources as rated objectively and subjectively and for all subgroups. The numbers required for child protection training needs to be greater and more specialized especially in terms of mental health workers and child protection social workers. However, the numbers of professionals to be involved in child maltreatment protection such as public health nurse visitors, parenting skill trainers or early childhood development teachers are already numerically greater but need further professional development in terms of knowledge of CMP and development and training in programme implementation and procedure for reporting and referral. The level of technical resources is also currently insufficient as there has been minimal emphasis on CMP but rather on increasing skills in child protection. Comparing scores across the subgroups of national, sub-national, government and non-government, there is a suggestion that sub-national and NGO group is relatively under-resourced, feels unsupported in terms of staffing, funding and political will. NGO and sub-national groups scored far less than the national government group for the dimension of 'legislation, mandates and policies' due to perceptions of lower effectiveness of the dimension in CMP in the former groups. In the interpretation of sub-national and NGO scores, it must be realised that in our study, there were 14 NGO respondents out of 19 sub-national respondents. Hence there is a strong correlation between the NGO and sub-national scores except that the sub-national scores were lower than the NGO group for informal social resources.

Limitation of the study

Several methodological issues need to be considered when interpreting the results of this study.

Design of the questionnaire

Although missing values for most items were relatively low in general, there were limitations in the interview schedule which may affect some aspects of the country's readiness score.

Large missing values were found in the 'knowledge assessment' section. It could be a result of interviewers not administering this section to all respondents. Respondents who have been working in the area of child maltreatment and child protection found this section redundant. The knowledge assessment section may be useful if these questions are posted to the general public or personnel who have little experience working in this area.

The questions on measures to improve various aspects of CMP have quite a number of missing values. Reasons that may explained this include; 1) interviewee may lack information in relation to specific topic of discussion, thus could not recommend any measure; 2) the same question was repeated in each domain, hence respondents may have run out of responses (or would have suggested some measures in earlier sections; 3) this question requires more reflection and time available to answer may be limited due to the length of questionnaire.

It should be noted that total scores for dimension on current programme implementation and evaluation may appear lower than it expected. This discrepancy may be due to many respondents being too exhausted at the end of the interview such that many interviewees answered this section hastily.

Similarly, one particular item asking about feedback for 'any important dimension missing from the model' generated only 50 percent of responses from participants. The placement of this item at the end of the interview schedule was more likely to be ignored by the interviewers due to time constraints. The most common comments that we gathered from the participants were that the interviews were too lengthy and long. We recommend that this item could be deleted as the rest of the individuals who had the opportunity to comment on this agreed that the model is comprehensive.

Sample size

The sample sizes were too small, thus lack of statistical power for more formal testing of the questions (e.g. factor analysis). The samples were purposive although efforts had been made to make sure the samples were representative of all stakeholders. Sample was comprised mainly by interviewees from the Federal state of Kuala Lumpur, Selangor, Kedah and Perak. Participants from the national level are overrepresented compared to the sub-national level.

In spite of the limitations inherent in the existing RAP-CM interview schedule, this instrument is well positioned as a relatively useful survey to measure country's readiness of CMP. The instrument underwent a comprehensive literature review, evaluation in the focus groups, and cognitive debriefing to clarify the nature and range of the content of each domain. It was also further pilot tested and field tested in the population. The instrument appears to have face validity, reasonable internal consistency, and acceptable to the stakeholders who were interviewed.

IMPLICATIONS FOR LARGE-SCALE CMP PROGRAMME IMPLEMENTATION

Factors to be considered for large scale CMP Programme implementation:

- Political will is an important driving force for adequate funding and material resources in Malaysia and important determinant of legislation, development and policies. There needs to be a repository of data such as a 'national clearing house' to assist political leaders and policy makers in making informed decisions. Targeting of large-scale selective CMP program is not yet feasible until there is a large well-designed prevalence study including data on the risk factors and high-risk population groups. Universal CMP programs should initially commence in the highly urbanized regions and poorer population based on the association between rapid urbanization and child maltreatment and local research data on social risk factors in urban areas
- Priority for improving human and technical skills before implementation of any such programme
- The existing networking of government agencies can be the focal points at community and state levels not only for child protection but for child maltreatment prevention
- More than 95 percent of children and their families are accessible in the newborn period and in primary school – an ideal age group for future large scale universal CMP programmes
- Monitoring and evaluation together with dedicated budget and staff for this, needs to be built into such large scale programmes

RECOMMENDATIONS AND CONCLUSIONS

Many countries on recognizing the phenomenon of child maltreatment embark on programmes for child protection, i.e. services after child maltreatment has occurred. Child maltreatment is a complex issue at the level of the child, family, community and society and the interactions between the levels. Like all public health and social issues, prevention is preferable to intervention after the event.

This country report has looked into the assessment of country readiness for CMP by key officials in related government departments, those in NGOs and community leaders based on the 10 dimensions which have been found to be an appropriate model for assessing CMP readiness [37]. Malaysia has made substantial efforts in child protection and to improve the overall health, education and developmental needs of our children. In order to address CMP, strategies need to tackle child maltreatment simultaneously at different development stages of development of the child and to strengthen the various dimensions of CMP readiness. Strategies to improve CMP readiness in Malaysia have been given by the respondents and by authors based on the study findings. The following are a

summary of the recommendations to prepare the country for the implementation of large-scale CMP programmes:

Recommendation 1

- **Improving attitudes towards child maltreatment prevention**

Prevention of child maltreatment requires a community prioritization of children's needs for healthy growth and physical, emotional and psychological development supported by national policy. This involves creating awareness of issues relating early childhood development, good child care, childhood trauma and consequences of child maltreatment as well as addressing children's rights to respect for their human dignity and physical and psychological integrity. A child rights approach rather than a welfare approach for the prevention and response to violence of all forms towards children has been recommended under the General Comment No. 13 of the CRC¹³.

Recommendation 2

- **Increasing knowledge of child maltreatment prevention**

A media campaign that is sustained and regular from various angles such as talk shows with professionals, positive ideas on parenting and coping under difficult circumstances, promotion of a respectful supportive child-rearing environment free from violence, documentaries on effects and causes, costs and consequences of child maltreatment, awareness of risk to disabled children, discussions on child safety, criteria for good child care centres, dissemination of the CRC and the effects of urbanization. Sensationalism and criminalisation of child maltreatment in media should be discouraged to avoid ad hoc programmes and inaccurate public perception that CM is only perpetrated by the bad parents, drug addicts or the mentally ill.

Recommendation 3

- **Increasing scientific data on child maltreatment prevention and the will to address the problem**

Child maltreatment is multi-factorial and intervention is intertwined with socio-cultural issues. Thus, quality information on these complex child maltreatment issues is required to direct political will and public concern into appropriate areas of priority, for planning of effective targeted prevention activities, and allocation of funding and resources into evidence-based programs which are culturally appropriate.

