World Health Organization
REGIONAL OFFICE FOR Europe

Situation analysis of child maltreatment prevention in Latvia

World Health Organization
REGIONAL OFFICE FOR Europe

Situation analysis of child maltreatment prevention in Latvia

By: Aivita Putniņa & Alise Skrastiņa

Abstract

This situation analysis report on prevention of child maltreatment in Latvia has been prepared with the cooperation of many stakeholders from different ministries, such as justice, welfare and health, agencies such as child protection, ombudsman and police, and nongovernmental organizations. Studies conducted in Latvia suggest that many children needlessly suffer from child maltreatment. As in other countries, most maltreatment occurs in the family and may not come to the attention of child protection agencies. It is nevertheless a grave public health and societal problem with far-reaching consequences for the mental, physical and reproductive health of children, and for societal development. This analysis found that while good progress is being made in availability of rehabilitation services, there is room for improvement in early prevention measures and data collection. Collaborative actions are required among all partners to tackle this public health and societal problem. This includes better information exchange and collaboration among stakeholders, improved detection and child-centred responses, enforcement of laws and social marketing to change attitudes to corporal punishment, and support to families in need. Health systems have a key role to play, not only in providing high-quality services for children who experience violence, but also in detecting and supporting families at risk and implementing prevention programmes, such as home visitation and parenting support. One way of ensuring this is to strengthen national policy on the prevention of child maltreatment, providing early and targeted support to all children and their families.

Keywords
CHILD ABUSE - PREVENTION AND CONTROL
VIOLENCE - PREVENTION AND CONTROL
PUBLIC HEALTH
HEALTH POLICY
NATIONAL HEALTH PROGRAMS
LATVIA

Address requests about publications of the WHO Regional Office for Europe to:

Publications
WHO Regional Office for Europe
UN City, Marmorvej 51
DK-2100 Copenhagen Ø, Denmark

Alternatively, complete an online request form for documentation, health information, or for permission to quote or translate, on the Regional Office website (http://www.euro.who.int/pubrequest).

Contents

Acknowledgements

This report was developed within the framework of the WHO Country Office in Latvia/ WHO Regional Office for Europe Biennial Collaborative Agreement 2016/2017 with the Ministry of Health of Latvia.

The report was written by Associate Professor Aivita Putniņa (University of Latvia) and Ms Alise Skrastiņa (University of Latvia). Preparation of the report was supported by the Ministry of Health and Ministry of Welfare of Latvia.

The authors wish to thank the following peer reviewers who contributed to improving the quality of the report: Ms Dimitrinka Jordanova Peshevska, WHO Consultant in Violence Prevention, Skopje, the former Yugolsav Republic of Macedonia; Ms Jenny Gray, WHO Consultant in Child Abuse Prevention, London, United Kingdom; Dr Dinesh Sethi, Programme Manager, Violence and Injury Prevention, and Dr Yongjie Yon, Technical Officer, WHO Regional Office for Europe; and Dr Freja Ulvestad Karki, Senior Policy Adviser, Norwegian Directorate of Health.

Exceptional thanks go to key stakeholders who kindly contributed to the document by participating in the semi-structured interviews and shared their knowledge, experience and commitment in the area of prevention of child maltreatment, and to SOS Children's Villages Latvia for allowing use of their research data on intersectoral collaboration in violence prevention.

Special thanks go to Dr Aiga Rūrāne, Head of the WHO Country Office in Latvia, and Dr Gauden Galea, Director, Division of Noncommunicable Diseases and Promoting Health through the Life-course, WHO Regional Office for Europe, for their contributions to the report and supportive comments.

Introduction

This report follows the WHO line of inquiry on the relationship between health and violence and subsequent policy documents tackling child maltreatment and health in Latvia. WHO defines child maltreatment as *(1)*:

> all forms of physical and/or emotional ill-treatment, sexual abuse, neglect or negligent treatment or commercial or other exploitation, resulting 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.

The first global report linking violence and health, published in 2002 *(2)*, presented a chapter on child abuse and neglect, discussing the definition of abuse and its forms in crosscultural perspectives.

Violence and injury prevention among children is an ongoing WHO priority. *Preventing child maltreatment: a guide for taking action and generating evidence (3)* framed child maltreatment as a public health problem and focused on data collection, prevention strategies and services. *Investing in children: the European child maltreatment prevention strategy 2015–2020 (4)* and its action plan *(5)* were built on the guiding principles of Health 2020, the European policy for health and well-being *(6)*. They focused not only on sexual, physical and mental abuse and neglect of children, but also adverse childhood experiences (ACEs) – dysfunctional family relations, parental violence, and having a household member experiencing mental illness, drug or alcohol dependency, or incarceration. The action plan stressed the importance of universal and health-care services in early risk-detection in prevention of child maltreatment.

WHO encourages the building of national action plans and has produced guidance, such as the *Handbook on developing national action plans to prevent child maltreatment (7)* and *Measuring and monitoring national prevalence of child maltreatment: a practical handbook (8)* in 2016. The same year, WHO and several international organizations published the INSPIRE report, *Seven strategies for ending violence against children (9)*, positioning child maltreatment among other forms of violence against children and offering evidence-based guidelines for combating it.

Child maltreatment in Latvia is mostly seen through a human rights perspective, with health being an aspect of violence-prevention policy. Latvia ratified the Convention on the Rights of the Child in 1992. It has built a multisectoral child maltreatment prevention system, with the Ministry of Welfare acting as the policy-coordinating institution. Latvia

has created sufficient legal grounds for protecting children through, for example, the Protection of the Rights of the Child Law (1998), which obliges all citizens to report cases of child abuse and grants victims access to rehabilitation. As local experts and the United Nations Children's Rights Committee point out, however, the legal norm is not always implemented.

This report presents an outline of the child maltreatment situation in Latvia and discusses the availability of data. It analyses trends in national policy and legislation and considers cross-sectoral collaboration in preventing child maltreatment. The report applies the social ecological model *(2)*, offering a new perspective on child maltreatment, and focuses on the health sector's role in combating child maltreatment and its negative effects.

The scope of the report

The report addresses data availability and policy frameworks focusing on all stages of child maltreatment prevention – early intervention and preventive work, detection and reporting of maltreatment, and rehabilitation.

It is based on analysis of international and national policy documents and national statistical data. Semi-structured interviews were conducted with key national-level stakeholders in Latvia in May–August 2017 to supplement the desk review, focusing on national policy and legal frameworks, data sources and their application, and stakeholder involvement. Twelve experts were interviewed: Kristīne Ķipēna and Indra Gratkovska (Ministry of Justice), Lauris Neikens (Ministry of Welfare), Inga Krastiņa (State Inspectorate for Protection of Children's Rights), Vineta Pavlovska and Andis Rinkevičs (State Police), Vaira Vucāne (Latvian Children's Fund), Jana Feldmane (Ministry of Health), Laila Grāvere (The Ombudsman), Laila Balode (nongovernmental organization (NGO) "Centre Dardedze"), and Ivita Puķīte and Dace Bernāre (SOS Children's Villages Latvia). As responsibility for preventing maltreatment of children is shared among national bodies and municipalities, secondary data analysis from a feasibility study of an early prevention system in Riga municipality[1] was conducted to include a case analysis at local level. The study was based on 58 interviews and four focus group discussions with specialists directly involved in prevention of child maltreatment.

Statistical data were obtained from publicly available reports published by the Central Statistical Bureau (CSB), ministries of health and welfare, and the State Police, covering

[1] The study was conducted between December 2014 and January 2015 in Riga. It is unpublished and is used here with the permission of SOS Children's Villages Latvia.

the period from 2005 to 2016. The report includes other research findings on the child maltreatment situation in Latvia, addressing topics such as domestic, sexual, peer, physical and emotional violence, and child neglect.

A draft report was presented at the high-level policy-maker discussion “Preventing child maltreatment – how to implement good and coordinated collaboration” on 31 May 2017. Discussants included ministers of the national government and members of parliament, WHO experts and other stakeholders, including representatives of local municipalities and NGOs. The discussion served as a valuable source of information for structuring the report and developing its recommendations. Presentations and discussions at the seminar of Baltic and Nordic countries on 1–2 June 2017, “Preventing child maltreatment: strengthening international cooperation”, provided valuable insights and opportunities to discuss the situation with stakeholders.

1

The scope of child maltreatment: providing data

The population of Latvia at the beginning of 2017 was 1 950 000. This represents a decrease of 8% (or 170 000) since 2010, mostly due to migration. According to data provided by the CSB, there were 300 294 children in the age group 0–14 years in 2010, decreasing to 296 444 at the beginning of 2017. These children comprise 15.6% of the Latvian population.

