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Child Abuse and Neglect in Saudi Arabia: Journey of recognition to implementation of national prevention strategies

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ABSTRACT

Objectives: To describe increased child abuse and neglect (CAN) reporting and the characteristics of the reports in the context of the development of a system of intervention for one of the hospital-based child protection centers in Riyadh, Saudi Arabia aligned with the United Nations Convention on the Rights of the Child (CRC) Article 19.
Methods: A retroprospective collection of data on all children evaluated by the Suspected Child Abuse and Neglect (SCAN) team in King Abdulaziz Medical City for the National Guard from 2000 to 2008. The cases were further divided into 3 subgroups corresponding to the years 2000–2004, 2005–2006, and 2007–2008 parallel to the stages of development of the national child protection system.
Results: During the study period, there were a total of 188 referrals to the SCAN team. Of these 133 (70.7%) were further investigated as CAN cases. The total number of referred cases increased 10-fold from 6.4 cases per year in the first period to 61.5 cases per year in the third period. The mean age was 5 years, evenly represented by males and females. Physical abuse was the most common form of abuse in the first (2000–2004) period at 61% and second (2005–2006) period at 76%, which changed to neglect (41.6%) as the most common form of maltreatment in the third (2007–2008) period. Parents were the perpetrators in 48.9% of cases throughout the 3 periods. Overall fatality rates were 4.4%, 14.3%, and 7.9% in the first, second, and third periods respectively.
Conclusion: Recognition of CAN is expanding in Saudi Arabia. This is due to the successful adoption of a system of intervention consisting of child protection centers in the medical facilities, in conjunction with mandatory reporting and data collection strategies. In addition, the changes in public attitudes towards a better understanding of CAN enhanced further recognition and reporting of neglect and milder forms of abuse. We believe that the number of reported CAN cases in Saudi Arabia will continue to rise, hence adequate multisectoral services for the abuse victims require further development and improvements throughout the country.

Introduction

Child Abuse and Neglect (CAN) is one of the most common and yet unrecognized and ignored phenomena affecting children around the world (WHO & ISPCAN, 2006). Although CAN practices in the Arabian Peninsula were described in

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historical anecdotes and Islamic literature, it was not until 1990 that the first case report from Saudi Arabia was published in the medical literature (Al-Eissa, 1991; Al Mugeiren & Ganelin, 1990). In 1996, Saudi Arabia signed and ratified the United Nations Convention on the Rights of the Child (CRC), and toward the end of the decade CAN was already recognized at major health facilities throughout the country. While hospitals continued to receive increased CAN cases, the magnitude of the problem in Saudi Arabia even in these settings was not known due to the lack of accurate statistics on incidence and prevalence. One consequence of the lack of information was that risk factors, indicators, categories, definitions, and the nature of the problem of child maltreatment were not well identified and therefore, multidisciplinary services for the victims of abuse and their families were not well informed and developed in the country.

Historically, CAN was initially recognized in Saudi Arabia by the health-care professionals as a rare problem affecting the well-being of few children in the country. Therefore, from 1990 to 2000 there were only 11 reports published in the medical literature and all were case studies (Al Ayed, Qureshi, Al Jarallah, & Al Saad, 1998; Al-Eissa, 1998, 1991; Al Jumaah, Al Dowaish, Tufenkeji, & Frayha, 1993; Al Mugeiren & Ganelin, 1990; Al-Odaidan, Ohikuaiteme, Fahmy, Al-Khalifa, & Ghazal, 2000; Elkerdany, Al-Eid, Buhaliqa, & Al-Momani, 1999; Karthikeyan, Mohanty, & Fouzi, 2000; Kattan, 1994; Kattan, Sakati, Abduljabbar, Al-Eissa, & Nou-Nou, 1995; Roy, Al Saleem, Al Ibrahim, & Al Hazmi, 1999). The official development of child protection started in the year 2000 when CAN was recognized as a public issue by the national media focusing on the lack of legislation and services. It was not until 2004 that national efforts were geared towards preservation of children's rights and the prevention of child maltreatment. During this first stage of development (2000–2004) various governmental agencies and NGOs were created and directed toward those goals and the first Child Protection Act was drafted. Most noticeable was the role played by national media in raising the public awareness of CAN practices in Saudi Arabia. In this stage (2000–2004), many multidisciplinary teams were also formed in major hospitals to serve abused children (Al Jasser & Al-Khenaizan, 2008; Al-Khenaizan, Almuneef, & Kentab, 2005).

