Dilemmas for international mobilization around child abuse and neglect

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A B S T R A C T

The goal of this commentary is to articulate some issues and dilemmas raised by various efforts to mobilize international action around child abuse and neglect (CAN). We will start by proposing a typology of international mobilization strategies, noting that initiatives to promote CAN programming in new settings have tended to emphasize one of three vectors: governments, professionals, or international NGOs. There are pros and cons to each emphasis, which we discuss. We also review the debates around some of the following dilemmas: Should low-income countries be a top priority for CAN mobilization? Are there cultural and institutional capacities that need to be present in a country in order for CAN programs to work or be ethical? Are some CAN programs more likely to be internationally transferable than others and why so? Has the field adequately considered whether non-CAN programming (e.g., family planning) might actually be more effective at preventing maltreatment than CAN programming? Does the field give adequate acknowledgment that policies and practices emanating from high-resourced and Western countries may not always be the best to disseminate? Are we relying too much on a model of program transplantation over a model of local cultivation? Should we aim for modest rather than ambitious accomplishments in international mobilization? How much emphasis should be placed on the priority dissemination of evidence-based programming? We conclude with some suggestions in the service of clarifying these dilemmas and making some of these decisions more evidence based.

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Introduction

Increasing numbers of organizations are working at the international level on the topics of child maltreatment and violence against children. The World Health Organization has made child maltreatment an important component of its global violence prevention initiative (Butchart, Harvey, Mian, & Firdniss, 2006). UNICEF has launched an End Violence against Children campaign that includes a "kNow Violence Global Learning Initiative" (UN News Centre, 2013). The U.N. General Secretary has a Special Representative on Violence Against Children who has been promoting worldwide action on this topic (SRSG On Violence Against Children, 2013). Large international foundations such as the Oak Foundation, UBS Optimus Foundation, and the Bernard Van Leer Foundation have programs targeted at child maltreatment. International non-governmental organizations (NGOs) such as Save the Children, Terre Des Hommes, International Rescue Committee and World Vision have

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become active on this issue (IRC Children and Youth Protection and Development Unit, 2012; Save the Children, 2013; Terre des hommes – Children’s Rights, 2010; World Vision International, 2014). The International Society for the Prevention of Child Abuse and Neglect (ISPCAN), the publisher of this journal, has a long history of trying to disseminate knowledge and practice internationally. All these mobilizations appear intended to prevent child maltreatment by providing expert knowledge, changing attitudes and practices, and addressing its causes.

The goal of this commentary is to articulate some issues and dilemmas raised by these various international mobilization efforts. We will pose some critical questions about assumptions sometimes made, try to delineate the logic model behind initiatives, and urge everyone look for evidence that tests the approaches being tried.

In this commentary we will be using the term child abuse and neglect (CAN) programming. This term is used to refer to practices, policies, and even cultural attitudes that have been embraced by advocates in the field of CAN and also violence against children (VAC), mostly in countries with longer histories on this issue but also increasingly elsewhere. This programming includes things as diverse as trained child protection workers who investigate maltreated children, mandatory reporting laws, parent education around non-violent discipline, trauma focused cognitive behavioral therapy for victims of abuse, sexual abuse prevention education, children’s advocacy centers, school programs for preventing bullying or dating violence, and legal systems that allow the placement of abused children in foster care. Programming in this sense is broader than specific organized and named programs and also includes, for example, the dissemination of non-violent parenting styles. All of these are practices that are increasingly widespread in high-resourced countries in North America, Europe, Australia, and New Zealand, but some have been grown or transferred to other places around the globe.

We will start by proposing a typology of international mobilization strategies and then raise some additional questions that some of these strategies face.

Dilemma 1: What is the Best Strategy for Mobilization?

Initiatives to promote CAN programming in new settings have tended to emphasize one of three vectors: governments, professionals, or international NGOs. There are pros and cons to each emphasis.