1.1 Survey data

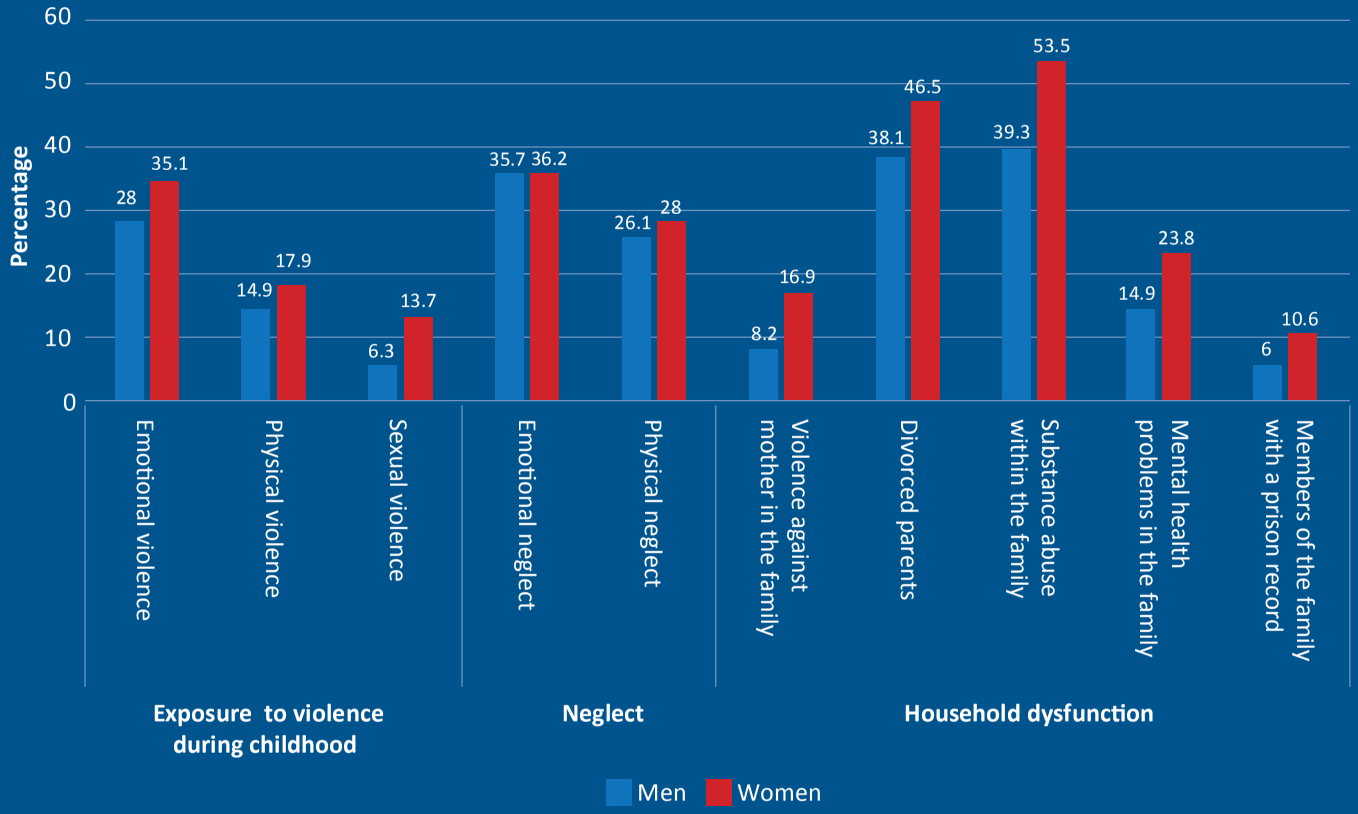
Child maltreatment is a complex health and social phenomenon. Estimates of its scope form the focus of many surveys and administrative data sources, and vary greatly in Latvia. The Latvian ACE study of 2012 *(10)* shows that only 16.9% of respondents had not reported any adverse or traumatic experiences during childhood, according to operationalized categories. Looking at the prevalence of the different forms of child maltreatment experiences (Fig. 1), indirect risk factors such as separation and divorce between parents, incarceration of a family member and substance abuse in the family dominate. More than a third of the adolescents reported having experienced emotional neglect, but over a quarter cited physical neglect. The category of divorced families within household dysfunction that causes indirect risk of child maltreatment is questionable, as divorce can be the best alternative where cases of physical, sexual and/or emotional violence are present in the family.

The study shows that young people with high ACE scores are more likely to have early sexual intercourse, have higher odds of ever using drugs and an increased likelihood for suicide attempt, among other risk behaviours. They rate their health as “rather bad” or “bad” more often, have been absent from school for at least three days during the last month because of stress or depression, and have a higher likelihood of weekly somatic and psychological subjective health complaints.

The Ombudsman’s Office conducted a study on violence against children in 2015, interviewing 500 children in grades 5–12 (age 11–18) *(11)*. It shows that 47% had reported having experienced some form of violence. The most common forms of child maltreatment identified by the study – shouting, name-calling, humiliation and scolding – were experienced at least once a week or more often by 20% of the children; punching, pushing, striking and pinching had been experienced once a week or more often by 13%, and 33% reported being spanked at least once.

A recent and not-yet published study by Kantar Millward Brown shows that 47% of respondents support corporal punishment as a method of discipline, and 39% believe it

Fig. 1. ACEs, n=1223 (2011)



Source: Velika et al. *(10)*.

should be legalized. Corporal punishment has been a criminal act in Latvia since 1998, but the study shows only 46% of respondents were aware of this.

1.2 Administrative data

The CSB prepares a yearly statistical report on children in Latvia that provides information on health status, social protection, age composition, births and deaths, the number of children involved in conflicts with the law, and violence against children. Data are provided by the National Health Service, Register of Patients Suffering from Certain Diseases, Centre for Disease Prevention and Control, State Social Insurance Agency, Ministry of Welfare, Ministry of the Interior, Court Administration, State Inspectorate for Protection of Children's Rights, Ministry of Education and Science, Road Traffic Safety Directorate, Eurostat and other institutions. The Ministry of Welfare also prepares two lengthy analytical reports – one on the situation of children, and one on domestic violence, including a chapter on child maltreatment. The United Nations Committee on the Rights of the Child expressed some concern in its 2016 recommendations on the quality and coverage of available data in Latvia and called for a more comprehensive data system *(12)*.

The administrative data sources show a higher incidence of child maltreatment being reported in data on rehabilitation services (Table 1). The number of cases is fluctuating, but an increasing trend has been seen in recent years, with the exception of 2016. Emotional violence is the most common form of violence, constituting 36–42% of cases between 2013 and 2015, followed by combined forms of violence and neglect. Social rehabilitation services provided to minors who have experienced violence include a maximum of 10 45-minute psychological consultations provided at the young person's place of residence, prison, social correctional establishment or childcare institution, or a social rehabilitation course ranging from 30 to 60 days in social rehabilitation institutions *(13)*.

The incidence of parental neglect in families is also registered in Orphans' Court data. The number of families and children where neglect has been identified has steadily decreased in the last decade (Table 2). Parental neglect here is understood in wider terms, and includes not only physical and emotional neglect, but also neglect of children's health and education needs, which do not necessarily fall under the criminal or administrative law (for more information on NGO-developed guidelines, access the "Centre Dardedze" website *(14)*).

Statistics of lost custody rights also can be used in estimating the incidence of child maltreatment (Table 3). According to Civil Law section 203 and the Law on Orphans' Courts section 22, the recorded circumstances of parental neglect here include: (1) factual obstacles that prevent parents from taking care of their children (health status, imprisonment etc.); (2) neglect that endangers a child's health and life; and (3) the intentional abuse of parents' rights and insufficient provision of necessary child care.

Recorded criminal offences against young people aged 0–17 years are shown in Table 4 by type of crime.

Table 1. Social rehabilitation services provided to minors

	2005	2010	2011	2012	2013	2014	2015	2016
Total number of rehabilitated children	2 142	2 646	2 738	2 738	2 035	2 453	2 473	2 293
Rehabilitated in institutions	1 125	1 317	1 322	1 322	854	1 195	1 237	NA
Rehabilitated due to emotional violence	765	1 092	1 174	1 174	807	890	1 034	977
Rehabilitated due to physical violence	186	152	167	167	101	115	54	126
Rehabilitated due to sexual violence	109	92	114	114	75	124	131	118
Neglect	158	296	332	332	259	293	424	234
Due to combined violence	924	1 014	951	951	793	1 031	830	838

NA: not available.
Source: CSB database.

Table 2. Parental neglect

	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
Number of parents	1 598	1 563	1 372	1 532	1 417	1 645	1 961	1 876	1 799	1 404	1 235	1 203
Number of children	1 943	1 905	1 652	1 914	1 657	1 953	2 300	2 189	2 032	1 605	1 465	1 378

Source: annual reports of orphans' courts.

Table 3. Lost custody rights

	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
Number of parents	1 598	1 563	1 372	1 532	1 417	1 645	1 961	1 876	1 799	1 404	1 235	1 203
Number of children	1 943	1 905	1 652	1 914	1 657	1 953	2 300	2 189	2 032	1 605	1 465	1 378

Source: annual reports of orphans' courts.

Table 4. Recorded criminal offences against minors (0–17) by type of crime

Offences	2010	2011	2012	2013	2014	2015	2016
Homicide[a]	1	0	2	0	2	1	3
Intentional assaults	3	5	3	3	2	4	3
Rape	28	19	9	15	21	25	14
Sex offences	19	16	3	20	148	53	13
Sexual contacts with persons under 16 years	10	21	17	24	17	27	25
Seduction[b]	48	100	9	51	63	75	11
Cruelty and violence against underage persons	125	91	78	73	75	61	13

[a] According to sections 116–118 of the Criminal Law.
[b] Seduction is sexual actions without physical contact with the body of a minor under the age of 16 years with the aim of satisfying an adult's sexual desires (Criminal Code, chapter XVI: Criminal offenses against morality and sexual inviolability; section 162).
Source: CSB data compilation.