The second stage of development was from 2005 to 2006, and was characterized by the initiation of additional governmental and non-governmental agencies specialized in child abuse and neglect prevention and treatment. Among the many positive programs and initiatives developed in the country during this stage (Al-Haidar, 2008; Al-Mahroos, 2007), the foremost was the formation of the National Family Safety Program (NFSP) in November 2005, by royal decree of the king, as an example of a specialized quasi-governmental agency dedicated to the prevention of child abuse and domestic violence. Furthermore, the Human Rights Commission (HRC) and the Human Rights Society (HRS) were also initiated in 2005 and were very active in the promotion of human rights issues, especially the implementation of the CRC in different governmental agencies.

The third stage in the development of the child protection field in Saudi Arabia occurred from 2007 to 2008 when the National Family Safety Program (NFSP) submitted a national project to establish Child Protection Centers (CPCs) in major hospitals throughout the country. The project received full approval and support by the National Health Council (NHC), which is the highest health services authority in the kingdom.

The strong recommendation to the project was primarily derived from the NHC legislatives and health-care decision makers, who believed in supporting basic rights of the children represented in the CRC (UNHCHR-CRC, 1989). Consequently, the council accredited 38 hospitals across the country as CPCs. CAN cases are now evaluated on a 24-h a day basis by on-call multidisciplinary Child Protection Teams. Advanced training is provided to the teams' staff members by the International Society for the Prevention of Child Abuse and Neglect (ISPCAN) and NFSP joint training programs. The CPC project also included drafting and issuance of health-care professionals' mandatory reporting laws and establishing a National Child Abuse and Neglect Registry (NCANR). Data on registered cases is to be entered into the registry from all CPCs from major Hospitals in the country. The case registration form adapted the World Health Organization (WHO) definitions for various forms of CAN (WHO & ISPCAN, 2006). The electronic form has bilingual (Arabic and English) entries to enable English speaking physicians and nurses to report CAN cases. It contains general information on the victim and perpetrator, form of abuse, investigation, disposition, and notifications and follow-up plan.

In this report we will describe the experience of one of the child protection centers and its Suspected Child Abuse and Neglect (SCAN) team established at the King Abdul Aziz Medical City for the National Guard in Riyadh (KAMC-R) since the year 2000, by relating its data on cases to the historical stages of the development of child protection efforts in Saudi Arabia.

Methods

Child abuse and neglect (CAN) data were collected retrospectively since January 2000 by the KAMC-R SCAN team. The SCAN team was established at King Abdul Aziz Medical City for the National Guard through an internal policy and procedure to serve abused children presenting to the medical city. The professional team, chaired by an attending pediatrician, is composed of members from social services, psychology and psychiatry, and legal department, as well as other medical disciplines as needed. A data collection form was designed to acquire information about victims and perpetrators including demographic data, forms of abuse, and patterns of injuries. Details on cases' substantiation, referrals for legal action, and final outcomes were also obtained.

All data on CAN cases from January 2000 to December 2008 were collected and analyzed using descriptive data. The cases were divided into 3 subgroups corresponding to the years 2000–2004, 2005–2006, and 2007–2008 according to the stages of the development of the child protection system in Saudi Arabia as stated above. The 3 subgroups were also analyzed separately in order to compare each of the subgroups to the other.

Results

From January 2000 to December 2008, a total of 188 cases were referred to the SCAN team. Of the total, 133 (70.9%) were investigated as CAN cases. The remaining 55 (29.1%) cases had insufficient evidence to support CAN claims at the time of case assessment and therefore they were not considered CAN cases. Of the 133 investigated cases, 94 (70.7%) were substantiated as abuse or neglect, while 39 (29.3%) were treated as suspected cases by the team (Table 1). The mean age of the victims was 5 years and males comprised 53.4% of the total number of cases. Taking all cases, physical abuse was the most prevalent form and noted in 65 (48.9%) cases followed by 43 (32.3%) cases of neglect, 20 (15%) cases of sexual abuse, and 5 (3.8%) cases of emotional abuse. Parents were the perpetrators in 65 (48.9%) cases. Other identified perpetrators included siblings in 18 (13.5%) cases, household workers in 12 (9%) cases, and others in 10 (7.5%) cases. In 58 (21.1%) cases the perpetrators could not be identified mostly in those cases where the child is preverbal or the injury was not witnessed and it was very difficult to make any assumption either by the family or the team (Table 1). Of all the investigated cases, 62 (46.6%) were referred to legal services, while 71 (53.4%) were followed in the SCAN clinic for rehabilitation and family counseling.