The Government Vector

The targeting of governments is an obvious policy strategy and reflects particularly the strategies of UNICEF and the Together for Girls initiative and the work of the U.N. Committee on the Rights of the Child (Pinheiro, 2006) and the World Health Organization. The logic to such efforts is that if a government makes CAN a policy priority, it will likely commit resources to set up programs, change laws, train professionals, and affect conditions for young people across a wide expanse of the population. Governments in many countries have public health bureaucracies that have broad jurisdictions, are part of international collaborations, and could be potentially mobilized to take on child maltreatment in addition to other health problems. One component in this strategic approach is to make arguments that might be particularly persuasive to governments, such as studies showing high population prevalence, potential cost savings, and broader economic and social benefits. Another component to this strategy is to oblige governments to take action through involvement in international conventions, such as the International Convention on the Rights of the Child. The strategy has great appeal in terms of the scope and magnitude of change that can occur quickly. A good example of the success of such a strategy was when American physician Henry Kempe and his allies were able to persuade U.S. politicians to enact the Child Abuse Protection and Treatment Act (CAPTA) of 1974. This legislation set up many elements of the universal child protection system in the United States and has provided ongoing funding for its activities to this day (Myers, 2006).

Despite such apparent successes, the strategy has pitfalls. Governments can be difficult to influence and slow to move. Some do not want sensitive issues exposed. Their commitments can be fickle, so that support for a policy at one point can disappear quickly. Political regimes may change, and new politicians may resent and suspect the programs of their predecessor. Governmental policies often carry a lot of political baggage, for example, interest groups that need to be placated or bureaucrats who are arbitrarily favored or alienated. When governments mobilize, they often prioritize political considerations over the evidence base.

The Professional Vector

The targeting of professionals as the agents of mobilization has been the long-term strategy of organizations like ISPCAN and other international professional groups such as the International Pediatric Association. Those targets include professionals in fields like pediatrics, social work, psychology, and law enforcement. One goal of this strategy has been to recruit and train professionals who will go back to their countries to disseminate information about CAN, implement programs, and recruit and train more colleagues. There appear to have been some notable successes to this strategy in generating child maltreatment programs in countries such as Malaysia, Estonia, and Saudi Arabia (Ahmed, 2009; Kasim, Shafie Mohd, & Cheah, 1994; Tartu Child Development Center, n.d.). The international network of pediatricians has been particularly influential in this strategy. Law enforcement networks have also been active internationally in disseminating cyber-crime investigation techniques (Interpol, 2014).
A key element in this logic model is to utilize professional ambitions and ideals. Modern professional training puts a premium on adoption of the most modern practice, and promotes staying current as important to professional competence. Professionals are often motivated to be seen as leaders in their profession by bringing home this new knowledge.

The strategy has some obvious strengths. Given a growing pool of professionals in many countries, there is often at least one person who can be interested in this topic. Knowledge transfer is relatively easy because it is done among colleagues who share common values, training, vocabulary and assumptions. The transfers tend to have longevity because the professionals have extended careers in a fixed locale and often rise to positions of prominence over time. This means that much can be done, even in relatively passive political environments. The capacity that is established can last a long time.

There are also problems with this strategy. In working with isolated professionals, change may be very slow and fragmented. Moreover, child protection is not a self-contained discipline like medicine or education; rather, it is an interdisciplinary field. The knowledge transfer can stay confined within one discipline like social work and not percolate into other fields (e.g., pediatrics) where it is also needed. Sometimes the CAN professionals may end up leaving their country of origin and going to other countries where the activities in the CAN area are more fulfilling. Sometimes the CAN issues get complicated in the career issues or personalities of the professionals.

The NGO Vector

The third strategy is organized around the fact that large numbers of NGOs operate worldwide to promote a variety of health, economic, and social programs. These organizations frequently have agendas that meld to some degree with the goals of CAN prevention because they concern related topics such as child health or education, women’s empowerment, or AIDS. For example, a recent initiative seeks to build CAN prevention programming into the world network that works on early childhood health and development (ECD+ Workshop, 2013). Another initiative involves adding child protection into international domestic violence programming (Barker, Ricardo, & Nascimento, 2007; REDMAS, Promundo, & EME, 2013).

There are many virtues to the NGO vector strategy. For one, many NGOs have a great deal of experience in various countries. They often have good reputations, strong networks of in-country collaborators, and time-tested methods and programs. The CAN initiatives can benefit from not having to recreate networks. The collaborations may foster important synergies that CAN work would not have on its own, for example helping to reduce unwanted childbearing at the same time as improving parenting practices. The collaborations also forestall competition and rivalries that can develop when new social programs arrive in communities that already have established activists, and the newcomers compete for attention of local officials.

