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Investing in children: the European child maltreatment prevention action plan 2015–2020

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ABSTRACT

Child maltreatment is common. Its prevalence in the WHO European Region ranges from 9.6% for sexual abuse to 22.9% for physical and 29.1% for emotional abuse. Child maltreatment may co-exist with household dysfunction, which also occurs frequently. Maltreatment and other adversity in childhood may cause toxic levels of stress, which impair brain development and may lead to the adoption of health-harming behaviours, poorer mental and physical health, worse educational and social outcomes and the intergenerational transmission of violence. Investing in the prevention of maltreatment and other adversity in childhood will thus bring immediate health gain to the lives of children and will improve the well-being of people throughout the life-course and society as a whole.

This document contains an action plan for the prevention of child maltreatment in the WHO European Region for the next six years 2015–2020. It focuses on priority actions and interventions that are informed by evidence and that will bring benefits which will outweigh any cost of investment.

The action plan has been developed through a consultative process, guided by the Standing Committee of the Regional Committee, and has sought the views of the Violence and Injury Prevention focal points and other stakeholders. Its formulation has been informed by the guiding principles of Health 2020: the European policy for health and well-being and Investing in children: the European child and adolescent health strategy. The evidence base which informs the plan has been published in the *European report on preventing child maltreatment.*

Keywords

CHILD MALTREATMENT
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CONTENTS

Page

Scope ... 1

Goal ... 2

Target ... 2

Objectives ... 2

Objective 1. Make health risks such as child maltreatment more visible by setting up information systems in Member States ... 2

Objective 2. Strengthen governance for the prevention of child maltreatment through partnerships and multisectoral action by developing national plans ... 3

Objective 3. Reduce risks for child maltreatment and its consequences through prevention by strengthening health systems in Member States ... 4

The role of the WHO Regional Office for Europe ... 4

Annex ... 6

Scale and consequences of the problem ... 6

Scope

1. In line with Health 2020 and "Investing in children: the European child and adolescent health strategy 2015–2020" (document EUR/RC64/12), this action plan promotes both population-level actions and targeted, selective approaches for high-risk groups, thereby seeking to redress inequality. The actions require a health-in-all approach, in which health systems have a coordinating role requiring strong governance. To maximize the gain from investment, the plan promotes a series of evidence-based programmes, summarized in the *European report on preventing child maltreatment*.[1] These will be achieved by redirecting existing resources towards more effective activities that provide a return on investment. The prevention of maltreatment and other adversity in childhood will help children and adolescents to realize their full potential for health, development and well-being throughout their life-course.

2. The action plan to prevent child maltreatment is based on the following approaches, in keeping with Health 2020 and "Investing in children: the European child and adolescent health strategy 2015–2020":

- a life-course approach
- an evidence-informed approach
- a health systems approach
- a partnership and intersectoral approach
- promotion of children's rights according to the Convention on the Rights of the Child.

3. Child maltreatment was documented as a particularly significant problem in Europe in the *European report on preventing child maltreatment*.[1] The aim of this action plan is to prevent child maltreatment in whatever form, whether sexual, physical or mental abuse, or neglect. The action plan will also cover other adverse childhood experiences – such as household dysfunction, including parental violence; having a household member with a mental illness; drug or alcohol dependency; or incarceration – because these are major risk factors for maltreatment.

4. This action plan calls for a greater preventive role of universal services to reduce maltreatment and its consequences rather than sole reliance on child protection services after abuse has occurred. Child maltreatment is common: the prevalence in the European Region ranges from 9.6% for sexual abuse (5.7% of boys, 13.4% of girls) to 22.9% for physical and 29.1% for mental or emotional abuse. Globally, the prevalence of physical neglect is 16.3% and that for emotional neglect is 18.4%. These high rates far exceed the capacity of child protection services to respond effectively. Household dysfunction is also common, ranging from a rate of 16.4% for alcohol dependency of a household member, 14.6% for witnessing parental violence, 14.1% for parental separation, 10% for a household member with mental illness, 5.3% for an incarcerated household member and 2.6% for drug dependency of a household member.