¹³ CRC General Comments no 13 (2011): The rights to the freedom from all forms of violence.
http://www2.ohchr.org/english/bodies/crc/docs/CRC.C.GC.13_en.pdf

A comprehensive and reliable national data collection system should be established to ensure systematic monitoring and evaluation of systems (impact analyses), services, programmes and outcomes. These outcomes should be based on indicators aligned with universal standards, and adjusted for and guided by locally established goals and objectives.

A national clearing house for scientific publications is necessary for systematic reporting, analysis and dissemination of scientific literature related to fields of public health, mental health, social work, psychology, law enforcement and anthropology among others.

Recommendation 4

- **Program implementation according to evidence based approach with monitoring and evaluation**

The National Action Plan for Children can be further developed by reviewing existing evidenced based successful programs and considering a 'top-down bottom-up approach'. Dissemination of services should include outreach services according to epidemiological data of child maltreatment, and taking into consideration poverty and socio-economic discrimination.

A public health approach can be utilised – with assessment of the problem, small scale intervention with monitoring and continuous improvement followed by larger scale implementation and evaluation of outcome and effectiveness. There should be a frank assessment of the capacity of all systems for the prevention of child maltreatment as well as an assessment of the form of service deliveries that would reach the targeted families and most effectively prevent child maltreatment within respective socio-cultural contexts. Program implementation should be structured and integrated into existing services, transparent in terms of funding and material resources, integrated from district to national level by using the existing health and social government infrastructure as well as expanding the scope of the Child Protection Teams. Community-oriented primary health care (COPC) is a tested practical model that uses community-based diagnosis, assessment, prevention planning, implementation, evaluation, and reassessment, and may be easily connected to prevention efforts [38-40].

There are various national committees that are well placed for the role of coordination and implementation such as the National Technical Subcommittee for Social Issues concerning Children. Others are the National Advisory and Consultative Council for Children and the Coordinating Council for the Protection of Children. However, unlike Child Protection Programmes, CMP committees should also include agencies involved with increasing parental capacities in child-rearing such as housing, employment, substance abuse programmes, religious bodies and counseling services.

Recommendation 5

- **Legislation, mandates and policies for Child Maltreatment Prevention**

Legal efforts should not only be focusing on the prosecution of perpetrators and enforcement of the Child Act 2001 but also on the enforcement of responsible parenting, satisfactory standards of child safety such as in schools, public transport, child care centres, child recreation centres, child care and city council planning and development in residential areas. Social policy measures should reflect government commitment to fulfilling child protection rights and provide for basic and targeted services. Malaysian programs are well placed to provide such services but require outreach services to vulnerable groups such as disabled children, urban poor and minority groups. Such social policy measures to be enhanced for CMP include poverty reduction strategies, housing and employment policies, “child friendly cities” planning, and crèches at work.

Recommendation 6

- **Improving human and technical resources**

Programs cannot be successfully implemented without sufficient numbers of skilled personnel at all levels of implementation and this is a priority strategy as it is the weakest dimension of CMP readiness. There needs to be collaboration between academic institutions and professionals to develop model curricula for child development and maltreatment “literacy” for all relevant professional undergraduate training. As this will take time to mature, there needs to be funds under the “*modal insan*” continuous professional development programme for training in specific aspects of CMP such as home visiting programmes, for the training of trainers for parenting programmes, increasing the funding presently available from MWFCF for NGO-run programmes; as well as budget for outsourcing for manpower and technical experts.

Recommendation 7

- **Improving institutional links and resources**

Multisectoral multiagency networking and cooperation is required not only to facilitate the above recommendations but also to provide dialogue at the local level to identify appropriate services at each locality. There should be support for systematic collaboration between NGOs, religious organisations and the corporate sector that have a shared goal of CMP.

Conclusion

Child maltreatment is preventable. According to this study, Malaysia is at the half-way mark in terms of readiness to implement large-scale CMP programmes. Public and political will to support future

functional adults who are unimpaired by childhood maltreatment need to be fostered by changing attitudes of violence towards children and promotion of their individuality and rights, and increasing awareness of the magnitude and health, social and economic consequences of child maltreatment in Malaysia. Recognition of child development, as a measure of effective economic development, would also help set a national agenda for CMP. The goal for a safe and healthy childhood should be integrated into all major policy decisions with intersectoral collaboration at all levels of government. The multi-dimensional model for assessment of CMP readiness in the country has been useful in elucidating the strengths and weaknesses of the country's conditions and to recommend strategies for addressing CMP with some degree of prioritization. The lowest scoring dimensions would be the rate limiting factors for the rate of successful CMP program implementation but obviously all ten dimensions are important just like the 'spokes of a wheel' for CMP to run smoothly. It is hoped that this report and recommendations by respondents who are workers in the field of CMP and protection will be useful in facilitating the promotion of child maltreatment prevention.

REFERENCES

1. Economic Planning Unit Malaysia. Malaysia: The Millenium Development Goals at 2010. Kuala Lumpur: United Nations Country Team, Malaysia; 2011.
2. World Bank. World Development Indicators Online. Retrieved from: <http://data.worldbank.org/country>; 2011.
3. Department of Statistics Malaysia. Population and Housing Census, Malaysia 2010. Retrieved from Department of Social Welfare Malaysia website: <http://www.statistics.gov.my>; 2010
4. Department of Statistics Malaysia. Malaysia Demographic Indicators 2010. Retrieved from Department of Statistics Malaysia website: http://www.statistics.gov.my/portal/download/Population/files/BPD/ind_2010.pdf 2011.
5. Economic Planning Unit Malaysia. Tenth Malaysia Plan 2011-2015. Putrajaya: Economic Planning Unit, Prime Minister's Department, Government of Malaysia; 2010.
6. United Nations Country Team Malaysia. Malaysia: Achieving the Millenium Development Goals. Successes and Challenges, Kuala Lumpur. United Nations Development Programme; 2005.
7. Ministry of Education Malaysia. Malaysia Educational Statistic Putrajaya: Ministry of Education, Educational Planning and Research Division. Retrieved from: http://emisportal.moe.gov.my/emis/emis2/emisportal2/doc/fckeditor/File/BukuPeran_gkaan10/BAB_o_INDEX.pdf; 2010.
8. UNESCO. Early Childhood Care and Education (ECCE) Programmes in Malaysia. Geneva, Switzerland: UNESCO International Bureau of Education; 2006.
9. World Health Organisation. World Health Statistics 2010. Geneva, Switzerland. Retrieved from: http://www.who.int/whosis/whostat/EN_WHS10_Full.pdf; 2010.
10. Malaysia Institute of Public Health. Recent Illness/Injury, Health Seeking Behaviour and Out-of-pocket Health Care Expenditure. National Health and Morbidity Survey 1996, Kuala Lumpur: Ministry of Health, Malaysia.; 1997.
11. Ministry of Health, Malaysia. Indicators for Monitoring and evaluation of strategy Health For All. 2010. 194 pp.
12. Kasim MS, George R, Kassim K, et al. Child abuse and neglect as seen in General Hospital, Kuala Lumpur--a two year study. Med J Malaysia 1989 44(2):111-121.
13. Kasim MS, Mohd. Shafie H, Cheah I. Social factors in relation to physical abuse in Kuala Lumpur, Malaysia. Child Abuse & Neglect 1994;18(5):401-407.