Law enforcement data show that only a small proportion of potential cases of child maltreatment are prosecuted. In 2015, only 542 criminal offences and 702 administrative offences committed against minors were registered, while 2473 minors received rehabilitation services that year.

Data show that recorded sexual offences against minors increased in 2014. Interviews did not offer an explanation for this, but the State Inspectorate for Protection of Children's Rights had organized a campaign on reporting sexual violence that year *(15)*. As interviewed stakeholders suggested, not all cases of violence are reported and law enforcement may be applied only in a limited number, ignoring cases of parental neglect and indifference even when they have caused harm to children. Administrative

procedures in cases of physical and emotional violence (section 172.2 of the Administrative Code) were initiated in 610 cases in 2015 and 702 in 2016. Of these repeated acts of violence, 49 and 51 respectively were perpetrated by state or municipal institution staff.

The low number of initiated administrative and criminal cases shows both high tolerance of child maltreatment and the existence of obstacles to the prosecution process of identifying and investigating cases. The United Nations Committee on the Rights of the Child expressed concerns in its 2016 evaluation about the ability of law enforcement institutions to register and investigate all reported cases and recognize those for which urgent intervention was required. The Committee also pointed to difficulties in identifying breaches of children's rights by parents and finding measures to tackle them *(12)*. The Trauma Register supplies data on number of minors hospitalized due to trauma and injuries (Table 5), but the number of cases registered under the category of domestic violence is low. The Register allows access to information on the circumstances of the incidents: in all cases between 2010 and 2016 in which children under 7 years had sustained violence-related trauma and injury, it was due to their parents.

Table 5. Recorded cases of hospitalized minors due to violence

Age (years)	2010	2011	2012	2013	2014	2015	2016
0–1	1	1	0	1	0	1	1
2	1	1	0	0	0	0	0
3	1	1	0	0	0	0	0
4–7	5	4	1	2	4	0	0
8–12	52	36	20	18	16	24	24
13–17	180	155	93	45	53	80	81

Source: Centre for Disease Prevention and Control, Trauma Register.

Despite the low recorded incidence of violence against children, Latvia has a comparatively high trauma and injury incidence rate that could partly be linked to low parental knowledge about child security and neglect. Trauma and injuries are seen and registered as medical problems rather than being considered the result of child neglect. In 2016, 2260 children aged 0–14 experienced injuries, poisoning and other consequences of external causes *(16)*; of these, 668 were under 4 years. Only one case, or 0.1% of all cases in this age group, has been recognized as being the result of violence, which suggests either that recognition of child maltreatment is low, or child maltreatment is understood to mean intentional harm only.

It is possible that many cases are categorized as "accident" rather than "neglect", which does not allow the problem of child maltreatment to be addressed systematically. High-level trauma among children is a source of ongoing public debate. The Centre for Disease Prevention and Control has prepared numerous information sheets and a booklet on child trauma that addresses the most common risks and details actions to take in cases of trauma and injury *(17)*; this information should be adjusted to medical consultation situations, meet the needs of parents and reflect age-specific risk factors.

Data from the Centre for Disease Prevention and Control indicate that violence-related causes led to the deaths of 16 children between 2010 and 2016 (Table 6). Nine were categorized as homicide in CSB data (see Table 4). Self-inflicted violence contributed to 27 deaths, most cases occurring among those aged 10–17 years. As research shows, higher suicide risks are related to ACEs.

Table 6. Deaths in children (0–17 years) due to violence and self-inflicted injury, 2010–2016

Age (years)	Violence-related causes	Suicide
0	3	0
1	2	0
2	1	0
3	2	0
4	0	0
5–9	4	0
10–14	2	5
15–17	2	22
Total	**16**	**27**

Source: CSB *(18)*; Centre for Disease Prevention and Control statistical data.

Latvia does not have a comprehensive database and monitoring system for children who have experienced maltreatment. The Information System for the Support of Minors (NPAIS) has been introduced to record and share information on individual cases, enable better monitoring and improve provision of aid. The Protection of the Rights of the Child Law (Article 67) lists a number of institutions and professionals, including medical specialists, as participants in the system, but several institutions and municipalities (including the largest municipality, Riga) do not use the system, even though required to

do so by law. Interviews suggest that stakeholders consider the data-exchange system to be not user-friendly and demanding of extra work. Supervising institutions consider the database unreliable, as it contains fragmentary data.

Social rehabilitation was allocated €1 138 296 from the state budget in 2012 and €1 223 668 in 2013. Social rehabilitation data show that the initiators of violence are mostly close family members – 1896, or 67%, of rehabilitated children in 2014 experienced violence caused by their parents, 303 (13%) by other persons living in the same household, and 139 (5%) by unknown people *(19).* These data indicate that the problem of violence should be tackled at family level to improve understanding of the causes of violence and apply the most effective preventive tools. As stakeholders suggest, data do not include a breakdown on children with disability, so do not provide sufficient information from which to target action.

1.3 A way forward

Data on child maltreatment are available from different sources, but do not allow comparison and exchange among institutions. Data on lost custody rights and parental neglect suggest a slow but steady decrease of cases detected, which, as experts suggest, might point to more effective prevention work. The trends may not be so straightforward, but recognition of violence against children is improving, leading to earlier and more accurate identification of cases.

Absence of data on individual cases does not allow tracking of support systems' efficiency. Data from the health sector are largely missing, as domestic violence and parental neglect are seldom recognized as causes of trauma or injury. Early detection of maltreatment and parental neglect risks would contribute to more precise statistics in the health-care system and lead to better targeted prevention action.

Surveys continue to show a disturbing tendency among half of the adult population in Latvia to support corporal punishment as a means of disciplining children. International comparative surveys should be performed regularly to monitor the situation and implement evidence-based policies that place emphasis on education and strengthening parental skills.

2

National legal and policy framework

Latvia does not have a comprehensive child maltreatment prevention policy, leading the 2014 global status report on violence prevention to report that there was no national plan or strategy to prevent child maltreatment in Latvia *(20)*. Issues related to child maltreatment have nevertheless been included in a number of sectoral policies and programmes.

This chapter explains the Latvian legal and policy approach to child maltreatment, particularly emphasizing cross-sectoral collaboration as a crucial factor for the success of decentralized policies. Delegation of responsibility of violence prevention to local government is a key characteristic of national policy: a best practice example from Riga, the capital of Latvia, is therefore offered to support understanding of policy implementation and cross-sectoral collaboration.

2.1 Defining policies

The national legal framework for preventing child maltreatment is built upon the Protection of the Rights of the Child Law. This law requires the Ministry of Welfare to develop a state programme on improving the situation of children and families each year, to be implemented by the ministry and the State Inspectorate for Protection of Children's Rights. The 2017 programme provides support in crisis situations, especially focusing on supporting foster families and improving the knowledge base of specialists working on implementing children's rights. The annual budget for the programme division is €633 115.

Child maltreatment-related programmes are also run by sectoral ministries. The Ministry of the Interior prepared *Guidelines for preventing child crime and protecting children from criminal offences 2013–2019* in 2012 *(21)*, and the Ministry of Welfare administers the *State family policy guidelines 2011–2017 (22).*

The family policy guidelines for 2011–2017 tackle domestic violence, defined as a specific form of violence because of the emotional tie between the victim and the perpetrator and its repeated nature: emotional, physical and sexual forms of domestic violence and its economic form are also considered. The objectives of the guidelines are to:

1. define domestic violence
2. evaluate data and research support to tackle violence
3. decrease tolerance in society towards violence
4. educate specialists
5. improve normative regulation
6. provide rehabilitation programmes for the perpetrators and victims of violence
7. improve intersectoral mechanisms for collaboration.

The guidelines were preceded by a decade of policy-planning documents, such as the Latvia for children 2004–2015 guidelines *(23)*, a concept paper on state family policy for 2004–2013 *(24)* and the *Programme for preventing domestic violence 2008–2011 (25)*. Their goal is to establish a coherent violence-prevention system and define domestic violence, the need for which stems from the Latvian legal context – domestic violence is not seen as a distinct form of abuse, but rather as aggravating circumstances in criminal law. Additionally, the identification of child maltreatment sometimes is controversial in practice – it can be seen as a rightful method for parents of disciplining their own children, or can be caused by lack of awareness of trauma and injury risks. Incidents are seen as accidents rather than the result of unintentional or intentional parental neglect.

The recent policy programme aims at early detection as it anticipates that the number of criminal cases of domestic violence will increase, but the number of victims admitted to crisis centres or hospitals will decrease due to early identification of cases.

The Ministry of Health has included child maltreatment issues in its recent public health guidelines for 2014–2020, which are discussed in detail below. Child maltreatment-related activities are scheduled towards the end of the guideline period (the end of 2020) and include preparatory steps with no specific budget allocated, indirectly indicating the low priority of child maltreatment in public health policy.

As interviewed stakeholders suggest, overall policy planning and funding of activities related to preventing child maltreatment depend largely on publicity around cases. Policies therefore often lack resources, follow-up and sustainability.

Latvia has delegated its rehabilitation services to an NGO, the Latvian Children's Fund, which further distributes the resources to crisis centres and rehabilitation specialists under the annual state programme for improving the situation of children developed by the Ministry of Welfare. Access to social rehabilitation services for children and families was problematic a decade ago *(26)*, but is no longer so. Early identification and prevention of child maltreatment are current challenges for the policy, as they are financed mostly by local authorities and international funds raised by the NGO sector. This creates uneven access to early prevention and support across the country.

