Exploration of Perceived Barriers of Implementing Child Protection Training in Saudi Arabia

Ejalal Jalal, Senior Psychologist, 7783 Ali Al Fabati, As Salamah District, Jeddah 23525 3015, Saudi Arabia; email: ejalal.jalal@hotmail.co.uk

Michelle O'Reilly, Associate Professor, Department of Sociology, University of Leicester, UK; mjo14@le.ac.uk

Treena Bhakta, Research Student, Department of Neurosciences, Psychology and Behaviour, University of Leicester, UK; email: treena14@gmail.com

***Panos Vostanis**, Professor of Child Mental Health, Department of Neurosciences, Psychology and Behaviour, University of Leicester, George Davies Centre, University Road, Leicester LE1 7RH; tel: 0044 116 2297174; email: pv11@le.ac.uk

*Corresponding author

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Barriers to Implementing Learning from Child Protection Training in Saudi Arabia

Abstract

The implementation of child protection training programmes can be influenced by a range of societal, policy, service and practice-related factors. The aim of this study was to establish the experiences of implementation barriers from 26 professionals from different disciplines in Saudi Arabia, 18 months after they had completed such training. The three identified themes related to customs and traditions; organizational, administrative and staff-related barriers; and challenges in contact with families. It is important that these inter-linked levels of barriers are tackled in co-ordination with policy, legislation, awareness campaigns and service development; and that they are anticipated holistically by educational programmes.

Key words: child protection; training; implementation; barriers; Saudi Arabia

Introduction

Uptake and full implementation of child protection training vary considerably across the world, and our understanding regarding the impact of child protection training and mitigating barriers to successful implementation has emerged predominantly from western countries. The evaluation of training packages related to child protection has often established improvement in awareness, knowledge, confidence and satisfaction (Munro, 2011). The translation of training into impact on practice, however, has tended to be less conclusive (Carter et al., 2006). Nonetheless, there is evidence that training can result in changes in attitudes (Al Dabaan et al., 2016), and increase in the reporting of incidents (Mathews et al., 2017). Although there has been some positive impact of these training programmes, there remain several barriers to successful implementation at individual, organizational and external level (Brattabo et al., 2016). These barriers are influenced by a range of factors such as policies, staff knowledge and competencies, carrying large caseloads, fear of blame, and resource constraints (Nen and Astbury, 2011; Louwers et al., 2012).

In recent years, evidence has also been emerging from non-western countries, including from the Middle East. These indicate that perspectives on children's rights are mediated by local, cultural and socio-political contexts; and that these contexts are in constant inter-play with legislative changes (Hutchinson et al., 2015). In Saudi Arabia, for example, interdisciplinary child protection teams and associated training are relatively new. In 2004, two years after the World Health Organization recognized child abuse and neglect as a global issue (WHO, 2002), Saudi Arabian media reported several serious or fatal cases occurring within the community. Subsequently, governmental and non-governmental agencies were created to specialize in the prevention of child

abuse. Additionally, policy on how to best respond to child maltreatment was developed, in order to strengthen government infrastructure and institutional resources (Davies and Duckett, 2016).

These changes are, however, often constrained by insufficient knowledge in recognizing and reporting child abuse cases (Alnasser et al., 2017). Al Faryan, Frederico and Young (2017) explored with managers and frontline child protection workers in Saudi Arabia the underlying reasons that hindered the implementation of child protection training. The findings indicated different levels, which included: lack of awareness among agencies such as the police and communities; cultural issues, with female child protection workers being perceived as a threat to traditional gender roles; and lack of resources and organizational capacity. These factors can be inter-linked, for example the police questioning child protection workers' authority to intervene in family matters (Butler, 2015). Consequently, barriers often led to frontline staff feeling powerless and being threatened by families, thus potentially placing vulnerable children at further risk of abuse (Al Faryan et al., 2017).

The understanding of the multiple factors that may hinder the implementation of training is thus particularly important in the early stages of setting up services in countries like Saudi Arabia. Even more so, given the importance of sustainability, it is valuable to establish whether training objectives are being embedded in practice and services over a longer period after staff have undergone training. This was the rationale for this study, the findings of which could be translated to other Middle Eastern welfare systems, as well as have implications for countries with relatively new policies and training programmes.