14. Kassim K, Kasim MS. Child sexual abuse: Psychosocial aspects of 101 cases seen in an urban Malaysian setting. *Child Abuse & Neglect* 1995;19(7):793-799.
15. Singh HSSA, Yiing WW, Nurani HNK. Prevalence of childhood sexual abuse among Malaysian paramedical students. *Child Abuse & Neglect* 1996;20(6):487-492.
16. Choo WY, Dunne M, Marret MJ, et al. Victimization Experiences of Adolescents in Malaysia. *Journal of Adolescent Health* 2011;49(6):627-634.
17. Hong J, Ismail AB, Jabbar A, et al. Trending of Child Abuse Cases Presented To Putrajaya Hospital. *Malaysian Journal Of Paediatrics and Child Health* 2010;Vol 16(2).
18. WHO Centre for Health Development. National Report on Violence and Health Malaysia: WHO Kobe Centre; 2006.
19. Kamaruddin Z, ed. Child abuse and neglect: A Malaysian perspective. Dartmouth: Ashgate, 2000.
20. Author. Talian Nur hotline launched. The Star Online (Malaysia) Retrieved from: <http://thestarcommy/news/story.asp?file=/2007/12/5/nation/20071205131631&sec=nation>. Dec 5, 2007.
21. Lembaga Penyelidikan Undang-Undang. Akta Kanak-Kanak 2001 (Akta 611) & Child Act 2001 (Act 611). Kuala Lumpur: International Law Book Services.; 2005.
22. Marret MJ, Choo WY, Othman S, et al. Parental perceptions of child abuse in Malaysia. 6-9 October 2011 (Presented at the 9th ISPCAN Asia Pacific Regional Conference on Child Abuse and Neglect, New Delhi).
23. Author. Malaysia to revive caning in schools. Agence France-Presse (AFP) News Retrieved from: <http://www.google.com/hostednews/afp/article/ALeqM5gioHTPUo9PrvtfxdU8hzchytDwpA>. Apr 6, 2009.
24. Choo WY, Walsh K, Marret MJ, Karuthan C, Tey NP. Are Malaysian teachers ready to assume the duties of reporting child abuse and neglect? *Child Abuse Review* 2012 (in press, accepted 23 Aug 2012).
25. Ministry of Health, Malaysia. Management of Rape. 1988:p. 15.
26. Hawa Ali S. In The Women's Centre for Change, Penang: empowering the women of Malaysia. In: Sharma M, ed. Improving people's lives: lessons in empowerment from Asia. New Delhi: Sage, 2003:56-100.
27. Azizan H. Malaysia: Sex education is already being taught in school. But is it enough? The Star Online (Malaysia) Retrieved from: <http://www.wippforg/en/News/Intl+news/Malaysia+Sex+education+is+already+being+taught+in+school+But+is+it+enoughhtm>. July 18, 2010.
28. Singh D, Tan EL. Sex education to go national. The Star Online (Malaysia) Retrieved from:

<http://thestarcommy/news/storyasp?file=/2010/10/2/nation/7145488&sec=nation>.
Oct 2, 2010.

29. Chieh YH. Govt mulls introducing sex education into core syllabus. The Malaysian Insider Retrieved from: <http://www.themalaysianinsider.com/malaysia/article/govt-mulls-introducing-sex-education-into-core-syllabus/>. Aug 4, 2010.
30. Letchumy Tamboo TK. Sex education, finally. Green light given by Education Ministry to teach subject next year. The Malay Mail Retrieved from: <http://www.mmail.commy/content/83759-sex-education-finally>. Oct 5, 2011.
31. Hussein R. Comment: Crime, punishment and the child offender. The New Straits Times Aug 5, 2007.
32. The Commissioner of Law Revision Malaysia. Laws of Malaysia, Act 550: Education Act 1996. Kuala Lumpur: Percetakan Nasional Malaysia Berhad, 2006.
33. OECD. OECD Health Data 2011. Retrieved from: http://www.oecd.org/document/16/0,3343,en_2649_34631_2085200_1_1_1_1,00.html; Nov, 2011.
34. Kirby D, Short L, Collins J, et al. School-based programs to reduce sexual risk behaviors: a review of effectiveness. Public Health Rep 1994 May-Jun;109(3):339-360.
35. UNICEF. Young people and family planning: Teenage pregnancy. UNICEF Fact Sheet Retrieved from http://www.unicef.org/malaysia/Teenage_Pregnancies_-_Overviewpdf Jul 11, 2008.
36. AAP. Care of Adolescent Parents and thier children. Pediatrics 2001;429-434.
37. Mikton C, Mehra R, Butchart A, et al. A Multidimensional model for child maltreatment prevention readiness in low- and middle-income countries. Journal of Community Psychology 2011;39:826-843.
38. Epstein L, Gofin J, Gofin R, et al. The Jerusalem experience: three decades of service, research, and training in community-oriented primary care. Am J Public Health 2002 Nov;92(11):1717-1721.
39. Gao Y, Lu ZZ, Shi R, et al. AIDS and sex education for young people in China Reproduction, Fertility and Development. 2001;13:729-737.
40. Gillam S, Schamroth A. The community-oriented primary care experience in the United kingdom. Am J Public Health 2002 Nov;92(11):1721-1725.

Appendix 1. Key country conditions

KEY COUNTRY CONDITIONS	
1. Official administrative divisions of country	
Country/state/district	
2. Population	
1. Total population of country	28,628,7000 ^{1,a}
2. Age structure – 0-14 years, 15-59 years, 60 years and over	26.7% (0-14), 65.4% (15-59), 7.9% (60+) ^{1, a}
3. % urban population	72% of total population ^{2,b}
4. Total fertility rate	2.4 children born/woman ^{2,a}
5. Adolescent fertility rate (births per 1000 women aged 15-19)	13 ^{5, c}
3. Economy	
1. GDP per capita (PPP*)	USD 14,700 ^{2,b}
2. Unemployment rate	3.49 % ^{2,b}
3. % of population below international poverty line of US\$1.25 per day	3.6% ^{5,b}
4. GINI index	46.2 ^{3,b}
4. Health	
1. Infant mortality rate (under 1)	5.4 per 1000 live births ^{2,d}
2. % of deaths among male children under five years of age due to injuries - GBD	7.7 (no specification for gender) ^{4,c}
3. % of deaths among female children under five years of age due to injuries - GBD	7.7 (no specification for gender) ^{4,c}
4. Life expectancy at birth (both sexes)	74.15 years ^{2,b}
5. Maternal mortality rate	27.3 per 100 000 live birth ^{4,a}
6. Under-5 mortality rate	6.3 per 1000 live births ^{2,d}
7. General government expenditure on health as percentage of total government expenditure.	6.9% (USD 353 per capita) ^{1,d}
8. Adult prevalence rate of HIV/AIDS	0.5% ^{3,b}
9. Per cent of children <5-years-old underweight (moderate & severe)	8% ^{4,e}
10. Per capita recorded alcohol consumption (litres of pure alcohol) among adults (>=15 years) – GHO	< 2.50 litres ^{5,c}
11. % received at least four antenatal visits - GHO	79 % ^{3,c}
12. Immunisation rate	95-98% ^{3,e}
5. Education	
1. Total adult literacy rate (%)	92.5% ^{3,d}
2. Primary school net enrolment (%)	96% ^{3,e}