2.2 Cross-sectoral collaboration

The Ministry of Welfare acts as a coordinating institution in violence-prevention policy and provision of rehabilitation, and supervises state budget-funded social services.

The Ombudsman's Office was created in 2007. It has a Children's Rights Department that promotes children's rights, reviews children's complaints and facilitates cross-sectoral collaboration among the state, municipal institutions and NGOs. The Office received 1022 complaints around children's rights issues in 2016, a 15% increase over 2015. The most frequent topics dealt with children's rights to live in family care (either with parents, a guardian or foster families) and custody of children in social care institutions *(27)*.

The State Inspectorate for Protection of Children's Rights was established in 2005. It supervises and controls the implementation of children's rights in state, municipal and nongovernmental institutions, especially in orphans' courts.

Stakeholders criticized the Inspectorate's efficiency when investigating cases in institutions. Data show that nine cases were investigated in 2015, leading to accountability according to the Code of Administrative Prosecution being established in seven and verbal remarks made in two. Twelve cases were investigated in 2016, leading to accountability in six and verbal remarks in one, but five cases were dismissed. Specialists point to difficulties in investigating the cases, including a lack of methodology and support instruments. Administrative transgressions are difficult to investigate, as institutions usually have back-up documentation to cover their actions. For example, investigation of a complaint of unjustified placement of a child in a mental care institution cannot take the actual case into account, but must depend on the documentation provided.

The Inspectorate also consults institutions, provides guidelines for better implementation of children's rights and runs a hotline (currently 24/7) with specialist consultations.

Cabinet of Ministers Regulation No.1613 on Procedures for Providing the Necessary Assistance to a Child who has Suffered from Illegal Activities (2009) outlines the system of assistance to children. It obliges **medical institutions** and **orphans' courts** to report all cases of suspected violence against children to social services and the police. If the violence occurred at a childcare institution, educational institution of social correction or place of imprisonment, the head of the institution and the child's parents, foster family or guardians are obliged to inform the orphans' court and social services. The regulations state that the opinion of a psychologist or social worker regarding the suspected abused child should be taken into account in all cases. The regulations also appoint the **Foundation for Children of Latvia** as the gatekeeper and provider of rehabilitation services to child victims.

Research shows that implementation of cross-sectoral collaboration varies across municipalities. Riga is often cited as a good example *(28)*. Riga has formally defined cross-sectoral collaboration through a collaboration agreement (15.07.2009, No. DL-09-169-lī) and a regulation on institutional collaboration in cases where children's rights are breached or there are suspicions of such (28.05.2010, Nr.LD-10-82-lī).

The collaboration scheme is based on two-level collaboration. The municipality Welfare Department, social workers for families with children, all municipality-contracted institutions (including health-care institutions), the municipal police, municipal Department of Education, Sports and Culture, preschool and general education institutions, and orphans' courts constitute the core of collaboration and are obliged to report and solve cases of child maltreatment. General physician practices, other health-care institutions, the State Police, preschools, NGOs, communities and other institutions – which lack special support staff to tackle the cases – are invited to collaborate voluntarily (Putniņa A, Linde Z, unpublished data, 2015).

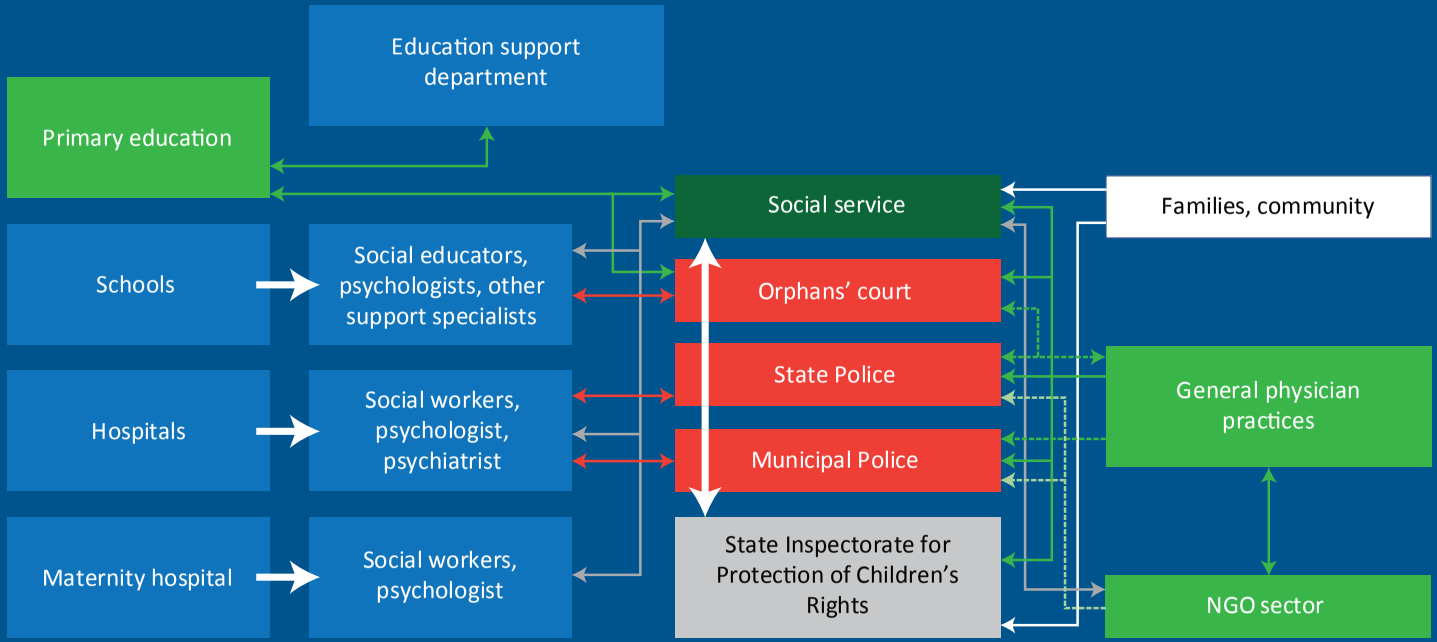
Practical implementation of the model varies in Riga districts, though participants are well informed about it.

All institutions highly regard cross-institutional meetings that include all sides involved in particular case solutions. These joint evaluations not only allow more effective tackling and solving of individual cases, but also strengthen personal collaboration. Health-care specialists play a marginal role, however, suggesting that involvement of the health-care sector needs to be strengthened.

Personal connections are important in practising effective collaboration – identifying risks, exchanging reports and coordinating actions. Fig. 2 shows the empirical scheme of collaboration. The arrows symbolize the strength of the collaboration, with a thicker line denoting stronger collaboration.

The situation analysis shows that health-care institutions are more involved in child maltreatment cases when they have a specialist working with cases of suspected maltreatment. For example, the municipality finances a social worker in Riga Maternity Hospital who conducts initial risk assessments of young parents. There is a gap, however, in the provision of further services for families with newborns who are experiencing some crisis and need short-term support, but are not considered social-risk families. A pilot project for supporting these families was run in 2016. Other hospitals are interested in working with families in crisis and acknowledge that early intervention is essential in

Fig. 2. Collaboration in Riga city municipality



Note: the arrows point in the direction of communication: the boldness of the lines indicates the intensity of collaboration, with dotted lines signalling fragmentary collaboration processes.
Source: Putniņa A, Linde Z, unpublished data, 2015.

preventing the development of further social risk of child maltreatment, but lack of resources presents an obstacle.

The Riga study shows that physicians see the risk factors for maltreatment, but that even the most motivated specialists lack knowledge in detecting the degree of risk, accessing resources and securing support for actions. Reporting to social services and police requires clear guidelines for medical specialists, but these currently are lacking. The study finds that general practitioners often fall out of the reporting system as they formulate their observations differently from other stakeholders, have concerns about confidentiality issues for their patients and themselves, and often lack knowledge on how to present evidence to confirm suspicions of maltreatment. Physicians who have good personal communication with social workers in their district were more apt, and ready, to report, but the study also detects obstacles that prevent medical specialists from reporting child maltreatment, such as risks that parents would complain to the Health Inspectorate on Maltreatment (which would then open an investigation into the practice), risks of disclosing their identity to clients when reporting, and the time and effort needed to file an official complaint to the police. The United Nations Committee on the Rights of the Child concludes that health-care professionals lack training in children's rights *(12)*, and the same problem was detected at national level in an evaluation of the protection of rights of young children in 2011 *(29).*

Recently, an initiative to strengthen cross-institutional collaboration at municipal level has been implemented following new regulations from the Cabinet of Ministers. These were issued in response to a case in Dobele in January 2017 in which the parents had died from drug overdoses along with a 9-month-old baby, who succumbed to starvation, while three children aged from 3 to 5 survived. Stakeholders are divided on whether stricter regulations are needed to avoid such cases. Existing provisions already oblige institutions to collaborate, and other municipalities have established efficient collaboration networks.

Looking at evidence from other countries, prevention in the community and primary care settings needs to be strengthened considerably, including engagement of the primary health-care sector, patronage nurses and school health services.