Methods

This study aimed to establish the perspectives and experiences of practitioners who had attended an inter-agency child protection training programme in Saudi Arabia, regarding its implementation. This training was conducted 18 months prior to the research, which was guided by the question: *‘What are the factors identified by practitioners as hindering the implementation of inter-agency child protection training in Saudi Arabia?’* A qualitative approach was undertaken due to the exploratory aims of the study, as this ensured that the methods could be flexibly applied in accordance with participants’ needs, local context, priorities and perspectives of all those involved in the study. Given the limited empirical evidence base available on child abuse in Saudi Arabia, and more specifically on new training programmes to tackle it, an exploratory design was thus indicated.

Context and setting

Child protection services in Saudi Arabia are overseen by two agencies, the General Administration of Social Protection (GASP) under the Ministry of Social Affairs, which coordinates 17 Social Protection Committees (SPC); and the National Family Safety Programme (NFSP) under the Ministry of Health, which integrates training activities. The NFSP was established in 2005. In 2008, the NFSP set up the first child protection centre at one of the major hospitals. There are currently 41 child protection centres distributed across all regions of the country, all consisting of interdisciplinary teams. These teams include social workers, medics (surgeons, obstetricians, paediatricians and forensic doctors), nurses, psychologist and psychiatrists. Through its department of training and development, the NFSP aims to increase practitioners’ knowledge and skills to identify and manage child abuse and domestic violence. This

training programme was launched in 2007. By 2014, it had co-produced 26 courses with local and international partners. These courses have since involved approximately 2,000 trainees from all disciplines and regions.

The child protection interdisciplinary training, which is the focus of this research, is part of the overall NFSP programme. The original course was developed by the International Society for the Prevention of Child Abuse and Neglect (ISPCAN). The NFSP adapted it according to the culture, religion and systems of Saudi Arabia. For example, this is adapted according to local legislation or procedures; or beginning to address new issues such as teenage pregnancy, which is not widely discussed within society. The NFSP has an ongoing partnership with ISPCAN. There are eight courses per year targeting different groups. The course described in this paper is run annually. Participants vary between 50 and 100 (58 attended the course of focus in this study), who attend for four full days. The course consists of four teaching modules on detection, assessment and intervention, procedures and casework, and prevention strategies.

Sample

The sample consisted of practitioners working in hospitals and other organizations across several regions of Saudi Arabia who had attended the training course in Tabuk city approximately 18 months earlier. This period was considered sufficient to reflect sustained implementation of knowledge and skills. Most participants came from the Tabuk region, but some originated from other regions such as Makkah and Asir. Out of 58 eligible participants, 26 were contactable by phone or e-mail, and agreed to participate. These consisted of 20 males and six females, working across 15 settings (11 hospitals, three shelters and one rehabilitation centre). These professionals

worked in child protection interdisciplinary teams, and consisted of: social worker (4), nurse (3), psychologist (4), psychiatrist (3), surgeon/obstetrician (4), policy maker (3), manager (4), and administrator (1).

For depth of information and a participant-driven approach to data collection, semi-structured interviews were conducted via telephone, to account for the large geographical spread. Telephone interviewing is a resource-effective method of data collection and one which, like face-to-face, provides a mechanism for participants to freely express their perspectives (Sturges and Hanrahan, 2004). The interview guide initially adopted a broad and flexible approach to the training, i.e. based on participants' recollection of important aspects, with gradual focus on the implementation of specific knowledge and skills such as on assessment and identification of child abuse. Participants were thus asked to consider different components of the training, lessons learnt, facilitators and barriers when implementing on the ground, and wider issues which impacted on this implementation. They were encouraged to provide supporting examples where possible. Data were recorded in Arabic, the participants' native language, translated to English, and subjected to a verification process by a second native speaker to check for accuracy of meaning. Ethical approval was obtained from the (anonymized), the King Abdullah International Medical Research Centre (KAIMRC), and the National Guard-Health Affairs (NGHA) research ethics committees.