3. Public current expenditure on primary education per pupil (PPP US\$)	1,324 ^{3,f}
4. Survival rate to last primary grade (%)	98 % ^{6,f}
6. Equality of access to healthcare and education and social protection	
1. Density of community health workers (per 10000 population) - GHO	Not available
2. Density of physicians (per 10 000 population) - GHO	7 ^{4,c}
3. General government expenditure on health as a percentage of total expenditure on health - GHO	44.1 per cent ^{4,c}
4. Healthcare for under-5	Free immunization in government clinics Free newborn health screening in government facilities and home visits for first month of life
5. Healthcare for school children	Free in government clinics and hospitals, free annual checks
In <i>Country</i> , is early childhood education available	Widely
Where early childhood education is available, is it:	
Is primary education compulsory in <i>Country</i> ?	Yes
Is primary education free in <i>Country</i> ?	Yes for citizens and permanent residents
Is secondary education compulsory in <i>Country</i> ?	No
Is secondary education free in <i>Country</i> ?	Fee paying
In <i>Country</i> , are benefits for children with disabilities:	Yes
Are income and/or food supplement available for those in need in <i>Country</i> ?	Yes income supplements, but no food supplements
Are the unemployed in <i>Country</i> entitled to unemployment benefits of some kind?	Yes – financial aid after social assessment
Are all families (with children) entitled to some kind of allowance/benefits regardless of family income?	No
Is there statutory paid maternity leave in <i>Country</i> ?	Yes (entitled for 300 days in 5 years but 3 months maximum per delivery, unpaid breastfeeding leave for 3 months for government sector)
Is there statutory paid paternity leave in <i>Country</i> ?	Yes (7 days for government sector)

¹ Data shown for year 2011

² Data shown for year 2010

³ Data shown for year 2009

⁴ Data shown for year 2008

⁵ Data shown for year 2007

⁶ Data shown for year 2002

^a Department Of Statistics, Malaysia

^b Central Intelligence Agency – World Factbook

^c World Health Organization – World Health Statistics 2010, 2011

^d The World Bank

^e UNICEF – country statistics

^f UNESCO (United Nations Educational, Scientific and Cultural Organization)

Appendix 2. Child maltreatment studies of Malaysia - journal publications

First Author (year)	Title of Paper/Report	Type of publication	Study design	Sample	Method	Major Findings
Kasim MS, Mohd. Shafie H, Cheah I (1994)	Social factors in relation to physical abuse in Kuala Lumpur, Malaysia	Journal	retrospective review	119 cases of physical abuse was detected by the Suspected Child Abuse and Neglect (SCAN) Team of General Hospital, Kuala Lumpur in 1991	Analysis of medical record	Among the 37 severely abused, the parents were either divorced or separated in 14 cases. There was a personality disorder in seven of the cases. Six of the abusers were also using drugs and nine were alcoholics.
Kassim K, Kasim MS. (1995)	Child Sexual Abuse: Psychosocial Aspects of 101 Cases Seen in an Urban Malaysian Setting	Journal	case note and interview study, cross-sectional	101 child abuse cases between June 1985 and December 1990 by the Suspected Child Abuse and Neglect (SCAN) Team of Kuala Lumpur General Hospital (Malaysia).	interview	A total of 15 children living in the extended family system were being sexually abused compared to 49 of the children living in a nuclear family. Approximately 80 percent of the perpetrators were known to the victims. Probable risk factors include the absence of other protective adults at home, drug abuse and unemployment of the perpetrators.
Kasim MS, Cheah I, Shafie HM. (1995)	Childhood deaths from physical abuse	Journal	retrospective review	30 cases of childhood deaths caused by physical abuse, detected by the Suspected Child Abuse and Neglect (SCAN) team, General Hospital, Kuala Lumpur	Analysis of medical record	Fathers formed the largest group of perpetrators, followed by mothers and childminders. Fifteen of the natural parents of the abused children were married, four were divorced and four were never married. Five of the abusers had aggressive personalities and three were drug addicts. Only one abuser was found to be an alcoholic even though a few were also under suspicion. For most

						cases, trigger factors could not be identified
Singh HSSA, Yiing WW, Nurani HNK (1996)	Prevalence of childhood sexual abuse among Malaysian paramedical students	Journal	Quantitative; cross sectional	616 trainee paramedical staff	Self-report survey	6.8% admitted to having been sexually abused in their childhoods, and of the abusers, 71.4% were known to the respondent.
Cheah IG, Kasim MS, Shafie HM, Khoo TH. (1997)	Intracranial haemorrhage and child abuse	Journal	Retrospective	All cases of child deaths from NAI from 1989 to 1991, Hospital KL	Medical records	41 deaths with 90% of children below 2 years old dying of head injuries. 80% of them had subdural haemorrhages, there were no signs of trauma in 54%. High index of suspicion for NAI in young child presenting with unexplained subdural haemorrhage.
Nooraudah AR, Mohd Sham K, Zahari N, Fauziah K. (1999)	Non-accidental Fatal head injury in small children – a clinic-pathological correlation	Journal	Retrospective	All cases of child deaths from NAI in 1999, Hospital KL	Medical records	10 child deaths in year 1999 – 80% of deaths due to head injury from shaking or direct trauma.
Leila Nathan, Woon Tai Hwang, 2002	Child abuse in an urban centre in Malaysia	Journal	prospective 2-year study	19 cases of child abuse at the University Hospital in Kuala Lumpur	Medical records	Multiple stress factors were identified and their prevalence in the 19 cases are discussed
Suhaila I, Fauziah MZ, TL Soo (2010)	Epidemiologic Features Of Child Abuse In Sabah Women And Children's Hospital From January 2010 To June 2010	Journal	retrospective study	children aged sixteen and younger suspected and confirmed as child abuse from from the Department of Social Welfare in SWACH	Medical records	Sexual abuse was the highest (79.2%) followed by physical abuse (14.2%) and child neglect (6.5%). Majority of child sexual abuse perpetrators were mainly from persons known to the victims (95%) such as boyfriend and father. In child physical abuse cases, mothers were the main perpetrators (45.4%).
Hong J, Ismail AB, Jabbar Al, JSL Wong, Kaur A, JS, Fuziah MZ,	Trending of Child Abuse Cases Presented To Putrajaya Hospital	Journal	retrospective review	56 cases of child abuse reported from 1st January 2007 to 31st December 2009	medical record	The increasing trend of child abuse may reflect the increasing population in and around Putrajaya consisting of mostly working parents who depend on child care