Nonetheless, there are also downsides to the NGO strategy. One is that in a collaborative effort the CAN programming may not have the same priority or salience. Professionals implementing programs may feel uncomfortable crossing over into fields outside their core expertise. Workers or participants may receive diluted training or may suffer from content overload because too much is being covered. In the end, there may not be enough people in a locality or country with a primary commitment to the CAN goals or practices.

In addition, in the prior history of CAN program development, it is clear that one of the strongest motives for dissemination has been a group with a sense of “ownership” of a program or content area. Programs spearheaded by “program entrepreneurs” and having distinct identities like Nurse Family Partnership or Triple P Parenting have often had the most successful dissemination patterns. These programs are often resistant to amalgamation with other programming because they want to preserve program fidelity. They are often also copyrighted and not affordable for implementers in many parts of the world. This can complicate collaborations. CAN is also a relatively new field with a weaker evidence base than some other fields. In collaborating with other mobilizations, the CAN component may not compete or fare very well.

In summary, although multiple mobilization vectors may be an optimal approach, in the real world, limited resources of time, individuals, and organizations mean that priority must be given to one vector over another, but not necessarily based on their likelihood of success. Frequently the choice is based on the skill sets or levers of influence an organization or an individual happens to possess. But this does not mean that large international strategy planners should not think through these strategic options in a more systematic way.

In thinking about pros and cons of various mobilization strategies, a variety of additional dilemmas also emerge.

Dilemma 2: Should Low-Income Countries (LICs) be a Priority for CAN Mobilization?

Many of the recent international organizations and funders in the CAN field have a priority of supporting LIC countries, and as they have embraced CAN advocacy, they have put increasing emphasis on moving CAN advocacy and programming to LICs. The arguments for this priority are four fold. There is growing evidence that violence and maltreatment are more severe in LIC environments, particularly given findings that maltreatment thrives under conditions of social disorganization and dislocation (Fluke, Casillas, Capa, Chen, & Wulczyn, 2010; Lansford & Deater-Deckard, 2012; Lansford et al., 2010; Runyan, 2008). In addition, many people believe there is an overriding moral obligation to protect children in LICs simply because of the disproportionate disadvantages they face. Donors and policy makers see the inadequate resources in LICs as a justification for their priority. Finally, advocates want to avail themselves of these funding opportunities.

There are, however, many challenges to mobilizing CAN activity in LIC environments (Wessells, Lamin, King, Kostelny, Stark, & Lilley, 2012), and some of these may necessitate deeper consideration before launching initiatives in these settings.
One challenge is that so much of the visible CAN programming and accumulated experience has been developed in high resource environments, which raises questions about whether such programs are appropriate for LICs and will work there. Many LICs lack fundamental capacities for doing CAN work (see Dilemma 3). In LICs, other kinds of programming (e.g., improving education) may be preferable given limited resources. LICs may be environments with high social change pay-offs, but may also entail much higher costs and likelihood of failure.

One possibility is to focus on gathering more experience on mobilizing in middle-resourced environments or in the low-income and disorganized portions of high-resourced countries. Places like Turkey, Venezuela, South Africa, or even the indigenous communities in the United States or Australia may be good proving grounds (Bekman, 1998; Jewkes et al., 2008). Another possibility is to emphasize the creation of enabling environments for CAN programming by first focusing on capacity building.

**Dilemma 3: Are there Capacities that Need to be Present for CAN Programs to Work or be Ethical?**

Consider the challenges of taking a sexual abuse prevention education program to a country where there is no child protection system, where law enforcement has no interest or ability to investigate or prosecute such crimes, where people see sexual abuse as the fault of the child or the family, and where there are no medical or mental health facilities capable of treating a victim. It is not clear that such a transfer is ethical, let alone capable of working.

The operation of many CAN programs from high-resourced environments appears to presuppose institutional capacities and cultural orientations that do not necessarily exist in many places. The CAN field is just beginning to develop a very specific inventory of capacities that may be necessary for CAN programs to operate. Mikton et al. (2013) identified 10 generic capacities related to the ability to adopt CAN programming. But specific program components may need specific preconditions. For any program that promotes a disclosure of maltreatment, do there need to be people who can protect children and their advocates from retaliation? Do there need to be a system for impartially investigating maltreatment and acting to remove or protect a child who is being maltreated? Does there need to be a cultural presumption among some fraction of the population that parents do not have unlimited authority over their children? Do there need to be medical personnel who can evaluate abuse?

