

Child Maltreatment Prevention Readiness Assessment in Oman

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تقييم الجاهزية للوقاية من اساءة معاملة الأطفال في سلطنة عُمان

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ABSTRACT: Objectives: This study aimed to evaluate Oman's readiness for implementing large-scale child maltreatment prevention (CMP) programmes. **Methods:** This cross-sectional study was conducted between May and August 2016 in Oman. Participants, referred to as key informants, were individuals with influence and decision-making powers over CMP. The multidimensional Readiness Assessment for the Prevention of Child Maltreatment tool, developed by the World Health Organization with the help of collaborators from middle- and low-income countries, was used to assess 10 dimensions of readiness, each with a maximum score of 10. **Results:** A total of 49 participants were included in this study (response rate = 98%). The mean total score for the 10 dimensions was 50.17 out of 100 possible points. The participants showed high mean readiness scores on legislation, mandates and policies (9.08) followed by knowledge of CMP (7.55), institutional resources and links (6.12), willingness to address the problem (5.35), informal social resources (5.15) and current programme implementation and evaluation (5.10). Participants had low scores in readiness in association with human and technical resources (2.44), attitudes towards CMP (2.90), scientific data on CMP (3.06) and material resources (3.46). **Conclusion:** The results of this study indicate that Oman has a moderate level of readiness to implement large-scale evidence-based prevention programmes against child maltreatment; however, several dimensions still need to be strengthened. It is important to develop a national strategy that outlines a framework for organising and prioritising efforts towards CMP.

Keywords: Child Maltreatment; Program Development; Attitude; World Health Organization; Oman.

المخلص: الهدف: هدفت هذه الدراسة إلى تقييم جاهزية سلطنة عُمان لتنفيذ برامج الوقاية من اساءة معاملة الأطفال على نطاق واسع. **الطريقة:** أجريت هذه الدراسة المستعرضة في الفترة ما بين مايو وأغسطس 2016 في سلطنة عُمان. كان المشاركون، والمشار إليهم كخبراء رئيسيين، أفراداً ذوي نفوذ ويمتلكون صلاحيات اتخاذ القرار في مجال وقاية الأطفال من اساءة المعاملة. تم استخدام أداة تقييم الجاهزية المتعددة الأبعاد للوقاية من اساءة معاملة الأطفال التي طورتها منظمة الصحة العالمية بمساعدة متعاونين من البلدان ذات الدخل المتوسط والمنخفض وذلك لتقييم 10 أبعاد للجاهزية واعطاء 10 نقاط لكل بعد منها كحد أقصى. **النتائج:** شملت هذه الدراسة ما مجموعه 49 مشاركا (معدل الاستجابة = 98%). كان متوسط مجموع النقاط للأبعاد العشرة هو 50.17 من أصل 100 نقطة يمكن الحصول عليها. أظهر المشاركون درجات عالية من الجاهزية من حيث القوانين والتشريعات القضائية والسياسات (9.08) متبوعة بمستوى الإلمام بالوقاية من اساءة معاملة الاطفال (7.55) والموارد والروابط الدولية (6.12) والرغبة في معالجة المشكلة (5.35) والموارد الاجتماعية غير الرسمية (5.15) وتنفيذ البرنامج الحالي وتقييمه (5.1). حقق المشاركون نقاط منخفضة بالنسبة لجاهزيتهم المتعلقة بالموارد البشرية والتقنية (2.44) ومواقفهم تجاه الوقاية من اساءة معاملة الأطفال (2.9) وتوافر البيانات العلمية عن الوقاية من اساءة معاملة الاطفال (3.06) والموارد المادية (3.46). **الخلاصة:** تشير نتائج هذه الدراسة إلى أن سلطنة عُمان لديها مستوى متوسط من الجاهزية لتنفيذ برامج الوقاية من اساءة معاملة الأطفال على نطاق واسع وبشكل قائم على الأدلة. ومع ذلك لا تزال هناك عدة أبعاد بحاجة للتعزيز. من المهم وضع إستراتيجية وطنية تحدد إطاراً لتنظيم الجهود وترتيب أولوياتها نحو الوقاية من اساءة معاملة الاطفال.

الكلمات المفتاحية: اساءة معاملة الطفل؛ تطوير برنامج؛ موقف؛ منظمة الصحة العالمية؛ عُمان.