Nora'i MS (2010)						services. Children younger than 2 years old had higher risk of being abused. Intracranial bleed is the leading cause of death.
Choo, W. Y. Dunne, M. Marret, M. J. Fleming, M. Wong, Y. L. (2011)	Victimization of adolescents in Malaysia	Journal	Quantitative; cross sectional	1800 secondary school students aged 16 years	Self-report survey	Emotional and physical abuse is common. Penetrative sexual abuse is found to be 3% and no gender difference is found for sexual abuse
Lukman Z.M. (2011)	Childhood Abuse among Children Involved in Prostitution in Malaysia	Journal	Qualitative interview	63 young women safeguarded from prostitution in two rehabilitation centres	semi-structured interview and narrative interview	Vast majority of prostituted young women were being emotionally and physically abused and half of them are being sexually abused during childhood before they were drawn into prostitution

Appendix 3. Item Analysis

Generally, missing values found in the study were minimal (less than 5 percent) except for several items and skip rules. Items with high missing values (excluding those with skip rules) are listed as follow:

- i. main consequences of child maltreatment – 7.1 percent
- ii. main costs of child maltreatment – 14.3 percent
- iii. main risk factors of child maltreatment – 9.5 percent
- iv. measures recommended to improve collection of data – 11.9 percent
- v. measures recommended to increase the influence of scientific evidence – 19 percent
- vi. measures recommended to improve legislation, policies and mandates – 14.3 percent
- vii. measures recommended to increase technical and human resources – 21.4 percent
- viii. measures recommended to strengthen the will to address the prevention of maltreatment – 11.9 percent
- ix. measures recommended to strength the link between institutions, increase resources and improve efficiency in child maltreatment – 16.7 percent
- x. measure to strengthen informal social resources – 21.4 percent
- xi. measures recommended to increase programme implementation and evaluation – 9.5 percent
- xii. number of people involved in institutions focus on child maltreatment prevention – 30.8 percent
- xiii. administrative efficiency in institutions focus on child maltreatment prevention – 9.5 percent
- xiv. any important dimension missing – 47.6 percent

The missing values in the first 3 items (see i, ii, iii above) are largely a consequence of the ‘knowledge assessment’ section not administered to all respondents due to earlier instruction in the RAP-CM that allows interviewer to decide if it is necessary to administered this section. The missing values in item xii (number of people involved in institutional focus on CMP) were much larger compared to item xiii (perception on administrative efficiency) although it belongs to the same core item.

Appendix 4. Details of scoring for each dimension for all respondents

Table I. Scores for each dimension - subjective assessment

	Mean	Standard Deviation	Minimum	Maximum	Median
DIM1	4.00	1.63	1.25	8.12	3.75
DIM2	5.19	1.01	3.64	8.18	5.00
DIM3	6.79	1.83	.00	9.58	7.08
DIM4	3.43	2.17	.00	8.67	3.00
DIM5	5.16	2.46	.00	10.00	5.00
DIM6	4.30	2.05	1.25	8.75	4.17
DIM7	6.05	1.16	3.16	8.16	6.05
DIM8	2.64	2.13	.00	7.67	2.00
DIM9	1.65	2.18	.00	10.00	.83
DIM10	3.76	2.27	.00	8.00	3.00
TOTAL	42.96	11.17	23.23	75.91	42.53

Table II. Scores for each dimension – objective assessment

Dimension	Raw score	Score on a scale of 1-10
Dimension 1: Attitudes towards child maltreatment prevention	6 /14	4.3
Dimension 2: Knowledge of child maltreatment prevention	5.5 /8	6.9
Dimension 3: Scientific data on child maltreatment prevention	14 /24	7.5
Dimension 4: Current programme implementation and evaluation	25 /30	8.3
Dimension 5: Legislation, mandates, and policies	9 /12	7.5
Dimension 6: Will to address the problem	17 /24	7.1
Dimension 7: Institutional links and resources	24.5/74	3.3
Dimension 8: Material resources	8 /14	5.7
Dimension 9: Human and technical resources	4 /12	3.3
Dimension 10: Informal social resources (non-institutional)	4 /10	4.0
Total child maltreatment prevention readiness score		57.9 /100

Appendix 5. Qualitative analysis - answers given to RAP-CM

- **DIM 2-2** – *What in your opinion are the most common forms of child maltreatment in Malaysia Country/Province/Community?*

Table I : Types of maltreatment mentioned by respondents

Types of maltreatment	Percent (%)*
Physical	85.0
Neglect	67.5
Sexual	66.0
Emotional	60.0
Malnutrition	2.5
Violence between peers	2.5
Child labour	2.5

*Multiple responses

Table II: Number of maltreatment mentioned by respondents

Number of maltreatment	Percent (%)
5 forms	2.5
4 forms	40.0
3 forms	20.0
2 forms	22.5
1 form	15.0
No form mentioned	0.0
Total	100.0

- **DIM2_2_3** – *In your opinion, what are the main consequences of child maltreatment for the victim?*

Table III : Types of consequences mentioned by respondents

Types of consequences	Percent (%)*
Cognitive and emotional development	67.5
Behavioural problem	40.0
Mental health	35.0
Development in general	25.0
Violence and aggressive	25.0
Trauma	22.5
Physical injuries	22.5
Death	10.0
Suicidal	7.5
Low education level	7.5
Broken marriage	5.0
Drug abuse	2.5
No consequences mentioned	5.0

* Multiple responses.

Table IV : Number of consequences mentioned by respondents

Number of consequences	Percent (%)
6 forms	2.5
5 forms	7.5
4 forms	20.0
3 forms	17.5
2 forms	42.5
1 form	5.0
No consequence mentioned	5.0
Total	100.0

- **DIM 2_2_4** – *What do you think are the main costs of child maltreatment in Malaysia Country/Province/Community – other than health and social consequences for the victims themselves ?*

Table V : Type of costs mentioned by respondents

Type of cost	Percent (%)*
Health system	42.5
Unemployment& social ills	40.0
Rehabilitation, homes and prisons	40.0
Human resources -loss of and for child protection	25.0
Legal cost	20.0
Prevention programmes and projects	15.0
Emotional cost	10.0
Educational cost – school drop out	7.5
Judiciary	5.0
Mention that costs are high without specifying	12.5
No costs mentioned	12.5

* Multiple responses.