2.3 The role of the health sector in early detection of child maltreatment and mental health problems

Child maltreatment has been included in health-care policies addressing a range of topics. The Ministry of Health developed the *Maternal and child health action plan 2012–2014* to improve maternal and child health indicators *(30).* The objective was to focus on reducing maternal and child mortality by providing better care and improved health services for mothers and children. Activities were directed towards increasing knowledge and changing behaviour in risk families, including in relation to domestic violence.

The public health guidelines for 2014–2020 are closely tied to the Health 2020 framework and systematize health-care policy in comprehensive guidelines. The guidelines define violence as "an important public health and human rights question". WHO approaches to violence and documents play a major role in framing the problem. They acknowledge that the knowledge and skills of medical specialists working with victims and cross-sectoral collaboration need to be improved. Trauma and violence are seen primarily as environmental safety issues, with child maltreatment falling under the policy objective of "promoting a healthy and safe life and work environment, and decreasing trauma and morbidity from external causes". This effectively describes the health-sector approach, which focuses on consequences rather than causes of maltreatment. The main indicators of the policy are trauma prevalence (0–17 age group) and death from external causes (0–1 and 2–4 age groups) among children.

Several policy actions to raise general awareness of trauma risk factors are planned, but only two activities directly linked to combating violence are included: defining measures for educating medical specialists on violence (end of 2018), and exploring problems of cross-sectoral collaboration in ending violence (end of 2020). No specific budget is allocated to the activities, and both are moved towards the end of the policy programme, reflecting the drafting of a plan rather than the implementation of a specific action. Issues such as the need for positive parenting programmes, nurse home visitation and training parents in trauma prevention are not considered. Stakeholders also looked sceptically at prospects for increasing demands on the health sector in relation to child maltreatment prevention at a time when the sector is experiencing a general crisis and the basic health-care needs of the population are not satisfied.[2]

[2] At the time of writing the report, discussions on additional health-care tax and renumeration of medical specialists are high on the policy agenda.

Interviewees suggest that the health sector lacks capacity to address child maltreatment, even if it acknowledges it as a problem. WHO has stressed the role of the health sector in detecting child maltreatment and local research supports its vital role. Health-sector involvement, however, remains weak. The Law on the Protection of Children's Rights already obliges every citizen to report on cases of violence against children. The heath sector's role in detecting violence was strengthened in 2011 with amendments to the Medical Treatment Law that require health-care institutions to report cases in which minors experience "lack of sufficient care and supervision or other violation of the rights of the child" (section 56.1).

The 2011 evaluation of the protection of rights of young children *(29)* stresses the role of early home visits in detecting child neglect in social-risk families. Cabinet of Ministers Regulation No. 1046 states the standard for home visits: the first is made up to three days after discharge from hospital and subsequent visits occur every 10 days during the first month. Monthly visits are planned until the age of 6 months, and thereafter prophylactic examinations are carried out twice a year to age 2. The regulations state that home visits should be conducted when young children under 1 year are not brought to the physician's practice. Additionally, Cabinet of Ministers Regulation No. 265, attachment 93, presented in 2011 a survey instrument for evaluating physical and mental development of children (1 week to 5 years) that included such factors as domestic violence, conflicts and safety, but its use is optional. None of the interviewed physicians used the instrument and health-care experts suggested that it was too complicated and time-consuming, even if it was designed to facilitate the evaluation process. Needs assessments of families at risk, parents with alcohol or drug problems, domestic violence, mental illness, incarceration or acrimonious divorce, socioeconomically disadvantaged and first-time mothers, and single parents would be essential to provide these families with more support.

An Internet-based survey of parents of young children in the evaluation report *(29)* showed that only a quarter of parents had home visits in the first month after childbirth and the number of patronage visits was on average much lower than recommended, although official statistics show higher prevalence of home visits. The role of primary health-care specialists has been debated since, and the opinion of primary care physicians on their role in detecting violence is divided. On the one hand, physicians representing the Association of Rural General Practitioners acknowledge their role in combating violence and support home visits as an important instrument. On the other, the Association of General Practitioners call for a "more realistic" approach that allows for choice between home visits and examinations in general practice, arguing that practices are better equipped for examinations *(31)*. The Riga case study shows that general practitioners feel overburdened by regulations and demands from national

and local institutions and give low priority to child maltreatment prevention, seeing it primarily as an issue for social services.

Another aspect of the health sector's role in preventing child maltreatment is seen in mental health care. The Ombudsman's Office, several NGOs and the study in Riga municipality show that the health sector is often involved in solving social problems such as behavioural issues and conduct disorders of children, especially those in institutions. The Ombudsman and the team of the current deinstitutionalization project conducting inspections at social care institutions claimed, among other things, that hospitalization in psychiatric care was used as a form of punishment of children *(32)*. Interviews conducted for this report show that this is a widely acknowledged problem but it has not been sufficiently documented, as children's rights and health-care inspectors and other specialists do not have capacity to examine whether medical conditions meet the criteria for hospitalization or medication.

Interviewees suggest that psychiatrists apply different standards in evaluating mental health and planning treatment. A lack of, and insufficient availability of, specialists in child psychiatry was also noted, posing a two-fold problem: on the one hand, scarce resources of psychiatric expertise being used for problems that should be solved socially, and on the other, use of mental health as an instrument of social control, preventing access to mental health-care services when they are necessary.

2.4 Priorities and challenges in preventing child maltreatment

2.4.1 Facilitating identification of maltreatment – working with children-victims

Identifying and investigating cases of violence against children remains a challenge. Children experience repeated acts of emotional violence in the process of investigation, and the investigation of violence, especially sexual violence, poses difficulties for law enforcement institutions, as the child often is the main witness of the crime.

A pilot project, "Children's house", was implemented in 2017 to provide cross-sectoral collaboration and child-friendly medical examinations and interviews, minimizing the risk of the same examinations or data-collection process being performed repeatedly. The goal is for a trained investigator or psychologist to conduct just one interview that follows internationally established protocols, with collected data being used in court as

evidence. Each case is approached holistically, with collaboration on collecting evidence and provision of support and rehabilitation, and with the recognition that children exposed to sexual violence form an especially vulnerable group.

The pilot project has been implemented by the Council of the Baltic Sea States and is co-funded by the European Commission. The health sector is actively involved.

2.4.2 Protection against sexual violence

The first comprehensive plan for tackling sexual violence and protecting minors was initiated in 2009 *(33)*. The programme focused on primary prevention and working with perpetrators by developing rehabilitation instruments, and a new programme is currently being devised. A set of instruments and programmes has been created for perpetrators entering the prison and probation system, but as stakeholders note, the detection and investigation stages of such crimes lead to a low proportion of criminal cases compared to the number of children in rehabilitation.

A primary prevention programme for children, "Džimba" *(34)*, addresses issues of sexual violence against children, among other personal safety issues. It is partly funded by the state programme and some municipalities. A Riga municipality project on early prevention of child maltreatment, "Children-safe kindergarten", included training of one kindergarten educator (from the "Džimba" programme) who organizes 10 activity classes in each kindergarten annually. Despite some initial hesitation about addressing prevention of sexual violence, teachers found the programme allowed them to talk for the first time about the body and its integrity. Some tasks were addressed through homework. Parents felt very positive about the programme, even though it was anticipated that they would resist their children's participation. Programme materials allowed other teachers to learn how to address sexuality-related aspects with children and parents. Even though it is aimed primarily at educators, medical specialists would also benefit from the programme, as it not only allows recognition of the risks of violence, but also promotes discussion.

The United Nations Committee on the Rights of the Child expressed concerns about sexual violence in childcare institutions for children with mental health problems *(12)*. Data on outcomes of the criminal investigations of these cases are still lacking. Children with intellectual disabilities are not enabled to understand or disclose sexual violence. The Committee recommends the development of guidelines for identifying and reporting cases for specialists and for children.

Child victims of (often undetected) violence who themselves become perpetrators (especially of sexual violence) are recognized as constituting one of the most vulnerable groups currently excluded from support systems. Instruments for working with this group are available only when they enter the justice system, which often occurs only after they have committed repeated crimes.

2.4.3 New forms of child maltreatment in Latvia

Recent research suggests that recognition of child neglect is changing, and new forms of child maltreatment are emerging. One of the identified problems relates to children experiencing parental divorce *(7)*. These children experience more than emotional stress by the separation of parents. Research on cohabitation patterns *(35)* suggests that Latvia lacks a regulation mechanism for the division of property, financial and parental liabilities among ex-partners. Children are often used as so-called hostages in fights for custody rights: parental financial responsibilities for children are well defined and protected by the state, but responsibilities towards ex-partners are not.

2.4.4 Deinstitutionalization project

Cabinet of Ministers Regulation No. 589 on Guidelines for the Development of Social Services 2014–2020 was approved on 4 December 2013. Since then, new directions for social services have been established, putting deinstitutionalization in focus *(36)*.

Children in out-of-family care are one of the target groups of the deinstitutionalization project. Through amendments to the Cabinet of Ministers Regulation No. 1037 of 19 December 2006, orphans' courts have been required to provide a report on options for placing a child in foster care prior to allocating the child to a long-term care institution since 2016. Stakeholders confirm that neglect and subjection to violence are well acknowledged problems for children in care institutions and political will to solve the problem currently is strong. At the same time, alternative care options should be better developed, and providing training and support to foster families is one of the priorities of the state programme.