ADVANCES IN KNOWLEDGE

- This study is the first in Oman to explore the readiness of the country to provide child maltreatment prevention (CMP) programmes.
- Obtained readiness scores could be used as a benchmark to compare Oman with other countries or to develop prevention programmes.
- This study has helped identify gaps in the existing system regarding CMP programmes.

APPLICATION TO PATIENT CARE

- Addressing identified gaps in CMP readiness will have a positive impact on child well-being in Oman.

CHILD MALTREATMENT (CM) IS A PROBLEM affecting children worldwide. It appears in different forms including physical, emotional and sexual abuse/neglect. According to the United

Nations International Children's Education Fund, approximately 95,000 children die due to homicide each year globally.¹ In 2002, it is estimated that 53,000 children (75% males and 25% females) died due to homicide

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worldwide.² Approximately 22,000 of these homicide victims were 15–17 years old.² The World Health Organization (WHO) has suggested a high rate of CM in all countries and it is estimated that around one-quarter of all adults were subjected to physical abuse as children.³

Studies from Arab nations have indicated the existence of CM, however, the actual size of this problem is not known because of the underreporting of child abuse.⁴ The use of corporal punishment in Egypt has been reported as a problem and, in Jordan, 27% of surveyed male college students reported being a victim of sexual abuse before the age of 14.^{5,6} Publications from Gulf Cooperation Council (GCC) countries have suggested that CM is common but underreported.^{4,7} A study conducted in Saudi Arabia among 2,043 adolescents in 2012 revealed that 75% had been subjected to psychological abuse, 57% had been physically abused, 50% had been neglected and 14% had been sexually abused.⁸ In Bahrain, Al-Mahroos reported 150 child abuse and neglect (CAN) victims, wherein 50 had been physically abused, 87 had been sexually abused and 10 had been both physically- and sexually-abused.⁷

Published case reports have indicated CM in Oman.⁹ Koul *et al.* reported five children between 1–11 years old with Munchausen syndrome by proxy.¹⁰ Al-Saadoon *et al.* conducted a case series discussing six children who had been subjected to CM, with the aim of increasing the level of awareness of CM among medical professionals and highlighting difficulties encountered in diagnosing CM and providing optimal care for it.¹¹ In 2015, Oman's Ministry of Social Development (MOSD) reported 102 cases of CM, 54% of which were male.¹² In total, 56.9% were cases of neglect, 23.5% were cases of physical abuse, 18.6% were cases of sexual abuse and 1% had been emotionally abused.¹²

Oman ratified the Convention on the Rights of the Child (CRC) in 1996 and its two Optional Protocols in 2004.^{13,14} After ratification, several sections of the Omani legislation were promulgated to strengthen child protection and better support CM prevention (CMP). This legislation includes but is not limited to the Care and Rehabilitation of the Disabled Act, Juvenile Accountability Act, Trafficking in Persons Act and the Omani Child Law issued in May 2014 (Royal Decree No. 22/2014).¹⁵ In 2008, the MOSD issued a decree for the establishment of 11 multi-disciplinary child protection working teams, subsequently upgraded to child protection committees, that were tasked with investigating, following-up, managing and rehabilitating victims of CM (Ministerial Decree No. 78/2008). The MOSD also established a welfare and rehabilitation home for such children through the newly developed Family Protection Department.¹⁴

The Omani Child Law and Omani Penal Code forbids all forms of physical and psychological violence against children, including deliberate humiliation, physical harm, maltreatment, neglect and exploitation.^{14,15} Since the creation of these laws, many public awareness campaigns have advocated for child protection and child rights and have included family education activities on child development, psychological health and educational needs.^{13,14} Governmental and non-governmental bodies have also produced television and radio programmes, publications and printed materials discussing articles of the CRC. In addition, there are training programmes on child rights for professionals and families.¹⁴ In 2016, the Child Protection Hotline was launched in Oman to receive reports concerning child protection issues.¹³