- **DIM 2_2_5**– *What do you think are the main risk factors for child maltreatment in Malaysia Country/Province/Community?*

Table VI : Risk factors mentioned by respondents

Risk factor	Percent (%)*
Low socioeconomic status	55.5
Dysfunctional family	45.0
Cultural	25.0
Lack of parenting skills	20.0
Lack of support group	17.5
Lack of religious belief	12.5

Exposure to negative influences	10.0
Parental psychological problem	8.0
Lack of education	5.0
Lack of awareness	5.0
Child disabilities	5.0
Peer pressure	5.0
Trauma in family	2.5
Lack of political will	2.5
Parental alcoholism	2.5
No risk factor mentioned	7.5

*Multiple responses.

Appendix 6. Available Programmes for Child Protection

Table I. List of secondary and tertiary programmes related to child maltreatment offered by the Ministries or NGOs

Organisations	PROGRAMME	DESCRIPTION
Ministry of Women, Family and Community Development	Telephone hotlines - Childline Malaysia	National, confidential helpline for outreach services to children under 18 years old (15999 Childline)
	National Urgent Response Alert (NUR Alert)	National hotline (15999) for reporting child maltreatment or when child under the age of twelve is reported missing.
	Child Protection Teams in major districts	Legally sanctioned multiagency team that functions as a support system for reported cases of child maltreatment to coordinate every agency involve in the child protection for immediate action. Counsellors from community have undergone awareness training in child maltreatment and basic counseling courses to attend to the “less complicated” cases of child maltreatment
	Witness support service programme for Children	Provides service to reduce anxiety and trauma of child witnesses and acts as a channel of communication between police, prosecutors and family of child witness.
	Children’s Homes and Institutions <i>i) Protection services for children</i> -Rumah kanak-kanak -Rumah Tunas Harapan -Special protection centre -Ehsan shelter home (street children) Kota Kinabalu	Provide substitute care to children and encourage growth and development of physical, emotional and mental health particularly those of 3 – 18 years old
	<i>ii) Recovery services for children</i> -Sekolah tunas bakti -Taman seri puteri -Probation hostel	Provide rehabilitation and care to children
Ministry of Health	One stop Crisis Centre (OSCC) – every government hospital	Hospital based one stop centre providing medical care, counseling and referral services for victims of domestic violence, sexual assault and child abuse.
	Suspected Child abuse and Neglect (SCAN) Team in specialist government hospitals	A multidisciplinary multiagency hospital based team with welfare officers and police officers which provides medical care, treatment and support services to maltreated children
Royal Malaysian	Child Interview Centres in Kuala Lumpur, Penang	Police centres with dedicated police officers who have been trained to interview children for Court purposes

Police	D11 unit for sexual abuse in children and women and child abuse	Dedicated team of police officers to handle child abuse victims who have undergone post-basic training in child maltreatment issues
NGOs	Many community NGOs who specifically attend to abused children , pregnant teenagers, abandoned babies, etc	Examples are PS the Children, Nur Salam, Shelter organisation

Appendix 7. Available programmes for child maltreatment prevention

Table I. List of primary prevention related to child maltreatment offered by the Government Ministries

MINISTRY	PROGRAMME	DESCRIPTION
Ministry of Women, Family and Community Development 1) National Population and Family Development Board (NFPDB) 2) Social Welfare Department	Parenting at work	One day course conducted at work regardless private or governmental agencies (by application) on technique of balancing family and career responsibilities, and acquire knowledge and parenting skills.
	SMARTSTART	Two days course with 7 sessions for premarital couple and newly married (the marriage age of 5 years and under) by provide knowledge and skills of early preparation for marriage and help mental preparation and construction of a positive attitude.
	I'm in control module	To increase the awareness of teenagers on the danger of engaging in unhealthy activities. The training hopes to empower participants to say 'NO' to pre-marital sex and unscrupulous behaviour. Involved children aged 15-18 years
	Children's Activity Centres in major districts	To provide centre for children to have activities away from home and for counseling of children and parents in parenting skills
Ministry of Education	Anti-bullying programme	Aims to enhance the overall capacity of schools to efficiently cope with bullying behaviour among students. Teaches children to respond to bullying in positive and constructive ways – and guides teachers, parents and bystanders on how they can play a role in creating a physically and emotionally safe environment within the school.
	Safe school programme	Programme to ensure the school environment free from internal and external threats and where the school community feels a sense of security. Inculcate positive attitude, practise good behaviour and morality, avoid violence behaviour, and report negative events among school children.
	Co-curriculum for Reproductive, Health and Social education	Sex education modules inserted within the various syllabi for Reproductive Health, Physical and Health Education and Moral or Civics class
Ministry of Health	Shaken baby syndrome prevention	Multi-media presentation available on CD for use in antenatal and paediatric clinics

		Child development course for nursery minders
	Violence injury prevention programme	Create public awareness about violence and injury
Royal Malaysian Police	Public forums organised by police liaison officer from police D11 branch	To build public awareness on issue of violence, child maltreatment, laws pertaining to sexual activities.

Table II. List of primary prevention programmes provided by NGOs

NGOs	PROGRAMME	DESCRIPTION
Women Centre for Change, Penang	Be Smart, Be Safe ' <i>Bijak itu Selamat</i> ' (BIS)	Educational package designed to enable teachers, school counsellors and educationists to teach children to be aware of the dangers of child sexual abuse. Specifically designed for children between 10 and 12 years of age. Personal safety programmes in primary schools. BIS package consist of a one-hour interactive personal safety session and a half-day workshop on personal safety. Aimed at Standard Five and Six students inclusive of boys and girls.
	Training for Educators	One day interactive training programme to teach school counsellors, educators, pre-school teachers and caregivers on how to conduct child sexual abuse prevention programmes for children.
Yayasan Chow Kit	Under-twelve centre	A 24 hour drop-in and crisis centre where children (below 12 years old), particularly those at-risk, can get food and shelter, as well as participate in educational, health and recreational programs, such as basic tutoring, computer classes, and an educational "toy library."
	KL KRASH PAD	The first centre for at-risk teens in Malaysia. The centre provides a similar mix of educational and recreational programs as the original children's centre. Activities are designed to be interesting for the youth, while at the same time engaging their creative expression and giving them skills for self-sufficiency; give teens alternatives to criminal activities and sex work
PS the Children	Child Sexual Abuse Prevention Training	Offers training and consultation on prevention of child sexual abuse to professionals and community organisations.
	Personal Safety curriculum	Develop curriculum that works to build a positive sense of self for children. The aim is to build self-esteem that will empower them to use the information and skills taught to protect themselves from all forms of abuse including bullying.
UNICEF	Get on Board	"Peoples' campaign" to provide the Malaysian public with

		the knowledge, insights and resources to stop child abuse. The digitally-driven campaign, a first by UNICEF in the region, aims to unite 100,000 supporters to raise their hand in support of children.
Human Rights' Commission of Malaysia (SUHAKAM)	<i>Amalan terbaik hak asasi di sekolah</i>	To highlight and increase awareness of human and child rights in schools