5. Maltreatment and other adversity in childhood may cause toxic levels of stress, which impair brain development and may lead to the adoption of health-harming behaviour, poorer mental and physical health, worse educational and social outcomes throughout the life-course and intergenerational transmission of violence. Maltreated children may be at greater risk for being a victim or perpetrator of violence, including bullying in schools. Children with a disability or behavioural problems may be at increased risk for maltreatment, as may children in institutional care, such as orphanages. Exposure to household dysfunction or living in a community with high levels of violence, poor schooling, high unemployment and inequalities is influenced by social policy. Maltreatment exacerbates inequality because of its health and social impacts, thereby perpetuating cycles of deprivation. Although brain

[1] European report on preventing child maltreatment. Copenhagen: WHO Regional Office for Europe; 2013.

development may be harmed throughout childhood, children are most vulnerable in the first three years of life, and the greatest returns will be made by investment in early child development.

6. The causes of maltreatment are multifactorial. Many of the consequences must be dealt with by the health sector, in both the short and the long term. Addressing the causes of maltreatment, however, requires coordinated, sustained efforts in multiple sectors (health, education, employment, welfare, justice, housing, trade and industry, media and communications, nongovernmental organizations) and health systems must be actively engaged in ensuring a response. Critically, preventing maltreatment would accrue benefits to all sectors and not just health. Whereas child protection services should be strengthened, society must address a broad range of factors further upstream, including supportive family environments, social networks, social capital, social and gender inequalities, social and cultural attitudes to violence, belief in corporal punishment and access to alcohol and drugs. Such investments will promote resilience and protect children and adolescents against maltreatment; others include strong parent–child relationships, strong relationships between parents, nurturing parental skills, high parental education, employment, self-esteem and child social competence.

Goal

7. To reduce the prevalence of child maltreatment by implementing preventive programmes that address risk and protective factors, including social determinants.

Target

8. Reduce the prevalence of child maltreatment and child homicide rates by 20% by 2020.[2]

Objectives

9. Three objectives, in keeping with those of the strategy for child and adolescent health, have been developed to achieve the goal of reducing child maltreatment by better prevention.

Objective 1. Make health risks such as child maltreatment more visible by setting up information systems in Member States

10. Few countries regularly collect reliable information on the prevalence of child maltreatment and other adverse childhood experiences. Operational definitions of child maltreatment should be standardized; information should be gathered from various sectors and agencies and should be shared. The information should include that from child helplines, from the justice sector and from child protection services, which are a measure of the response to child maltreatment. Countries should use existing or incipient self-reported or parent-reported community surveys to assess the underlying prevalence and incidence of child maltreatment. They should focus not only on the various types of maltreatment and adversity but also on risk factors, age, gender and socioeconomic determinants. Standardized tools are available for use in such surveys and such surveys are in keeping with children’s right to be heard.[3] The information systems should be used to evaluate preventive programmes under objective 3, to determine whether national targets are being met; such assessments require standardized tools and methods. Children’s mental well-being and health are harmed by maltreatment and other adverse experiences and school-based surveys of the mental well-being of children could provide additional supportive indicators.

[2] As homicide is a relatively rare event, a three-year average would be more reliable.
[3] United Nations Convention on the Rights of the Child, Article 12.

11. **Outcomes**: Countries should publish comprehensive reports on the status of child maltreatment using standardized criteria and should participate in standardized surveys undertaken by WHO and other United Nations bodies.

12. **Indicators**: numbers of countries that have:

(a) measures of national child maltreatment incidence and prevalence;

(b) surveys of child maltreatment (physical, sexual and mental abuse and neglect) and mental well-being, based on standardized survey instruments and methods;

(c) comprehensive reports showing a reduction in child maltreatment;[4] and

(d) reports showing improved child mental well-being.