By evaluating the practiced prevention strategies, future strategies and programmes can be consolidated and/or improved. The Readiness Assessment for the Prevention of Child Maltreatment (RAP-CM) tool was developed by the WHO to evaluate a country's consideration of CMP. This tool was administered in mostly middle-income countries in 2011 and in all GCC countries, including Oman, in 2016 (data not yet published).^{16,17} The RAP-CM consists of 10 dimensions that, when combined, yield a numerical representation of a country's consideration of CMP: dimension 1 measures attitudes towards CMP; dimension 2 examines knowledge of CMP; dimension 3 looks at a country's scientific data on CMP; dimension 4 measures current CMP programme implementation and evaluation; dimension 5 reflects legislation, mandates and policies; dimension 6 considers a country's willingness to address the CM problem; dimension 7 examines institutional resources and links; dimension 8 measures material resources; dimension 9 reflects human and technical resources and dimension 10 examines informal social resources (non-institutional). Each dimension is evaluated by two questions except dimension 4, which is evaluated by one question. Most questions have closed responses except the question(s) in dimensions 2, 4 and 7 which require listing programmes, risk factors or consequences. The findings of the WHO report indicated that almost all participating countries had a low-to-moderate level of readiness for CMP.^{16,17} The mean score of GCC countries on the RAP-CM was 46.32, with dimension 5 yielding the highest score (7.97) while the lowest score was for dimension 9 (1.85). This study aimed to evaluate Oman's readiness for implementing large-scale CMP programmes.

Methods

This cross-sectional study was conducted between May and August 2016 in Oman. Participants were individuals with influence and decision-making power over CMP, including policy makers, programme planners, administrators, high-level practitioners and civil servants with a strong interest in CM. These participants, also referred to as key informants, were from different types of organisations and selected based on specific categories to ensure representation from all relevant organisations and sectors. A total of 50 key informants were approached but only those that consented to completing the interview were included.

The National Family Safety Program (NFSP) in Saudi Arabia was the lead site for the study. Prior to data collection, the principal investigator in Oman attended a two-day training workshop at the NFSP in collaboration with the WHO. The methodology and aims of the study, interview techniques, data collection tool and accuracy of collection, ethical considerations and data transfer were discussed with the principal investigator and other site investigators for standardisation of study outcomes at all sites.

The RAP-CM tool was developed by the WHO in collaboration with individuals from Brazil, North Macedonia, Malaysia, Saudi Arabia and South Africa.^{18,19} The questionnaire was translated into Arabic for the purpose of the current study and back-translated for comparison. Ethical approval was obtained from the Institutional Review Board of the King Abdullah International Medical Research Center at the Ministry of National Guard Health Affairs, Riyadh, Saudi Arabia (RC 15/067) and the Ethics Committee of the College of Medicine and Health Sciences at Sultan Qaboos University, Muscat, Oman (SQU-EC/013/16, MREC 1233).

A convenience sampling technique was used to recruit participants who were representative at the national level. Potential participants were initially contacted via telephone calls in which they were invited to participate in the study and agreed on an appointment day for the interview. All interviews were initiated by sharing an invitation letter describing the goals and confidentiality of the study. Informed consent was obtained from each participant before starting the interviews. Each interview took approximately 30 minutes to complete. No incentive was offered for participation. No obstacles were encountered during the data collection phase except for interview scheduling difficulties.

The scoring of the questionnaires, data entry processes and statistical analyses were conducted at the study's lead site. Data were analysed using Statistical Package for the Social Sciences (SPSS), Version 23 (IBM Corp., Armonk, New York, USA). Frequency distrib-

utions were calculated for all aspects of the sample including participants' socioeconomic characteristics and responses to various interview items. According to the scoring system provided by the WHO, the responses to most items (except dimension 4) are scored on a scale of 0–2, with zero corresponding to a negative evaluation of a statement, one to a low level of an attribute and two as the highest possible level of an attribute.¹⁸ Scores were first calculated for each respondent. Then, mean scores for all participants in

Table 1: Raw and mean scores for the 10 dimensions of the Readiness Assessment for the Prevention of Child Maltreatment tool in Oman (N = 49)

Dimension of RAP-CM tool	Raw score*	Mean score [†]
Dimension 1: Attitudes towards CMP	1.16	2.90
Dimension 2: Knowledge of CMP	3.02	7.55
Dimension 3: Scientific data on CMP	1.22	3.06
Dimension 4: Current programme implementation and evaluation	2.04	5.10
Dimension 5: Legislation, mandates and policies	3.63	9.08
Dimension 6: Willingness to address the problem	2.14	5.35
Dimension 7: Institutional resources and links	2.44	6.12
Dimension 8: Material resources	1.38	3.46
Dimension 9: Human and technical resources	0.98	2.44
Dimension 10: Informal social resources (non-institutional)	2.06	5.15
Total Scale	20.07	50.17

RAP-CM = Readiness Assessment for the Prevention of Child Maltreatment; CMP = child maltreatment prevention

*Scores were out of 4. [†]Scores were on a 10-point scale.