The demographic characteristics of all cases, subdivided in relation to the 3 periods of child protection development in the country are illustrated in Table 2. The total numbers of CAN referrals in the first period (2000–2004) were 32 cases (6.4 cases per year). The number of referrals increased to 33 cases (16.5 cases per year) for the second period (2005–2006). However, in the third period (2007–2008) the number of referrals increased to 123 cases (61.5 cases per year) (Table 2). There were no differences in the percentages of proven cases compared to the suspected cases throughout the three periods; the demographic characteristics of the cases in terms of the mean age and sex and the perpetrators also did not differ from one period to the other. However referrals to legal services increased in the third period to 50.6% compared to 38% in both first and second periods. This was due to the mandated reporting law and increased public awareness.

The most common form of abuse in the first (2000–2004) and second (2005–2006) periods was physical abuse, at a rate of 61% and 76.2% respectively. This decreased to 39.3% in the third period (2007–2008) and neglect was established as the most common form of abuse in the third period at a rate of 41.6% compared to the first (13%) and the second periods (14%). This is due to recognition of milder forms of abuse that were not previously identified. The frequencies of different patterns of physical injuries reported to the SCAN team during the period 2000–2008 are shown in (Fig. 1). Head injury was the most prevalent, noted in 24 (22.4%) cases followed by bruises, contusions and fractures, each noted in 18 (16.8%) cases. In further subdividing the injuries into superficial and internal injuries; skin injuries were the most common superficial injury; patterns were noted in 33 (58%) cases. These injuries included bruises and contusions in 18 (16.8%) cases and superficial burns in 11 (10.3%) cases. However, cut wounds and bites were noted only in 2 (1.9%) cases. Among internal injuries, head injury was the most common, reported in 24 (22.4%) cases followed by 6 (5.6%) cases of genital injuries, and 5 (4.7%) chest and abdominal injuries. Other forms of injuries included 11 (10.3%) cases of fractures, 5 (4.7%) cases of eye injuries, and only 2 (1.9%) cases of ear injuries.

A total of 11 children died as a consequence of their inflicted injuries, for a case fatality rate of 8.3%. Severe inflicted head trauma (IHT), intoxication, and suffocation were the most common causes of death for these victims. The annual fatality rates associated with CAN were 0.25 cases per year in 2000–2004, 1.5 cases per year in 2005–2006, and 3.5 cases per year in 2007–2008 (Fig. 2).

Table 1
Demographic characteristics of Child Abuse and Neglect cases reported to Suspected Child Abuse and Neglect team between 2000 and 2008.

Total referred cases	188
Total substantiated cases	133 (70.7%)
Proven	94 (70.7%)
Suspected	39 (29.3%)
Referrals to legal services	62 (46.6%)
Mean victim age	5 (±2.9) years
Victim gender	
Male	71 (53.4%)
Female	62 (46.6%)
Form of abuse	
Physical	65 (48.9%)
Sexual	20 (15%)
Emotional	5 (3.8%)
Neglect	43 (32.3%)
Total fatalities	11 (8.3%)
Perpetrator	
Parent	65 (48.9%)
Sibling	18 (13.5%)
House worker	12 (9%)
Others	10 (7.5%)

Table 2
Demographic characteristics of Child Abuse and Neglect cases reported to Suspected Child Abuse and Neglect team divided into 3 periods.

Characteristics	2000–2004	2005–2006	2007–2008
Total referred cases	32 (6.4 cases/year)	33 (16.5 cases/year)	123 (61.5 cases/year)
Total substantiated cases	23 (71.9%)	21 (63.6%)	89 (72.4%)
Proven	15 (65.2%)	16 (76.2%)	63 (70.8%)
Suspected	8 (34.8%)	5 (13.8%)	26 (29.2%)
Referrals to legal services	9 (38%)	8 (38%)	45 (50.6%)
Mean victim age	4.5 (±0.2) years	4.5 (±0.3) years	5.2 (±0.5) years
Victim gender			
Male	11 (47.8%)	11 (52.4%)	49 (55%)
Female	12 (52.2%)	10 (47.6%)	40 (45%)
Form of abuse			
Physical	14 (61%)	16 (76.2%)	35 (39.3%)
Sexual	6 (26%)	2 (9.5%)	12 (13.5%)
Emotional	–	–	5 (5.6%)
Neglect	3 (13%)	3 (14.3%)	37 (41.6%)
Fatalities	1 (4.4%)	3 (14.3%)	7 (7.9%)
Perpetrator			
Parent	11 (47.8%)	9 (42.9%)	45 (50.6%)
Sibling	4 (17.4%)	2 (9.5%)	12 (13.5%)
House worker	3 (13%)	3 (14.3%)	6 (6.7%)
Others	1 (4.4%)	–	9 (10.1%)
Unknown	4 (17.4%)	7 (33.3%)	17 (19.1%)