2.4.5 Children with behavioural and communication problems

Children with behavioural problems often present a challenge at school and require special support measures. An action programme aims to increase the efficiency of social services working with risk clients, specifically with children with behavioural and communication problems *(37)*.

A recent legal initiative, "Prevention of antisocial behaviour of children", targets earlier and more comprehensive introduction of social correction programmes. The Law on the Protection of Children's Rights (Article 58) already requires municipalities to develop such programmes, but some do so late or only under instruction from police. The main objective of the legal initiative is crime prevention, but it also touches on the problem of early intervention. As the annotation to the legal initiative states: "Parents have difficulties in accepting the fact that behavioural problems can be caused by neurological causes, mental health issues or the choice of inadequate methods of disciplining" *(38)*. Again, this points to the fragile borderline between social and medical support and identification of the optimum sector for providing support measures. Alongside crime prevention, the initiative could also target the benefits of children receiving timely support. Stakeholders suggest that the success of the programme depends largely on sufficient funding.

2.5 A way forward

International evaluators and experts often cite implementation of the legal and policy framework as a problem. There is no single child maltreatment prevention policy document: instead, prevention is mainstreamed through different sectors and levels of governance. The Ministry of Welfare is responsible for the state programme and monitoring, but local municipalities are responsible for granting access to services and protecting children's rights. The system of allocating responsibilities in the local and national sectors creates disparities in support across municipalities, which is recognized as a national problem.

The comprehensiveness and sustainability of the policy presents another challenge. Preventing child maltreatment is a responsibility shared among different sectors, so greater priority and more targeted action should be assigned to it, strengthening intersectoral collaboration. Currently, as experts note, it is driven by case-by-case action, reacting to failures in the system rather than designing it proactively. Understanding and identifying violence against children nevertheless is changing, which offers new opportunities. The deinstitutionalization project, support for families in the process of separation or divorce and actions to address sexual violence are currently being implemented. Health-care sector involvement should be improved, not only on data collection, but also in early identification and prevention of violence against children.

The Latvian high-level policy-maker discussion on "Preventing child maltreatment – how to implement good and coordinated collaboration" in 2017 addressed collaboration

issues among the national health-care, welfare and judiciary sectors. Discussions tackled the lack of clear child maltreatment identification and action algorithms between the sectors. Significant changes in the system are being discussed currently, with plans to place locally appointed orphans' courts under direct state regulation and define municipal responsibilities and cross-sectoral collaboration more strictly. Ensuring equal rights and support for all children regardless of their place of residence is one of the policy challenges.

3

Prevention programmes

Prevention programmes implemented in Latvia have mainly been initiated by NGOs and target parents, children and teachers. These initiatives often lack stable and long-term funding, however. The state covers part of prevention activities, but local municipalities decide how support is organized.

3.1 Positive parenting and disciplining of children

The Ombudsman's Office 2015 report *(11)* highlights the gap in understanding of acceptable forms of discipline. A considerable proportion of children believe that shouting (14% of respondents), corporal punishment (10%) and threats of physical punishment (8%) are acceptable methods. Parents echo children's opinions: shouting at home (14%) and threats of physical violence (9%) are seen as acceptable methods of discipline, and spanking as a disciplinary measure at home is supported by 5% of parents. Teachers believe that confiscation of phones and other personal belongings of children (58% of respondents), and ignoring and requesting children to stand up in class or stay behind for some time after class is over (both 9%) are acceptable methods. The United Nations Committee acknowledges the necessity to promote positive, nonviolent and collaborative methods of discipline *(12).*

The State Inspectorate for Protection of Children's Rights has detected insufficient skills among parents in preschool institutions in disciplining children, identifying and reporting violence, and solving conflicts. The state programme has been supporting creative workshops for educators to improve their skills and knowledge since 2015, with €8000 allocated for these activities in 2017. Similarly, the Inspectorate has concluded that school management and support personnel lack problem-solving (domestic violence, communication and behaviour problems of children) and conflict-resolution skills that include the child's perspective.

Some positive parenting programmes are nevertheless available, including "Children's emotional education", an adapted Canadian programme (which is the most popular), a programme for fathers *(39)*, "Guardian angel" (a programme for families with young children aged 0–2 in crisis) *(40)*, Parent Recourses for Information, Development and Education ("PRIDE", local name AIRI) *(41)*, and guidelines and methodology for social correction and social work programmes *(42).* The Incredible Years resource – a series of interlocking parent, teacher and child programmes supported by more than 30 years of clinically proven worldwide research – also could be used *(43).* Some of the programmes are partly funded by the state or municipalities, and some are self-financed by parents. Stakeholders identify sustainability of the programmes as the main challenge: they are developed on a project-by-project basis and implementation depends on municipal resources and priorities.

3.2 Early risk-detection and support system

Different parenting training programmes are funded by municipalities. The state and several municipalities fund a safety training programme for children created by the "Centre Dardedze". SOS Children's Villages Latvia and "Centre Dardedze" introduced the first comprehensive early warning system in kindergartens, including training of teachers, support-team building and a digital risk-evaluation tool, in 2016 *(44)*. The early warning system is aimed at using preschool resources to establish child-friendly kindergartens, with a team focusing on early risks by educating and supervising parents (as well as children) on personal safety, including sexual integrity. The project also extends to early risk-detection in Riga Maternity Hospital, providing support consultations for mothers at risk; this has created interest from other hospitals.

Though several Latvian municipalities have expressed interest in these programmes, implementation depends greatly on municipal priorities and readiness to invest in early prevention. Paediatric and maternity hospitals lack resources to support families in crisis who experience severe health problems, face a child's disability or suffer the loss of a child. Chaplains, psychologists and social workers are unable to offer systematic support. Municipal support fails to address the needs of families in short-term crisis, as specialist hospitals are concentrated in regional centres or in the capital, Riga, so are often sited outside the municipality of family residence.

3.3 Education programmes

Most policy documents and legal initiatives identify "lack of understanding" of violence, detection and reporting mechanisms as areas in need of further attention. Although identified less often, the lack of easy-to-use risk assessment instruments allowing for a unified risk identification system and borderlines between risk and crisis detection in cross-sectoral collaboration is also a problem. Guidelines have been developed by the State Inspectorate for Protection of Children's Rights, but they need to be further elaborated and a user-friendly interface to encourage specialists to use them more often is necessary.

3.4 Information campaigns

Campaigns related to child safety are run by almost all sectors. The "Help the child to grow up!" campaign *(45)* is targeted towards reducing trauma and increasing child safety by tackling the high trauma incidence among children. A social campaign on

child safety on water is planned for 2017. “Centre Dardedze” developed a campaign on positive parenting and prevention of corporal punishment *(46)*. State Police run a long-term prevention campaign featuring two characters, Tomcat Rudy and Beaver Bruno, for education institutions with child-specific education activities *(47)*.

3.5 A way forward

One of the main challenges in implementing successful prevention programmes is the current dominance of the punitive approach to child violence over a supportive approach to families at risk. Change in this situation is linked to understanding the importance of early detection and prevention of violence.

Violence prevention is a comparatively new direction in Latvian policy. Social work with families and rehabilitation services have been strengthened, and public awareness-raising campaigns have been implemented over the last decade. It is nevertheless time to move the focus to early intervention, which is the stage of child maltreatment prevention that still poses challenges. Working with high-risk families is a priority, but the scarcity of municipal resources does not allow reallocation of human resources and funding to preventive measures.

The WHO INSPIRE manual *(9)* offers evidence-based programmes that match policy areas. Original and adapted prevention programmes are available in Latvia, but implementation is limited due to lack of resources. Project-based programme development rather than targeted policy strategy makes prevention activities sporadic and selective. Programmes on parenting support are opened to social-risk families in some municipalities, while in others they are available to every parent in need.

With scarce resources available, programme evaluations do not adopt the randomized controlled trial method, but are based mostly on qualitative methods. The evidence base does not play an important role in continuing implementation of programmes, as the link between particular programmes and the wider policy strategy is missing. The state does not plan national funding for prevention programmes outside existing societal integration project grants, where NGOs can apply to implement prevention activities. The funding, however, cannot maintain prevention programmes as effectively as it supports social rehabilitation services.

Greater national government involvement in prevention would compensate for geographical disparities in service availability and allow a more comprehensive,

strategically oriented policy to be built. Tackling behavioural problems and the role of schools and social services in supporting minors at risk and their families is one of the directions of the Antisocial Behaviour Law. A national programme on antisocial behaviour would allow the problem to be addressed comprehensively and enable local differences in availability of support to be smoothed out.

Conclusions and recommendations

1. Latvia has achieved good results in providing support at the social rehabilitation stage, the last stage of child maltreatment prevention. It is time to move further, however, by improving the detection and registration of cases and implementing early prevention to avoid further suffering, health problems and deaths of children. The early prevention system should be strengthened at national level, implementing a strategic vision based on evidence and ensuring accountability of local government and service providers.

2. Lack of access to violence-prevention programmes is an important obstacle that reduces participants' motivation to identify, report, collaborate on and solve cases. Though many programmes have been developed and adapted, this mostly happens on a project-by-project basis, and investments lack sustainability. Annual national and municipal service procurement allows for competition among programme providers and consequent reductions in cost, but does not allow service providers to develop and plan their resources for the long term.

3. A child-centred view, instead of a problem-based approach (antisocial behaviour, trauma, etc.), should be used when designing policies.