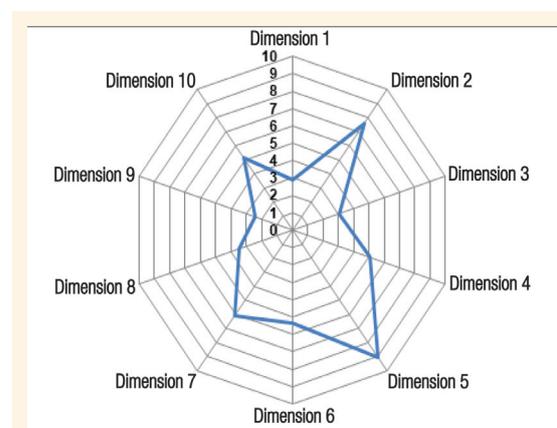


Figure 1: Participants' mean scores in each of the 10 dimensions of the Readiness Assessment for the Prevention of Child Maltreatment tool on a scale of 1–10 in Oman (N = 49).

Table 2: Participants' responses to the 10 dimensions of the Readiness Assessment for the Prevention of Child Maltreatment tool in Oman (N = 49)

Dimension of RAP-CM tool	Category	n (%)
Dimension 1: Attitudes towards CMP		
1. In Oman, compared to other health and social problems, how much of a priority is CMP (i.e. taking measures to prevent CM before it occurs)?	High priority	7 (14.3)
	Moderate priority	22 (44.9)
	Low priority/don't know	20 (40.8)
2. Do you think that measures taken so far to prevent CM in Oman have been adequate?	Adequate	2 (4.1)
	Neither adequate/nor inadequate	17(34.7)
	Inadequate	30 (61.2)
Dimension 2: Knowledge of CMP		
1. In your opinion, what are the main types of consequences of CM for the victim in Oman? Please list as many types as you can think of.	5 or more types mentioned	32 (65.3)
	1–4 types mentioned	17 (34.7)
2. What do you think are the main types of risk factors for CM in Oman? Please list as many types as you can think of.	5 or more types mentioned	19 (38.8)
	1–4 types mentioned	29 (59.2)
	No types mentioned/don't know	1 (2.0)
Dimension 3: Scientific data on CMP		
1. Is there data on the magnitude and distribution of CM in general in Oman? If so, how good is the quality of these data?	Yes and the quality is good	4 (8.2)
	Yes, but the quality is low/fair or don't know about quality	27 (55.1)
	No data exists/don't know	18 (36.7)
2. Is there data on the magnitude and distribution of child sexual abuse available in Oman? If so, how good is the quality of these data?	Yes and quality is good	1 (2.0)
	Yes, but the quality is low/fair or don't know about quality	23 (46.9)
	No data exists/don't know	25 (51.0)
Dimension 4: Current programme implementation and evaluation		
1. Please list the names of CM programmes you are aware of that are currently being or have in the past been implemented in Oman.	5 or more programmes listed	7 (14.3)
	4 programmes listed	10 (20.4)
	2–3 programmes listed	18 (36.7)
	1 programmes listed	6 (12.2)
	No programmes listed/don't know	8 (16.3)
Dimension 5: Legislation, mandates and policies		
1. Are any governmental or non-governmental agencies officially mandated with CMP in Oman?	Yes	41 (83.7)
	No	8 (16.3)
2. Is there an official policy—or are there official policies—specifically addressing CMP in Oman? If so, can you tell me about it/them?	Yes	41 (83.7)
	No	6 (12.2)
	Don't know	2 (4.1)
Dimension 6: Willingness to address the problem		
1. In Oman, are there political leaders who express strong commitment to the issue of CMP and are taking effective measures to address the problem?	Yes	26 (53.1)
	Unclear	13 (26.5)
	No/don't know	10 (20.4)
2. How intensive have communication efforts been concerning CMP in Oman?	Intensive	6 (12.2)
	Moderate	28 (57.1)
	Weak/don't know	15 (30.6)
Dimension 7: Institutional resources and links		
1. Can you list the names of any institutions currently involved in CMP? Please list as many as you can think of.	5 or more institutions listed	32 (65.3)
	1–4 institutions listed	15 (30.6)
	No institutions listed/don't know	2 (4.1)
2. Can you list the names of any partnerships, alliances, coalitions or networks of institutions in Oman that are wholly or in a large part dedicated to CMP? Please list as many types as you can think of.	3 or more listed	11 (22.4)
	1–2 listed	19 (38.8)
	None listed/don't know	19 (38.8)

RAP-CM = Readiness Assessment for the Prevention of Child Maltreatment; CMP = child maltreatment prevention; CM = child maltreatment.