Appendix 8. Poverty reduction programme in Malaysia

Table I. Overview of Anti-Poverty Developments, Malaysia, 1960–2010

1960–1970	1971–1990	1991–2000	2001–2010
Pre-NEP	New Economic Policy (NEP) OPP1	National Development Policy (NDP) OPP2	National Vision Policy
First Malaysia Plan (1966–1970)	Second Malaysia Plan (1971–1975) Third Malaysia Plan (1976–1980) Fourth Malaysia Plan (1981–1985) Fifth Malaysia Plan (1986–1990)	Sixth Malaysia Plan (1991–1995) Seventh Malaysia Plan (1996–2000)	Eighth Malaysia Plan (2001–2005)
Economic Objectives and Strategies Related to Poverty			
<ul style="list-style-type: none"> Diversification of the economy from primary products to manufacturing and nation building through education. Increasing per capita income and consumption of the rural population. Providing adequate infrastructure to the poor. 	<p>Two-prong approach of</p> <ul style="list-style-type: none"> Poverty eradication Society restructuring 	<ul style="list-style-type: none"> Eradication of hard-core poverty and reducing relative poverty. Boosting productivity via enhanced human resource development strategies and through the promotion of science and technology to accelerate the process of eradicating poverty. 	<ul style="list-style-type: none"> Raising the quality of development and generating high sustainable growth. National unity is the overriding objective. Promoting economic growth along side continued poverty eradication and society restructuring.
Major Poverty Eradication Programmes			
<p>-Land consolidation and rehabilitation.</p> <ul style="list-style-type: none"> FELDA (1956) MARA (1966) FELCRA (1966) MARDEC (1966) JENGKA KETENGAH 	<p>-Continued focus on the agriculture and rural development. Creation of:</p> <ul style="list-style-type: none"> MADA (1970) LKIM (1971) RISDA (1973) <p>to modernize the rural and agricultural sector.</p> <ul style="list-style-type: none"> IADP programmes launched (1983). AIM established (1987) Micro-credit schemes (1986) 	<p>-Development programme for the hard-core poor (PPRT).</p> <p>-Continued focus on programmes launched in the previous long term plans (i.e. land consolidation and rehabilitation, commercialization of farms and expansion of education and training).</p> <p>-Participation of the private sector</p>	<p>-Target groups better identified.</p> <p>-Cabinet committee on urban poverty created (2001).</p> <p>-Launching of special HIS on <i>Bumiputera</i> minorities in Sabah and Sarawak (2002).</p> <p>-Targeting urban poverty - mapping urban poverty to allow for better monitoring of poverty programmes (2003).</p> <p>-Continued focus on</p>

	<ul style="list-style-type: none"> • Settlement schemes for the indigenous groups <i>Orang Asli</i>. • Text book on loan schemes • Scholarship for low income families. 		enhancing the skills and education of the vulnerable groups.
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Table II. Malaysia: Involvement of Non-Governmental Organisations in Poverty Reduction Programmes, 1970 -2000

NGO	Activity	Funding Source
Amanah Ikhtiar Malaysia (AIM)	Credit Facility	Private sector contributions and government assistance
Yayasan Basmi Kemiskinan Selangor (Selangor Poverty Eradication Foundation)	Housing, Education, training, small economic projects.	Private sector contributions and government assistance
Yayasan Kemiskinan Kelantan (Kelantan Poverty Eradication Foundation)	Education	Government contribution
Yayasan Pahang (Pahang Foundation)	Education	Self-financing
Yayasan Terengganu (Terengganu Foundation)	Education	Self-financing

POVERTY REDUCTION PROGRAMS OF THE MINISTRY OF RURAL DEVELOPMENT

In 1989, the Ministry of Rural Development started working for poverty reduction in a comprehensive way through *Program Pembangunan Rakyat Termiskin* (PPRT) for the hardcore poor. The program includes income generation, attitude change, and direct support for nutrition and housing. In 1992, a micro-credit component (ASB-PPPT) targeting the hardcore poor was started. In addition, the Rural Planning Division and the Rural Development Division (KEDAS) of the Ministry support the poor and socially disadvantaged groups by means of

- (1) Community development through non-formal education,
- (2) Visionary Village Movement (*Gerakan Desa Wawasan*),
- (3) the provision of training institutes, and
- (4) Training for supplementing PPRT.

POVERTY REDUCTION IN MALAYSIA

Land settlement

The government's land settlement scheme was aimed at resettling the landless and those with uneconomic holdings in new land development schemes. Settlers were given rights to the land they worked on which then became an intergenerational asset, thus giving them a strong incentive to make long-term capital investment and increase productivity. In addition, these land settlement schemes were provided with basic infrastructure such as piped water, electricity, and roads that linked the land schemes to the nearest town. The settlers were also provided with single unit houses as exemplified by the FELDA schemes

Increasing productivity

To increase agricultural productivity, the government undertook *in situ* development of existing agricultural land through rehabilitation and consolidation (the FELCRA schemes), replacing old commercial crops with new higher-yielding clones and the adoption of better planting techniques. A sizeable amount of financial resources was channelled towards R&D in agriculture, especially for the development of new high-yielding rubber clones. These high-yielding clones raised the productivity of the rubber smallholders significantly, thus increasing their income. Financial support was provided for the replanting of rubber with the new high-yielding clones. At the same time, the double cropping of paddy farms was made possible by investments in the provision of water (for example, the *Muda* and *Kemubu* irrigation schemes).

Integrated agricultural development programme (IADP)

IADPs are essentially *in situ* development programmes that aim at improving farm productivity through the rehabilitation of old irrigation schemes, drainage systems, as well as the provision of agricultural inputs and other support services. A common feature of the IADPs is the formation of Area Farmers' Associations under the guidance and direction of the Farmers' Organisation Authority (FOA), another statutory agency created within the ambit of the Ministry of Agriculture (currently known as the Ministry of Agriculture and Agro-Based Industry). Under the IADPs, agricultural and rural development programmes were integrated with downstream processing of farm products, while village industries and rural entrepreneurship were encouraged to generate additional sources of income.