Data analysis

Thematic analysis was utilized for its meaning-making focus (Braun and Clarke, 2006). Thematic analysis is an epistemologically flexible approach, but its person-centred focus and data-driven strategy to analysis is congruent with the macro-social constructionist approach we adopted. This macro-social constructionist framework ensures an interrogation of language and meaning, while

attending to broader contextual features of the data (Gubrium and Holstein, 2008). A layered approach to coding and analysis was undertaken, consistent with the three levels of categorisation proposed by Boyatzis (1998) of first order (descriptive coding), second order (conceptual categorisation) and third order (thematizing) of data. NVivo facilitated this coding process, with extracts coded inclusively, while contextual meaning was retained by the lead researcher (Bryman, 2008) and was verified through a team-based approach. Throughout the analysis meetings were held to collate coding frameworks, discuss discrepancies and make refinements. To ensure sampling adequacy, the analysis continued to verify data saturation, i.e. when new themes no longer emerged (Fusch and Ness, 2015), thus ensure that no further data were required.

Results

Three themes were identified, which reflected the challenges that practitioners believed they faced in the practical implementation of the lessons learned. This created a tiered framework of three levels. First, barriers were identified at the *societal level* such as embedded *customs and traditions*. These included *policy and legal* issues, which reflected the limited child protection awareness and consideration in organizations across the country. Second, challenges were posed at an *organizational* level, i.e. in relation to service, procedural, administrative, and staff issues. Third, were challenges at an *interpersonal* level between staff and families (Figure 1).

Insert **Figure 1** about here

Theme one: Societal and policy level concerns

The attitudes, beliefs and cultural values of a society inevitably influence the ways in which child protection training programmes are delivered, but also how these are received and subsequently implemented by delegates. Those delivering and receiving the training are part of the broader Saudi culture and society, and in practice must work within those social and cultural practices. An important level of challenges faced by the practitioners, therefore, reflected the customs and traditions embedded in most of Saudi society. At this level, there was perceived lack of readiness from the society to process issues of child protection, in part due to the associated stigma.

“Sometimes other circumstances prevent us from applying what we have learned, because of customs and traditions imposing themselves on us.” Participant (14), Social Worker

“We live in a society that prevents you from entering it, and incursion into or getting deep inside it. Especially from a domestic violence perspective.” Participant (24), Psychiatrist

Because of culture and tradition, participants thus felt pressurized from their society not to report maltreatment. Within the Saudi society there is a tendency for residents to conceal those actions which relate to safeguarding, and there is often resistance to allowing practitioners to penetrate family life. Such social pressures result in people not fully engaging with agencies due to fear and stigma. Consequently, practitioners dealing with child protection and domestic violence face the challenge of concurrently addressing stigma, managing community concerns and raising awareness.

“It has a small community where there is a fear of reporting abuse cases. It is a sensitive subject...everybody knows each other and tries to hide the truth.” Participant (6), Surgeon

Participants cited lack of child protection awareness programmes in the country, limited clarity in guidance for their professional working, and deficits in legal frameworks governing their decisions. At policy level, it was recognized that they were unable to implement knowledge and to instigate child protection without approval from a higher authority. This was complicated further by confusion and misunderstanding regarding the overlap of responsibilities between three Ministries, i.e. Health, Education and Social Affairs (Welfare).

“If we want to present any courses or sessions, we must have consent from the Ministry of Social Affairs.” Participant (2), Social Worker

Interviewees also reported that a key strategic difficulty they faced was related to limited awareness amongst practitioners who worked with children. Several participants highlighted the lack of child protection education programmes in schools and other settings such as domestic violence shelters, which made dealing with child abuse more difficult.

“I never heard before of any sessions held in schools, particularly for teachers for this purpose.” Participant (5), Social Worker

It was argued that teachers received no training in safeguarding, which in turn can have negative consequences for children. For this reason, it was highlighted that policy should drive school awareness programmes.

“Awareness is lacking. The awareness education programmes are supposed to spread in schools...including the teachers in the primary grades that should be a targeted group to assist in the discovery of abuse cases.” Participant (13), Director in Ministry of Education

Theme two: Organizational level concerns

Tied to the previous theme were local organizational issues that further impeded professionals' role in the child protection process. These included staff shortages among both health and social care staff, inflexible work schedules, obstacles from the administration, and high magnitudes of responsibilities. The lack of designated centres limited options for referral after the initial assessment.

“Honestly, we face problems when we try to treat the cases connected with shortages or non-availability of resources. Lack of resources such as available healthcare centres.”