There are several dimensions along which pre-requisites to CAN programming might be conceptualized. One dimension may be resources for human survival: a minimum level of public safety, shelter, and food availability. Another dimension may be the cultural recognition of children’s rights: CAN advocacy did not emerge in places until children’s rights as distinct from parental and family prerogatives had developed in a culture. Another dimension may be in terms of institutional infrastructure in law enforcement, health, and education. There may also be other sets of conditions that are required to sustain such programming. The importance of these capacities may be evaluable with empirical data.

An argument could be made that before working in LICs, the CAN field should acquire more experience at disseminating CAN programming to high- and middle-income countries that are missing some conventional elements of the child welfare capacity. This could include countries lacking conventional child welfare investigation systems or countries with few concepts about children’s rights. Mikton et al. (2013), in exploratory work, have found that in five middle-income countries readiness for the implementation of CAN programming was only low-to-moderate. CAN advocates may want to be cautious about taking on the challenge of countries with even fewer resources and instead focus there on capacity building in areas like legal frameworks, generic scientific and research skills, and creating professional workforces in law enforcement, social work, mental health, and education.

The argument has also been made that programs need to be culturally adapted before being applied in other contexts. Interestingly, however, some meta-analyses of the effectiveness of evidence-based interventions in new settings suggest that un-adapted interventions were not necessarily less effective when implemented in new settings (Benish, Quintana, & Wampold, 2011; Quintana, & Wampold, 2011; Gardner, F., Knerr, Montgomery, P., in press; Griner & Smith, 2006; Huey & Polo, 2008; Panagiotou, Contopoulos-Ioannidis, & Ioannidis, 2013). This should not be assumed as an article of faith but tested on a case-by-case basis.

**Dilemma 4: Which CAN Programs are Likely to be the Most Internationally Transferable?**

What tends to make some programs more readily portable? The most portable programs are those that entail the practices of individual professionals within rather circumscribed organizational settings. Thus, a social worker or psychologist might readily adopt the use of TF-CBT with clients who have been identified as having suffered from abuse or violent trauma. A pediatrician might adopt the use of a shaken baby prevention education module. By contrast, programs that involve whole institutions or cross-disciplinary collaborations might be considerably more difficult to transfer, because institutional and professional arrangements and responsibilities may be so different. These might make it harder to disseminate programs such as children’s advocacy centers or mandatory reporting systems.

Some programs may be more transferable if they have actually thrived and been successful in multiple cultural contexts. One example that comes to mind is bullying prevention. These school-based programs have been tried in the most diverse of international environments, and have had considerable cross-cultural evaluation (Ttofi & Farrington, 2011). But the evaluation has almost all been in high resource environments with relatively good schools. Will bullying prevention work in environments with schools burdened by other problems?
There is also the issue of the adoption of values and attitudes. Attitudes about the role of children, their discipline, the authority of parents, and the utility of violence – these may be among the most important elements of creating safe environments for children. But the methods for promoting nurturing values – and promoting them in different cultural environments – have not been formally conceptualized.

In the current climate, a strong emphasis is being put on giving dissemination priority to evidence-based practice. It should be remembered, however, that much of the evidence base is confined to the smaller scale programs and not the policies and systems that make up a great deal of the CAN practice. The policies and systems that have not been systematically evaluated include mandatory reporting, the decision criteria for removing children from families, policies of arrest and prosecution of offenders against children, or media publicity about sexual abuse or child maltreatment. These practices are likely to be copied, but because they have been embraced elsewhere, does not necessarily mean that they are optimal or without serious side effects.

One might assume that professionals located within various countries are in the best position to judge the kinds of programs that are more likely to be successfully transferred there. Their adoption decisions, however, may be made primarily as a result of programs that interest them or things that they can personally adopt rather than an assessment of local needs or readiness.

It might be useful to conduct an international inventory of CAN program adoption (Weinert, 2002) to get a sense of what is being most frequently adopted and what is not, along with whatever is known about how well it is working. There are many barriers to such inventories, including how to define various practices and how to decide whether such a practice has in fact been adopted. The World Health Organization and United Nations appear to be attempting such efforts (SRSG On Violence Against Children, 2013), and this development is a positive one.

Dilemma 5: Could Non-CAN Programming Actually be More Effective than CAN Programming?

It is possible that to reduce CAN, programs that are not specifically about CAN (e.g., family planning) could actually be more effective than specific CAN programs (e.g., parent education, anti-spanking campaigns). We know very little about the CAN impacts of most population level social policies. Some of these policies like contraception promotion took effect in high-resourced parts of the world before CAN was being measured or studied, so their effects on CAN are not well understood.