Appendix 9. Available programmes which could allow integration of CMP components

Table I. List of programmes for healthy child development and family assistance offered by the Government

MINISTRY	PROGRAMME	DESCRIPTION
Ministry of Women, Family and Community Development National Population and Family Development Board (NPFDB)	Café @ teen (interactive youth centre)	The adolescent reproductive health programme was delivered through Cafe@TEEN which is a one-stop service centre especially for adolescents aged between 13 – 24 years. Services provided include information and education related to adolescent reproductive health, counseling, medical treatment for reproductive health problems such as body weight, smoking, mental health, skin problem and acne.
Ministry of Health	Home visitation programme	By public health nurses for new born and mothers – 4-6 home visits after every birth – to insert shaken baby syndrome prevention programme and parenting skill for newborns
	Child development programme	Monitor or evaluate child growth, provide vaccination
	Food basket program	Basic food supplies are provided to improve the food intake of malnourished children below 6 years old from poor families
Prime Minister's Department	Permata Negara Early Childhood Education and Care Centres	To provide integrated quality care and early education services based on the needs of the local community to children below five years old.
Ministry of Education	Preschool	Set-up to increase accessibility to preschool education for families with very low income in sub-urban, rural and remote areas. Early childhood education for children from age of 5 years
	Preschool education for children with special needs	Special integrated primary schools for children with special needs. The 28 special schools consist of 22 for the hearing impaired, 5 for the visually impaired and 1 for those with learning disabilities in 2003.
	The poor students trust fund (PSTF)	Provide financial aid specifically to poor Malaysian children under compulsory

		education policy since 2003
	The supplementary food programme (SFP)	Increase nutritional value of food consumed by pupils for their physical growth, mental health and general well being
	The 3K programme (safety, health and aesthetics), 1991	Strengthen the school system focusing on school safety, health and aesthetics
	The School Boarding Programme	To provide convenient accommodation for students especially those in rural and remote areas and whose family earns less than RM1000 per month.
	The Assistance Programme for Students with Special Needs	To ease the financial burden of parents of students with special needs by providing financial assistance of RM25 per month. Students with special needs who stay in school hostel are also eligible to receive full aid such as free food and accommodation.
Ministry of Rural and Regional Development	<i>Kemas</i> preschool	To provide preschool education to children aged 4- 6 years, particularly those from families with very low income. Classes are conducted at the community halls (rented or provided free), housing estates, private property, shophouses (rented) or at premises built by the Ministry.
Department of National Unity	<i>Perpaduan</i> preschool	To provide preschool education to children aged 4- 6 years Established with the objective of nurturing unity values at an early stage so that children will love their country and adapt themselves to live harmoniously in a multi-racial community. First set up in 1976 in urban and suburban areas, specifically in areas with ' <i>Skim Rukun Tetangga</i> ' - a 'friendly neighbour' scheme.
Ministry of Women, Family and Community Development Department of Social Welfare	Childcare Centres or Nurseries (<i>Community taska</i>)	To providing quality childcare services that is more accessible and affordable to the local community
	Financial assistance 1) <i>Children assistance</i> (<i>bantuan kanak-kanak</i>)	Provide financial assistance of RM100 per month for purchase of school uniforms, transportation, and examination fee for school children of families with income below poverty threshold.
	2) <i>Fostering allowance</i>	To encourage the participation of public to

	<i>(Elaun Anak pelihara)</i>	care for orphans and children who could not live with their families. An allowance of RM250 per month for each child was given to the foster family.
Department of National Unity and Integration	Volunteer Patrol Scheme (Rukun Tetangga)	To assist crime prevention and to tackle social problems, assist law enforcement and increase neighbourhood spirit
Royal Malaysian Police	Rakan cop SMS services	Hotline to promote community safety, enable crime to be reported

Appendix 10. Coalitions or Networking of organisations example

Welfare of Children :-

1. Malaysian Council For Child Welfare (MCCW)
2. Malaysian Foster Care Association
3. Malaysian Association for the Protection of Children
4. Child Welfare Council, Kedah Darul Aman
5. Malaysian Children's Aid Society (MACAS)
6. Malaysian Paediatric Association

Health Care of Children :-

7. Children's Asthma Club of Selangor and Wilayah Persekutuan
8. National Autistic Society of Malaysia (NASOM)

Care & Development of children :-

9. Malaysian Association of Kindergartens
10. Malaysian Child Resource Institute (MCRI)
11. Association of Registered Childcare Providers Malaysia
12. SHELTER Home for Children
13. Pertubuhan Kebajikan Anak Yatim Malaysia (PEYATIM)
14. Pertubuhan Anak Yatim Klang (PEYAKIN)
15. Persatuan Kebajikan Anak-Anak Yatim Islam, Pulau Pinang
16. Darul Bakti (Home for Orphans and Needy Children), Kota Belud, Sabah

Rehabilitation of disabled children :-

17. National Society for the Deaf
18. St. Nicholas's Home for the Blind
19. Spastic Children's Association of Selangor and Federal Territory
20. Spastic Children's Association of Penang
21. Selangor and Federal Territory Association for Retarded Children
22. The Penang Welfare Association for Mentally Retarded Children
23. Persatuan Kanak-Kanak Terencat Akal Seberang Prai Tengah
24. Rumah Kebajikan Kanak-Kanak Cacat Negeri Perak

Well-being of the family :-

25. National Council of Women's Organisation Malaysia (NCWO)
26. University Women's Association
27. Pertubuhan Perkumpulan Perempuan Semenanjung Malaysia (W.I)
28. Pertubuhan Tindakan Wanita Islam (PERTIWI)
29. Pan-Pacific and South-East Asia Women's Association of Malaysia (PPSEAWA)

30. MALAYSIAN CARE (Malaysian Christian Association for Relief)

Planned parenthood :-

31. Federation of Family Planning Associations, Malaysia (FFPAM)

Consumerism :-

32. Federation of Malaysian Consumers Association (FOMCA)

Appendix 11. Material resources in some programs

Table I. Types of allocations for various programme

Programme	No. of workers	No. of institutions	Budget (RM)	Funder – state related ministry or NGOs
Welfare homes	976	158- Gov 263-NGOs	15.8 million	Ministry of Women, Family and Community Development ¹⁴
Child activity centres	NA	142	1 million ¹⁵	Ministry of Women, Family and Community Development, Department of Social Welfare
Child protection team activity	131 child protection team	NA	1.78 m	Ministry of Women, Family and Community Development, Department of Social Welfare
Safe school programme	Existing school staff	All schools	NA	Ministry of Education
Childline 15999	NA	NGOs and DSW	NA	NGOs and Ministry of Women, Family and Community Development
Subsidy to poor children	NA	DSW, MOE	43 million in year 2005	MWFCD
Public health visitors	Existing nurses for postnatal home visits	Public Health nurses	NA	Ministry of Health
VIP unit	4	One unit in Ministry of health	According to projects Dedicated budget available for personnel	Ministry of Health
Early childhood development	2,163	522 ¹⁶	NA	Ministry of Education, Department of Social Welfare, Department of National Unity (Kemas) Private agencies

¹⁴ Department of Social Welfare (DSW) statistics report, 2010

¹⁵ Report by government of Malaysia to the Committee for CRC, 2006

¹⁶ <http://unesdoc.unesco.org/images/0014/001471/147196e.pdf>

NA not available

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