Participant (7), Psychologist

“When they come at night time, no one will communicate with them...when they receive a case at night time, they should be told that they should come again in the morning.”

Participant (11), Co-ordinator of Child Protection Committee

Because of such limited resources, incidents reported during the night were usually left unrecognized and unresolved, without follow-up arrangements to establish whether these merited further investigation. Specifically, the participants felt that communication was a central issue. It is plausible, therefore, that these included some children with more serious injuries, who were brought to emergency departments 'out of hours'. A key challenge for staff was that child protection duties were often added on top of their existing and busy generic (e.g. social work or paediatrics) caseload, which meant that sometimes these were difficult to prioritize. For example, one participant shared their experience as a protection committee member, that these additional responsibilities were usually considered as secondary. Consequently, staff had to prioritize their full-time job responsibilities, thus leaving little to no time for safeguarding.

“There is a protection committee, but members who are in this committee have many other responsibilities...there should be an independent person with an office and telephone number that is just for him/her, in charge of child protection only.” Participant (21), Surgeon

The lack of a designated child protection budget is an aligned explanation for overburdened and underperforming staff. Most institutions would try to compensate for the lack of budget by increasing their employees' workload; thus, staff were expected to multi-task and to focus on more than one responsibility at a time. Consequently, certain duties - usually those related to child protection - were neglected. The proposed solution was to appoint a designated co-ordinator who could prioritize these responsibilities.

“There should be a responsible person in the hospital...so, there are no other duties of this person.” Participant (24), Psychiatrist

Overall, participants complained that there were no clear mechanisms and procedures they could follow. The roles of the Bureau of Investigation and of the judiciary usually took effect after the occurrence of the offence. In cases which posed high risk of further violence, practitioners needed to intervene early and refer the case to the Social Affairs Department for investigation. Staff should, therefore, be able to initiate timely procedures and refer such cases to the judiciary, if there were no concessions.

“I mean, we don't receive any cases at the preventative stage.” Participant (25), Head of Audit Office and Implementation, Prison Service

This agency usually received the case, whether domestic violence or other, only after the incident. When they sensed from the presented evidence that there was a need for preventive strategies, they instead tried to intervene early by transferring the case to specialists in social affairs or to the child protection committee. In terms of dealing with the police, some participants stated that they had developed a good relationship, and minimal difficulties were reported. Whenever the presence of the police was needed, the process involved writing an official letter to the police department, followed by which the police would file a report.

“There is strong co-operation between specialists and the police. It is easy to deal with them. We have freedom in reporting, even in the worst cases, and we find the police are consistently respectful and appreciative.” Participant (7), Psychologist

However, police were sometimes contacted prematurely, or even unnecessarily in the absence of clear procedures within the healthcare system. This increased the chance of rejecting cases.

“If police come in, then my role is ended.” Participant (22), Nurse

“Police do not take any action if there is just a report. The police movements may be slow because of the lack of situational background, whether it’s from the health sector or other authorities. The police lack the preventative side, nor full themed backgrounds.”

Participant (25), Head of Audit Office and Implementation, Prison Service

The lack of a co-ordinated approach to child protection, as well as of designated staff, meant that concerns often went unreported. Participants complained about the lack of regular meetings to discuss cases, available staff to attend these meetings, and co-operation with other institutions. In

addition, practitioners expressed concerns about their own protection in taking responsibility for reporting and dealing with child protection.

“In the last meeting, we were discussing the lack of co-operation from other hospitals with us in reporting cases. Also, there has been a debate about who will protect us if we report the cases, and because of this, cases are not reported.” Participant (1), Psychologist

Interdisciplinary working in any public sector environment is essential in maximizing its effectiveness and outputs. This is particularly important for the detection and management of child maltreatment, where communication of difficult issues and establishment of evidence are pertinent. Some participants highlighted the importance of having a good relationship with other agencies that would facilitate a supportive environment, wherein dealing with complex cases such as child abuse is not entirely the responsibility of a single person. Co-operation and a supportive atmosphere in some hospitals were identified as particularly important in addressing child abuse cases, although this was not consistent across all settings.

“Co-operation between specialists is essential for us, because it helps confidence grow in dealing with cases of violence. If there are cases of violence, we try to do above and beyond what our energy levels permit, by working hard to handle and treat the condition.”