Consider a short list of non-CAN policies and programs that may be highly effective at reducing CAN. Promotion of contraception may reduce family size and allow and motivate parents to treat their children better (Fluke, Casillas, Cappa, Dhen, & Wulczyn, 2010). Universal schooling may reduce child maltreatment in a number of ways: reducing time with parents, increasing children’s authority and value, or reducing the need to control children for their physical labor. Health care may increase child survival and thus promote investment by parents in children. Women’s empowerment may increase the value of girls or the more nurturing parenting culture that empowered women may promote. Alcohol control policies may reduce drunkenness, which is a strong contributor to family violence (World Health Organization, 2005). Economic growth, higher wages, and limits on working hours may reduce parental stress (Sidebotham & Heron, 2006).

In an evidence-based environment, the question needs to be asked: Would the best investment of a rational funder to prevent CAN actually be in one of these other policy areas? This is not a question that CAN advocates have been eager to consider. Someone might argue that it is best to do both, but in a resource limited environment, it could be the case that anything going into CAN programs may be coming at the expense of something else. Should CAN policy strategists be required to demonstrate not just that their programs have effects, but that they are superior to other social investments for the overall welfare of children? This issue is particularly important when CAN advocates collaborate with multi-program NGOs. Many of these collaborators may honestly believe that their non-CAN programming is more effective in all-around child welfare promotion than CAN programming, and may even be better at reducing CAN. CAN advocates should not ignore this issue, and should collaborate to try to understand more about the impacts of a broad range of social and economic policies on CAN.

Dilemma 6: Is the West Always the Best?

Those advocating for CAN programming must be careful not to overlook protective institutions that already exist in other countries. Preservation of these institutions may represent a better approach than the adoption of new ones. The importation of Western style child welfare institutions should not be done uncritically. For example, in some countries orphanages may be a hub around which to construct new initiatives in child protection awareness and practice (Shang & Fisher, 2013). Orphanages have a poor reputation in western child welfare thinking, but their strengths as seeds for new practice should not be dismissed. Other preservation issues come to mind. Westerners have come to accept a parenting environment that tolerates high rates of divorce and marital dissolution. While some have argued that liberalized divorce helps children escape from abusive parents, some aspects of the divorce culture may increase the risk for maltreatment. In countries with low rates of divorce, CAN advocates may want to develop programs to protect the positive aspects of this divorce-resistant culture. Similar efforts might be made in regard to the kinds of social supports that families receive from kin and neighbors, which may have maltreatment protective effects. In another example, studies have suggested that Chinese societies have low rates of sexual abuse (e.g., Ji, Finkelhor, & Dunne, 2013) perhaps because of some cultural practices. Understanding and insuring
the preservation of such cultural features may be a more important priority than introducing Western style prevention programs.

**Dilemma 7: Transplantation Versus Local Cultivation?**

Many mobilization strategies may start with the assumption that the goal is to find successful practices that can be transplanted, perhaps with modification, to other locales. This is an attractive model because experience with a program or policy suggests that it can be effective and has had a chance to work out the implementation challenges. However, there is also an argument, in principle, for trying to find or develop new models in new environments that might offer some new dimension to child protection practice.

Several examples come to mind. The concept of the confidential doctor is a model of child welfare practice that grew up in the Netherlands based on very different values and assumptions than what was being practiced in the more investigation-focused English speaking world (Christopherson, 1981). In New Zealand, the concept of family group conferencing emerged from the indigenous Maori culture that took a very different approach to the resolution and management of parental offending and youth delinquency (Hudson, Morris, Maxwell, & Galaway, 1996) and proved to be beneficial outside of that culture. It is crucially important to recognize that other cultures may have useful innovations to offer to CAN practice, and resources should be provided to both search for such models and help foster their growth to the point that they can be evaluated. Examples of indigenous cultivation are available in other fields (Prost et al., 2013). Large numbers of often poorly presented but possibly feasible and interesting proposals from countries around the world get submitted to agencies when international solicitations are made. Should more of these be supported even if they have little precedent?