Table 2 (cont'd): Participants' responses to the 10 dimensions of the Readiness Assessment for the Prevention of Child Maltreatment tool in Oman (N = 49)

Dimension of RAP-CM tool	Category	n (%)
Dimension 8: Material resources		
1. Does the ministry (or department) of social welfare (or nearest equivalent in the country) have a dedicated budget for CMP?	Yes	16 (32.7)
	No	7 (14.3)
	Don't know	26 (53.1)
2. Are there dedicated budgets in other parts of the government (e.g. other ministries, departments, etc.) in Oman for CMP besides the ministry (or department) of social welfare?	Yes	11 (22.4)
	No	7 (14.3)
	Don't know	30 (61.2)
Dimension 9: Human and technical resources		
1. Overall in Oman, do you think the number of professionals specialising in child maltreatment prevention is adequate for large-scale implementation of CMP programmes?	Adequate	4 (8.2)
	Neither adequate nor inadequate	7 (14.3)
	Inadequate/there are none/don't know	38 (77.6)
2. How widely available are undergraduate or postgraduate educational institutions that devote some of the curriculum to CMP?	Widely available	1 (2.0)
	Some or few available	31 (63.3)
	None available/don't know	17 (34.7)
Dimension 10: Informal social resources (non-institutional)		
1. What level of citizens' participation is there typically in efforts to address various health and social problems in Oman?	High	16 (32.7)
	Moderate	19 (38.8)
	Low/don't know	14 (28.6)
2. How good at getting things done through their joint efforts are the people living in Oman?	Good	18 (36.7)
	Moderate	14 (28.6)
	Poor/don't know	17 (34.7)

RAP-CM = Readiness Assessment for the Prevention of Child Maltreatment; CMP = child maltreatment prevention; CM = child maltreatment.

each dimension and mean total scores on a scale of 1–10 were calculated. The scores for each dimension were categorised as follows: a mean score of five or above represents high readiness and a mean score below five represents low readiness.^{17,18}

Results

A total of 49 participants were included in this study (response rate: 98%). Participants were predominantly female (73.5%) and more than half (59.1%) worked in governmental organisations, while some (20.4%) represented non-governmental organisations (NGOs).

Oman's mean total score for the 10 dimensions was 50.17 out of a possible 100 points. The participants expressed high readiness scores in dimension 5 (9.08), followed by dimensions 2 (7.55), 7 (6.12), 6 (5.35), 10 (5.15) and 4 (5.10). Participants perceived the lowest readiness in dimensions 8 (3.46), 3 (3.06), 1 (2.90) and 9 (2.44) [Table 1 and Figure 1].

In dimension 2 (knowledge of CMP), the majority of participants (65.3%) were able to list more than five consequences of CM. In dimension 4 (current programme implementation and evaluation), most participants (71.4%) listed two or more CMP progr-

ammes. For dimension 6 (willingness to address the problem), more than half of the participants (53.1%) reported that Oman has political leaders who express strong commitment to the issue of CMP and are taking effective measures to address the problem. Many participants (65.3%) in dimension 7 (institutional resources and links) listed five or more institutions currently involved in CMP [Table 2].

In dimension 1 (attitudes towards CMP), few participants (14.3%) thought that CMP is given a high priority in Oman compared to other social and health problems. In dimension 3 (scientific data on CMP), the majority of participants (55.1%) thought that data on the magnitude and distribution of CM exists but it is of low/fair quality or did not know about the quality. Some participants (14.3%) in dimension 8 (material resources) believed there was no dedicated budget for CMP in Oman's governmental institutions. In dimension 9 (human and technical resources), the majority of participants (77.6%) reported that the number of professionals specialising in CMP was inadequate for large-scale implementation of CMP programmes and most participants (63.3%) stated that some or few undergraduate or postgraduate educational institutions devoted curricular attention to CMP [Table 2].