4. Parenting programmes and preschool education to train children and parents in social skills need to be developed in a more systematic way at municipal level, involving health-care, welfare and education specialists.

5. Strengthening the information exchange system between institutions would facilitate not only follow-up for individual cases, but also evaluation of support measures and the work of institutions and specialists. Current legal provisions requiring institutions to use the NPAIS information exchange system are not being implemented, and the system needs improvement to make it more user-friendly. Medical specialists are cited among potential users in the law and a user-friendly information system would allow for easier reporting and following-up of cases of maltreatment of children.[3] The quality and coverage of data should be improved. Better data recording for hospital admissions and emergency room attendances is needed to ensure that cases of violent assault and neglect in children are properly recorded and followed up.

[3] It should be acknowledged that the e-health data exchange system *(48)* has created much controversy and dissatisfaction. According to a 2015 State Audit Office report *(49)*, €14.5 million had been invested in the system over nine years towards the end of 2015, and it was still not functioning. This recommendation should therefore be well timed to avoid associating it with general e-health problems.

Administrative data should be supplemented by community surveys. The inclusion of questions such as the Short Child Maltreatment Questionnaire in the Health Behaviour in School-aged Children surveys would be a cost-effective way of obtaining comparable information on the prevalence of child maltreatment.

6. The health sector should be involved in early risk detection using a simple warning system and methodological toolkit for child maltreatment. Health-sector involvement depends to a large degree on the current crisis in health care – it would not be realistic to place more obligations on the sector while the crisis is ongoing. Health systems' and professionals' capacity for detection and support nevertheless needs to be strengthened considerably.

   The health sector should also play an important role in early prevention, working with families that show potential risks, educating on child maltreatment risks and encouraging parenting skills.

7. Discussions should be started with the health and social sectors on therapeutic and supportive approaches to children with behavioural problems that otherwise result in mental health, social and criminal problems, with guidelines provided. Better collaboration between the health and social sectors should be established. The current approach of using mental health care as a punitive tool has stigmatized mental health issues, preventing children and parents from seeking help when necessary.

8. Tackling the needs of the most vulnerable groups of children – those in institutions (including mental health institutions) and children with disabilities – is necessary. The deinstitutionalization project has exposed the problems in social care institutions and offers a potential solution: children need systematic and long-term support from, and safe attachment with, guardians and foster parents, not just a change in placement.

   Children who are both former victims and also current perpetrators of violence compose a special group who are currently excluded from support systems. Such children may have behavioural problems: supportive and therapeutic approaches, including parenting programmes, may prevent them from entering the criminal justice system. Investment in social support programmes, supported by a move away from a crime-prevention approach towards one governed by the best interests of the child, is required.

9. More efficient law enforcement in cases of child maltreatment is necessary, alongside regular support for children who are victims and witnesses of violence as a permanent, nationally funded feature of the state programme, not a pilot activity.

10. Health and welfare services should invest in a supportive approach to families at risk (such as households in which a member has an alcohol or drug problem, mental illness, history of parental violence or has experienced incarceration, or households with single, young or isolated parents) as suggested by WHO *(20)*, rather than responding punitively after the event.

11. Greater investment is needed for concerted social marketing and enforcement campaigns aimed at changing social norms towards violence.

References[4]

1. Report of the consultation on child abuse prevention. Geneva: World Health Organization; 1999 (WHO/HSC/PVI/99.1; http://apps.who.int/iris/handle/10665/65900).

2. World report on violence and health. Geneva: World Health Organization; 2002 (http://www.who.int/ violence_injury_prevention/violence/world_report/en/).

3. Preventing child maltreatment: a guide for taking action and generating evidence. Geneva: World Health Organization; 2006 (http://apps.who.int/iris/bitstream/10665/43499/1/9241594365_eng.pdf).

4. Investing in children: the European child and adolescent health strategy 2015–2020. Copenhagen: WHO Regional Office for Europe; 2014 (EURRC64/12 + EUR/RC64/Conf.Doc.5; http://www.euro.who.int/en/health-topics/Life-stages/child-and-adolescent-health/policy/investing-in-children-the-european-child-and-adolescent-health-strategy-20152020).

5. Investing in children: the European child maltreatment prevention action plan 2015–2020. Copenhagen: WHO Regional Office for Europe; 2014 (EURRC64/13 + EUR/RC64/Conf.Doc.5; http://www.euro.who.int/__data/assets/pdf_file/0009/253728/64wd13e_InvestChildMaltreat_140439.pdf).

6. Health 2020: a European policy framework supporting action across government and society for health and well-being. Copenhagen: WHO Regional Office for

[4] All weblinks accessed 30 November 2017.

Europe; 2014 (http://www.euro.who.int/en/publications/abstracts/health-2020-a-european-policy-framework-supporting-action-across-government-and-society-for-health-and-well-being).

7. Handbook on developing national action plans to prevent child maltreatment. Copenhagen: WHO Regional Office for Europe; 2016 (http://www.euro.who.int/__data/assets/pdf_file/0019/329500/Child-maltreatment-PAP-handbook.pdf).

8. Measuring and monitoring national prevalence of child maltreatment: a practical handbook. Copenhagen: WHO Regional Office for Europe; 2016 (http://www.euro.who.int/__data/assets/pdf_file/0003/317505/Measuring-monitoring-national-prevalence-child-maltreatment-practical-handbook.pdf).

9. INSPIRE: seven strategies for ending violence against children. Geneva: World Health Organization; 2016 (http://apps.who.int/iris/bitstream/10665/207717/1/9789241565356-eng.pdf).

10. Velika B, Pudule I, Grīnberga D, Spriņģe L, Gobina I. Adverse childhood experiences of young adults in Latvia. Study report from the 2011 survey. Riga: Centre for Disease Prevention and Control; 2012 (https://www.spkc.gov.lv/upload/Petijumi%20un%20zinojumi/Jauniesu%20vardarbibas%20pieredze/jauniesu_berniba_guta_vardarbibas_pieredze_pilns_teksts_eng_2012.pdf).

11. Tiesībsarga pētījums par vardarbības izplatību pret bērniem Latvijā [Ombudsman's study on the prevalence of violence against children in Latvia]. Riga: Ombudsman's Office; 2015 (http://www.tiesibsargs.lv/uploads/content/legacy/4239_TNS_Vardarbibas_pret_berniem_izplatiba_Latvija_2015.pdf) (in Latvian).

12. Concluding observations on the third to fifth periodic reports of Latvia. Geneva: United Nations Committee on the Rights of the Child; 2016 (http://www.cilvektirdznieciba.lv/uploads/files/g1604925_crc.pdf).

13. Sociālās rehabilitācijas pakalpojumi no vardarbības cietušiem bērniem [Social rehabilitation services for children affected by violence]. In: Ministry of Health [website]. Riga: Ministry of Health; 2008–2012 (http://www.lm.gov.lv/text/1972) (in Latvian).

14. Novārtā pamešana [Child neglect]. In: "Centre Dardedze" [website]. Riga: "Centre Dardedze"; 2017 (http://www.bernskacietusais.lv/lv/vardarbiba_pret_bernu_teorija/definesana/novarta-pamesana-85/) (in Latvian).

15. Turpinās informatīvā akcija par seksuālo vardarbību [Information campaign on sexual violence continues]. In: Inspectorate of Children's Rights [website]. Riga: Inspectorate of Children's Rights; 2017 (http://www.bti.gov.lv/lat/uzticibas_talrunis/pretvardarbibas_kampana/?doc=3775&page=) (in Latvian).

16. Traumas, ievainojumi un saindēšanās [Trauma, injuries and poisoning]. In: Statistikas dati par 2016. gadu [Statistical data for 2016] [website]. Riga: Centre for Disease Prevention and Control; 2016 (https://www.spkc.gov.lv/lv/statistika-un-petijumi/statistika/veselibas-aprupes-statistika1/get/nid/14) (in Latvian).

17. Bērnu traumatisms [Children's trauma]. Riga: Centre for Disease Prevention and Control; undated (https://spkc.gov.lv/upload/Traumatisms/Bernu%20drosiba/egramata_traumatisms.pdf) (in Latvian).

18. Latvijas veselības aprūpes statistikas gadagrāmata 2010.–2015. gadam [Latvian health statistics yearbook 2010–2015]. Riga: Central Statistical Bureau; 2016 (in Latvian).

19. European report on preventing child maltreatment. Copenhagen: WHO Regional Office for Europe; 2013 (http://www.euro.who.int/__data/assets/pdf_file/0019/217018/European-Report-on-Preventing-Child-Maltreatment.pdf).

20. Global status report on violence prevention 2014. Geneva: World Health Organization; 2014 (http://www.who.int/violence_injury_prevention/violence/status_report/2014/en/).

21. Bērnu noziedzības novēršanas un bērnu aizsardzības pret noziedzīgu nodarījumu pamatnostādnes 2013.–2019. gadam [Guidelines for preventing child crime and protecting children from criminal offences 2013–2019]. Riga: Ministry of the Interior; 2013 (www.iem.gov.lv/files/text/IeMPamn_100113_berni.doc) (in Latvian).

22. Valsts ģimenes politikas pamatnostādnes 2011–2017 [State family policy guidelines 2011–2017]. Riga: Ministry of Welfare; 2010 (http://www.lm.gov.lv/upload/berns_gimene/lmpamn_200111_gvp.pdf) (in Latvian).