Participant (7), Psychologist

“The hospital needs more publicity, and lots of work in term of co-operation is not 100%, say it is 50%.” Participant (21), Surgeon

Other participants complained about the lack of teamwork and communication among colleagues. This affected staff morale, as they felt that they were left on their own to deal with complex and

high-risk situations. As a result, some practitioners had to make potentially life-changing decisions without support. Such a risk had a direct impact on the practitioners and left them questioning their position.

“For me, I want to resign from them entirely. There is no co-operation among doctors or the people who are responsible for this hospital.” Participant (12), Psychiatrist

“I am feeling very unsatisfied, and it is unacceptable because of this whole situation...no response and no treatment. I tried to face many cases, and there are more cases that are worse that I didn’t talk about it...I tried, and fought to help kids who are exposed to violence, even if I don’t have the authority.” Participant (4), Psychologist

Some staff were fearful of adverse consequences if they reported sensitive cases, for which reason they sought reassurance from their organizations. However, so far neither the government nor the local authorities had legislated to protect practitioners who reported child abuse cases. Participants were further hindered in their reporting by operational policies. For example, they were often subject to prohibitions that would not allow them to gather sufficient evidence, if the case were to reach the courts. One participant reported that taking photographs of children was forbidden.

“In brief, I cannot do anything without the authority, unfortunately...the fact I cannot intervene, because I do not have sufficient authority to make the decision, means I cannot take any action.” Participant (4), Psychologist

Theme three: Interpersonal level (interaction between families and services)

Notably, systemic challenges at the societal and organizational level were reflected within the family, a unit which in the Saudi society may consist of one husband and up to four wives, due to

practiced polygamy. The family system can thus result in multiple incidents of domestic violence. However, most practitioners and the public remained unaware of the details and implications of recent legislation to protect abused women and children, hence they still could not take full advantage of it.

“People need to be full aware of the case situation to use these rules. It is good, but those who want to use it must be understanding of the situation, and for these systems to understand the situation of the community, must be open-minded. Its purpose in the liquidation of differences, has exploited some weak people to gain other purposes. It was developed to protect vulnerable people and reform society.” Participant (25), Head of Audit Office and Implementation, Prison Service

“Two married young ladies came to us who suffer from domestic violence.”
Participant (22), Nurse
Indeed, participants pointed out the well-established relationship between domestic violence and child maltreatment.

“Last time I had a case of a child and the child’s eye had come out. No one from his family wanted to tell me the truth, they said he fell down on a bottle. But it was obvious it was domestic violence, and the talk was not very logical.” Participant (21), Surgeon

“The perpetrators are usually brothers or fathers in the majority of abused female cases and sometimes the husband is the perpetrator for his wife.” Participant (14), Social Worker

Most family members would refuse to give any details about their children, or they would provide false information to conceal the truth from the practitioners for fear of being reported to the authorities. Although this pattern is not different to other countries, some mediating sociocultural

factors may be more specific to the Saudi society. Thus, the responsibility lies on the practitioner to extract the truth from the parents by utilizing the skills acquired from their training in investigating the incident without appearing accusatory in the absence of sufficient evidence.

“There are no parents that clearly admit that they abuse their kids.”

Participant (1), Psychologist

“A lot of children come to us and signs of abuse appear on them, but families refuse to give us any information.” Participant (21), Surgeon

As family relationships were different to those in western societies, participants highlighted that fathers frequently held the misconception that they owned their child or wife. For example, one interviewee argued that abusive fathers would sometimes justify their behaviour and refusal to report incidents on the grounds that family relationships should be kept private, and that the government and the health practitioners should not interfere in those.

“They say it’s not your business, this thing between me and my wife, or between me and my child.” Participant (22), Nurse

To that effect, practitioners who dealt with abused children reported being pressurized by families to maintain confidentiality as an excuse of avoiding responsibility and facing consequences. They were thus often expected to keep information to themselves rather than report it to the authorities.