Objective 2. Strengthen governance for the prevention of child maltreatment through partnerships and multisectoral action by developing national plans

13. Substantial gains in preventing child maltreatment can be made by coordinating actors in multiple sectors. Leadership to harness these strengths should be provided by national and local governments. An important first step is to develop and review any existing action plans in relevant sectors. Most countries have plans for child protection; governments are also urged to focus on prevention. Existing legislation to protect child rights and to prevent child maltreatment might have to be strengthened; for example, corporal punishment has still not been banned in all settings in half the countries in the Region. Action plans or policies are more effective if there is a national coordinating framework that is multisectoral and properly funded, if progress in implementation is monitored and if feedback on their impact on maltreatment is provided. Local authorities are critical players in implementation at the municipal level and their engagement in the development and implementation of plans and programmes is essential. In developing action plans and policies for the prevention of child maltreatment, links should also be made with those for the prevention of intimate partner violence, youth violence and maltreatment of the elderly and with strategies for reducing risk factors such as alcohol abuse and inequalities. Country assessments and documentation are being prepared, including the *Global status report on violence prevention*.[5]

14. **Outcomes**: Countries should prepare or review any existing national action plan or policy or national coordinating framework on the prevention of child maltreatment, based on a whole-of-society approach, socioeconomic contexts, capacity, evidence-based actions and monitoring to coordinate the actors. There should be the necessary links with other policy areas, such as domestic violence, education, justice and child rights.

15. **Indicator**: Number of countries with comprehensive, inclusive multisectoral prevention plans or policies.

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[4] These should contain information sources and indicators, such as child homicide rates, emergency department assault rates, national surveys of child health or multicountry surveys of self-reported adverse childhood experiences. Surveys such as the European Longitudinal Study of Pregnancy and Childhood, Health Behaviour in School-aged Children and Adverse Childhood Experiences offer potential mechanisms for data collection at the population level, on both maltreatment and mental well-being. Self-reported reductions in abuse by parents or carers as reported in adult health surveys, such as general health surveys, are another valuable resource. Surveys should be selected and adapted as appropriate for country contexts. Tailoring planned surveys would be a goal.

[5] The Global status report on violence prevention (2014) is to be launched later this year by WHO, the United Nations Development Programme, and the United Nations Office on Drugs and Crime and is listed here as an example of work in progress (http://www.who.int/violence_injury_prevention/violence/status_report/en/, accessed 18 April 2014).

Objective 3. Reduce risks for child maltreatment and its consequences through prevention by strengthening health systems in Member States

16. Safe, nurturing relationships with parents and other caregivers, including in institutions, are central to a child's healthy development. The earlier preventive interventions are made in children's lives, the greater the benefits to the child. The focus should therefore be on services to promote family health and safe family environments, so as to give every opportunity for positive relationships and improved health and social outcomes.

17. Health systems and preventive services should therefore offer a continuum of care, starting with nurturing family and institutional settings, where support is provided for antenatal care, to postnatal care and through infancy, childhood, adolescence and parenthood. This will involve front-line staff in primary health care, public health and in maternal, reproductive, child and adolescent, school and mental health services. Health systems will require strengthening in advocacy and prevention. Services dealing directly with children should actively seek children's views.

18. Universal interventions should be targeted in proportion to need. Children who find themselves below the threshold for action by child protection services may require welfare and parenting support, whereas coercive intervention by child protection services may be required for others. Similarly, deprived areas, where maltreatment may be more common, may require greater capacity. Whenever possible, families should be provided with parenting and welfare support, with out-of-home care as a last resort and a focus on fostering or family-type community-based alternative care. Institutional care, such as orphanages, should be avoided. When such care lasts longer than three months, development, especially for children under three years, may be seriously impaired, with possible adverse health and developmental consequences. Families with household dysfunction, such as those in which a member has mental illness or alcohol or drug dependency, or in which there is domestic violence, may be known to health, education, police and social services, which have a pivotal role in preventing maltreatment by providing intensive support and supervision to these at-risk groups.

19. **Outcomes**: Interventions that are effective for prevention should form the core of the plan. These include positive parenting for both male and female caregivers, nurse–family partnerships, hospital-based training of parents to prevent "shaken baby syndrome" or abusive head trauma, school-based programmes to train children to recognize signs of sexual abuse and other types of maltreatment, training of health care staff and other professionals such as teachers, social workers and police in early detection and appropriate responses to maltreatment to protect children from further harm, rehabilitation of victims and social marketing campaigns to change attitudes towards violent familial discipline (including all forms of corporal punishment). Universal approaches proportional to need should be applied to reduce inequality. An evaluative framework would improve the evidence base.

20. **Indicators**:

(a) number of countries implementing evidence-based preventive programmes at both universal and targeted levels; and

(b) number of countries undertaking capacity development through staff training.