**Dilemma 8: Ambitious Versus Modest Objectives?**

A dramatic reduction in violence and maltreatment is an appealing and perhaps attainable goal in many places, given the great leaps in child welfare that have occurred historically. But CAN advocates also need to keep in mind the relative inexperience of the field in mobilizing internationally, and the lack of a strong evidence base for much of its programming. There may be pitfalls to promoting an urgent mobilization that leaves policy makers frustrated by the lack of proven programs or the failure of ambitious efforts. Advocates need to be careful not to oversell what the field has to offer currently.

An argument can be made for some initially modest objectives in international mobilization. For example, priority might be given to pilot projects. A modest goal could be a self-sustaining child maltreatment prevention, assessment or treatment program with a staff of 3+ professionals in a country or region that lacks such to find out what problems are encountered and whether a larger program could be sustained. Alternatively, in a country with little CAN policy history, a modest objective might be one governmental authority at least part of whose mandate is to plan for, respond to child maltreatment, and for whom there is a commitment of 50% of the time of at least one staff person within that structure. Such small scale efforts did play a part in the history of CAN mobilization in high resource countries, and they might do the same elsewhere.

**Dilemma 9: How Much Emphasis Should Be Put on the Priority Dissemination of Evidence-based Programming?**

The current mobilization has a strong focus on evidence-based programs. These programs are typically well conceptualized, have substantial experience, have materials that facilitate their transfer, and have been shown to work in at least some contexts. They seem preferable investments over programs that have not been shown to work, even in their original setting, let alone when moving to a different cultural and institutional context.

There are also good arguments against a slavish pre-occupation with evidence-based programs. First, some kinds of programs are easier to evaluate than others. In particular, as mentioned, policies (e.g., mandatory reporting) or systems (e.g., a confidential doctor agency) are harder to evaluate than educational programs and mental health treatment and so have less of a track record. But they may be very effective. Strict adherence to adopting only evidence-based programs may create a bias in what is adopted. Second, all new approaches have to start as unevaled experiments somewhere. In the same way that folk practices sometimes highlighted the merits of herbal medicines that turned into effective evidence based remedies, there may be new ideas in practices from less resourced regions that merit consideration by the rest of the world. Advocates must be open to local ideas and ideally even actively look for homegrown solutions first. Third, the pre-occupation with adopting evidence-based strategies may put a priority on strict fidelity of implementation, rather than a sensitive assessment of what might work and what is needed in a specific cultural context.

There are some challenging calibrations and trade-offs in the debate over evidence-based programs. This debate might be well informed by the study of other fields of practice and learning how transferable other Western family, child and mental health interventions have been across cultures in the past. Other efforts should probably be directed at the study of the effective “components” of programs rather than whole programs, since it might be easier to adopt or adapt such components (Gardner, F., Knerr, Montgomery, P., in press; Wilson & Lipsy, 2007). Moreover, few can dispute the need for using systematic logic models, assessment and evaluation in new programs that are developed around the world, even if they are not based directly on successful programs from other environments.
Conclusion

Based on the foregoing discussion, we would make a few suggestions in the service of clarifying these dilemmas and making some of these decisions more evidence based. First, it may be useful to convene some forums, through meetings and journals, where some of these issues can be more specifically discussed and the issues more carefully conceptualized. Second, more case studies are needed about the process of mobilization and adoption of CAN practices in various countries. Also, more studies are needed of the cultivation of homegrown programs in unexpected places. Moreover, it is important to have examples of failures as well as successes. Third, it would be useful to have studies of the dissemination and prevalence of various CAN policies and practices in countries around the world. Fourth, efforts need to be made to draw on the experience of other health and social problem mobilizations with longer histories (Wejnert, 2002). Fifth, more evaluations are needed of CAN practice in different cultural environments, and especially evaluations of policies not just and programs.

Sixth, attention might be paid to looking at how countries cluster in terms of cultural and institutional patterns relevant to CAN practice. The distinction between low-income and high-income may not be the most relevant dimension. For example, Gardner et al. (in press) found that dimensions related to traditional values about child rearing were more relevant to the success of parenting programs (positively) than economic variables. There may be clusters of countries with particular risk factors or particular commonalities that would suggest particular programming or particular transfer affinities. Seventh, more attention may need to be placed on the conceptualization, evaluation and development of capacities, including research capacities, that may be required for effective CAN mobilization.

This is a time of growing international enthusiasm about the potential to help the world’s children through a mobilization against violence and abuse. Hopefully that mobilization will occur in well-informed and organized way that allows us to accumulate the wisdom we need.

References