“The biggest problems we face are with parents. In some cases, there are young girls seeking to make a complaint, but parents interfere. The father and brother threaten the girl to prevent her from making a complaint.” Participant (7), Psychologist

“I face a problem when I tell the parents that I need to record the case...they refuse to co-operate with me. As such, I cannot deal with them.” Participant (3), Psychiatrist

Children’s powerlessness and fear to disclose abuse were highlighted, as in any other society. While the societal, community, and systemic levels of the template were broadly discussed, the individual level of concern for implementation was considerable in terms of the content and volume of the quotations. Participants noted that there were important factors related to the child that mattered in terms of implementing the training, which were intrinsically tied to the broader family; that is, the child was viewed as the focal point for the relevance of implementation. One emerging culture-specific issue was family honour.

“This child is possibly afraid of his family and afraid of punishment in the case where he confesses, so their refusal to talk may have an impact on the psyche in the future without knowing their family...the child has become anxious of the society around him, and dreads and fears everybody around him/her.” Participant (14), Social Worker

“There were a few cases involving issues of honour.” Participant (7), Psychologist

Similar connections were made in relation to gender issues, as also already raised under Theme One. These were perceived as barriers by practitioners in dealing with abuse cases in isolation from wider sociocultural beliefs, or from addressing with the family.

“Sometimes, the father brings the child and leaves the child with us, and doesn’t appear again. For example, a father once brought his child to us, and he was unclear with us by saying the mother was not present and did not exist. There are many circumstances of the case he does not want to disclose. The case involved a girl between the ages of 9 to 10 years old.”

Participant (11), Co-ordinator of Child Protection Committee

“We try to work hard to help, but there are some cases where we are unable to intervene, because of the threat from parents. The victim cannot complain because of the pressure from parents - even the police are unable to intervene.” Participant (7), Psychologist

Risk was higher for more vulnerable groups such as younger children and children with disabilities. This was attributed to their perceived weaknesses and dependency on adults. Another reason was negative child rearing attitudes and practices in managing challenging behaviours that resulted in physical abuse. Lack of integrated supports for both prevention and intervention were challenges for child protection staff.

“What people usually do: they don’t confess and say the truth, especially when the case is a child...what makes it worse is when the child cannot express what has happened.”

Participant (4), Psychologist

“In the case of special needs, it is more sensitive, and more individuals with special needs are exposed to abuse.” Participant (5), Social Worker

“I received one psychological outline of a 13-year-old girl, her teacher was making fun of her in school... the girl does not speak at all, despite her ability of speech. Using an IQ test, I discovered that her intelligence is actually very high, although her father was convinced that his daughter was mentally retarded. All these issues were because of her teacher in primary school.” Participant (4), Psychologist

Concurrent social and mental health difficulties were observed, which necessitated access to mental health services, with positive signs of some units aiming to provide a co-ordinated

response, although this was not automatically translated to frontline integration. This fragmentation was particularly prominent in cases of deliberate self-harm.

“We deal with all children cases that are referred to us, such as cases with incurable learning difficulties, or psychological cases involving isolation, introversion, shyness - all types of cases that need our help or support. We have members from the mental health and special needs education committees. We have a comprehensive and integrated unit.”

Participant (13), Supervisor, Ministry of Education

“There was a 7-year-old child who came to us directly through the Emergency Department by the school after attempting suicide.” Participant (16), Nurse

“There were attempted cases of suicide, we receive abuse cases in the hospital not on a daily basis, but they come in from time to time.” Participant (14), Social Worker

Due to the structure of the Saudi household, other members such as housemaids can also be positioned as perpetrators of violence. Thus, in any implementation of child protection training, practitioners needed to account for the extended household and potential implications.

“Abuse from maids, these are the majority of cases in our hospital...faced one case, this case involved an individual suffering from depression. We found an intense of fear in this case with regards to the maid.” Participant (5), Social Worker

Discussion

The key overarching finding of this study was that the implementation of child protection and safety training should reach well beyond the transfer of knowledge and acquisition of skills, as this cannot be disentangled from wider societal, policy, organizational and operational issues. This is

particularly prominent in countries like Saudi Arabia, with relatively new child protection systems. Adopting a holistic framework in integrating child, family and community-related needs can thus be useful to national organizations at their early stages of development. Although most findings on procedures, co-ordination and inter-agency working are fairly universal, there are additional culture-specific implications related to beliefs, family status and gender. All these levels need to be anticipated and incorporated into future child protection training, rather than only focus on procedural, assessment and intervention issues, especially in similar sociocultural contexts. In this context, it is important to highlight the difficulty in disentangling the implementation of training from wider changes that are well beyond the nature of workshops and other educational forums, and which were often intermingled in participants' reports.