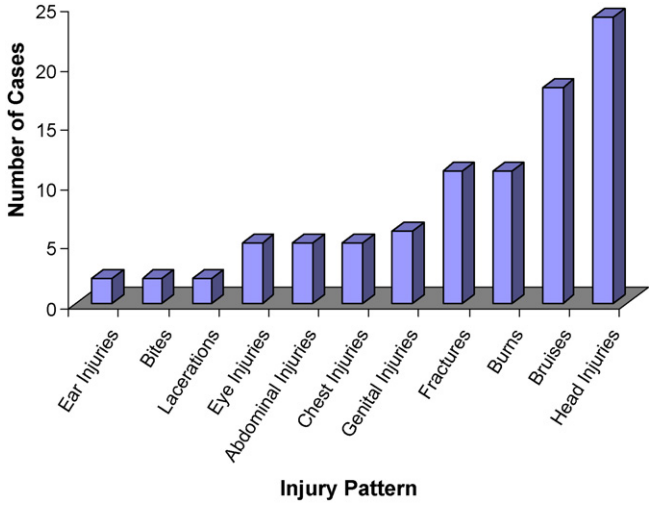

Fig. 1. Patterns of injuries in reported Child Abuse and Neglect cases 2000–2008.

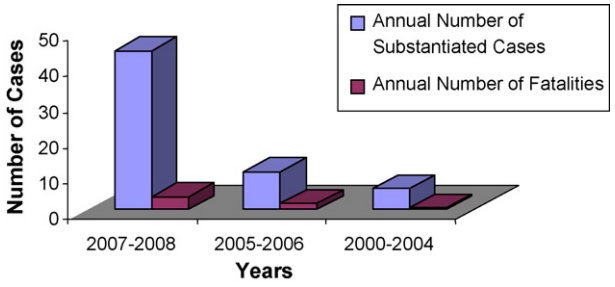

Fig. 2. Child Abuse and Neglect annual fatality ratio to substantiated cases in reported ca se s 2000–2008.

Discussion

The reported annual referral rate of CAN cases to the SCAN team of the KAMC-R Child Protection Center increased 10-fold from 6.4 cases per year in 2000–2004 to 61.5 cases per year in 2007–2008. This may represent an increase in recognition and reporting of child abuse by both families and professionals as a result of the cultural changes and public attitude toward CAN rather than an actual increase in the incidence. This information reported from one center in Riyadh could neither be used to define the rate of child abuse victimization in Saudi Arabia nor to compare it to reported rates of Child Abuse and Neglect of other countries. However, it reflects the impact of increasing awareness about child rights and the application of mandatory reporting of child abuse and neglect cases by healthcare professionals, issued by the Ministry of Health in January 2008. The general public and the professionals working with and for children subsequently became more eager to report child abuse cases and collectively took a leap forward in the direction of child protection. Nevertheless, we believe that the problem is more prevalent in Saudi Arabia than is generally recognized and that the annual reporting rate will continue to escalate in the next few years as public and professional awareness continues to increase.

Data from the National Child Abuse and Neglect Data System (NCANDS) for 2006 (National Child and Neglect Data System, 2006) indicated that 25.4% of the investigated cases by the Child Protection Services (CPS) in United States are substantiated. Conversely, the Saudi Arabia overall rate of substantiation is notably higher and it ranges between 63 and 72%. This dissimilarity is attributed to different reasons. First, the source of referral of our cases was a hospital-based team of professionals addressing children's injuries while in United States' NCANDS it included reports from professionals in various disciplines (e.g., teachers, law enforcement, and social services) as well as non-professionals. Hence, the cases presented to hospitals are likely to be far more serious and unambiguous compared to the ones referred from schools, social services, or the community at large. Second, the recognition and the mandatory reporting of child abuse and neglect in Saudi Arabia is in it beginning stages and professionals may only be reporting the most apparent and evident cases. Third, professionals in Saudi Arabia are still reluctant to report suspected cases of abuse and neglect in order to avoid any complications that might arise in the event the allegations are not substantiated.