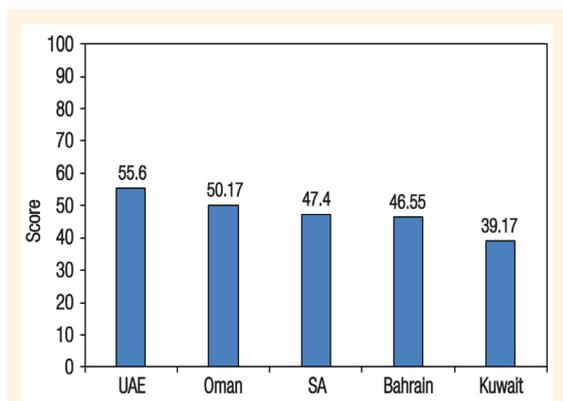


Figure 2: Total child mistreatment prevention readiness scores on the Readiness Assessment for the Prevention of Child Maltreatment tool among Gulf Cooperation Council countries

UAE = United Arab Emirates; SA = Saudi Arabia.

Discussion

This is the first study to explore Oman's CMP readiness. Overall, the results showed that Oman has a moderate level of readiness to provide CMP programmes as the overall score was 50.17. Oman ranked second in comparison to other GCC countries in the WHO GCC report and had the highest scores for dimension 2 (knowledge of CMP) and 5 (legislation, mandates, and policies) [Figure 2]. Oman's score was also higher than values reported from other countries that used a similar tool and obtained scores ranging from 31.2–45.8.^{16,17}

The dimensions with the highest scores concerned legislation, mandates and policies followed by knowledge of CMP, which is similar to the finding from GCC countries and other countries that conducted similar studies.^{16,17} The scores of these two dimensions may have been positively affected by the establishment of the National Committee for Family Affairs to monitor the implementation of the CRC and the enactment of Oman's Child Law in 2014. Furthermore, the high mean score for dimension 5 (legislation, mandates, and policies) reflects that agencies are officially mandated to uphold CMP in Oman. Many of the Child Law articles ensure obligation of the state and guardians to assure prevention of CM. For example, Article 7 in the Civil Rights Chapter gives the child the right to be protected from violence, exploitation and abuse. The social rights legislation comprehensively covered most of the risk factors of CM so that children in Oman may live in a cohesive family, enjoying adequate standards of living in the context of freedom and human dignity.¹⁵ The participation in training workshops and activities targeting professionals working with children might explain the high level of knowledge found in this study.¹³

Dimensions 7 (institutional resources and links) and 4 (current programme implementation and eval-

uation) also had high mean scores in the current study. Other countries in the WHO GCC report had variable scores in these domains. For example, the lowest score among GCC countries for dimension 7 was 2.27 and the highest was 7.61; Oman had a score of 6.12. Dimension 4 scored lower with a range of 1.05–5.22; Oman's score was 5.10. The scores were even lower in a 2011 study.^{16,17} After Oman's Child Law was passed, different governmental bodies and NGOs started to address the problem of CM by initiating awareness and advocacy activities, which could explain the obtained score. However, one reason for moderate scores in some dimensions may be that the current focus is on child protection requirements rather than prevention. For example, the MOSD launched child protection committees with representatives from different governmental bodies and NGOs, which enhanced the links between the institutions.¹³ However, it appears the committees focus has been on dealing with reported cases of CM and providing protection and rehabilitation for victims, siblings and families. This role may have been created as a result of identification of victims of CM by the Ministry of Health (MOH) since 2007, thereby resulting in a greater effort to initiate protection services for detected cases. A similar programme was also initiated in the Ministry of Education.¹² The training programmes that were conducted by different institutions improved the detection rate of victims with more demand for child protective services.

The limited involvement of informal social resources (dimension 10) in CMP activities likely does not reflect a lack of interest in CM. This finding might simply be due to a generalised low involvement of communities and individuals in voluntary work. The mean score of this dimension indicates an average level of citizens' participation in addressing various health and social problems in Oman. Similarly, low scores (2.7–4.1) were obtained in this dimension in North Macedonia, Malaysia, Saudi Arabia, South Africa and Brazil in 2011.¹⁶ The scores for GCC countries were slightly higher and ranged from 3.75–5.61; Oman received a score of 5.15.