Several encouraging conclusions should be acknowledged on the impact of this relatively new training programme. These relate to its interdisciplinary constitution at different skills levels; reaching a large number of practitioners, managers and administrators; the emerging body of evidence to inform its future planning; the wide geographical spread and systematic selection of trainees; and the gradual incorporation of both child protection and domestic violence, although admittedly participants predominantly focused on child protection issues (Almuneef and Al Eissa, 2011). Nevertheless, several key barriers were also raised, which merit in depth consideration.

The overall lack of 'readiness' (Almuneef et al., 2014) of society was demonstrated through denial of abuse, taboos, fear of challenging predominant beliefs (Cameron et al., 2018), family structure - namely polygamy, and the perceived role of women (Afshar, 2016). These effects were evident throughout the reporting, assessment and intervention process, continuously

hindering practitioners' attempts to engage with families, in order to protect vulnerable children and women. Clearly these issues cannot be tackled in isolation, instead they require multiple and integrated strategies at policy, media, public and service level. It is plausible to assume that such beliefs exist within central and local government systems, thus they need to be worked through and be articulated consistently, before being translated to policy and operational guidelines.

Ongoing awareness and education should target different groups, including practitioners and teachers, who were also reported to demonstrate negative or punitive attitudes. Active involvement of community and religious leads and mediators is important in this process, and will help identify adaptation to training according to cultural and socioeconomic differences within the country (Daro and Dodge, 2009). Studies in other contexts around the world such as Africa (Morantz et al., 2013), other Middle Eastern countries and Kulczy, 2008) (Boy and Southeast Asia (Rafferty, 2007) have shown that awareness, prevention and intervention initiatives within communities proved effective over time to tackle similar sociocultural barriers.

These challenges can permeate everyday practice in terms of contacts with families in hospital settings and the community, establishing and corroborating evidence, reporting, and setting up care plans. Practitioners often felt overwhelmed because of lack of support, including a legal framework when threatened by suspected perpetrators. Their position was further undermined by the lack of clarity on their role, procedures, care pathways, jurisdictions, co-ordination, designated budget and resources. Such barriers often hindered the instigation of early intervention. Lack of communication and collaboration among various disciplines and organizations have sometimes resulted in fatal outcomes in societies with well-developed safeguarding systems (Elliott, 2009). These findings support the importance of linking

legislation, policy, service structures and safety procedures; and in addressing those throughout the training, in the presence of all responsible bodies, who can thus directly hear trainees' testimonies. Despite the interdisciplinary nature of the training programme and the sample of this study, inter-agency working was not usually evident in participants' experiences. This can fragment further care plans, as well as disengage families without offering parallel support and other family-focused interventions. The same applies to involving schools, community agencies and child mental health services, in developing both responsive and preventive strategies.

The findings also need to be interpreted with caution, because of certain limitations. The sample may not be generalizable to other regions of Saudi Arabia, or indeed to other Middle East countries with different sociocultural and religious profiles, as well as to child safeguarding systems at different stages of development. It would have been useful to corroborate participants' perspectives with quantitative service activity data on their practice, and on the potential impact on child and family outcomes. There were limited quotations on domestic violence, with participants predominantly focusing on child protection issues. This possibly reflects the limited policy and service attention on domestic violence. Future research should aim to understand more similarities as well as differences in implementing child protection and domestic violence policies on the ground, before addressing the emerging findings in developing integrated training programmes.

Overall, the findings contribute to the evidence-based development and evolution of child and family safeguarding programmes in societies at early stages of readiness and awareness, hence not accessing adequate and integrated support systems. By interviewing participants 18 months

after they had undergone the training, we were able to explore their experiences on the ground over a longer period, in addition to establishing their perceived knowledge and skills. The findings can thus be of value to training programme developers in similar contexts (O’Leary et al., 2018). The key messages are the need to link training with ongoing changes in policy, legislation, service development and procedures; and its integration with ongoing awareness and education in tackling wider beliefs that can place children at risk or hinder their protection.

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