The demographic characteristics of our patients were analogous in some aspects and different in others when compared to the data from NCANDS and other reports from United States (Dubowitz & Bennett, 2007; Kellogg and the Committee on Child Abuse and Neglect, 2007). Results from Saudi Arabia and the United States match in terms of age of victimization and sex. However, they differ in the prevalence of each of the abuse forms. The most common form of abuse in our first (2000–2004) and second (2005–2006) stages of our report was physical abuse (61% and 72.6% respectively), which shifted to neglect (41.3%) in recent years (2007–2008) as noted earlier. In industrialized countries including the United States, neglect is the most prevalent form of abuse representing 60–70% of the cases. The increasing reports of neglect in recent years may reflect a pattern of increased awareness and be due to the major changes in child protection services in Saudi Arabia, which now recognize neglect as a form of abuse. Previously, even professionals seldom acknowledged neglect as a form of maltreatment.

Other factors contributed significantly to the change of public attitudes toward CAN. The local media campaigns to highlight the issue in 2004 and afterward were the most notable. This active reporting succeeded in converting CAN practices of various levels of severity into socially unacceptable behaviors. The other major factor was the governmental support to human rights issues in the country and its commitment to supplement regular reports on the country's adherence to the CRC articles (UNHCHR-CRC, 1989). The establishment of HRC and HRS in 2005 drew public attention to children's rights, including the right for protection against abuse and neglect. Concomitantly, service oriented specialized social agencies were founded to provide intervention and rehabilitation services for CAN victims at provincial level. Thus, while the experience of one hospital-based program cannot be over generalized, the recently initiated specialized social service agencies are anticipated to begin referring more cases to the hospital teams for evaluation of CAN.

Finally, the overall fatality rate of victims of abuse was surprisingly high in our data (8.3%) compared to that in the USA (Dubowitz & Bennett, 2007; Kellogg and the Committee on Child Abuse and Neglect, 2007; National Child and Neglect Data System, 2006). This does not correspond to inadequate health-care services provided to the victims given that health care is well developed in the country. This may, however, be related to the fact that it is mostly the severe cases of physical abuse that present to health facilities, while milder forms (e.g., isolated skin injuries) may not necessarily be reported. The most common cause of death in physically abused children in the USA was inflicted head trauma (IHT) (Kellogg and the Committee on Child Abuse and Neglect, 2007), and as noted in (Fig. 1), IHT was the most frequent pattern of physical abuse seen by our SCAN team.

This report presents the largest data series from Saudi Arabia to date and discusses it in relation to the stages of national child protection efforts. Our report has limitations in generalizing the situation of child abuse and neglect nationally, since it represents the data of a single child protection center located in a military tertiary care center in a large metropolitan city.

Researchers should focus on launching the different versions of ISPCAN Child Abuse Screening Tool (ICAST) at national level. Application of these large-scale surveillance studies will help us to gain full understanding of the issue. Combining the outcomes of ICAST tools and NCANR data analysis will help inform policy and practice design in the future.

Our promising national CPCs and CAN data surveillance experience can be used by other countries in the region as a model for developing these services and programs, taking into consideration that middle-eastern and north African populations share many similarities in characteristics and demographic features. Development of these national data surveillance systems and subsequent data analyses projects, followed by establishing a regional network for sharing of these data are of paramount

importance. Analyzed data will enhance child protection systems development in less economically privileged countries in the region. Implementing these systems aligns with the CRC and the recommendations of the United Nations Secretary General's Study on Violence Against Children (Pinheiro, 2006). These projects should be encouraged and supported by regional organizations such as the Arab Professional Network for the Prevention of Violence Against Children (APNPVAC) and League of Arab States as well as international organizations and agencies such as ISPCAN and UNICEF.

In conclusion, child abuse is currently acknowledged in Saudi Arabia as a public health issue. The initiation of the National Family Safety Program (NFSP) that helps coordinate the multi-sectoral efforts and which advocated for mandatory reporting laws appears to have led to a noticeable increase in CAN recognition at the KAMC-R. The successful model of a hospital-based child protection center led to its replication nationwide. In the future, more data will be available from different centers nationwide through the National Child Abuse and Neglect Registry (NCANR), with more detailed demographics delineating the actual magnitude of the problem.

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Appendix A. Supplementary material.

For an Arabic version of this paper, see doi:10.1016/j.chiabu.2009.08.011.

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