The role of the WHO Regional Office for Europe

21. To achieve these objectives, support will be provided to all Member States in the form of:

- national and international advocacy at the highest level;
- guidance on preparing national reports, action plans, with data collection standards and surveillance, programming and evaluation to help ensure a consistent approach;

- guidance for action plans containing detailed information on objectives, evidence-based action proposed, timetable for implementation, responsible parties and indicators for monitoring and evaluation;
- building health system capacity for child maltreatment prevention action plans and programmes based on a whole-of-society approach, including the health sector; and
- a baseline European status report and another at five years, with support for country profiles.[6]

22. WHO will provide in-depth support to several countries in preparing national action plans, reporting, surveillance and implementing programmes, including through biennial collaborative agreements.[7]

23. Partnerships will be forged with Member States, United Nations bodies such as the United Nations Children's Fund, the European Union and its institutions, nongovernmental organizations and professional associations.

[6] 43 countries in Europe are participating in the *Global status report on violence prevention*, which will be published in 2014 and have nominated national data coordinators; country profiles will be prepared from the data collected. The next survey is planned for 2019.

[7] 10 countries have conducted surveys of adverse childhood experiences, and several have chosen child maltreatment prevention as a priority.

Annex. Scale and consequences of the problem

1. Child maltreatment leads to the premature death of at least 850 children under 15 years in the European Region every year. Not all deaths from maltreatment are properly recorded and this figure may be an underestimate; the mortality data are the best available currently. Deaths, however, are only the tip of the iceberg. Much abuse may not come to the attention of child protection services. National practices on maltreatment vary between countries, making it difficult to take a regional view.

2. Analyses of community surveys in Europe and around the world have confirmed the extent of abuse in the community. They show a prevalence rate of 9.6% for sexual abuse (13.4% in girls and 5.7% in boys), 22.9% for physical abuse and 29.1% for mental abuse, with no real gender difference. Worldwide research on neglect shows that the prevalence is high: 16.3% for physical neglect and 18.4% for emotional neglect. Applying these figures to the population of children in Europe suggests that 18 million children suffer from sexual abuse, 44 million from physical abuse and 55 million from mental abuse. More studies in European countries, undertaken periodically with the same methods, are needed to better understand not only the scale of the problem but also the risk factors and long-term outcomes. Most maltreatment in the community is relatively mild, although it may persist for a long time. This type of abuse warrants parental supportive interventions by welfare and family support services, rather than investigation by child protection agencies.

3. Child maltreatment is a leading cause of health inequality and social injustice, with poorer and disadvantaged populations at greater risk. The rates of homicide of children below 15 years in low- and middle-income countries in the Region are more than twice those in high-income countries: 7 of 10 child homicide deaths occur in those countries. Differences also exist within countries: child death rates are several times higher in disadvantaged populations than in wealthier communities and children living in deprived neighbourhoods more likely to be admitted to hospital for assault.

4. Maltreatment may cause stress that affects children's brain development, especially in the early years but also into adolescence. Throughout the life-course, mental and physical health and well-being may be damaged by health-harming behaviour. The evidence for development of mental ill health, such as depression, anxiety, eating disorders, behavioural problems, suicide attempts, self-harm and illicit drug use, after maltreatment is strong and indisputable. Post-traumatic stress disorder has been reported in as many as one fourth of abused children. Child maltreatment may be responsible for almost one fourth the burden of mental disorders, especially in association with other adverse or negative experiences in childhood. There are also strong associations with risky sexual behaviour and sexually transmitted infections, alcohol misuse, including binge-drinking, and there is emerging evidence for the development of obesity and other noncommunicable diseases. Maltreatment affects schooling, leading to lower educational attainment and poorer employment prospects. Further, it may lead to the transmission of violence between generations, from parents to children, so that abuse victims continue to both suffer and inflict violence.

5. Emerging evidence suggests that the economic and social costs are very high, with heavy costs for health care, social welfare, justice and lost productivity, perhaps running into tens of billions of Euros. The extent of maltreatment, its far-reaching health and social consequences and high economic costs emphasize the importance of its prevention. There is an urgent need for better preventive services, and not only for protection services, to lessen its consequences.

The WHO Regional Office for Europe

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