The dimensions that showed the lowest scores dealt with scientific data on CMP (dimension 3), attitudes toward CMP (dimension 1), material resources (dimension 8) and human and technical resources (dimension 9). This finding was similar to the results obtained by other GCC countries in the WHO GCC report with the exception of attitudes toward CMP, in which the United Arab Emirates had a high score compared to Oman (5.44 versus 2.90, respectively). Research is still at an early stage of development in Oman as there are no population-based studies on CM. However, a few small-scale studies have measured

the prevalence of CM and some of the associated risk factors.^{10,11,20} Recently, data collection systems have been established in the MOH with the launch of the notification of suspected cases of CM in 2007 as well as in the MOSD with the activation of child protection committees in 2014.¹² However, the results of the current study indicate inadequate communication or not sharing these data with professionals across different governmental sectors and NGOs.

Professionals are not satisfied with the level of commitment and effort directed towards CMP in Oman from both governmental and non-governmental sectors. This dissatisfaction may reflect a level of expectation of professionals working in that area, who aimed to provide a high level of service to families and children in order to prevent CM. In addition to data-sharing, material, human and technical resources are important in improving CMP programmes. Participants' responses indicated that the existing resources are inadequate, which might also be related to the expectations of the participants and a sense that more effort is required to provide better services.

Numerous public awareness campaigns have advocated for child protection and children's rights (e.g. family education activities on the stages of a child's development, psychological health and educational needs).^{13,14} Governmental and non-governmental bodies also have produced numerous television and radio programmes as well as provided publications and printed materials covering the CRC articles. These bodies have also developed and disseminated training programmes on the rights of the child for professionals and families.¹⁴ Nevertheless, the results of this study show that there is a demand for more effort in this area.

This study was subject to some limitations. The small sample size should be considered when interpreting the results of this study. In addition, bias that might arise from the selection of the participants and collecting the data through face-to-face interviews.

The study indicates a need to address the dimensions of the RAP-CM with low scores. In response to these low scores, the authors make a number of recommendations. First, a national strategy is needed that outlines a framework for organising and prioritising efforts towards CMP. Such a strategy would also provide a direction for organisations that are involved in CMP and would highlight the role of public and private engagement. Second, it is important to initiate a child welfare centre with an adequate budget that will take responsibility for coordinating all services provided to children in order to assure the delivery of all rights and protection from violation of any stipulated rights. Third, it is important to implement specifically tailored and evidence-based CMP programmes directed towards

different target groups, including children and care-givers in the country. For example, compulsory parenting programmes might target parents and couples planning to get married. Nationwide and sustainable awareness campaigns are required which focus on changing public attitudes and social norms that encourage violence. The materials used for this purpose should be age-appropriate, user-friendly and in an accessible format. Fourth, at a certain stage, an evaluation of existing intervention programmes will be needed in order to provide information about their strengths and limitations. In addition, these evaluations should identify excellent regional and international CMP programmes for the purpose of collaboration and for adaptation into the Omani context. Fifth, it is important that Oman establishes a unified nationwide registry for data collection including the use of valid and reliable instruments for measuring CM and ensuring the dissemination of results to decision-makers, researchers and the public. This step would also facilitate and encourage research in the field of CM and ensure the dissemination of results to these stakeholders. Sixth, the implementation of all of the articles in Oman's Child Law should be enhanced by accelerating the issue of executive regulations. It is essential to increase the knowledge of all concerned, including professionals and the public at large, about Oman's Child Law with the aim of emphasising the responsibilities of people, the rights of children and the repercussions for violators. Seventh, it is essential that stakeholders improve intersectoral collaboration for preventing and combatting CM and increasing the contribution and number of NGOs in Oman that work for children's rights. Eighth, the government should allocate a fixed and specific budget for preventing and combatting CM within the concerned ministries. Finally, it is important that the entities with specialised expertise in the CM field can offer interdisciplinary training programmes. This training might be in the form of in-service training, providing continuous development opportunities, supporting graduate and post-graduate education in the identification and management of CM cases and encouraging young scientists to conduct research on CM.

Conclusion

The results of this study indicate that Oman has a moderate level of readiness to implement large-scale evidence-based prevention programmes against CM; however, several dimensions still need to be strengthened. The participants in this study, who are also stakeholders, made many recommendations that could improve CMP in Oman. It is important to develop a national strategy that outlines a framework for organ-

ising and prioritising efforts towards CMP. It is also recommended that a child welfare centre be established to take responsibility for coordinating all services provided to children in order to assure the delivery of all rights and protection from violation of any of their stipulated rights.

CONFLICT OF INTEREST

The authors declare no conflicts of interest.

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