23. Pamatnostādnes: "Bērniem piemērota Latvija". [Guidelines on making Latvia suitable for children]. Riga: Ministry of Children and Family Affairs; 2003 (http://polsis.mk.gov.lv/documents/1232) (in Latvian).

24. Valsts ģimenes politika, koncepcija [State family policy, concept paper]. Riga: Ministry of Welfare; 2002 (http://polsis.mk.gov.lv/documents/372) (in Latvian).

25. Programma vardarbības ģimenē mazināšanai 2008.–2011. gadam [Programme for preventing domestic violence 2008–2011]. Riga: Ministry of Welfare; 2008 (http://polsis.mk.gov.lv/documents/2754) (in Latvian).

26. Putniņa A, Zīverte L, Rimļina N, Dupate K, Terehova O, Brants M et al. Vardarbība un veselība. Ziņojums par situāciju Latvijā 2007 [Violence and health. Report of the situation in Latvia in 2007]. Riga: Ministry of Health; 2007 (http://www.lm.gov.lv/upload/berns_gimene/bernu_tiesibas/vardarbiba_veseliba.pdf) (in Latvian).

27. Latvijas Republikas tiesībsarga 2016.gada ziņojums [Ombudsman of Latvia report 2016]. Riga: Ombudsman's Office; 2017 (http://www.tiesibsargs.lv/uploads/content/lapas/tiesibsarga_2016_gada_zinojums_1489647331.pdf) (in Latvian).

28. Broka A, Kūle L, Kūla E. Sociālā cilvēkdrošība: bērni un ģimenes ar bērniem Latvijā. Rokasgrāmata sociālajā jomā strādājošiem [Social human security: children and families with children in Latvia. A handbook for social workers]. Riga: LU Akadēmiskā apgāds; 2014 (http://www.lm.gov.lv/upload/berns_gimene/sociala-drosiba_gimene.pdf) (in Latvian).

29. Putniņa A, Linde Z. Mazu bērnu tiesību aizsardzības situācijas izvērtējums [Evaluation of the protection of rights of young children]. Riga: "Centre Dardedze"; 2011 (http://www.centrsdardedze.lv/data/kampanas/Zinojums_NodibDardedze_Apr2012.pdf) (in Latvian).

30. Mātes un bērna veselības uzlabošanas plāns 2012.–2014.gadam [Maternal and child health action plan 2012–2014]. Riga: Ministry of Health; 2012 (http://polsis.mk.gov.lv/documents/4010) (in Latvian).

31. Grope I. Diskusija par jaundzimušo patronāžām [Discussion about newborn patronage]. Riga: Ministry of Health; 2013 (http://www.vm.gov.lv/images/userfiles/Sabiedribas%20lidzdaliba/diskusijai_par_jaundzimuo_patronm.pdf) (in Latvian).

32. Nepaklausīgos bērnu namu bērnus nosūta uz psihiatrisko slimnīcu, saka Tiesībsargs [Resistant children are sent to psychiatric hospital, says the Ombudsman] [online news report]. All Media Latvia. 26 February 2015 (https://skaties.lv/zinas/latvija/sabiedriba/nepaklausigos-bernu-namu-bernus-nosuta-uz-psihiatrisko-slimnicu-saka-tiesibsargs/) (in Latvian).

33. Rīcības plāns nepilngadīgo aizsardzībai no noziedzīgiem nodarījumiem pret tikumību un dzimumneaizskaramību 2010.–2013.gadam [Action plan for the protection of minors from criminal offences against morality and sexual inviolability 2010–2013]. Riga: Ministry of the Interior; 2009 (http://polsis.mk.gov.lv/documents/3126) (in Latvian).

34. Džimba [website]. Riga: "Centre Dardedze"; 2017 (http://www.dzimba.lv/lv/) (in Latvian).

35. Putniņa A, Dupate K, Mileiko I, Brants M. Pētījums par laulību nereģistrēšanas problemātiku [Research on problems in unregistered partnerships]. Riga: Pārresoru koordinācijas centrs; 2015 (http://www.pkc.gov.lv/images/Gala_zi%C5%86ojums_19012016.pdf) (in Latvian with English summary).

36. Rīcības plāns deinstitucionalizācijas īstenošanai 2015.–2020.gadam [Action plan for implementing deinstitutionalization 2015–2020]. Riga: Ministry of Welfare;

2015 (www.lm.gov.lv/upload/aktualitates/null/2015_15_07_ricplans_final.pdf) (in Latvian).

37. Darbības programma "Izaugsme un nodarbinātība" [Operational programme "Growth and jobs"]. Riga: Ministry of Finance; 2014 (http://www.esfondi.lv/upload/Planosana/FMProg_270115_DP_2.pdf) (in Latvian).

38. Paziņojums par līdzdalības iespējām likumprojekta "Bērnu antisociālas uzvedības prevencijas likums" [Statement on the possibilities for participation in the draft law "The Antisocial Behaviour Children's Law"]. In: Ministry of Justice [website]. Riga: Ministry of Justice; 2017 (https://www.tm.gov.lv/lv/cits/pazinojums-par-lidzdalibas-iespejam-likumprojekta-bernu-antisocialas-uzvedibas-prevencijas-likums-i) (in Latvian).

39. Tēvu grupas [Fathers' groups]. In: "Centre Dardedze" [website]. Riga: "Centre Dardedze"; 2012–2017 (http://www.centrsdardedze.lv/lv/pakalpojumi/vecakiem/tevu-grupas) (in Latvian).

40. Sargeņģelis – atbalsts vecākiem [Guardian angel – support for parents]. In: "Centre Dardeze" [website]. Riga: "Centre Dardedze"; 2012–2017 (http://www.centrsdardedze.lv/lv/pakalpojumi/vecakiem/drosais-pamats---vecakiem-krizes-situacijas) (in Latvian).

41. AIRI vecākiem apmācība [AIRI's early training] [website]. Riga: SOS Children's Villages Latvia; 2017 (https://www.sosbernuciemati.lv/lv/mes-palidzam/airi-apmaciba/airi-vecakiem-apmaciba/) (in Latvian).

42. Sociālās korekcijas un sociālās palīdzības programmas vadlīnijas un metodika [Social correction and social assistance programme guidelines and methodology]. Riga: Swiss Confederation, Sabiedribas Integracijas Fonds; 2011 (http://www.bti.gov.lv/in_site/tools/download.php?file=files/text/Soc_korekcija_soc_palidz_programma.pdf) (in Latvian).

43. The Incredible Years [website]. Seattle (WA): The Incredible Years; 2017 (http://www.incredibleyears.com/).

44. "Bērnam drošs un draudzīgs bērnudārzs" – kompleksa preventīvā programma pirmskolām ["Child-safe and -friendly kindergarten" – a complex preventive programme for preschools] [website]. Riga: E-Skola; 2017 (http://www.e-skola.lv/public/84064.html) (in Latvian).

45. Valsts programma bērna un ģimenes stāvokļa uzlabošanai 2017.gadam [State programme for improvement of the situation of children and families 2017]. Riga: Ministry of Welfare; 2017 (http://www.lm.gov.lv/upload/berni-b/vp_2017.pdf) (in Latvian).

46. Palīgs vecākiem [Support for parents] [website]. Riga: “Centre Dardedze”; 2012 (http://paligsvecakiem.lv/resursi/kampanas/noliec-siksnu/) (in Latvian).

47. Valsts policijas tēli [Images of the State Police] [website]. Riga: Valsts Policija; 2011 (http://www.vp.gov.lv/?id=532) (in Latvian).

48. E-veselība [E-health] [website]. Riga: National Health Service; 2016 (https://eveseliba.gov.lv/) (in Latvian).

49. Vai projekts “E-veselība Latvijā” ir solis pareizajā virzienā? [Is the “E-Health in Latvia” project a step in the right direction?]. Riga: State Audit Office; 2015 (http://www.lrvk.gov.lv/uploads/reviziju-zinojumi/2014/2.4.1-7_2014/e-veseliba_publicesanai1.pdf) (in Latvian).

The WHO Regional Office for Europe

The World Health Organization (WHO) is a specialized agency of the United Nations created in 1948 with the primary responsibility for international health matters and public health. The WHO Regional Office for Europe is one of six regional offices throughout the world, each with its own programme geared to the particular health conditions of the countries it serves.

Member States

Albania
Andorra
Armenia
Austria
Azerbaijan
Belarus
Belgium
Bosnia and Herzegovina
Bulgaria
Croatia
Cyprus
Czechia
Denmark
Estonia
Finland
France
Georgia
Germany
Greece
Hungary
Iceland
Ireland
Israel
Italy
Kazakhstan
Kyrgyzstan
Latvia
Lithuania
Luxembourg
Malta
Monaco
Montenegro
Netherlands
Norway
Poland
Portugal
Republic of Moldova
Romania
Russian Federation
San Marino
Serbia
Slovakia
Slovenia
Spain
Sweden
Switzerland
Tajikistan
The former Yugoslav Republic of Macedonia
Turkey
Turkmenistan
Ukraine
United Kingdom
Uzbekistan

World Health Organization Regional Office for Europe
UN City, Marmorvej 51, DK-2100 Copenhagen Ø, Denmark
Tel.: +45 45 33 70 00 Fax: +45 45 33 70 01
Email: euwhocontact@who.int
Website: www.euro.who.int